ESSAYS IN CRIMINAL AND FORENSIC PSYCHOLOGY NO.7

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CONTENTS

ISBN: 978-1-904542-62-9

1. A COMBINED MODEL TO EXPLAIN MASS MURDER

1.1. MASS KILLERS

Serial killers murder several people over a long period of time, whereas individuals who kill many people in a single event [1] are known as mass murderers or spree killers ("multiple victims in more than one location") (Jager 2004).

It is often assumed that mass murderers are a relatively new phenomenon with all the media interest that surrounds them. But multiple killings, often called massacres, have occurred throughout history.

Today the focus is upon the lone individuals with firearms, though other methods of killing have been used as well [2]. For example, Hickey (1997) recorded 32 cases in the USA between 1949 and 1996 (table 1.1). Crook (1998) listed twenty-five events between 1971 and 1997 in Australia.

YEAR	OFFENDER	DEATH TOLL
1949	Howard B. Unruh	shot 13 neighbours
1966	Charles Whitman	shot 16 bystanders
1986	Patrick Sherrill	shot 14 co-workers
1991	George Hennard	shot 23 in restaurant
1996	Joshua Jenkins	beat/stab 5 family members

(After Hickey 1997)

Table 1.1 - Selection of mass murderers in the USA, 1949-1996.

In the UK, two cases are prominent in the late twentieth century:

- Hungerford, Berkshire, England where on 19 August 1987, 15 strangers and his mother were killed by Michael Ryan

[1] Usually three or four minimum (Jager 2004).

[2] Terrorist attacks tend to be overlooked here and/or classed as a separate category.

ISBN: 978-1-904542-62-9

(before his suicide) [3].

- Dunblane, Scotland (13 March 1996) Thomas Hamilton killed 16 children and 1 teacher at school before killing himself [4].

In attempting to explain the behaviour of spree killers, explanations tend to be individual or social-based [5]. The former looks for individual characteristics that such perpetrators have in common that make them different to the general population, while social-based explanations focus upon changes in society, for example, that account for such behaviour. In reality, the explanation for why a particular individual behaves in this way is a combination of both. The individual is both the same as others, but different to them; the individual has both specific characteristics and common social patterns.

1.2. CHARACTERISTICS OF PERPETRATORS

Attempts have been made to establish the common characteristics of the perpetrators. They are usually male with no previous criminal conviction and no psychiatric problems (Jager 2004). This latter point is important because the media portrayal is that of a "mad man", a "psycho", or a "nut" (Jager 2004).

The perpetrators are socially isolated with poor relationships and little intimacy (Cantor et al 2000).

Meloy et al (2001) divided 34 adolescent mass murderers in North America into three groups - family annihilator, classroom avenger, and criminal opportunist. Most individuals were "loners" with a history of depression and/or anti-social behaviour including alcohol and drug abuse. Themes of control and anger were also involved. There was a key precipitating event that triggered the murders.

However, care should be taken about classifying different individuals as a similar type or category, and in simplifying complex motivations into easy answers. Also Jager (2004) noted that there are "many different offender characteristics separating a parent who undertakes a murder-suicide with multiple homicide

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[3] Details on events at http://news.bbc.co.uk/onthisday/hi/dates/stories/august/19/newsid_2534000/2534669.stm.

[4] Details on events at http://news.bbc.co.uk/onthisday/hi/dates/stories/march/13/newsid_2543000/2543277.stm.

[5] Individual-social dualism (Hollway 2007).

victims and a perpetrator of a massacre where strangers are the predominant victims. Both are mass murders as currently defined" (p409).

1.3. SOCIAL CAUSES

Collier (1997) noted how the media presented Thomas Hamilton after the Dunblane killings using "the vocabulary of evil". But with such language "Hamilton is transformed into something 'beyond human', his actions emblematic of an inhumanity beyond comprehension and understanding" (Collier 1997 p180). However inexplicable a crime appears, it does not happen in a vacuum and there is a context to the actions.

Hamilton was presented in juxtaposition to the "ordinary people" of the town - he was evil, they were good. "The dominant image of the community of Dunblane itself as embodiment of comfortable, crime-free existence rests upon, and derives from, a heterosexual familial frame signified as such by virtue of the presence of children. Dunblane is presented as a place where 'families moved' and where 'children would be safe'" (Collier 1997 pp182-183). In this context, Hamilton was an outsider as a single (unpartnered) man - "within the present reconfiguration of the familial, the figure of the single male outsider has increasingly come to appear as an embodiment of social disorder, normlessness, and dislocation" (Collier 1997 p183).

Yet he was, in contradiction, a member of the community. He "was not a loner at all. He was the exact opposite. He wanted to run boys clubs. He wanted to run Scout camps. He belonged to a gun club. He wrote peeved letters to everyone. He had his own business. Lots of people knew him. Some loner" (Guardian newspaper, 13 July 1996 quoted in Collier 1997 p184).

Collier (1997) placed the emphasis on the fact that spree killers are male, and what that says about the construction of masculinity, in particular the reaction of violence and destruction.

Whatever the common characteristics of spree killers, they are presented in varying ways as "social failures" - loner, desire for revenge, desire for status, "odd but not mentally ill", unable to communicate emotions, problems with anger. Other than the search for individual characteristics of spree killers, the features of "social failures" are features of the "crisis" in masculinity today (Collier 1997).

Hamilton can be seen as attempting to "masculinise himself within the ideals of traditional heterosexual masculinity" through key activities in his life - participation in youth clubs, and his involvement with

firearms and gun clubs. These were combined "in his ultimate invasion, re-framing, and destruction of the largely feminised space of the Primary School at Dunblane which resulted in the death of sixteen children and their teacher" (Collier 1997 p192).

Newman (2004) in exploring the "rampage" school shootings in the USA also accepts the role for the perpetrators as males struggling to live up to masculine ideals, But, for her, this is one factor of many. Most of the 25 rampage shootings in the USA between 1974 and 2002 [6] that she studied took place in relatively stable small towns not inner city deprived areas. Such environments with close knit families and networks of friends leave few options for individuals who do not fit in and/or who find themselves the focus of bullying.

Thus the shooter perceives themselves as marginalised. This is one of five "necessary conditions" for rampages. Secondly, there is a "cultural script" that places violence as high status for men. Added to these two factors are psychological problems/vulnerability of the individuals, access to weapons, and the failure of others to see the warning signs (Davies 2005).

1.4. COMBINING EXPLANATIONS

I (Brewer 2003) proposed a synthesis model to explain aggression, and this can be applied to spree killers.

The model contains two elements (figure 1.1):

i) The general level of aggression of an individual, which is a combination of individual, group, and social factors.

ii) How this general level is converted into a specific act of aggression. The main factors involved here will be disinhibitions, and/or environmental triggers.

Table 1.2 gives some examples of elements of the model from spree killers.

[6] The best known being at Columbine, Colorado on 20 April 1999 where 12 students and 1 teacher at school were murdered by Dylan Klebold & Eric Harris before killing themselves.

ELEMENTS OF MODEL	EXAMPLES
Individual level	Eg: personality characteristics: Often reported as "loners" having psychological problems (eg: paranoia, depression), and repression of anger.
Group level	Bullying, problems with peer relationships at school, and family problems.
Social level	Spree killers are male and construction of masculinity, and "cultural scripts" about violence for men.
Environmental triggers	Factor(s) that precipitate spree on particular day. Eg: Michael Ryan - doting mother going to job interview (Badcock 2004). Eg: Jeff Weise suspended from school (Buncombe 2005).
Disinhibitors	Factor(s) that reduce inhibitions of doing behaviour (eg: alcohol; feelings of not left to lose).

Table 1.2 - The synthesis model of aggression as applied to spree killers [7].

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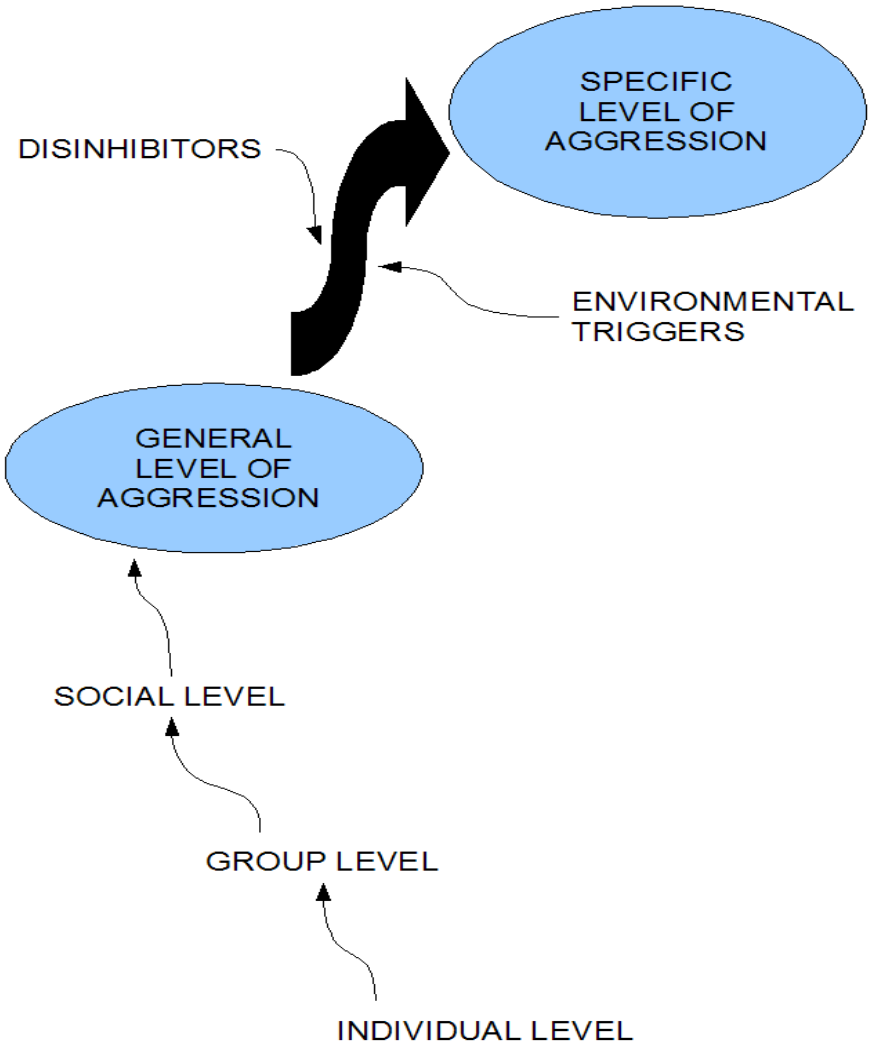

Figure 1.1 - Synthesis model of aggression.

ISBN: 978-1-904542-62-9

2. "KNIFE CRIME" IN ENGLAND TODAY

2.1. INTRODUCTION

"Knife crime" is a commonly-used phrase in England in recent years. It describes the carrying and use of knives, predominantly by teenagers and young people, and the consequent risk of stab wounds (fatal and non-fatal). As with any frequently reported aspect of crime, the question is whether there is a genuine problem or that it is a product of increased media attention (sometimes called a "moral panic").

Media reports often quote surveys, which vary in their methodological soundness. For example, simply asking an individual if they have carried a knife in the last month can ignore the frequency of the behaviour and the type of knife carried (eg: penknife).

The first problem when trying to accurately measure a criminal or deviant act is the definition of terms. "'Knife crime' potentially encompasses a very broad range of offences and thus causes problems in both the definition and determination of its prevalence. Clearly, the production of a knife in the commission of a crime, such as in a robbery or sexual assault, even if not used to cause injury, is a 'knife crime' under any interpretation. But it is less clear whether the term may also be accurately applied to, for example, a burglary during the course of which the perpetrator is arrested and found to be in possession of a knife which was never produced or used" (Eades et al 2007 p9).

Narrow definitions might only include offences where an individual is stabbed, while wider definitions would include an offender having a knife on their person if it was not used. Garside (2004) noted that "Seeking a definitive figure for crime levels is akin to asking how many headaches there are, or how many beetles. Though in principle, and given perfect knowledge, the question is answerable, in practice no definitive answer is possible" (quoted in Eades et al 2007 p9).

2.2. MEASURING THE "HOW MUCH"

Data about crime comes from three sources, each with strengths and weaknesses (table 2.1):

ISBN: 978-1-904542-62-9

- Official police statistics (known as "recorded crime").
- Victim surveys, like the British Crime Surveys (BCS) [8].
- Offender surveys.

	STRENGTHS	WEAKNESSES
Police	1. Official figures of "notifiable crimes". 2. Extensive collection of data.	1. Only reported crime. 2. Only those recorded by police (eg: not recorded as viewed too trivial).
Victim	1. Sampling of households - eg: BCS interviews 47 000 people. 2. Individuals will report experiences of victimisation, even those not reported to police.	1. Depends on sampling process - eg: BCS only samples private households. 2. Depends on honesty of respondents.
Offender	1. Sampling of individuals to see who has committed offences. 2. The anonymity will encourage individuals to admit to undetected offences as well as detected ones.	1. Very dependent on honesty of respondents. 2. Depends on sampling process.

Table 2.1 - Main strengths and weaknesses of three sources of data on crime.

1. Knife carrying

The Youth Justice Board Youth Surveys (YJB-YS), which question large numbers of 11-16 year-olds (over 5000) every year in England and Wales, found that one-third of respondents reported carrying a knife in the last twelve months in 2005. This was an increase from 20% in 2002 (MORI 2006). However, the wording of the question varied between surveys which limits the comparability of findings (Eades et al 2007).

When the respondents are asked about the type of knife, as in 2004, 9% of them said a flick knife, 5% a kitchen knife, and 25% a penknife. These figures are higher for individuals excluded from school (30%, 16% and

- [8] Details at http://www.statistics.gov.uk/ssd/surveys/british_crime_survey.asp.

ISBN: 978-1-904542-62-9

46% respectively) (MORI 2004).

The Offending, Crime and Justice Surveys (OCJS), undertaken by the Home office, questioned 5000 10-25 year-olds living in private households in England and Wales. The 2005 survey found that 4% of respondents had carried a knife in the previous twelve months, of which the majority were penknives (41%), and most carried the knife rarely (50% "once" or "twice"). Only 10% of knife-carriers had a kitchen knife, and 16% of the total carried their knife "ten times or more" in the year (Wilson et al 2006).

Though the figures are drastically different, the YJB-YS and OCJS are not comparable because of the different age groups sampled and methodologies used (Eades et al 2007).

2. Use of knives in crime

Knives can be used as threats or as part of the physical violence during a crime. Analysing data from ten years of the BCS, Eades et al (2007) reported little change in the use of knives in that period. The figure was stable at between 3-9% of all violent crime reported by BCS respondents (ie: victims). There were increases and decreases over the period in different categories (eg: knife use in domestic violence), but no changes were significant.

3. Deaths caused by the use of knives

The Home Office's Homicide Index records all suspected homicides in England and Wales. In 1995, 37% of victims were killed by a "sharp instrument". Sharp instruments include objects like glass and screwdrivers as well as knives, and there is no separate category for knives. By 2005-6 the figure was 28% (Eades et al 2007).

Despite the weaknesses of the methodology of data collection, it does appear that "knife crime" is relatively small in scale and not increasing in recent years.

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ISBN: 978-1-904542-62-9

3. MEASURING THE TRUTH OF COGNITIVE DISTORTIONS BY CHILD SEXUAL OFFENDERS

3.1. COGNITIVE DISTORTIONS

Child sexual offenders often show cognitive distortions (ie: distorted beliefs) that justify their behaviour. Abel et al (1984) described seven basic categories of cognitive distortion:

i) The child not refusing is taken as a sign of being a willing sexual partner.

ii) The educational value of adult-child sex.

iii) Children keeping the abuse secret is a sign that they enjoyed it.

iv) In the future, adult-child sexual behaviour will be acceptable.

v) Non-penetrative sexual abuse is not harmful to the child.

vi) The fact that children ask sexual questions is because they want to experience sex.

vii) Having sex with a child strengthens the emotional bond between the adult and the child.

Other categories of cognitive distortion have subsequently been added (eg: "lots of people do it so it can't be all that bad"; "I can't control myself so I'm not responsible") (Gannon et al 2007).

3.2. MEASURING COGNITIVE DISTORTIONS

Cognitive distortions have been measured in different ways, but the issue, in each case, is whether the measurement is accurate.

ISBN: 978-1-904542-62-9

1. Psychometric questionnaires

These structured questionnaires ask individuals to rate their agreement with a series of statements. Total scores can be used to distinguish between offenders and non-offenders. This is quantitative data.

For example, the Abel and Becker Cognitions Scale (ABCS) (Abel et al 1989) contains 29 items, like "When a young child has sex with an adult it helps the child learn how to relate to adults in the future". The scores on the ABCS can distinguish between child sexual offenders and controls, but has been criticised as not able to distinguish between adult and child sexual offenders (Gannon et al 2007).

Such questionnaires are dependent on the honesty of answers whether it be a deliberate lie to deceive or a socially desirable bias to maintain impression management (though both are technically the same - falsehoods), or an "honest liar" (ie: the individual is unaware of their beliefs).

Psychometric questionnaires do allow the comparison of groups across situations and time, and usually have good reliability and validity.

2. Analysis of offence-supportive statements

Offenders are asked to talk or write about their offences, and then it is analysed for cognitive distortions. In methodological terms, this is quantitative data analysis.

For example, Hartley (1998) analysed the comments made by incest child sexual offenders for justificatory themes. These were intended to reduce the responsibility for the behaviour - eg: the child was in control ("I only did what she would let me do"), and the child was not harmed ("If it was really that much bothering her, why would she lay down without being asked") (Gannon et al 2007 p408).

This technique allows the offender to freely talk about their behaviour, but Gannon et al (2007) noted that there is "no reliable way of knowing which statements truly reflect offence-supportive belief structures and which statements reflect normative post-hoc impression management strategies" (p409).

3.3. HONESTY OF REPLIES

"Perhaps the most important problem associated with self-report scales lies in the difficulty of determining

the extent to which participants shape their responses to create a favourable impression of themselves" (Sutton and Farrall 2005 p212).

One way used to deal with this problem is to include "lie scales" in questionnaires. These measure the tendency to respond in socially desirable ways. Questions are asked, like "I have never been annoyed with an opinionated person", where agreement is socially desirable but probably not true, or where disagreement is socially desirable (eg: Have you ever taken anything (even a pin or button) that belonged to someone else?") (Sutton and Farrall 2005) [9].

An example of a well-known lie scale is the Marlowe-Crowne Social Desirability Inventory (Crowne and Marlowe 1960), which has 33 items answered true or false (table 3.1).

- I never hesitate to go out of my way to help someone in trouble.
- Before voting I thoroughly investigate the qualifications of all the candidates.
- On occasion I have had doubts about my ability to succeed in life (*).
- I sometimes feel resentful when I don't get my way (*).
- I have never intensely disliked anyone.

(* disagreement = socially desirable answer)

(Source: Paulhus 1991)

Table 3.1 - Examples of items from Marlowe-Crowne Social Desirability Inventory.

3.3.1. Bogus Pipeline

An alternative to lie scales that has been used in order to reduce socially desirable answers in attitude research is known as the "bogus pipeline" (BPL) technique (Jones and Sigall 1971). This involves making the respondent believe that the researcher can tell if a lie is being given to a question. It might include telling participants that non-verbal cues are accurate signs of truth-telling, or using previously (or covertly) acquired information about the respondent. The respondent is attached to a machine measuring physiological changes that participants are led to believe is an accurate lie-detector.

[9] Of course lie scales are flawed if answered by "good" individuals who do genuinely never get annoyed with opinionated people, for example. There may also be individuals able to recognise the lie scale questions and answer them in non-socially desirable ways, but give socially desirable answers on the other questions.

The use of the BPL technique peaked in the late 1970s and early 1980s, and waned in the 1990s (Roese and Jamieson 1993). Roese and Jamieson (1993) distinguished three waves in its use:

- 1st wave (1970-1974) - BPL used to study racism mainly.
- 2nd wave (1975-1981) - BPL extended to study other attitudes.
- 3rd wave (1982-1991) - Extended use of BPL in different areas of study (eg: drug use).

In the traditional BPL design, a participant is shown an impressive machine for measuring physiology which is introduced as able to ascertain "true" attitudes. These claims are supported by questioning the participant and highlighting false answers based on information collected about them at an earlier point in time (eg: apparently unrelated questionnaire). Once the machine's ability is established in the mind of the participant, they are asked about their attitudes on the topic of the study.

Using the BPL with child sexual offenders, Gannon (2006) asked a small group of extra-familial offenders (ie: victims outside family) to fill out a psychometric questionnaire, and found that many of them disagreed with cognitive distortion statements. A week later the same individuals were asked similar questions while attached to a fake lie detector. Surprisingly, the answers did not change much. The participants did believe in the lie detector's credibility. These findings suggest that child sexual offenders were not altering their answers to questionnaires, but that their beliefs were so implicit that they were not fully accessible to the conscious mind.

Other studies have found differences between answers to pen and paper questionnaires, and answers using the BPL technique, particularly among intra-familial child sex offenders (Gannon et al 2007).

General Evaluation

1. Does the BPL work? In other words, is it a valid measure of honest attitudes? This is difficult to answer because it is hard to obtain objective information to know if the participants are giving their "true" attitudes. So indirect evidence of validity is where the participants "shift toward more negative responses.. because social desirability biases are usually presumed to engender more positive self-reports" (Roese and Jamieson 1993 pp364-365).

However, a negative presentational bias might occur

ISBN: 978-1-904542-62-9

where participants unconsciously produced negative self-reports because of the expectations of the situation ("demand characteristics") rather than their "true" attitudes (Arkin 1981). In a meta-analysis of studies comparing BPL to self-report questionnaires, Roese and Jamieson (1993) found significantly less socially desirable responses with BPL.

2. The BPL involves individually testing participants which limits its use with large numbers of people (Ostrom 1973).

3. Ethical issues

i) Deception.

ii) It restricts the freedom of participants not to self-disclose information which is possible with traditional questionnaires.

There has been a debate about the use of BPL throughout its history. The two sides of the debate can be summarised thus:

> The first side of the debate argues against using the BPL. This side argues that the BPL is a unique deceptive research method that involves actively lying to participants, forcing them to disclose information that may be personal or sensitive, preventing participants from freely withdrawing, and generating an image of psychologists as people who regularly lie. Therefore, this position argues that the BPL should never be used because it violates participants' dignity, privacy, and autonomy; and because it risks losing the trust and respect that participants have in the experimenter and in the field of psychology. The other side of the debate favours using the BPL. According to this second position, the BPL would be justified if the benefits outweigh the costs to participants
> (Aguinis and Henle 2001 p355).

Aguinis and Henle (2001) found that students tended to support the latter view when 180 of them at universities in Colorado, USA were given descriptions of BPL studies to read. "Although they might experience some unpleasant emotions when exposed to the BPL, potential participants believed that the studies using the BPL should have been conducted and that their benefits outweighed the costs" (Aguinis and Henle 2001 p352). Of course, the participants may have been giving socially desirable responses! There is an irony that researchers

will believe participants when they want to and not in other situations.

3.3.2. Implicit Association Test

The Implicit Association Test (IAT) (Greenwald et al 1998) is a computer-based test using response times to pressing certain keys when words appear on the screen. Pairs of words (which contrast like dog and spider) are presented on the screen, and the task is to press a right side key for dog or pleasant words and a left side key for spider or unpleasant words. The keys are then changed, so that right is for dog or unpleasant and left for spider and pleasant, and the same words are presented again.

If the participant is slower in their reaction time in the second version (ie: spider/pleasant and dog/unpleasant) compared to the first version, this is taken as evidence of an implicit positive attitude towards dogs relative to spiders.

Applied to child sexual offenders, such individuals should respond quicker to pairings like children and sex words (eg: "school", "climax") than to children and non-sex words (eg: "school", "book") or adult and sex words (eg: "mature", "climax"). Studies have found these differences (Gannon et al 2007).

Though this technique is able to discover implicit attitudes (ie: deliberately hidden or unaware), there are general concerns about its validity (Brewer 2008).

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4. PARAPHILIAS AND CO-MORBIDITY

4.1. PARAPHILIAS

Paraphilia is the sexual arousal to unusual objects or situations, and is based around three types in DSM (Clark 1995):

- Non-human objects - eg: rubber fetish.
- Suffering and humiliation - sadism and masochism [10].
- Non-consenting partner - including rape/sexual violence, and children (paedophilia).

The last type tends to include sexual offenders (ie: illegal behaviour) more than the other two.

Based on the work of sexologist, John Money, Feierman and Feierman (2000) distinguished six groups of paraphilias (many of them very rare) (table 4.1).

4.2. CO-MORBIDITY

Some individuals are diagnosed with co-morbid disorders. This is "when the client's problems include clear evidence of symptoms that meant the diagnosis criteria for more than one identifiable disorder" (Marshall 2007) [11]. But there is always the question of

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[10] The terms "sadism" and "masochism" were first coined in 1886 by Baron Richard von Krafft-Ebing in "Psychopathia Sexualis". Then Sigmund Freud combined the terms into "sado-masochism" (Langdridge 2006).

Hopton and Hopton (2001) defined sado-masochism (SM) as "consenting adults causing each other physical pain for the purpose of sexual gratification and/or acting out scenarios wherein sexual arousal is heightened by the anticipation and/or realisation of ritualised dominance of one party by the other" (p18).

"A considerable amount of the research conducted to date has started with the assumption of pathology, conflated consensual and non-consensual practices and focused almost exclusively on clinical cases. There is no doubt that the voices of the medical and legal professions have, for the last hundred years, drowned out the voices of those actually engaged in such practices and constructed a psycho-medical SM subject that bears little relation to the people in SM communities engaged in these practices" (Langdridge 2006). This has led to some practitioners using the term "erotic power exchange" (EPE) as an identity as opposed to SM which is explicitly sexual and has the generally negative social meanings associated with it (Langdridge 2006).

[11] "It is not enough to have some features of another disorder or to have at one time displayed some features of another disorder. To receive a diagnosis of any disorder, a client must clearly meet the minimum requirements (ie: display the minimum criteria) of a given a diagnosis" (Marshall 2007 p23).

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TYPE	DESCRIPTION	EXAMPLES
Sacrificial/ expiatory	Sexual arousal related to danger and power	Asphyxiophilia (self-strangulation) Sadism Masochism Bondage
Marauding/ predation	Sexual arousal related to forbidden love or imposed by force	Biastophilia (rape) Hybristophilia (sexual arousal with partner known to have committed crime)
Mercantile/ venal	Sexual arousal related to payment for sex	Chrematistophilia (payment for sex) Troilism (observing partner with another person who has paid for that pleasure)
Fetishistic/ talismanic	Sexual arousal by object	Hyphephilia (fur, leather) Transvestism(pleasure from wearing clothes of other sex)
Stigmatic/ eligibilic	Sexual arousal of "unusual" partner	Paedophilia (child) Necrophilia (corpse) Gerontophilia (age of own grandparent) Zoophilia (animal)
Solicitational/ alluritive	Sexual arousal focused outside intercourse	Exhibitionism (causing shock by exposing genitals) Telephone scatophilia ("dirty phone calls") Voyeurism (risk of being discovered while watching others having sex)

Table 4.1 - Categories of paedophilia.

whether co-morbidity is "the co-occurring of multiple mental disorders or the presence of one disorder that is being given multiple diagnoses" (Widiger and Coker 2003 quoted in Marshall 2007 p22).

Co-morbidity in sexual offenders (eg: paedophiles) can include multiple paraphilias or paraphilia with another mental disorder.

In the first case, convicted sexual offenders can be asked about other paraphilias. But because these behaviours may be illegal, the offenders must have a guarantee of anonymity. Abel et al (1988), in the USA, obtained such a guarantee from the Federal Bureau of Investigation (FBI). They found that 61.1% of paedophiles with female victims had three or more additional paraphilias compared to 54.2% of those with male victims. While 55.5% of rapists had three or more additional paraphilias. This study did not use DSM criteria for paraphilias (Marshall 2007). Also as with all self-reported questionnaire it relied on the honesty of the replies.

In terms of co-morbidity of offending against children and adults, Bradford et al (1992), for example, found that 23% of pre-pubescent child molesters had sexually assaulted an adult and 34% of post-pubescent child molesters. The offenders were not given guarantees of confidentiality (Marshall 2007). Marshall et al (1991) found that few offenders had multiple paraphilias.

Concerning co-morbidity of paraphilia and other mental disorders, studies have found varying numbers - eg: 3% of sexual offenders had mood disorders (Seghorn et al 1987) through to 95% (Kafka and Prentky 1992). While Levenson (2004) found that 7% of 450 sexual offenders had more than three other diagnoses.

In a large-scale Swedish study, nearly a quarter of 8596 sexual offenders were in-patients at some time between 1988 and 2000 for a co-morbid psychiatric diagnosis compared to co-morbidity of mental disorders in 5% of the general population sample (n = 19 935)(Sjostedt et al 2003 quoted in Marshall 2007) [12]. Because the data used were in-patient records they may be underestimates of the prevalence (Marshall 2007).

Co-morbidity may also occur between paraphilia and personality disorders. For example, 52% of sexual offenders had any personality disorder, and one-third of the offenders had anti-social personality disorder (Firestone et al 1998) [13].

Marshall (2007) observed that:

> Overall, sexual offenders appear likely to have a number of associated problems many of which reach the criteria for a diagnosable disorder. These co-morbid disorders are in some instances so intimately associated with the sexual offences that specifically treating the co-morbid disorders of these clients reduces their sexually deviant inclinations and makes them more tractable in treatment; this may be particularly true of psychotic disorders and perhaps mood disorders (p26).

[12] The odds ratio was 6.3 (ie: six times more likely to be hospitalised for mental disorder and have committed sexual offence than general population) (Seena et al 2007).

[13] Different categories are used for sexual murderers. For example, Hill et al (2006a) made the distinction between sexual sadistic murderers (SeSa) and non-sadistic sexual ones (NSaSe). The former showed sexual masochism, sadistic personality disorder, childhood isolation, multiple sexual homicide, previous rape, chronic lying, and attention deficit hyperactivity disorder among other characteristics.

Multiple sexual murderers show differences to single homicides in being higher scoring on measures of psychopathy as well as other personality disorders (Hill et al 2006b).

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5. STUDYING THE MENTALLY DISORDERED OFFENDER

5.1. INTRODUCTION

The mentally disordered offender (MDO) is an individual who commits a crime while being mentally ill. In simple language they are mad and bad as opposed to "normal" criminals who are just bad.

If a crime is committed by an individual suffering from mental illness, then they are treated differently in the criminal justice system. There are variations between different countries, but the issues tend to be whether the individual is fit to stand trial, and how to punish them if found guilty. In most cases it involves being sent to secure psychiatric hospitals. The aim being to both punish (prison element) and to treat them (hospital element).

MDOs who are convicted of a serious offence and/or are viewed as a high risk to others are placed in high security (special) hospitals in the UK. Less serious MDOs are detained in medium or lower secure units.

MDOs are not a homogeneous group in terms of their mental disorders, their crimes, and their experiences in the criminal justice system. The three studies below give a flavour of this, and of the different methods of study.

5.2. GENDER DIFFERENCES IN RE-CONVICTION

Many studies are limited to small numbers because of the time and/or money available to researchers. Statistics collected by official bodies, like government departments, are less restricted by these factors, and can include details of a whole cohort. A cohort is a specific group of individuals being studied. The important point is that it is the whole group, not a sample (table 5.1).

The "Pathways out of Medium Security" study (Maden et al 2004) included all individuals discharged from medium-secure psychiatric units in England and Wales between 1st April 1997 and 31st March 1998. It was

STRENGTHS	WEAKNESSES
1. Involves all the individuals in the cohort. 2. Usually large-scale and not limited to small samples.	1. The criteria by which the cohort is defined can influence its make-up. 2. Not clear if cohort is representative of whole population. The cohort may have particular characteristics or experiences that affect them and not other cohorts. This is known as the "cohort effect", and is particularly relevant if studying age groups.

Table 5.1 - Main strengths and weaknesses of studying a cohort.

commissioned by the Department of Health to include 28 units within the National Health Service and six independent units. There were 959 individuals in total (843 men and 116 women).

Maden et al (2006) used the "Pathways out of Medium Security" study data to investigate re-offending after discharge (table 5.2), and in particular, gender differences in the behaviour. The Offenders' Index [14] kept by the Home Office was used to check for re-offending within two years of release.

- The accuracy of data about re-offending.
- The time period of follow-up (which includes the problem of a time lag between offending and conviction).
- Where the individual goes on release - some individuals who are released from secure units go to a psychiatric hospital (or other institution), where they are unlikely to re-offend. There is also the problem of emigration or death after release.

(After Jamieson and Taylor 2004)

Table 5.2 - Key problems with re-conviction/re-offending studies.

It was found that 16% of men and 9% of women re-offended. This meant that women were significantly less

[14] The Offenders' Index is an active computerised database based on court appearance, and is designed to contain details of all persons convicted since 1963 in England and Wales. There are small gaps in the database, but details are not deleted on death of the offender (as with police databases usually) (Jamieson and Taylor 2004).

likely to re-offend (odds ratio: 0.49) [15].

Logistic regression analysis of individual variables found that the gender differences could be explained, in the main, by:

- History of self-harm - higher among women: 78% vs 38% of men.
- Alcohol and drug problems - less among women: 35% vs 53% (drugs) and 35% vs 42% (alcohol).
- Previous criminal convictions - men more likely to have two or more previous convictions (65% vs 37% of women) (figure 5.1).

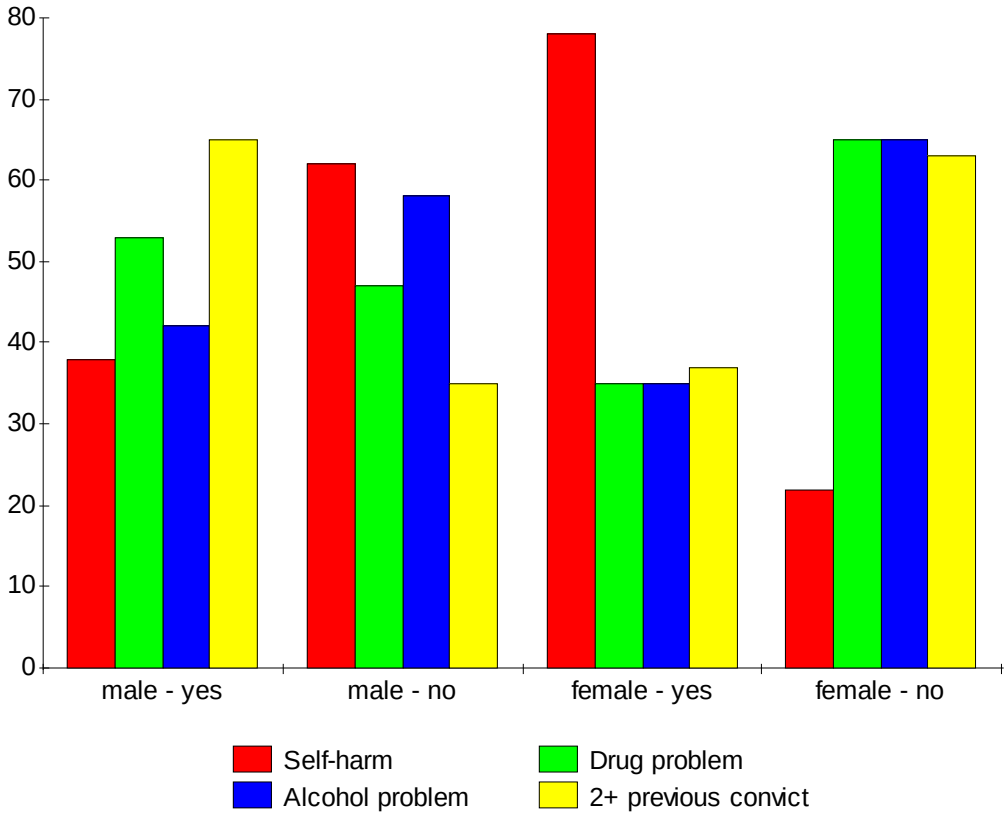

Figure 5.1 - Variables showing significant differences between men and women re-offending.

Though this study involved a large number of individuals whose details were fully analysed, there are key limitations as listed in table 5.3.

[15] This is a standardised comparison figure where 1 equals the standard (ie: male re-offending rate).

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- Only convicted crimes included as re-offending. This means that minor offences or undetected ones are not included.

- Only data from the Offenders' Index were used. This official statistic would not include cases that the police did not pursue. There is also a risk of manual errors in recording information by staff.

- The cohort was limited to one year, and only those in medium-secure psychiatric units in England and Wales.

Table 5.3 - Key limitations of Maden et al (2006) study.

5.3. RE-CONVICTION AFTER RELEASE FROM HIGH SECURITY HOSPITALS

Jamieson and Taylor (2004) used a "discharge cohort" of all individuals who left the three high security hospitals in England in 1984 [16]. This produced 204 individuals (167 male/thirty female) (after exclusion of seventeen deaths and two repatriations) [17]. Each individual was traced up to the end of 1995 (ie: twelve-year follow-up).

It was found that 74 patients (38% of cohort) [18] were convicted of at least offence after discharge (a total of 518 offences; figure 5.2) [19]. The vast majority of offences were committed while living in the community as only 14% of offences occurred while living in hospital accommodation. Individuals with personality disorders (as opposed to mentally ill) were seven times more likely to re-offend.

5.4. MDOs AND HOMICIDE

Laajasalo and Hakkanen (2004) investigated the differences between individuals who had committed homicide in Finland. The statements to psychiatrists of 182 such individuals were content analysed for ninety background characteristics (eg: criminal history of parents, parental alcohol abuse). The offenders were divided into four groups of MDOs - diagnosed with schizophrenia (n = 43), alcohol addiction (n = 43), drug addiction (n = 15), and personality disorders (n = 44) - and compared to offenders with no diagnosis of mental ill (n = 37).

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16 Broadmoor, Rampton, and Ashworth hospitals (at time of study).

17 Information could not be verified for seven cases, which left a cohort of 197.

18 52 patients convicted of serious offences (27% of cohort).

19 However, one individual committed 101 of these offences, and two others 86 of them.

(a) ALL (n = 197)

(b) Male (n = 167)

(c) Female (n = 30)

Figure 5.2 - Breakdown of re-convictions in cohort studied by Jamieson and Taylor (2004).

The reliability of coding was checked by the two researchers independently scoring the statements for each variable as present or absent. The scores were then correlated.

The following patterns emerged about the background characteristics of each group of offenders:

- MDOs with personality disorders - More likely to have experienced institutional placement in childhood, parent/step-parent alcohol abuse, multiple childhood problems, own marital problems and divorce, and have a previous history of violence.

- MDOs with schizophrenia - More likely to have psychopathology in non-parent family members, and

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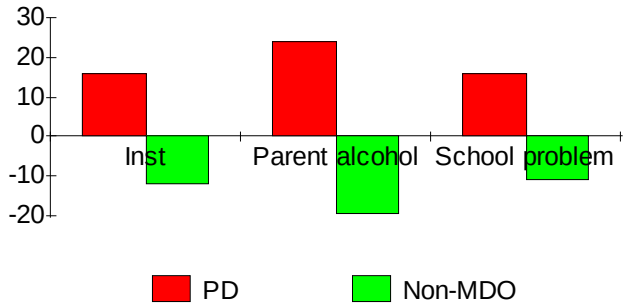
social isolation in adolescence, but relatively well-adjusted in childhood.

- MDOs with drug addiction - More likely to have had multiple problems in childhood (including at school), and to be younger at the time of the offence.

- MDOs with alcohol addiction - Resembled non-MDOs with less childhood problems that other MDOs, but more likely to have had parental alcohol abuse.

- Non-MDOs - Less likely to be unemployed and live alone with less previous crime.

The MDOs with personality disorders were different to non-MDOs on a number of variables (figure 5.3).



(Inst = institutional placement as child; PD = MDO with personality disorder)

Figure 5.3 - Percentage of personality-disordered and non-MDOs showing three variables in relation to the average for the whole group.

Evaluation of Laajasalo and Hakkanen (2004)

1. The use of self-reports or reports from relatives to psychiatrists. There could be forgetting of childhood problems or embarrassment to say (under-reporting) versus "recall bias" (Cannon et al 1997) (over-reporting). The latter is where, for a mother, say, "the knowledge of child's adult outcome may influence memories of childhood behaviour" (Laajasalo and Hakkanen 2004 p470).

2. Diagnosis of the mental disorder (or not) was not made by the researchers. They were dependent of the decision made by psychiatrists at the time of assessment.

3. The use of "real-life" data rather than that created for research purposes. The psychiatric examination reports used including data gathered from various sources

including school, medical, and military records, psychological tests, and interviews by social workers.

4. The problem of converting the qualitative data of the interviews etc into quantitative scores. This does depend on some subjectivity in categorisation, and it is also reductionist.

5. The problem of missing data. Laajasalo and Hakkanen (2004) said: "In many cases some information could not be found in the statement. It was impossible to infer reliably whether the missing data indicated that the variable was actually absent or that the presence of the variable was not written down in the statement. In some studies all missing categorical values are coded as zero [absent], however, this might be misleading.." (p454).

6. Laajasalo and Hakkanen (2004) argued that their study was of value: "Despite these limitations, however, forensic psychiatric examinations are a unique source of information in research on mental illness and criminality. Since there is usually a considerable time lag between early individual and environmental risk factors and outcome in terms of adult mental illness and criminality, information covering the individual's life-span is highly valuable.." (p470).

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