Mentally ill sex offenders in a regional secure unit. II: cognitions, perceptions and fantasies

KIRPAL SAHOTA and PAUL CHESTERMAN

ABSTRACT  This study explores the aetiological role of deviant sexual interests, cognitions, perceptions, fantasies, assertiveness and self-esteem in sexual offending by the mentally ill. Established psychometric instruments were administered to a sample of mentally ill sex offenders in a secure psychiatric facility (RSU) and the results compared with norms for the non-mentally ill sex offenders and non-offending community groups. The results revealed similarities between the mentally ill and non-mentally ill sex offenders in the extent of cognitive distortion on all scales of the Sexual Offence Attitudes Questionnaire. High levels of sexual obsession, sexual dysfunction and faulty sexual knowledge and beliefs were found when using the Multiphasic Sex Inventory on the mentally ill sex offender, in comparison with the non-mentally ill sex offender. Pre-morbid IQ scores on the mentally ill and non-mentally ill sex offenders were comparable with population norms. The mean scores using the Culture Free Self-esteem Inventory and the Rathus Assertiveness Schedule were low. These preliminary findings suggest that the presence of mental illness alone may provide only a partial explanation of sexual offending by the mentally ill, and support the need for further study of the psychological profile of the mentally ill sex offender.

Keywords: mentally ill sex offenders, cognitions, perceptions
The psychosexuality of non-mentally ill sex offenders has been the subject of considerable attention from both psychologists and psychiatrists. Canter and Heritage (1990) summarized existing hypotheses on aetiology to suggest a fivefold framework for sexual offence behaviour: sexuality; violence and aggression; impersonal sexual gratification; criminality; and interpersonal intimacy. Marshall et al. (1990) suggest that a capacity to be sexually aggressive is conferred biologically on males. Finkelhor (1984) described a four-factor framework for offending against children, which included motivation to abuse sexually and the overcoming of internal, external and victim resistance. The relevance of these models in the presence of mental illness needs to be considered when treating the mentally ill sex offender. To date, aetiological frameworks of sexual offending by the mentally ill have ignored the relevance of deviant sexual interests, the presence of mental illness alone being proposed as an adequate explanation. Management of the mentally ill sex offender has largely involved treatment aimed at the resolution of psychiatric symptoms. In contrast, the prison service and probation service are involved in the treatment of non-mentally ill sex offenders for which they provide comprehensive programmes based on the cognitive behaviour model used to address deviant sexual interests and motivations to offend (Beckett et al., 1994).

Psychosexual development, childhood experiences and social and cultural factors have been considered to have aetiological significance in sexual offending but have received little attention in respect of the mentally ill. The significance of personality traits such as self-esteem, assertion and social skills of the non-mentally ill sex offender have been highlighted, although research findings have been conflicting. Pithers et al. (1987) concluded that social skill deficits were precursors of rape. Stermac and Quinsey (1985) found that rapists were less assertive than non-sex offenders in heterosexual social situations, although the findings were not replicated by Segal and Marshall in 1985. It has been hypothesized that rapists have faulty decoding skills resulting in a tendency to misinterpret negative cues from women (Lipton et al., 1987).


This study aims through evaluation of their psychosexual profile to further the understanding of sexual offending behaviour by the mentally ill. Using instruments established in both clinical practice and research (Salter, 1988), the cognitions, fantasies, perceptions, assertiveness and self-esteeem of the mentally ill sex offender are explored. The results are compared with norms already established in the non-mentally ill sex offender groups and non-offending community samples.
METHOD

The sample comprised 20 adult males with an index sexual offence who were admitted to an RSU under the Mental Health Act 1983 over a 12-year period (as described in the preceding article).

Each subject completed seven self-report measures to assess intelligence (pre-morbid IQ), self-esteem, assertiveness, sexual fantasy life, attitudes to sexual offending and behaviour, knowledge and experience of sexual and non-sexual relationships. The subjects were supervised by the same researcher for the duration of the task. The completed tests were then re-examined with the patient to confirm responses as accurate. In addition to the obtaining of informed consent, the issue of confidentiality was discussed in detail. It was agreed that information generated as a result of this study relating to individual patients would not be routinely available to their clinical teams for management purposes. Thus, patients were assured that responses to questionnaires would not affect their length of stay in hospital, medication, or leave status. All of the patients approached agreed to participate in the study.

RESULTS

The results of the mentally ill sex offender (MISO) sample under study were compared with norms established by the authors of the tests on non-mentally ill sex offenders (NMISO) and non-offender populations where appropriate.

Intelligence Quotient (IQ)

The NART and Schonell are reading tests which are used to generate pre-morbid WAIS-R IQ approximations. The mean IQ score using the Schonell was 95.05. The mean IQ score using the NART was a full score of 94.47, a verbal score of 94.00 and a performance score of 95.37. The ranges for the sample were as follows: NART full score 77–117; NART verbal 78–115; NART performance 80–116. One person achieved a very low score on the Schonell and did not proceed to complete the NART.

THE CULTURE-FREE SELF-ESTEEM INVENTORY

The group as a whole demonstrated problems associated with self-esteem, a significant minority demonstrating low self-esteem.
Table 1: Self-esteem: the Culture-free Self-esteem Inventory

<table>
<thead>
<tr>
<th>Battle scale</th>
<th>Range for norms*</th>
<th>Mentally ill sex offenders</th>
<th>Mentally ill scores grouped</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very high</td>
<td>Very low</td>
<td>Mean</td>
</tr>
<tr>
<td>General</td>
<td>15</td>
<td>&lt; 4</td>
<td>8.50</td>
</tr>
<tr>
<td>Personal</td>
<td>8</td>
<td>1</td>
<td>3.60</td>
</tr>
<tr>
<td>Social</td>
<td>8</td>
<td>1</td>
<td>5.15</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>&lt; 14</td>
<td>17.60</td>
</tr>
</tbody>
</table>

* Battle, 1981

THE RATHUS ASSERTIVENESS SCALE

The mean score in a study of a community sample of males was 9 (SD 23.86) (Hull and Hull, 1976). The mean score for this sample of mentally ill sex offenders was −1.3 (SD 19.3). Overholser and Beck (1986) reported a Rathus score of 5.8 (SD 20.9) on their sample of non-mentally ill rapists. In the same study, low socioeconomic class volunteers scored 17.1 (SD 27.9), non-sex offender prisoners scored 5.2 (SD 22.9) and child molesters scored −10.3 (SD 20.9).

WILSON’S SEX FANTASY QUESTIONNAIRE

The results suggest that this sample of mentally ill sex offenders maintain an active sexual fantasy life with higher scores on impersonal themes than non-offender controls.

Table 2: Sexual fantasies

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean for normal population*</th>
<th>Sado-masochistic group* Mean</th>
<th>MISO Mean</th>
<th>MISO range</th>
</tr>
</thead>
<tbody>
<tr>
<td>SM</td>
<td>2.3</td>
<td>17.8</td>
<td>4.9</td>
<td>0 21</td>
</tr>
<tr>
<td>Exploratory</td>
<td>8.1</td>
<td>11.3</td>
<td>11.8</td>
<td>1 25</td>
</tr>
<tr>
<td>Impersonal</td>
<td>7.6</td>
<td>12.8</td>
<td>13.7</td>
<td>5 25</td>
</tr>
<tr>
<td>Intimate</td>
<td>16.9</td>
<td>19.5</td>
<td>19.5</td>
<td>5 35</td>
</tr>
<tr>
<td>Total</td>
<td>34.9</td>
<td>61.4</td>
<td>49.8</td>
<td>23 97</td>
</tr>
</tbody>
</table>

* Gosselin and Wilson, 1980
Table 3 The multiphasic sex inventory

<table>
<thead>
<tr>
<th></th>
<th>NMISO Rape Group* N = 30</th>
<th>MISO group N = 20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Social sexual desirability</td>
<td>10.43</td>
<td>2.99</td>
</tr>
<tr>
<td>Sexual obsessions</td>
<td>3.61</td>
<td>3.48</td>
</tr>
<tr>
<td>Justifications</td>
<td>5.63</td>
<td>3.77</td>
</tr>
<tr>
<td>Treatment attitudes</td>
<td>4.00</td>
<td>1.53</td>
</tr>
<tr>
<td>Cognitive distortion and immaturity</td>
<td>6.73</td>
<td>2.42</td>
</tr>
<tr>
<td>Sexual knowledge and beliefs</td>
<td>17.07</td>
<td>3.17</td>
</tr>
<tr>
<td>Sexual dysfunction</td>
<td>1.83</td>
<td>3.28</td>
</tr>
<tr>
<td>Atypical sexual outlets</td>
<td>4.18</td>
<td>4.52</td>
</tr>
<tr>
<td>Child molestation</td>
<td>2.25</td>
<td>2.69</td>
</tr>
<tr>
<td>Exhibitionism</td>
<td>1.46</td>
<td>3.14</td>
</tr>
<tr>
<td>Rape</td>
<td>8.48</td>
<td>6.13</td>
</tr>
</tbody>
</table>

* Nichols and Molinder, 1984

MULTIPHASIC SEX INVENTORY (MSI) BY NICHOLS AND MOLINDER

MSI subscale: social sexual desirability

The sexual desirability scale is designed to measure ‘normal sex drives and interests’ and identifies those responding to MSI in a social desirable response set. Of this sample 45% fell within the range ‘normal sex drives and interests’, 40% fell within the ‘questionable’ range, 10% fell within the range ‘denies sex drives and interests’ and only 1 patient presented an ‘asexual’ image. Therefore, appreciable levels of sexual interest are demonstrated in the mentally ill group. The means for the mentally ill group were higher than the means for the non-mentally ill group suggesting that the MISO group were more open about sexuality with less tendency to present an asexual image.

MSI subscale: sexual obsessions

The construction of the sexual obsessions scale assumes that sex offenders are driven by sexual urges. It measures preoccupation with sexual matters and also the offender’s tendency to exaggerate his problems; and it assesses the individual’s obsession with sex. Of this mentally ill sample, 55% fell within
the ‘expected deviant range’. Sex offenders who are honest about their high interest in sexual matters would score in this range. In the range 10 to 16 fell 45%, who reported a preoccupation with sex and maybe were having problems with sexual thoughts and impulses. These are grouped as ‘sexually obsessed’.

**MSI subscale: justifications**

The justifications scale is based on the assumption that a sex offender commits a sexual assault because that is what he wants to do. Of the MISO 60% scored in the ‘justifies sexual deviance’ result; 15% ‘justifies sexual deviance marked’; and 15% ‘severe lack of accountability’. One patient’s score was in the range ‘accepts accountability’. The means for the non-mentally ill group and the mentally ill group were similar. Of the mentally ill group 90% offered some degree of ‘justifications’ for their action.

**MSI subscale: treatment attitudes**

In treatment attitudes, 45% fell within the group ‘motivated’ and 1 of the sample was ‘highly motivated’. A further 25% were ‘not motivated’ and 25% fell within the group ‘may not be motivated’.

**MSI subscale: cognitive distortion and immaturity scale**

The distortion/immaturity scale assesses childhood cognitive distortions, which relate to personality traits that are relevant in sexual deviancy. It is a measure of ‘victim stance’. The majority (95%) of the mentally ill group demonstrated some degree of cognitive distortion regarding their offending. Only 1 of the sample fell within the range ‘acceptable range of accountability’. The majority, 65%, fell within the group ‘cognitive distortions and immaturity’; 30% fell within ‘character disturbance and victim stance’ – this group see themselves as victims. None of the mentally ill sample fell within the ‘extreme’ group, which had ‘severe lack of accountability’ for their actions.

**MSI lie scale for rape**

The lie scale for rape is a measure of denial of the extent of offending. The average score for the NMI rapist was 5/13, whereas the average score for the MSI group was 10/13. The majority (83%) of the mentally ill group were at the top end of the scale: ‘dishonest about sexual deviancy and sexual deviant interests’.
MSI sexual knowledge and beliefs

The sexual knowledge scale has items relating to anatomy and physiology. A score below 17 indicates a need for accurate sex information and education. All except 2 of the mentally ill group had scores of less than 17. For the NMISO norms, the average number of items passed was 18. The NMISO and college sample studied by Nichols and Molinder (1984) had scores which did not indicate a knowledge deficit.

MSI sexual dysfunction scale

The sexual dysfunction scale has items relating to sexual inadequacies, premature ejaculation, physical disabilities and impotence. The MISO group reported more problems with sexual dysfunction (mean 6.05) than the non-mentally ill group (mean 1.83). In general, community samples of males and non-mentally ill sex offenders do not report problems with their sexual functioning.

MSI atypical sexual outlets

The atypical sexual outlets scale provides information on an individual offender’s sexuality and pattern of offending. The mean scores for the non-mentally ill group (4.18) and mentally ill group (4.50) are similar. Therefore, the MISO group and the NMISO group endorse atypical sexual outlets (obscene calls, voyeurism, bondage, SM, fetishes) to a similar extent.

SEX OFFENCE ATTITUDES QUESTIONNAIRE
(SOAQ)

The results on all scales of the SOAQ for the mentally ill sample fell within the range of results for the non-mentally ill (Procter, 1994). Mean scores for this sample were similar to scores for the NMISO (Procter, 1994) on the cognitive distortion scale, the planning scale, victim empathy and perception of risk. The results on the denial scale were higher for the mentally ill than for the non-mentally ill norms.

SOAQ subscale: planning distortion

This scale is a measure of denial in planning of the offence. The planning scale contains seven items which measure the offender’s attitude in grooming the environment to permit the commission of the sexual offence. For the
Table 4 Mean scores on the five SOAQ scales

<table>
<thead>
<tr>
<th></th>
<th>Cognitive distortion</th>
<th>Planning</th>
<th>Victim empathy</th>
<th>Denial</th>
<th>Perception of risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentally ill sex offenders: N = 20</td>
<td>101.2</td>
<td>26.8</td>
<td>20.6</td>
<td>9.15</td>
<td>36.4</td>
</tr>
<tr>
<td>All types non-mentally ill sex offenders: norms*</td>
<td>96.5</td>
<td>25.2</td>
<td>20.2</td>
<td>5.6</td>
<td>34.3</td>
</tr>
<tr>
<td>Non-mentally ill rapists: norms*</td>
<td>99.7</td>
<td>27.4</td>
<td>19.2</td>
<td>5.9</td>
<td>36.7</td>
</tr>
</tbody>
</table>

* Proctor, 1994

non-mentally ill group no one fell at the 'low' end of the range (7–13) for planning distortion. The majority (55%) were at the 'high' end of the range (28–35). For the untreated non-mentally ill group, 47% fell at the 'high' end of the range (28–35) and 8% fell at the 'low' end of the range (7–13). The pattern and degree of planning denial in the non-mentally ill group and mentally ill group were similar.

SOAQ subscale: denial distortion

The denial distortion scale measures the extent to which the offence is denied. Of the NMISO group 78% fell in the 'low' (4–7) end of the range, whereas of the MISO group scores 45% fell in this range. Proportions of scores at the 'high' end of the range (16–20) were similar for both groups.

SOAQ subscale: victim empathy distortion

The victim empathy distortion scale measures an offender's awareness of the consequences of his offence to the victim and the extent to which an understanding of the impact on the victim is distorted. There were 5% of the NMISO group and none of the MISO group who had a score at the 'low' (6–9) end of the range; 32% of the NMISO group and 15% of the MISO group had a score at the 'high' (26–30) end of the range.

SOAQ subscale: perception of risk distortion

The perception of risk distortion scale is a measure of the perception that a sex offender himself has in terms of his risk, dangerousness and seriousness. There were no scores at the 'low' end of the range (9–15) for either the NMISO group or the MISO group; 40% of the MISO group and 40% of the NMISO group had scores at the 'high' (40–5) end of the range.
SOAQ subscale: cognitive distortion

The cognitive distortion scale measures the extent to which a sex offender justifies, minimizes and denies the nature of his offending, and the risk and harm that he poses to victims. There were no scores for the MISO group at the 'low' end of the range (30–45) and only 1 person in the NMISO group scored in this range. According to the results, the MISO group show cognitive distortions on all scales of the SOAQ, relating to victim empathy, risk of offending, planning of offence and cognitive distortions overall.

DISCUSSION

Results of the study are considered preliminary and will need further exploration using a larger sample. Consequently, the results should be interpreted with caution and are not intended as conclusive. Published norms of some tests, although widely used clinically, are based on American and student populations. None the less, a number of interesting observations have been generated which have implications both for clinical practice and for future research.

All studies which use self-report measures rely on the respondent's accurate self-perception and honesty in responses. To some extent these can be improved by an empathic approach by the interviewer and an assurance of confidentiality. Some patients, in fact, may be more comfortable with the objective nature of instruments which examine sexuality.

The mean pre-morbid IQ score for the sample (Schonell 95.05, NART 94.47) is comparable with the population mean of 100. The pre-morbid IQ of this sample was comparable with the IQs of non-mentally ill sex offenders studied in the STEP report, in which the rapists had a mean IQ of 99 and the total sample had a mean IQ of 102. The mean IQ score for this sample was higher than the mean IQ score (83) of mentally ill sex offenders in maximum security reported by Murray Briggs and Davies (1992). In this sample the lowest IQ score, for an Asian patient, was probably not an accurate reflection of intelligence; it was more likely a product of cultural bias in the test. The IQ scores suggest that with supervision and adequate motivation, mentally ill sex offenders in general have an adequate intellectual capacity to co-operate with the completion of psychometric instruments and would be expected to be able to participate in basic cognitive behavioural treatment programmes currently in use for NMISO populations.

The mean scores for the sample on the Self-Esteem Inventory and the Rathus Assertiveness Schedule were low. It is unclear to what extent this is a feature of pre-morbid personality or a result of conviction and hospitalization. Nevertheless, this aspect of personality may need to be addressed in sex offender programmes. Further enquiry into self-esteem is required,
specifically in relation to sexual relationships, which may reflect poor sexual functioning in view of the high scores on the sexual dysfunction scale of the MSI.

There are inherent difficulties relating to the use of instruments (SOAQ and MSI) on the mentally ill which have been standardized on the non-mentally ill sex offender population. These scales are based on the proposition that there is a pattern of cognitive and behavioural progression involving antecedent thoughts and actions typical of all sex offenders. These assumptions underlie sex offender programmes for the non-mentally ill and have been considered valid. Application of similar treatment programmes to the mentally ill may also lead to disclosure by the mentally ill of elements of planning in their offence. A cautious approach is required, particularly in interpretation of the scales which measure justifications, lie and denial. These scales are based on the assumption that the sex offender planned and deliberately committed a sexual offence as a result of sexual urges and motivation. For instance, with the MSI justification scale a sex offender is considered to have committed a sexual offence because that is what he wanted to do and not, for example, because of 'poor communication', which is rated as a justification.

The results show that the MISO group show cognitive distortions on all scales of the SOAQ. There was an absence of low scores on the victim empathy, risk, planning and cognitive distortion scale. Contrary to expectations, high levels of sexual interest were disclosed by the mentally ill population. These included deviant sexual interests as illustrated by scores on the MSI ASO scale and fantasies on the Wilsons Sex Fantasy Questionnaire. It is of interest that the MISO and NMISO admit to a range of deviant sexual interests on the MSI ASO scale to a similar extent. The non-mentally ill sex offenders admitted to a range of sexual fantasies with a mean score which was higher than the non-offender norms. This may, however, reflect cultural changes since the norms were established some 16 years previously. The MISO group means scores were similar to the sadomasochistic group norms on the exploratory/intimate and impersonal themes. On the MSI sexual obsession scale the mentally ill reported high levels of sexual interest and preoccupation with sexual matters. This was much higher than the non-mentally ill and community groups (Nichols and Molinder, 1984). Taking these two together, 70% are reporting a high interest in sex, not necessarily predictable in a mentally ill, predominantly schizophrenic population. The existing literature does not refer to the penile plethysmograph responses of mentally ill sex offenders. This would be of interest.

In contrast to the non-mentally ill sex offender norms, the mentally ill group had low scores on the sexual knowledge and beliefs scale. This indicated a need for accurate sex education and information. However, the non-mentally ill sex offenders are considered to have adequate levels of sexual
knowledge (Nichols and Molinder, 1984). The mentally ill sex offenders reported higher levels of sexual dysfunction on the MSI sexual dysfunction scale, but this may be influenced by the use of antipsychotic medication. This suggests a need for inquiry into sexual functioning in assessing all mentally ill sex offenders.

Sexual offending by the mentally ill is a neglected area. There are similarities in the psychosexual profiles of non-mentally ill sex offenders and mentally ill sex offenders with implications for clinical practice and future research. The apparent overlap in motivation to offend between the MISO and the NMISO groups requires replication. Further exploration of the role of mental illness in sexual offending is needed, using a larger sample and including, for comparative purposes, a group of mentally ill violent offenders. It is not clear whether denial and distortion in relation to offending are a symptom of all mentally ill offenders or merely of sexual offenders. A larger sample size may also allow determination of any relationship between key background variables and responses to the psychometric test, which was not apparent in this study. These preliminary findings suggest that the management of mentally ill sex offenders needs to incorporate assessment of cognitions, perceptions and fantasies in addition to the treatment of the mental illness itself.

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