Assessment and treatment of (sexually) violent forensic psychiatric patients

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  – Measurement instruments
  – Evaluation of program

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Aggression Replacement Training (ART) for Dutch violent forensic psychiatric in- and outpatients

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www.Agressiehanteringstherapie.nl
Contents

• New measurement instruments
• Dynamic criminogenic needs
• Development and evaluation of adapted ART
• Behavior on the ward
• Consequences for treatment policy
New measurement instruments
Evaluation of existing measurement instruments

Problems
• Self-report questionnaires mostly developed using college or university students
• No investigation on the psychometric properties of these questionnaires in Dutch forensic psychiatric in- and outpatients
• Observation scales about aggression mostly developed for general psychiatric patients in crisis

Findings
• Questionnaires are reliable and valid when used for Dutch forensic psychiatric patients, but most divisions in subscales do not fit
Measurement instruments for program evaluation

Current instruments
• Aggression Questionnaire (AQ; Hornsveld, Muris, Kraaimaat, & Meesters (2009)
• Novaco Anger Scale-Provocation Inventory (NAS-PI; Hornsveld, Muris & Kraaimaat (2011)
• Bermond Vorst Alexithymia Questionnaire (BVAQ; Hornsveld & Kraaimaat, 2012)

New instruments
• Adapted version of Rosenzweig Picture-Frustration Study (PFS-AV): Hostility
• Observation Scale for Aggressive Behavior (OSAB): Behavior of forensic psychiatric inpatients on the ward
Adapted Version of Rosenzweig Picture-Frustration Study (PFS-AV): Hostility

You are not allowed to cross the street when the light is red.
Observation Scale for Aggressive Behavior (OSAB; Hornsveld et al., 2007)

Six subscales:
• Irritation/anger (5 items)
• Anxiety/Gloominess (4 items)
• Aggressive behavior (10 items)
• Prosocial behavior (12 items)
• Antecedents (6 items)
• Sanctions (3 items)

Scoring: Behavior on the ward during last week
Scores of subscales

Scoring of items: ‘no’ = 1, ‘seldom’ = 2, ‘occasionally’ = 3, and ‘frequently’ = 4

Range of subscale scores:
• Irritation/anger: 5 - 20
• Anxiety/Gloominess: 4 - 16
• Aggressive behavior: 10 - 40
• Prosocial behavior: 12 - 48
• Antecedents: 6 - 24
• Sanctions: 3 - 13
Dynamic criminogenic needs of forensic psychiatric patients
Inpatients versus norms ($N = 136$)

*p < .001*
Inpatients versus norms ($N = 136$)

* $p < .001$
Inpatients \((N = 136)\) versus detainees \((N = 100)\)
Inpatients ($N = 136$) versus detainees ($N = 100$)

* $p < .004$
Outpatients versus norms ($N = 200$)

* $p < .001$
Outpatients versus norms ($N = 200$)

* $p < .004$
Young outpatients \((N = 123)\) versus male students \((N = 160)\)

*\(p < .05\)
Model for aggressive behavior

- Conflict of interests
  - Low score on psychopathy
  - High score on psychopathy
  - Cognitions: • high level of aspiration • antisocial norms
  - Limited or inadequate social skills

- Lack of emotion
  - Emotion: • irritation, anger, rage, fury

- Proactively aggressive behavior: • verbal • physical (violence)
- Reactively aggressive behavior: • verbal • physical (violence)

- Positive short-term consequences: • goal achieved • satisfaction • higher status
- Negative long-term consequences: • escalation of conflict • in contact with the judicial system • being avoided by others
Development and evaluation of the Aggression Replacement Training (ART)
Adaptation of Aggression Replacement Training (ART)

Framework
• Anger management (session 1-5)
• Social skills (session 6-10)
• Moral reasoning (session 11-15)
• Self-regulation skills (session 6-15)
• Follow-up, evaluation, and report

• Manual for trainers
• Portfolio for patients
Anger management

Aim
• Management of emotions such as irritation, anger, and fury

Method
• Psycho-education and exercise of virtual situations

Subjects
• Observing behavior of others
• Interpreting behavior of others
• Lowering heightened arousal
• Differentiating between emotions
• Realizing short-term and long-term consequences of behavior
Social skills

**Aim**
- Increase of prosocial and decrease of antisocial skills

**Method**
- Role play

**Subjects**
- Choosing by patients of five skills
12 social skills

1. Making contact
2. Ending a situation
3. Making a request
4. Refusing a request
5. Reacting on a refusal
6. Criticizing
7. Reacting on criticism
8. Giving one’s opinion
9. Standing up for oneself
10. Complimenting somebody else
11. Appreciating yourself
12. Reacting on a compliment
Moral reasoning

Aim
• Management of moral dilemmas

Method
• Practicing of situations with a moral dilemma

Subjects
• Virtual situations and situations of patients
Self-regulation skills

• Making programs for learning new behavior
• Lowering high aspiration level
• Reinforcing oneself for making progress in learning new behavior
• Completing program in five to ten sessions
Inpatients: aggressive behavior, measured with the OSAB

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Control group</strong></td>
<td>16</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td><strong>Therapy group</strong></td>
<td>16</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>
Outpatients: personality traits of completers ($N = 62$) compared with drop-outs ($N = 61$)
Outpatients: problem behaviors of completers ($N = 62$) compared with drop-outs ($N = 61$)
Outpatients: Physical aggression, measured with the AQ

![Graph showing physical aggression levels for outpatients and students before (Pre) and after (Post) treatment.](image-url)
Behavior on the ward
Literature

• PCL-R scores relate only modestly with disruptive behavior during hospitalization
  • Hildebrand, De Ruiter, & Nijman (2004): PCL-R and incidents

• Stay in a forensic psychiatric hospital can result in a small improvement of dynamic criminogenic needs
  • Belfrage & Douglas (2002): HCR-20
  • De Jonge, Nijman, & Lammers (2009): HKT-30
  • Nijman, De Kruyk, & Van Nieuwenhuizen (2004): REHAB
  • Chakhssi, De Ruiter, & Bernstein (2010): BSI
Observation Scale for Aggressive Behavior (OSAB; Hornsveld et al., 2007)

Three of the six subscales:
- Irritation/anger (5 items)
- Aggressive behavior (10 items)
- Prosocial behavior (12 items)

Scoring: Behavior on the ward during last week
Table 1. *Number of patients assessed on seven measurements*

<table>
<thead>
<tr>
<th>Total group</th>
<th>Personality disordered</th>
<th>Chronically psychotic</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>N</em></td>
<td><em>M (SD)</em></td>
<td><em>N</em></td>
</tr>
<tr>
<td>1</td>
<td>253</td>
<td>37.49 (10.38)</td>
</tr>
<tr>
<td>2</td>
<td>248</td>
<td>37.40 (10.44)</td>
</tr>
<tr>
<td>3</td>
<td>236</td>
<td>37.17 (10.41)</td>
</tr>
<tr>
<td>4</td>
<td>213</td>
<td>37.20 (10.34)</td>
</tr>
<tr>
<td>5</td>
<td>178</td>
<td>36.97 (10.46)</td>
</tr>
<tr>
<td>6</td>
<td>146</td>
<td>37.03 (10.17)</td>
</tr>
<tr>
<td>7</td>
<td>115</td>
<td>36.97 (10.27)</td>
</tr>
</tbody>
</table>
Figure 1. Course of irritation/anger and aggressive behavior during the first three years of stay
Figure 2. Course of prosocial behavior during the first three years of stay
Figure 3. Course of irritation/anger and aggressive behavior during the first three years of stay.
Figure 4. Course of prosocial behavior during the first three years of stay
**Table 2. Mean scores and SD’s in personality disordered and chronically psychotic patients**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Factor or sub-scale</th>
<th>Personality disordered</th>
<th>Chronically psychotic</th>
<th>Differences between subsamples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$N$</td>
<td>$M$ (SD)</td>
<td>$N$</td>
</tr>
<tr>
<td>PCL-R</td>
<td>Psychop</td>
<td>159</td>
<td>22.25 (8.06)</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>Interpers</td>
<td>159</td>
<td>3.57 (2.47)</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>Affective</td>
<td>159</td>
<td>6.13 (1.72)</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>Lifestyle</td>
<td>159</td>
<td>5.94 (2.76)</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>Antisoc</td>
<td>159</td>
<td>5.11 (2.81)</td>
<td>94</td>
</tr>
<tr>
<td>NEO-FFI</td>
<td>Neurot</td>
<td>97</td>
<td>32.24 (8.49)</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>97</td>
<td>41.59 (5.23)</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Anger</td>
<td>92</td>
<td>17.91 (6.64)</td>
<td>47</td>
</tr>
</tbody>
</table>
## Table 4. Correlations assessed shortly after admittance

<table>
<thead>
<tr>
<th>Measure</th>
<th>Factors or sub-scales</th>
<th>Personality disordered patients</th>
<th></th>
<th>Chronically psychotic patients</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Irritation/Anger</td>
<td>Aggressive behavior</td>
<td>Pro-social behavior</td>
<td>Irritation/anger</td>
</tr>
<tr>
<td>PCL-R</td>
<td>Psychp</td>
<td>.236**</td>
<td>.208**</td>
<td>.016</td>
<td>.169</td>
</tr>
<tr>
<td></td>
<td>Interper</td>
<td>.097</td>
<td>.069</td>
<td>.057</td>
<td>.192</td>
</tr>
<tr>
<td></td>
<td>Affect</td>
<td>.177*</td>
<td>.122</td>
<td>-.051</td>
<td>.078</td>
</tr>
<tr>
<td></td>
<td>Lifest</td>
<td>.207**</td>
<td>.199*</td>
<td>-.001</td>
<td>.245*</td>
</tr>
<tr>
<td></td>
<td>Antisoc</td>
<td>.290**</td>
<td>.274**</td>
<td>.091</td>
<td>.051</td>
</tr>
<tr>
<td>NEO-FFI</td>
<td>Neurot</td>
<td>.199*</td>
<td>.209*</td>
<td>-.107</td>
<td>.059</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>-.097</td>
<td>-.160</td>
<td>.093</td>
<td>-.111</td>
</tr>
<tr>
<td>STAS</td>
<td>Anger</td>
<td>.140</td>
<td>.214*</td>
<td>.023</td>
<td>.157</td>
</tr>
</tbody>
</table>
Table 5. Change scores on the OSAB (measurement 1 vs. measurement 7)

<table>
<thead>
<tr>
<th>OSAB sub-scale</th>
<th>Personality disordered patients</th>
<th>Chronically psychotic patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Measure-ment 1</td>
<td>Measure-ment 7</td>
</tr>
<tr>
<td>Irrit./Anger</td>
<td>M (SD)</td>
<td>M (SD)</td>
</tr>
<tr>
<td></td>
<td>10.57 (3.31)</td>
<td>10.46 (3.04)</td>
</tr>
<tr>
<td>Aggr. beh.</td>
<td>14.93 (5.38)</td>
<td>15.16 (4.67)</td>
</tr>
<tr>
<td>Prosoc. beh.</td>
<td>29.50 (8.39)</td>
<td>32.70 (6.94)</td>
</tr>
</tbody>
</table>
Table 6. *Outflow of patients*

<table>
<thead>
<tr>
<th>Patients</th>
<th>Percentage</th>
<th>Age</th>
<th>PCL-R</th>
<th>Aggression on the ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 measurements</td>
<td>56.4</td>
<td>36.97 (10.27)</td>
<td>20.49 (7.97)</td>
<td>14.97 (5.66)</td>
</tr>
<tr>
<td>3 year of stay but no 7 measurements</td>
<td>22.1</td>
<td>39.38 (11.78)</td>
<td>17.68 (7.94)</td>
<td>15.92 (4.60)</td>
</tr>
<tr>
<td>Reselection</td>
<td>9.8</td>
<td>36.95 (8.89)</td>
<td>22.63 (7.86)</td>
<td>16.16 (5.23)</td>
</tr>
<tr>
<td>Long-stay</td>
<td>2.9</td>
<td>55.00 (8.46)</td>
<td>23.40 (7.57)</td>
<td>18.40 (2.61)</td>
</tr>
<tr>
<td>Finishing TBS or leave</td>
<td>3.4</td>
<td>41.29 (11.94)</td>
<td>17.00 (8.25)</td>
<td>14.14 (2.48)</td>
</tr>
<tr>
<td>Others</td>
<td>5.4</td>
<td>35.89 (6.31)</td>
<td>25.67 (9.35)</td>
<td>15.67 (3.20)</td>
</tr>
</tbody>
</table>
Conclusions

• No relation between length of stay and mood, aggressive behavior, and sanctions.
• However, social skills are related to length of stay.
• Personality disordered patients exhibit more anger, more aggressive behavior, and more prosocial behavior than chronic psychotic patients.
• Patients with relatively high scores on the PCL-R exhibit more anger, more aggressive behavior, but also more prosocial behavior than patients with relatively low scores on the PCL-R.
• In general, base rates of negative behaviors are low.
Discussion and recommendations

• Outcome of treatment programs should not be based on negative but on positive behavior.
• Limited validity of risk assessment instruments if they are based on negative behaviors.
• Protective factors, which refer to positive behavior, can contribute considerably to a better prediction of recidivism risk (SAPROF).
• There is a group of inpatients for which a stay longer than three of four years has no incremental value.
Treatment of violent offenders

Almar J. Zwets
Ph.D. candidate
Contents

• Reactive and proactive aggression
• Aggression Replacement Training (Long version)
• Evaluation of ART (long version)
• Evaluation of a prolonged program for violent offenders
Reactive & Proactive aggression

- Reactive aggression: Aggressive behavior as a response to a provocation

- Proactive aggression: Aggressive behavior to reach a certain goal

Source: Dodge & Coie, 1987
# Reactive & Proactive aggression

<table>
<thead>
<tr>
<th>Reactive aggression</th>
<th>Proactive aggression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intense autonomic arousal</td>
<td>Minimal or absent autonomic arousal</td>
</tr>
<tr>
<td>Subjective experience of emotion</td>
<td>No conscious emotion</td>
</tr>
<tr>
<td>Primary emotional / defensive</td>
<td>Primary cognitive / attack</td>
</tr>
<tr>
<td>Heightened and diffuse awareness</td>
<td>Heightened and focused awareness</td>
</tr>
<tr>
<td>Perceived threat</td>
<td>No imminent perceived threat</td>
</tr>
<tr>
<td>Goal is threat reduction</td>
<td>Variable goals</td>
</tr>
<tr>
<td>Reactive or immediate violence</td>
<td>Planned or purposeful violence</td>
</tr>
</tbody>
</table>

Anger driven

![Image](image1.png)

Goal driven

![Image](image2.png)
Reduced Prefrontal and Increased Subcortical Brain Functioning Assessed Using Positron Emission Tomography in Predatory and Affective Murderers

Adrian Raine, Ph.D.,* J. Reid Meloy, Ph.D., Susan Bihrlie, Ph.D., Jackie Stoddard, M.A., Lori LaCasse, BSc., and Monte S. Buchsbaum, M.D., Ph.D.

There appear to be no brain imaging studies investigating which brain mechanisms subserve affective, impulsive violence versus planned, predatory violence. It was hypothesized that affectively violent offenders would have lower prefrontal activity, higher subcortical activity, and reduced prefrontal/subcortical ratios relative to controls, while predatory violent offenders would show relatively normal brain functioning. Glucose metabolism was assessed using positron emission tomography in 41 comparisons, 15 predatory murderers, and nine affective murderers in left and right hemisphere prefrontal (medial and lateral) and subcortical (amygdala, midbrain, hippocampus, and thalamus) regions. Affective murderers relative to comparisons had lower left and right prefrontal functioning, higher right hemisphere subcortical functioning, and lower right hemisphere prefrontal/subcortical ratios. In contrast, predatory murderers had prefrontal functioning that was more equivalent to comparisons, while also having excessively high right subcortical activity. Results support the hypothesis that emotional, unplanned impulsive murderers are less able to regulate and control aggressive impulses generated from subcortical structures due to deficient prefrontal regulation. It is hypothesized that excessive subcortical activity predisposes to aggressive behaviour.
Raine et al. (1998)

Comparison ('Normal')

Reactive murderer

Proactive murderer
Psychopathy and aggression

- Psychopathy is related to an increased risk for instrumental aggression (Blair, 2007)
- Cornell et al. (1996)
In Cold Blood: Characteristics of Criminal Homicides as a Function of Psychopathy

Michael Woodworth and Stephen Porter
Dalhousie University

This study investigated the relationship between psychopathy and the characteristics of criminal homicides committed by a sample of 125 Canadian offenders. It was hypothesized that the homicides committed by psychopathic offenders would be more likely to be primarily instrumental (i.e., associated with premeditation, motivated by an external goal, and not preceded by a potent affective reaction) or “cold-blooded” in nature, whereas homicides committed by nonpsychopaths often would be “crimes of passion” associated with a high level of impulsivity/reactivity and emotionality. The results confirmed these predictions; homicides committed by psychopathic offenders were significantly more instrumental than homicides by nonpsychopaths. Nearly all (93.3%) of the homicides by psychopaths were primarily instrumental in nature compared with 48.4% of the homicides by nonpsychopaths.

93.3% of the homocides by psychopaths were primarily instrumental in nature compared to 48.4% of the homocides by nonpsychopaths
Instrumental offenders could be reliably distinguished from reactive offenders on the basis of violent crime behavior and level of psychopathy.
Aggression Control Therapy

- Anger management
- Social skills
- Moral reasoning

- Prosocial thinking
- Character formation
- Prosocial network
- Attitudes towards women
Prosocial thinking

• Aim
  – Changing antisocial cognitions into prosocial cognitions

• Method
  – Discussion about situations and homework examples

• Topics
  – Sympathize with someone
  – Egocentrism
  – Minimizing own behavior
  – Suspiciousness
  – Blaming others
Character formation

• Aim
  – Differentiation between consequences of behavior on the short term and long term

• Method
  – Discussion about situations and homework examples

• Topics
  – Responsibility
  – Servitude
  – Respect
  – Collaboration
  – Honesty
Prosocial Network

• Aim
  – Making new social contacts and terminating antisocial contacts

• Method
  – Discussions, homework examples and role playing

• Topics
  – Meeting people
  – Making appointments
  – Getting to know each other better
  – Informing others about TBS
  – Responding to a rejection
Attitude towards women

• Aim
  – Interact with women in different levels of intimacy

• Method
  – Discussions, homework examples and role playing

• Topics
  – Showing the need for intimacy
  – Responding to a rejection
  – Responding to a approach
  – Strengthen the relationship
  – Dealing with relational conflicts
First results with ART ($N = 30$)
Psychomotor Therapy

Method: Therapy in which physiological sensations are central (physical exercises)

- Awareness of the physiological sensations
- Coping behavior (e.g. relaxation)
- Skills during tension
Evaluation of PMT

Treatment group
- Aggression Control Therapy (38 sessions)
- Psychomotor therapy (25 sessions)

Control group
- Aggression Control Therapy (38 sessions)
- Sports (25 sessions)
Measures

- PCL-R  Psychopathy
- NAS  Anger
- AQ-SF  Aggression
- ABSQ  Bodily awareness during anger
- UCL  Coping
- OSAB  Aggressive behavior
  Social behavior
Participants

<table>
<thead>
<tr>
<th>Condition</th>
<th>N</th>
<th>Compl.</th>
<th>Dropouts</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT – PMT</td>
<td>22</td>
<td>16</td>
<td>5 (1)</td>
</tr>
<tr>
<td>ACT – Sports</td>
<td>15</td>
<td>11</td>
<td>2 (2)</td>
</tr>
</tbody>
</table>

- Cluster B personality disorder
- No psychotic disorder
- Violent offence
Effects of PMT

Awareness of physiological changes (ABSQ)
Effects of PMT

Coping behavior (UCL)

Pre | Post | FU
--- | --- | ---
10 | 11 | 12
10,5 | 11,5 | 12,5

Sports | PMT
---|---
Effects of PMT

Aggression (AQ-SF)

- **Pre**, **Post**, **FU**

- Blue line: Sports
- Red line: PMT
Effects of PMT

Aggressive behavior (OSAB)
Preliminary conclusions

- Patients in the PMT condition show significant improvement compared to the Sports condition on self-reported coping

- Patients in the PMT condition do not show significant improvements compared to the Sports condition on aggression and bodily awareness

- However, at this moment there are power issues
## Dropouts

<table>
<thead>
<tr>
<th></th>
<th>PMT</th>
<th>Sports</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Compl. (n = 16)</td>
<td>Dropout (n = 5)</td>
</tr>
<tr>
<td>PCL-R Total</td>
<td>22.99</td>
<td>31.72</td>
</tr>
<tr>
<td>PCL-R F1</td>
<td>3.56</td>
<td>7.20</td>
</tr>
<tr>
<td>PCL-R F2</td>
<td>6.06</td>
<td>7.60</td>
</tr>
<tr>
<td>PCL-R F3</td>
<td>6.38</td>
<td>9.00</td>
</tr>
<tr>
<td>PCL-R F4</td>
<td>5.44</td>
<td>5.40</td>
</tr>
</tbody>
</table>

F1 = Interpersonal  
F2 = Affective  
F3 = Lifestyle  
F4 = Antisocial
Preliminary conclusions

- Dropouts have significantly higher PCL-R scores

- Dropouts have significantly higher scores on the interpersonal factor and the lifestyle factor

e.g. Stokes et al., 2009
Development and evaluation of a treatment program for sexually violent forensic psychiatric inpatients

Thijs Kanters
“I love them, I love those girls, dirty girls. Bad girls have more fun. We’re constantly surrounded by girls like that, girls for sex. I’m not saying she didn’t enjoy the rape, but I’m saying she had an ulterior motive. She was a slut and she suited my purpose. It was a game of cat and mouse, and she lost the game. And out of spite she attacked me through the law, the best way that she could.”
Cognitive distortions

• Abel’s cognitive distortion theory
  (Abel et al., 1984)

  “Cognitive distortions are rationalizations and justifications for sexual offending or deviant preferences and behavior.”

  “The function of cognitive distortions is to justify offenders' continuing sexual abuse without feeling crippled by guilt, anxiety, or lowered self-esteem caused by the recognition that they had violated important social norms.”
Cognitive distortions

• Ward’s implicit theory model
  (Ward, 2000)

  “Cognitive distortions emerge from underlying causal theories (schemas) about the nature of victims.”

  “Implicit theories unconsciously influence the way information is interpreted, leading to distorted interpretations of self, other people, and the world.”
Cognitive distortions

Implicit theories in child molesters
(Ward & Keenan, 1999)

- Children as sexual beings
- Nature of harm
- Entitlement
- Dangerous world
- Controllability
Cognitive distortions

Implicit theories in rapists
(Polaschek & Ward, 2002)

• Women are unknowable
• Women are sex objects
• Male sex drive is uncontrollable
• Entitlement
• Dangerous world
Cognitive distortions

Cognitive distortions plays an important role in the onset and persistence of sexual offending (e.g., Ward & Beech, 2006)

- Child molesters display significantly greater sexual interest in children compared to men who do not molest children (e.g., Harris, Rice, Quinsey, & Chaplin, 1996)

- Sexual interest in children is one of the best predictors of sexual recidivism (Hanson & Morton-Bourgon, 2004)
Cognitive distortions

Therapy session

- Opening
- Discussing homework
- Introduction of the topic
- Problem situations
- New homework
- Evaluation of the session
Lars’ problem situation

Lars is a single man of 36 years. He is often depressed and insecure in social contacts. Lars has no friends and his only contact is with family members. In the company of underage boys Lars feels at ease. Lars works as an ICT assistant at an elementary school. In this profession Lars has much contact with underage boys. Lars feels that he becomes more and more sexually attracted to a few boys and thinks about them when he masturbates at home.

On the playground, Lars starts a conversation with the 10-year-old Raymond. They appear to have a common interest, namely playing computer games.
Lars’ problem situation

Lars has just bought a brand new game console and invites Raymond to come and play at his house. While Raymond is playing the video game, Lars asks Raymond if he wants to masturbate with Lars in exchange for the video game. Raymond really wants the video game and approves. This way, Lars regularly commits sexual abuse with other underage boys in exchange for video games.
Lars’ problem situation

1. What do you think is the main problem of Lars?

2. Is it a coincidence that Lars works at an elementary school as ICT assistant?

3. Is it OK for Lars to have sex with underage boys if these boys say they are interested in sex?

4. Do you think Lars should inform the school about his sexual orientation?
Describe a situation when you thought: *I'm so horny, I need to have sex!*

The situation was: ........................................................................................................

Who where involved: ..................................................................................................

Where were you: ........................................................................................................

The other person did/said: ..........................................................................................

What were your thoughts or how did you feel: ......................................................

What did you do:? ....................................................................................................

What was the other person’s reaction: .................................................................

How do you look back on your behavior afterwards: .................................

What could you have done differently: .................................................................
Self-regulation skills

Improving social skills through role-playing in the areas of:
(protective factors)

- Work and leisure activities
- Prosocial network
- Relationships and sexuality
- High risk situations and relapse prevention
Clinical practice

Mixed groups of sex offenders

Resistance from the child abusers
  "I have no problems with ..."
  "It was due to the circumstances that...“

Social anxiety/inappropriate behavior

Diagnosis or treatment?
  Unfortunately, not every patient makes progress

Criminal record
SVR-20 (sexual recidivism risk) and PCL-R (Psychopathy)

Hyper sexuality
Treatment framework

Treatment of rapists

• Offense script (van Beek & Mulder, 1991, 1992)
• Psycho-education (15 sessions)
• Cognitive distortions (25 sessions)
• Self-regulation skills (25 sessions)
• Aggression Control Therapy (35 sessions)

Treatment of child molesters

• Offense script (van Beek & Mulder, 1991, 1992)
• Psycho-education (15 sessions)
• Cognitive distortions (25 sessions)
• Self-regulation skills (25 sessions)
• Libido inhibiting medication
Research questions

• Can child molesters be differentiated from other offenders based on (sex-related) implicit cognitions?

• Are (sex-related) implicit cognitions of child molesters related to risk of recidivism, deviant behavior and/or personality traits?
Method

Patients
28 child molesters, 36 rapists and 59 violent patients

Measures
• Implicit Association Test (IAT)
  - flower/unpleasant associations
  - child/sex associations
  - submissiveness/sex associations

Hypotheses
• Child molesters associate children with sex
• Child molesters associate submissiveness with sexy
• Rapists associate submissiveness with sexy
Implicit Association Test

flower
pleasant

insect
unpleasant

← or →
Implicit Association Test

child
not sex

or

feck

adult
sex
Implicit Association Test

dominant
not sexy

↔ or →

submissive
sexy
flower-unpleasant IAT

F(3,118)=1.03

D600EP

-1.00

-0.80

-0.60

-0.40

-0.20

0.00

-0.20

-0.40

-0.60

-0.80

-1.00

Flower - Unpleasant / Insect - Pleasant association

Child molesters
Rapists
Violent offenders
flower-unpleasant IAT

**ANCOVA (corrected for age)**

<table>
<thead>
<tr>
<th></th>
<th>Child molestors ( n=28 )</th>
<th>Rapists ( n=36 )</th>
<th>Violent off. ( n=58 )</th>
<th>Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>flower-unpleasant</td>
<td>(-0.93 (0.37))</td>
<td>(-0.94 (0.34))</td>
<td>(-0.81 (0.42))</td>
<td>(F(3,118)=1.03)</td>
</tr>
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</table>

No differences between child molesters, rapists and violent patients
child-sex IAT

$F(3,119)=5.40^{**}$
# child-sex IAT

**ANCOVA** (corrected for age)

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<th>Rapists (n=36)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>M (SD)</td>
<td>M (SD)</td>
<td>M (SD)</td>
<td></td>
</tr>
<tr>
<td>child-sex</td>
<td>0.13 (0.49)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-0.16 (0.39)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-0.23 (0.36)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>F(3,119)=5.40**</td>
</tr>
</tbody>
</table>

*Note: means not sharing a similar superscript differ at p < 0.05.*

**Child molesters**

- Stronger associations between children and sex
- Effect sizes (Cohen’s $d$): moderate - large
submissive-sexy IAT

D600EP

Child molesters
Rapists
Violent offenders

$F(3,104)=6.06^{**}$
**submissive-sexy IAT**

**ANCOVA** (corrected for age)

<table>
<thead>
<tr>
<th></th>
<th>Child molesters (n=24)</th>
<th>Rapists (n=33)</th>
<th>Violent off. (n=51)</th>
<th>Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M (SD)</strong></td>
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<td><strong>M (SD)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>submissive-sexy</td>
<td>0.18 (0.61)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-0.29 (0.51)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-0.17 (0.50)&lt;sup&gt;ab&lt;/sup&gt;</td>
<td>F(3,104)=6.06**</td>
</tr>
</tbody>
</table>

*Note: means not sharing a similar superscript differ at p < 0.05.*

**Child molesters**

- Stronger associations between submissiveness and sexual attraction
- Effect sizes (Cohen’s d): moderate – large
Discussion

• Child-sex and submissive-sexy associations proved to be characteristic for child molesters

• Correlations between the implicit associations and external variables did not yield particularly impressive results
Discussion

This study provides further evidence that IAT measures may be assessing cognitions relevant to sexual offending against children, but what exactly is being assessed by these measures remains unclear.

Future research

• Address questions regarding the overlap, distinctions, and relationship between sexual interest, implicit theories, schemas, cognitive distortions, and attitudes (e.g., Ó Ciardha, 2011)
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