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Submitted for The Doctorate of Psychology (PsychD)
In
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University of Surrey**

**POLYGRAPH EXAMINATION OF BRITISH SEXUAL
OFFENDERS:
A Pilot Study on Sexual History Disclosure Testing**

Psychol

**Daniel T Wilcox
2002**

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ABSTRACT

This Doctoral portfolio chronicles my professional development in many respects. I completed my Masters Degree in the late 1970's with a dissertation focusing on behavioural self-control techniques for the control of obesity. This research examined the effectiveness of cognitive behavioural techniques at a time when 'learning theory' and 'behaviour modification' were still regarded as the only therapeutic tools necessary in many clinical settings.

My professional work began with a series of clinical psychologist posts in treatment settings for the intellectually disabled. My emphasis on working with individuals who presented challenging, socially inappropriate behaviours led to a gradual forensic emphasis and eventually to 'partnership' with the West Midlands Probation Services, Sex Offender Unit in the early establishment of a groupwork programme for intellectually disabled sex offenders. This work has led to my involvement in national and international training events focusing on the development of effective treatment techniques for working with intellectually disabled offenders who commit sexual offences. This work has culminated with the production of my review article, 'Treatment of Intellectually Disabled Individuals who have Committed Sexual Offences: A Review of the Literature', a slightly longer version of which has now been accepted for publication by the *Journal of Sexual Aggression* (Wilcox, accepted for publication).

The second review article, 'The Application of the Clinical Polygraph Examination to the Assessment, Treatment and Monitoring of Sex Offenders' (Wilcox, 2000), was published in the *Journal of Sexual Aggression*. This paper and the research dossier, which is currently being prepared for publication, is the direct result of the supportive and forward thinking attitudes of the Probation Service management at that time. The West Midlands Probation Services Sex Offender Unit's Community Sex Offender Groupwork Programme was developed and achieved Home Office Accreditation during this period when Wilcox Psychological Associates was providing the

psychological assessment and consultancy services to the Sex Offender Unit. In keeping with the Unit's general attitude toward improving effectiveness, I was at that time pursuing the use of physiological measures to improve the treatment, assessment and monitoring of offenders. This led to making contact with various professionals and ultimately to research and evaluation of the effectiveness of the polygraph in this regard via the research dossier. Since that time I have made a number of conference presentations and published numerous articles with colleagues in this area (Wilcox, Sosnowski and Middleton, 1999; Wilcox, Sosnowski and Middleton, 2000; and Wilcox, Sosnowski, Middleton and Grubin, 2002).

In many respects, the case study most substantially reflects the kind of professional work I have undertaken since achieving Chartered status as a clinical and forensic psychologist. This paper details a common focus of my clinical evaluation and risk assessment work employing specialised and more general psychometric measures. The case study includes information about clinical interviews conducted and professional liaison efforts to address obvious public protection concerns that have arisen. The initial assessment report describes the work I have undertaken within the context of providing expert witness testimony in legal proceedings. The treatment component of this paper provides, through a case example, evidence of my work with the National Probation Service in developing and running Sex Offender Assessment and Treatment Programmes.

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I would also like to express my gratitude to Peter Harvey who provided me the necessary guidance to achieve Chartered Status as a foreign applicant to the British Psychological Society. This enabled me to pursue my clinical psychology practice in Britain and created the opportunity for me to undertake this doctoral work.

Within the specific field of sex offender work I have had the good fortune of spending time with a number of leading authorities. I have found their availability and willingness to share information to be a source of both motivation and inspiration that I have not readily found in other areas of psychological research. In particular, Bill Marshall and Anna Salter have influenced my approach to clinical practice and have offered me much valued personal encouragement. In my ongoing clinical/forensic practice, my close associates Mary Leyland and Dan Sosnowski have, in their respective fields of expertise, i.e. group work with (intellectually disabled) sexual offenders and applying the polygraph to assessment, treatment and monitoring of sex offenders, provided me with significant insights and enormous support.

I would also like to thank my office manager, Rita Donathy and my former secretary, Sandi Callander for their assistance and eye for detail in the production of this manuscript. Zerine O'Keeffe, Caroline Foss, Carrie-Ann Pash and Satwinder Purewal also made helpful research and administrative contributions in the development of this portfolio. I also very much appreciate Tony Beech's willingness and flexibility in making himself available as an external examiner at short notice, especially in view of his exceptionally busy schedule. Along with internal examiner, James Murray, they identified a number of positive text alterations, which have improved the overall quality of this doctoral manuscript.

Lastly, my wife Helen has given me assistance at every level, proofing, advising, morally supporting and at times, by necessity, undertaking the roles of mother and father for our two daughters, Tara and Roz. Without the patience and ongoing support of my family, this doctoral work could not have been completed. For this, I am especially grateful.

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DISSERTATION**

A COMPARATIVE ANALYSIS OF ABBREVIATED

BEHAVIOURAL

TREATMENTS OF OBESITY

BY

DANIEL T WILCOX

A Thesis Submitted in Partial Fulfilment
of the Requirements for the Degree
of Master of Arts in Psychology

State University College of Arts & Science
Geneseo, New York

August 1978

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I would like to extend my thanks to the members of my Thesis Committee, especially Dr Timothy DeChenne for his assistance. I also thank my family for their consistent support and encouragement. Grateful thanks also to Beverly Dutcher, Gabrielle Verkey and Jane Clark who particularly assisted me through the various revisions.

ABSTRACT

The purpose of this study was to determine the comparative effectiveness of three abbreviated weight loss techniques. Thirty-seven overweight women were assigned to one of three conditions: a) will-power control; b) coverant control; and c) stimulus control. Each of these groups received one hour of initial instruction in the particular self-management procedure assigned; in addition all groups received general information on obesity, nutrition, and healthy dieting. Subjects attended eight weekly weigh-ins, each approximately five minutes in duration, and a four-week follow up weighing. Analyses indicated that the coverant control group showed significant weight loss over the treatment period, and that this loss was retained at the four week follow up. The other groups showed no significant weight loss. The implications for the use of these techniques in more complex behavioural weight control programmes were discussed.

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CHAPTER I

INTRODUCTION

Traditional treatments of obesity have included psychotherapy (Penick, Fillion, Fox, & Stunkard, 1971), medication (Penick, 1970), a vast array of crash diets, and therapeutic starvation (Bruch, 1957). The overall ineffectiveness of the techniques which preceded the behavioural approach prompted Stunkard (1958) to say, "Most obese persons will not stay in treatment for obesity. Of those who stay in treatment, most will not lose weight and, of those who do lose weight, most will regain it" (p.87). However, the advent of behavioural control techniques has changed this picture considerably; the demonstration of effective behaviour modification programmes for weight reduction (Ferster, Nurnberger, & Levvitt, 1962; Stuart, 1971; Wollersheim, 1970) now permits a more optimistic appraisal. Among the more promising of the behavioural approaches to obesity are those techniques which have come to be called "self-control" procedures.

In 1953, Skinner offered his interpretation of how a person can regulate his own behaviour; he subscribed to the term "self-control" and provided justification for its use. He asserted that for a given response to increase in frequency it must be reinforced; it does not matter who or what provides the reinforcement – in many situations, an individual can present his own reinforcement. He can modify his responses by changing the environmental stimuli that influence his behaviour. Therefore, the concept of self-control, unlike will power, is a measurable phenomenon which falls within the realm of scientific study.

The earliest comprehensive paper advocating the use of behavioural principles for the control of overeating came from Ferster et al (1962). Since its appearance, this work has substantially influenced the nature of behaviourally oriented weight-control programmes in a variety of contexts. Ferster et al identified a number of variables that influence eating. Among these are the stimulus control effects, or the

environmental stimuli which tend to elicit or inhibit eating responses. An example of response elicitation might be having company stop at your home, thus providing a common social cue for food consumption. Presumably, such elicitation cues may be purposefully manipulated by the individual in an effort to decrease the eating response. In addition, eating behaviour may be viewed as a chain of responses following the initial stimulus and terminating with the consummatory response. It is therefore possible to increase or decrease the probability of eating by adjusting the number of intermediate steps to suit the desired end. a consummatory chain might be lengthened, for example, by buying foods which require extra preparation. According to Ferster, one should also be aware of deprivation effects on eating: the likelihood of excessive eating is greatly increased when an individual becomes extremely hungry. Further, Ferster suggested that people are less successful at buying low calorie foods when they are hungry.

Reinforcement factors are also considered to influence eating. Although Ferster et al (1962) indicated the limited applicability of escape and avoidance procedures, they most strongly favoured the employment of positive reinforcement. Subsequent research has given much support to their position. For example, when subjects in a weight control study were asked to award or fine themselves a portion of their own deposit money contingent upon changes in their weight and eating habits, the subjects who self-rewarded showed significantly more weight loss (Mahoney, Moura, & Wade, 1973).

Ferster also spoke of the value of competing, prepotent response repertoires in modifying eating. Competing responses are behaviours which by their nature tend to reduce the possibility of an eating response occurring simultaneously with them, e.g., chewing gum, taking a walk. A prepotent response is one which already has a high probability of occurrence independent of eating. Smoking, reading, or watching television are possible examples of prepotent responses depending upon the individual. It is therefore possible for responses to be both prepotent and competing

with reference to eating behaviour and thus may effectively serve as alternatives to eating.

Research with obese subjects has shown that it is possible to shape effective response repertoires to avoid overeating, via manipulation of cues, reinforcement, or competing or prepotent responses. The model supplied by Ferster et al (1962) has become a standard for many of the self-control weight studies discussed below (Harris, 1969; Penick, et al, 1971; Stuart, 1967, 1971; Wollersheim, 1970). An additional assumption in many of these studies is that the consumption of food is reinforced by more immediate consequences, i.e. the taste and smell of food and feelings of satiety. The negative consequences of overeating, e.g. decreased attractiveness, decreased longevity, health, problems and getting fat, are all cumulative long-range effects which presumably have little influence on the diner sitting down to a meal which promises immediate, pleasurable gustatory and olfactory sensations. The treatment goal in part is to manipulate the negative consequences of improper eating and/or the positive consequences of proper eating to enable important delayed reinforcers to compete with pleasurable immediate ones.

Goldiamond (1965) used a behavioural self-control procedure emphasising the narrowing of eliciting or discriminative stimuli, as well as the consumption of nutritionally appropriate food in his treatment of an obese young man. In his illustrative example he required that eating be restricted to specific locations and times. He further required that eating be done in the absence of all other activities. The rationale here was that eating would be reduced by breaking up the associations between eating and other behaviours. This method had a further source of effectiveness since it created a mildly aversive, stimulus-deprived environment when the individual ate. The significant weight loss reported for Goldiamond's subject suggests that this approach may have considerable utility.

An article by Homme (1965) lent further support to the feasibility of using self-control in the treatment of obesity. It presented a paradigm for “coverant conditioning”, based on the notion that private mental events are subject to the same principles of conditioning as overt behaviours. In particular, Homme proposed the application of the Premack principles to “mental responses” which he called coverants (covert operants). Premack (1965) has shown the value of ranking behaviours in terms of their natural probability of occurrence and then reinforcing a lower probability behaviour with the opportunity to engage in a higher probability one. For example, if a student likes science better than math, the probability of doing math work may be increased by making the opportunity to do science work contingent on completion of the math assignment. Homme asserted that a somewhat analogous principle applies to the reinforcement of covert events or thoughts. He suggest that low probability thoughts (coverants) that are incompatible with overeating can be strengthened by following them with a high probability behaviour. Specifically, Homme had proposed that overweight people should repeatedly engage in the following sequence: (a) become aware of an eating stimulus; (b) emit a negative coverant; (c) emit a positive coverant; (d) engage in a reinforcing or high probability behaviour. A negative coverant would be an anti-eating covert response, e.g. “If I eat too much, I’ll get fat and die young”. A positive coverant would be a pro-non-eating covert response, e.g. “If I eat appropriately, I will be attractive and healthy”.

Recent studies by Carter and DeJulio (Note 1), Horan, Baker, Hoffman, and Shute (1975), and Horan and Johnson (1971) provide evidence of the utility of this technique. Carter and DeJulio indicate that coverant control is effective even when the therapy sessions are faded out over the treatment period. Subjects in their coverant control groups met with the therapist for one-hour sessions during the 1st, 3rd, 6th and 10th week and showed significantly more weight loss than the weekly treatment groups. While the therapist in all groups was supportive, he did not answer idiosyncratic questions; instead, he merely reiterated the coverant control procedure. Evidence reported by Horan et al (1975) suggests that the Homme techniques, a four-step sequence, may be shortened. They showed a significant weight reduction in two

groups, one treated with the four step sequence and the other within which the negative or anti-eating coverant was eliminated from the procedure.

Among the most impressive case studies is that described by Stuart (1967), who used self-management techniques in the treatment of eight obese families. Stuart obtained statistically significant results using treatments similar to those applied by Ferster et al (1962). He later added to the scope of his weight programme by including exercise and dietary planning instructions (Stuart, 1971; Stuart & Davis, 1972). This "three dimensional" programme, as it is referred to by Stuart, requires proper knowledge of nutrition, the monitoring of calorie intake, and the monitoring of energy expenditure.

Several experimental studies also attest to the effectiveness of self-control procedures in the treatment of obesity. For example, Harris (1969) used a complex self-management procedure as well as "covert sensitisation" in an experimental study concerning weight loss. Covert sensitisation, a term coined by Cautela (1967), is an aversive conditioning technique involving the association of noxious imagery with an undesirable impulse. In the Harris study, subjects were trained to imagine that, as they approached problem foods, the sensory cues of the food made them increasingly nauseous. The rationale was that through the pairing of imaginal representations of the unwanted behaviour (overeating) with vivid images of nausea and vomiting, the aversive nausea-vomiting images would become associated with the consequently diminish the frequency of inappropriately eating. The other self-management procedures in this study consisted of a triad of Ferster et al (1962) techniques. There were: (a) positive reinforcement for appropriate eating, (b) stimulus narrowing, i.e. reducing the number of stimuli associated with eating, and (c) lengthening the response chains involved in eating. This procedure produced a significantly greater weight loss than a no treatment control group. For two and a half months the treatment group met twice weekly for one hour of training in Ferster et al (1962) self-management procedures. During the remainder of the four-month study, half the treatment group received individual covert sensitisation training held weekly and half continued to employ only the initial techniques. The covert sensitisation procedure

did not have an additional effect, i.e. the sub groups did not significantly differ at the final weighing. It is doubtful, in fact, whether covert sensitisation is an effective technique in the treatment of obesity. For example, Diament and Wilson (1975) compared covert sensitisation to an attention-placebo group and a no treatment control group with obese college students as subjects. The results showed no significant difference among the three groups in weight loss. Diament and Wilson also reviewed the empirical findings on covert sensitisation applied to obesity and found them often to be either negative or subject to confounding factors.

Wollersheim (1970) used procedures described by Ferster et al (1962) to demonstrate the superiority of behavioural self-control over a positive expectation-social pressure group, analogous to the nation-wide weight reducing clubs, TOPS (Take Off Pounds Sensibly), and a non-specific therapy group focusing on "recognising the underlying causes and unconscious motives" of overeating. Using female undergraduates as subjects over a twelve-week treatment period Wollersheim found that all three groups lost significantly more weight than a no treatment control group. However, post hoc comparisons revealed that the self-control treatment was more effective than either social pressure or non-specific therapy.

A final study showing the efficacy of behavioural self-control comes from Penick et al (1971). Traditional group therapy was compared with self-control as employed by Ferster et al (1962). The self-control group showed significantly greater weight loss at the end of the twelve-week treatment period.

The above noted studies (Harris, 1969; Penick et al, 1971; Wollersheim, 1970) provided controls and comparisons of behavioural techniques with some traditional weight control methods. All three studies indicated that self-control techniques were significantly more effective than controls or other treatments. The present study is prompted by the need to compare techniques within the often multifaceted self-control packages (Abramson, 1977; Hall & Hall, 1974). As Jeffrey (1975) has indicated, "future research needs to move beyond the demonstration stage that weight

loss can be achieved and to begin investigating more carefully methodological issues such as . . . cost effectiveness analyses" (p. 96). Jeffrey suggests that we concentrate on establishing which self-control techniques are most effective and economical.

Many behavioural programmes may be thought of as complex in that they combine a variety of techniques to effect weight loss. However, simple or abbreviated self-management techniques have been introduced (Fowler, Fordyce, Boyd, & Masock, 1972; Goldiamond, 1965; Hall, Hall, Hansen, & Borden, 1974; Homme, 1965; Horan et al, 1975; Romanczyk, 1974; Romanczyk, Tracey, Wilson, & Thorpe, 1973) which show significant effectiveness. Fowler et al (1972) introduced a simple self-management technique involving the monitoring and systematic reduction of bites of food consumed each day. This technique was compared by Hall et al (1974) with the standard full-scale treatment package as described by Ferster et al (1962). Both treatments were more effective than a no treatment control though the treatments did not differ from one another. Romanczyk (1974) and Romanczyk et al (1973) demonstrated the effectiveness of self-recording daily weight and daily calorie intake. In both studies this simple self-control technique produced a significant weight loss and was as effective as a full scale behaviour management package. Typically, these abbreviated techniques which emphasise reduced complexity and minimal therapist involvement, have been contrasted with a complex full scale programme. Consequently, the comparative effectiveness of individual, abbreviated techniques is largely unknown. Comparisons of these methods might aid in determining the most significant features of behaviour weight loss programmes.

Although the result of most studies employing behavioural treatments of obesity have been positive, the studies have important shortcomings that demand scrutiny. Many studies do not have extended follow up assessments to determine how well the weight loss is maintained. While weight loss in some short-term follow ups has remained significant (Hagen, 1975; Wollersheim, 1970), experimental groups tended to regain weight at the end of treatment. In most cases where follow ups have been extended six months or more, significant weight loss has not been retained (Hall & Hall, 1974).

Hall and Hall further indicate that the amount of weight loss is often clinically insignificant. It is also notable that premature termination rates are high and show a great deal of variability between studies. Hall and Hall reduced attrition by requiring subjects to pay a cash deposit at the outset of the experiment; return of the money was made contingent upon the completion of treatment.

Treatment effects may also be influenced by sex and age. Most behavioural weight studies have used female subjects exclusively. Evidence presented by Sikes and Singh (1974) suggests that females are less compliant than males in following these procedures. Concerning the age variable, Wollersheim (1970) identifies chronically overweight adults as the "hardcore obese" suggesting the limited probability of successful dieting. Other variables which have been investigated include degree of overweight and the personality trait, locus of control. Schachter (1968) asserted that obese people are more responsive to environmental cues concerning food than are the non-obese. Schachter further provided evidence that if directly confronted with food, obese people will eat more than normal weight people, but if the food is known to be present but not within immediate sensory range, obese people will eat less than normals. If Schachter is correct this would add an additional attractive feature to the stimulus control technique to be discussed later. Evidence provided by Kilmann, Albert, and Sotile (1975) indicates that subjects judged to be high in internal locus of control (Rotter, 1966) perform significantly better in self-managed behavioural weight programmes than high external locus of control subjects. A final consideration is the pressing need to standardise techniques and methods of measurement in order to separate effective from ineffective components in the self-control packages.

The present study compared two abbreviated weight control programmes, as well as a control condition. The first treatment group involved stimulus control techniques analogous to those presented by Ferster et al (1962) and Goldiamond (1965). It focused on controlling the eating situation through the use of stimulus narrowing and chaining. Subjects were asked to expose themselves to stimulus situations unlikely to be associated with eating, and to eat only at specific times and in predetermined

places. In addition, they were instructed in methods of increasing the length of the consummatory response chain. The second treatment group involved coverant conditioning as described by Horan et al (1975). Subjects were instructed in how to strengthen low probability thoughts that are incompatible with overeating by following them with high probability thoughts. Pro-non-eating coverants were strengthened by following them with self-awarded tokens. Preferred goods and activities were purchased with tokens. Experimental groups were compared with a "will power" group analogous to that used by Jeffrey and Christensen (1972). This was a control condition within which subjects were asked in non-behavioural terms to exert self-discipline to lose weight.

Since the purpose of the present study was to make comparisons among weight loss techniques not previously done, the basis for a hypothesis is limited. The two experimental conditions have been compared with complex behavioural control procedures, however results have varied among the studies and relevant population characteristics have differed considerably. Even if this information were ferreted out, it would be of questionable value. Such speculations could also have provided experimenter bias. Weighing these considerations the only hypothesis that could be drawn was that the two experimental groups would lose more weight than the will power control group.

CHAPTER II

METHOD

Subjects

Thirty-seven female college students were enlisted in a weight reduction programme and randomly assigned to one of three groups, two treatments and a control. subjects were recruited from introductory psychology classes at the State University College at Geneseo, New York, and received course credit for participating. Potential subjects were informed that they had to meet the following criteria to be considered for the study: female, age 18-30, a minimum of 15 pounds over desirable weight based on the Metropolitan Height and Weight Tables for individuals with medium bone structure (United States Department of Health, Education and Welfare, 1966), no current involvement in a weight control programme, and willingness to attend eight weekly meetings and a four week follow up session. A total of fifty-eight women were initially interviewed. Heights and weights were determined and the criteria for entry individually assessed. Of the original fifty-eight volunteers, thirty-seven were determined to meet the requirements for inclusion in the study. Each subject was required to give written consent to participate in the study and to secure a signed physician's statement declaring that weight reduction was not contraindicated at that time (Appendix B). Subjects then received a general description of the study (Appendix A) and were randomly assigned to conditions. At the time of the first experimental session all subjects reported to their assigned groups and were allowed to participate if they continued to meet the weight criterion and their consent forms were properly completed. One subject with a thyroid condition was disqualified at that time.

Procedure

The author served as experimenter and used a standard physician's scale to determine all height and weights reported. At the first experimental session subjects within each condition met as a group to receive one hour of weight control instruction. This instruction involved a description of the specific weight loss technique that the group

would employ, i.e. will power, stimulus control, or covert control. This was supplemented with a hand out of instructions appropriate to the particular group. In each of the three conditions approximately fifteen minutes was devoted to the discussion of an additional hand out on obesity, nutrition, and safe dieting, as well as a brief question and answer period. The nature of the one hour instruction sessions is more specifically described below.

In the Will Power Group (1) subjects were asked to employ will power to lose weight. They received one hour of instruction focusing primarily on the importance of determination and self-discipline for the accomplishment of weight loss. These verbal instructions were accompanied by the Will Power hand out shown in Appendix D. This instruction session also included a brief discussion (approximately fifteen minutes) of the hand out on obesity, nutrition, and dieting (Appendix C), after which a question and answer session occurred. All answers were drawn from the information in the two hand outs. Weighings were conducted immediately after this first experimental session. This group represented the study's control condition although it is obviously not a no treatment control. It may best be viewed as an attention-placebo control in that subjects were encouraged to lose weight but the treatment technique was non-behavioural and non-specific.

The techniques for the Stimulus Control Group (2) were similar to those espoused by Ferster et al (1962) and Goldiamond (1965). Subjects were instructed to treat overeating as a situational problem and not a personal problem. The programme focused on modifying the antecedents or discriminative stimuli for eating as well as the actual eating response; the method focused primarily on stimulus narrowing and a lengthening of the consummatory response chain. For example, subjects were asked to eat in one place only and to do nothing else while eating. This is a stimulus narrowing technique, intended to reduce the probability of associating eating with other activities. Subjects were also requested to lengthen the response chain involved in eating by buying foods that required some preparation, by storing of only non-fattening items in the kitchen, etc. The instructions were supplemented with the hand

out presented in Appendix E. This was followed by a discussion of the general hand out on obesity, nutrition, and dieting (Appendix C), as well as a question and answer period. All questions were answered in terms of the two hand outs. Again, weighings were conducted immediately after this session.

The Coverant Control group (3) was instructed to engage in the coverant control sequence described by Horan et al (1975). Subjects were asked to prepare five to ten pro-non-eating coverants to follow stimuli for impulses toward eating. A pro-non-eating coverant emphasises positive reasons for not overeating. An example of such a coverant is "by eating properly, I will be attractive, strong, healthy, etc." Subjects were also asked to prepare a list of ten pleasurable or rewarding behaviours which would be used as reinforcers to increase the emission of the pro-non-eating coverants. The subjects were instructed to follow each eating impulse with a coverant, and each coverant with the mental awarding of a "token" or point. These points, which the subject was to record as soon as feasible, were used to buy preferred activities at a cost which was individually determined by the subject with assistance from the experimenter. In establishing a pay off schedule the subjects were advised to begin with liberal reinforcement and to assess within the first two weeks whether points should be made more difficult to earn. These instructions were supplemented by the instructions presented in Appendix F. As in the other groups, this initial session closed with a discussion of the general dieting information (Appendix C), a question and answer period, and a weighing. All information: the lists of preferred activities, the pro-non-eating responses, and the pay off schedules, were initially shown to the experimenter for approval and were reviewed at the subsequent weekly weigh-ins.

All subjects were asked to report for a five minute weekly weigh in for the next seven weeks, as well as for a follow up session four weeks later. The five minute weigh-ins included weight determinations, supportive involvement on the part of the experimenter, recapitulation of the basic principles of the appropriate behavioural management technique, and answering of questions based on the information each subject received.

At the last experimental session (week eight) subjects were required to complete an evaluation form of the weight reduction programme (Appendix G). Subjects rated on a scale of one to five the degree of effort involved in their weight programmes, the degree to which they believed that their weight programmes would work, and the degree to which the experimenter seemed committed to their weight reduction method. Subjects indicated which group they were in but did not sign the forms. This information was used to assess experimenter effects and demand characteristics since the author was the only experimenter for all groups and subtle bias might therefore result. To reduce the likelihood of such effects, it was necessary to precede the present study with a pilot investigation. Three subjects were assigned to each of the three conditions and received the same initial instructions as the treatment groups. These subjects completed the evaluation forms and there were no differences found between groups.

CHAPTER III

RESULTS

Attrition

At preliminary weighings, thirty-seven subjects were determined to have met all the entrance criteria except a physician's approval. Of these, twelve subjects were randomly assigned to the will power group, twelve to the stimulus control group, and thirteen to the coverant control group. However, three subjects withdrew before the first session. In addition, one subject was disallowed at the first session when the physician's statement indicated a thyroid condition. As the study began, therefore, there were 33 subjects – ten each in the will power and stimulus control groups and thirteen in the coverant control group.

During the remainder of the study seven additional subjects dropped out. A subject was considered a drop out if she missed more than two of the eight treatment period weigh-ins. This was a meaningful cut off because although many subjects missed or cancelled attendance of two sessions, (56%), very few missed more than two meetings without ceasing participation altogether (3%). Using this criterion, the drop out ratio after the first session was 20% (two subjects) for the will power group, 31% (four subjects) for the coverant control group, and 10% (one subject) for the stimulus control group. These attrition ratios did not differ significantly. However, there was a significant difference for some groups in the proportion of full term subjects who missed one or two weighings (will power, 13%; stimulus control, 67%; and coverant control, 44%). For Group 1 vs. Group 2, $z = 3.86$ $p < .01$; for Group 1 vs. Group 3, $z = 2.2$ $p < .05$. Groups 2 and 3 did not differ significantly. It could be argued that the significant differences noted above may have in themselves accounted for the experimental findings in some way. Although this is technically possible it is considered unlikely. This issue will be addressed in the discussion.

Treatment Effects

A 3x3 mixed ANOVA was applied to the weight data, using treatment group as the between subjects variable and weeks as the within subjects variable. Only weeks 1, 8 and 12 (or follow up) were used in the analysis. These weeks only were selected for inclusion in the analysis for two reason: (a) although many subjects missed one or two sessions during the course of treatment, all subjects included in the final analysis had attended the weighings at weeks 1, 8 and 12; and (b) weeks 1, 8 and 12 were the most important since the represented pre-, post- and maintenance weights, respectively. Although it would have been possible to include all weeks in the analysis by resorting to procedures for the estimate of missing data, such procedures are extremely tedious computationally, and in the final analysis are of only questionable value. Since the most important data points were already available for all subjects, it seemed well advised to use only these points in the analysis. The data from all weeks are included in Appendix H.

Table 1 presents the mean weights for each of the three groups at each of the three weeks. The results of the analysis of these data are presented in Table 2. Results reveal a significant main effect for weeks, $F(2,46) = 6.42$, $p < .05$, indicating a significant change in the overall mean weights across time. In addition, there is also a significant Group x weeks interaction, $F(4,46) = 3.16$, $p < .05$, indicating that the nature of the weight charge across weeks differed significantly as function of treatment group.

Table 1. Mean Weights of Treatment Groups at Pre, Post and Follow Up Trials				
Group	Week			Mean
	1	8	12	
Will Power	164.24	161.97	161.84	162.70
Stimulus Control	155.36	155.69	156.14	155.73
Coverant Control	153.28	149.33	148.75	150.45
Mean	157.64	155.66	155.58	

Table 2. 3x3 Mixed ANOVA on Weight Data			
Source	df	Mean Square	F
Group (G)	2	977.6458	0.67
Error b	23	1462.0558	
Week (W)	2	35.2531	6.42**
G x W	4	17.3784	3.16*
Error w	46	5.4891	

In exploring the Group x weeks interaction, tests for simple effects were applied to the data of the three groups at week 1, week 8, and week 12, none of these analyses reached significance; following Keppel (1973) and Myers (1966), the error terms in these analyses were based only upon the data actually involved in the comparisons. The use of a heterogeneous error term would be advisable in this case, since such a term introduces systematic bias when a low n is involved. Consequently, additional tests for simple effects were applied to the data of each treatment group across weeks; of these additional analyses, only the one for the coverant control condition reached significance, $F(2,16) = 11.86, p < .001$. Follow up comparisons with Duncan's Multiple Range Test revealed that for the coverant group, the mean weight at week 1 was significantly greater than the mean at week 8 or week 12 ($p < .05$ and $< .01$, respectively), while the means of weeks 8 and 12 did not differ significantly.

Thus, the nature of the Group x weeks interaction lay in the significant loss of weights for only the coverant control group. However, this differential weight loss was not of sufficient magnitude to produce a significant difference between groups at any of the three weeks.

Experimenter Effects and Demand Characteristics

As noted previously, at week 8 all subjects were asked to evaluate the perceived degree of effort involved in their weight programmes, the degree to which they believed their programmes would work, and the degree to which the experimenter seemed committed to the weight reduction method. These were rates on scales of one to five as shown in Appendix G. The mean response for each group to each item was:

3.10, 3.25, and 3.82 for Group 1; 2.48, 3.35, and 3.45 for Group 2; and 3.02, 3.17, and 3.56 for Group 3. One way ANOVA's were conducted on the responses to each item and none reached significance.

CHAPTER IV

DISCUSSION

The most important finding was that coverant control, even in this abbreviated form, produced a significant weight loss over the treatment period. A mixed ANOVA revealed a significant main effect for weeks and a significant group x weeks interaction. Tests for simple effects indicated that only the coverant control condition showed a significant weight change across time. Further analyses indicated that the mean weight for this group at week 1 was significantly greater than the mean weight at week 8 or 12.

Separate analyses were performed to assess the influence of confounding variables. Based on scaled (1 to 5) subject responses, it was determined that the groups did not differ in belief in their assigned weight programme, in their perceived effort or in their perception of the experimenter's commitment to their assigned treatments. It was further determined that the groups did not significantly differ in attrition. However, one source of confounding was noted. This concerned the significant difference between groups 1 and 2 and groups 1 and 3, in the proportion of subjects who missed one or two meetings. It could be argued that these differences alone account for the experimental findings in some way. Although this is undeniably possible, it does not seem probable; in pragmatic terms, the absence of a subject from one or two five minute contacts would not seem to be a factor of much importance. The issue can not be resolved by speculation of course, and the possibility of an important confounding variable remains; again, however, such a possibility seems remote to the present author.

The subjects and data in the present study also bear further consideration. Subjects were defined as obese according to a liberal standard which coupled with their relative youth might cause a comparison with the chronically and excessively obese to be less applicable or even spurious. This however must be determined empirically

and is an appropriate subject of future experimentation. Also the type of data reported (pounds) was somewhat arbitrary since percentage weight loss would have been a viable alternative. Poundage data was deemed acceptable because the groups did not differ according to weight or height and this data type is most amenable for comparison and most frequently reported. The raw data is however available in Appendix H if additional comparisons are desired.

Probably the most important consideration is the factors underlying the superiority of coverant to stimulus control in the present study. This could be due to the fact that coverant control focuses more on consequences, i.e. reinforcing appropriate eating behaviour, while stimulus control focuses more on antecedents, i.e. modifying environmental cues associated with eating. Though a plausible explanation, this seems less likely than an interpretation based on the differential applicability of the techniques to the population in this study. It would seem likely that stimulus control techniques are maximally effective when employed by relatively autonomous individuals who are capable of structuring their environment to minimise eating cues. It is clear that in residence college students are somewhat limited in this regard. While the college students could easily carry out the coverant control procedures, some of the stimulus control procedures were difficult for them. A breakdown of the stimulus control hand outs (Appendix D) may aid in this explanation. For example, points 1, 2, 3, and 4 seem generally harder for these students and in some respects almost inappropriate. Point 1 stresses "eating in one place and doing nothing else while eating". Although dining hall students can eat in more or less the same place every day, it is particularly hard not to engage in social interaction in this stimulus rich environment. Point 2 concerns the "buying of non-fattening foods". Again this presents a difficulty since students whose primary meals are prepared by the college have less control over this variable than many people do. Points 3 and 4 both have features relating to the buying, storage, and preparation of foods; all of limited relevance to in-residence college students. Points 5 and 6 seem just as easy for college students as anyone else. Respectively, they concern the avoidance of states of

loneliness, boredom, fatigue, and excessive hunger; and a technique for slowing down eating rate.

In retrospect, it seems logical that institutional populations in general would be less appropriate for stimulus control than coverant control weight loss procedures. At least it is unlikely that stimulus control procedures are generally as ineffective as they proved to be in the present study. For example, with a population of urbanites averaging 37 years of age, McReynolds, Lutz, Paulsen, and Kohrs (1977) found stimulus control procedures as effective as a full behavioural treatment package and significantly more effective at both a three and six month follow up. The differences at follow up were attributed to: (a) the unwieldiness of a complex programme when self maintenance is required, (b) direct and focal bearing on specific stimulus control manipulations which may have served as permanent “do” and “don’t do” guidelines.

It should be pointed out however that some type of “stimulus control” approach may be the treatment of choice in certain institutional settings. Probably, the flexibility of the milieu needs to be weighed against the practicality and innovative limits of contingent reinforcement. For example, to minimise obesity in an institutional population of mentally retarded people it might be argued that employing permanent structural changes to create a ‘non-(over)eating’ environment would be a more practical approach than focusing on the reinforcement of appropriate eating habits.

It is evident from the results that significant weight loss can be achieved even when an extremely abbreviated weight loss technique is applied. The weight loss produced, however, was of little clinical significance, possibly indicating that such a drastically abbreviated approach is too much of a minimisation.

At present, this author would not favour any singular, simple weight loss technique. Streamlining of the complex procedures is needed but a single technique may too easily “miss the mark”. A small armament of carefully chosen techniques seems more prudent since the therapist would then be free to determine the relative

importance of each technique as the population characteristics and environmental features become clearer. With more empirical data about simple behavioural techniques and how they relate to specific populations, specific behavioural treatment recipes may become a realistic goal.

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APPENDIX A

The Weight Study

This weigh control study will span eight weeks but the techniques involved may be used by the weight loser independently after the study.

To complete the programme, you are asked to meet with the experimenter once each week to be weighed and to follow the weight control instructions provided for you. These instructions are uncomplicated and will be thoroughly explained by the experimenter. The purpose of this study programme is to compare some simple weight losing techniques since there is some question as to which methods are more effective. Therefore, at the end of the study, you will be given the results of the study if you so desire and the opportunity to utilise the most effective technique.

APPENDIX B
Consent for Participation
in A Weight Reduction Study

I _____ of _____ consent to
(name) (Address)

participate in a weight reduction study to be carried out in the spring semester of 1977. The study will be conducted by a graduate student in psychology, Daniel Wilcox, at the State University College in Geneseo.

I further submit that I have no known history of medical problems which would make weight reduction inadvisable and will secure a physician's consent (below) before entering into the study.

I have read and fully understand the above statements.

I have received no guarantee or assurance of the results that may be obtained.

Signed _____
(Signature of Participant) (Date)

At this time, I have observed no medical reasons contraindicating the above named person's participation in a weight reduction study.

Signed _____
(Signature of Physician) (Date)

APPENDIX C

Obesity and Weight Control Information

What exactly is obesity? Obesity refers to the condition of fatness or the presence of an excessive amount of adipose tissue in the body. It is not the same as overweight. Overweight refers to body weight in excess of the average. This could represent muscle, fluid, fat, bone, or any combination thereof. As a more common example of this distinction, a professional football player is almost always overweight but he is very unlikely to have too much fatty tissue. His overweight condition is due primarily to excessive muscle. As a rule, obese people are almost always overweight while overweight people are not necessarily obese.

What causes obesity? Obesity is caused by caloric intake in excess of energy expenditure. This, of course, is the simple answer. The more complex question that this statement gives rise to is; how does this imbalance occur? For this answer, we have a whole technology and indeed, a civilisation to deal with. Riding lawnmowers, electric can openers, highly palatable, high calorie junk foods, and sedentary jobs shed a little light on the scope of the problem. The method of overcoming this unavoidable consequence of eating too much and moving too little is obvious. One must reduce caloric intake and exercise more. For best results, both these components should be included in your weight control programme. There are some good reasons for this, too. To lose weight through reduction of food intake alone, is to experience constant hunger. However, moderate exercise seems to decrease appetite, thus serving a twofold purpose, i.e. burning up fat and reducing consequent food intake. Further, obese people use up more fat than average weight people when they exercise because moving their extra weight requires more work.

Having established what obesity is and how it is caused, it is necessary to consider what good nutrition is. This amounts to properly balancing some 40 to 45 food elements needed for health. To get this balance, we should eat foods from five basic categories each day. These categories are, 1) milk products, 2) meats, 3) fruit, 4)

vegetables, and 5) cereals. There is also a sixth division, that of miscellaneous foods. In this department most Americans overindulge, for this is the category of the ever popular, high calorie, low nutritional value, junk foods. Examples include potato chips, soda pop, alcoholic beverages, candy, and most desserts. In large part, these foods should be considered “empty” in that they provide only a high concentration of calories that will be converted to fat and almost nothing else which contributes to good health.

At this point it is necessary to look at nutritional concepts in order to get a better understanding of dieting. A commonly used term is “calorie”. A calorie is a measure of the energy value in food. When we do work, the food calories we’ve consumed are converted and “used up” by the body. Foods vary enormously in caloric content. Excess calories are stored up, mainly as fat. There are approximately 3,500 calories in one pound of fat. To lose that pound, you must consume 3,500 fewer calories than you would need to maintain your present weight. This can be accomplished over an extended period by consistently consuming fewer calories than your quota for weight maintenance. This may be further facilitated by expending additional calories through increased physical activity.

When one considers reducing food intake, it is important to examine the nutrients the body requires so that health will not be jeopardised. These nutrients include fats or lipids, carbohydrates, proteins, minerals, vitamins, and water. These elements serve as raw materials or as catalysts for metabolic processes. As an open, dynamic, and working system, the body requires frequent replenishing of these materials. All these components have specific functions and must be represented in a good diet. As an example, carbohydrates provide heat and energy, they perform regulatory functions, and the raw materials for various structural features.

The following guidelines are suggested for health dieting:

- 1.) Eat at least six ounces of lean meat, fish, fowl or other high protein food per day (alternatives include nuts, peas, beans, cheese, eggs, and peanut butter).
- 2.) Eat four or more servings of cereals per day. Examples of servings are, one slice of bread, one half cup of pasta, or cooked grains, or three fourths cup of ready to eat cereal.
- 3.) Fruits, especially citrics and vegetables, green and yellow, should be eaten frequently.
- 4.) Adults should drink at least two glasses of milk daily, preferably skimmed.
- 5.) Don't eat too much! Cleaning your plate won't help a single Chinese orphan. If you're full, stop!
- 6.) Don't eat too much sugar and fat. Highly processed foods contain extra amounts of these substances, but, again, be aware that their actual food values are often limited while their caloric contents are very high. Fat contains twice as many calories as equal weights of protein or carbohydrate.
- 7.) Don't restrict your diet too much. A diversity of foods assures good nutrition and makes dieting easier from a practical standpoint. For instance, if your diet specifically calls for one half cup of beets for lunch and you don't have access to a can opener (or the beets and a stove) your diet, too, is canned! Diversify your diet and include enough fruits, vegetables, and meats.

Proper dietary planning is the safe way to lose weight. By taking precautions, one can reduce the quantity of food ingested while actually improving the quality of the diet. Understanding of nutrition is an important starting point. Conscientiously attending to the kinds of food you consume is the second step. Employing a two faceted approach including both decreased caloric intake and increase energy expenditure is the final step to the goal of weight reduction.

APPENDIX D

Will Power Group

It has been claimed by participants in weight control programmes that ultimately success depends upon determination and will power. Therefore, it is of central importance that you, the participant, be sufficiently interested and motivated to exert this needed will power. By becoming a participant in this programme, it is obvious that you have the desire to lose weight. It is a matter now of maintaining this desire and consciously making yourself refrain from eating too much and too often. You must learn to tell yourself "No", as many weight losers before you have learned to do. It is no trick. It is hard work but extremely rewarding. Most important, you must be determined. Tell yourself you can lose the weight you desire to lose. It will happen; it has to happen if you resolve to eat less. Your body fat is like energy units. These are called calories. Three thousand, five hundred calories equal one pound of fat. You must exert energy at all times – to work, to walk, even to breathe. If you resolve to eat less, your unwanted fat – calories – will be burnt up as energy. To assist you in properly dieting, an information sheet about obesity, diet, and nutrition is also provided. The most important thing to remember is that, if you exert enough will power, your task will be accomplished.

APPENDIX E

Stimulus Control Technique

It has been demonstrated that the stimulus control technique is an effective method of weight control. This approach focuses on changing the antecedents of eating as well as modifying the actual eating response.

The following specific methods were developed to help gain control over eating:

1. Arrange to eat in one place only and when you eat do nothing else. This involves a process called stimulus narrowing. It breaks down the associations we commonly make between eating and other behaviours. An example is the automatic hunger some people get for popcorn when they start watching a movie (Think of examples which apply to you).
2. Buy non-fattening foods. It is important to keep on hand a variety of safe foods to use as snacks, etc.
3. Look for times of weakness. Shop only after you have eaten; then you are not hungry and will be less likely to shop unwisely. Prepare meals when you are not hungry (after lunch for instance). This also reduces the temptation to overeat.
4. If you must buy fattening foods, keep them out of sight and see that they require some preparation. Prepare only what is needed for the meal and if you make too much, never put it on the table where 'seconds' will be more tempting. Try to make small portions look larger; eat supper on a luncheon plate, put more roughage on your plate, plan meals ahead of time, etc. Eating requires a number of behaviours which are linked together in a chain. Some of the major links in this chain include purchasing, transporting, preparing, and chewing food. There are three benefits that come from lengthening this chain.

A) The longer the chain, the more energy/calories are used up. B) You will eat less frequently just because more time is required to complete a long chain than a short chain. C) We all know that the more work one must do to get something the less likely he is to finish the task. In other words he will be less likely to eat.

5. Avoid loneliness, boredom, fatigue, and excessive hunger. All are dangerous times when uncontrolled eating can occur. To avoid them, make a list of people you can call or things you can do at these times and eat balanced, regularly scheduled meals.
6. It is important to learn to control the way you eat by slowing down the rate. Begin by slowing down at the end of the meal and gradually backtrack until eventually you are eating slowly throughout the meal. This has a dual effect. It gives confidence that you can control your eating by removing automatic aspects of the behaviour and, since it takes about twenty minutes for the brain to get the message that the stomach has received food, it assists you in stopping before you have overeaten.

By being conscientious and patient and by making a determined effort to follow the programme prescribed, your task will be made less difficult. It is, under no circumstances easy to lose weight and keep it off; however, by faithfully employing the stimulus control technique each day, you can turn the awesome task of losing weight into a manageable job. And like any hard job, along with the need to persevere comes the enormous satisfaction of accomplishing your aim.

APPENDIX F

Coverant Control Technique

It has been demonstrated that weight reduction can be effectively carried out by employing the coverant control technique. Coverant control is a method for learning self-control which is for the most part a mental process, i.e. it can not be directly seen as behaviour. What is most important is that it does effect behaviour change in the form of weight loss.

The rationale for coverant control is as follows. Private mental events are subject to the same principles of conditioning as are overt behaviours. Overt and covert events can be increased in frequency by following them with reinforcement. The word coverant means covert (not openly shown) operant (a behaviour operating on the environment to produce rewarding effects). In self-control, however, the individual must do his own rewarding since he alone knows if he has made the proper mental response. This is legitimate so long as he consistently adheres to his programme.

This is an example of how coverant control works:

- A) You receive an environmental cue, e.g. you look on the kitchen table.
- B) Your body is stimulated to eat a piece of cake.
- C) You make a mental response, "I sure would like some cake".
- D) This you follow with a positive reason for refraining, e.g. "when I eat properly, I will be more healthy and attractive".
- E) Then you mentally award yourself a token for making the above pro-non-eating response which you record on paper later.
- F) Later you watch a movie for which you have set a cost of five tokens.

The sequence can be carried out under any eating situation whether you refrain altogether or simply modify the quantity and quality of the food. The most important thing to bear in mind is that as the pro-non-eating response is repeatedly paired with self-reward, it becomes strengthened. Therefore, it becomes increasingly easier to indulge in weight loss oriented eating.

The first step in covert control is to make a list of mental statements that you find attractive about proper eating. These may include: good health, increased lifespan, increased attractiveness, ability to wear more fashionable clothes, increased vigour, or increased praise received from others. A list of five to ten positive mental thoughts about proper eating should be brought to the first group meeting.

After developing this list of pro-non-eating thoughts, you should list favourite activities such as going for walks, reading, bike riding, watching television, movies, listening to music, etc. Try to think of ten activities and bring this list to the meeting, too. At this point a "token" system will be instituted whereby each time you desire to eat unwisely you will mentally make a pro-non-eating statement and award yourself one "point" or "token". The tokens will be used to pay for the items on this list according to a pay off schedule we establish together.

To assist you in your weight loss programme, an information sheet is provided which includes facts about obesity, diet, and nutrition. It is extremely important that you consistently follow the routine of making the mental response and awarding yourself the token. You must also remember it is better for your pay-offs to be more easily earned than to create a situation where you will be tempted to cheat.

By being conscientious and patient and by making a determined effort to follow the programme prescribed, your task will be made less difficult. It is, under no circumstances, easy to lose weight and keep it off; however, by faithfully following the programme outlined above and to be further elaborated upon, you can turn the

awesome task of losing weight into a manageable job. And like any hard job, along with the need for perseverance comes the enormous satisfaction of accomplishing it.

APPENDIX G
Weight Reduction Programme
Evaluation Form

Please indicated by circling the number of your choice:

I. The degree of effort involved in your weight programme.

1.	2.	3.	4.	5.
(Very difficult)	(More difficult than expected)	(Neutral)	(Easier than expected)	(Very easy)

II. The degree to which you believed your weight programme would work.

1.	2.	3.	4.	5.
(Very doubtful)	(Somewhat doubtful)	(Neutral)	(Somewhat confident)	(Very confident)

III. The degree to which the experimenter seemed committed to the weight reduction method.

1.	2.	3.	4.	5.
(Very uncommitted)	(Uncommitted)	(Neutral)	(Committed)	(Very committed)

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APPENDIX H
Subject Weights at Each Week of Treatment and Follow-Up

GROUP	SUBJECT	HEIGHT	WEEKS										Follow Up	
			1	2	3	4	(Weight in lbs)				7	8		12
							5	6	7	8				
P W O I W L E L R	1	67"	234	233	230	227	225.5	226	224.75	224.75	222.5	222.5		
	2	62.5"	140	137.25	137.75	137.75	134	135	137.5	137	137.75	137.75		
	3	65.5"	151	148.5	148.75	148.5	---	151.5	150	152	152.5	152.5		
	4	64"	145.75	145.75	140.25	141.75	141	140.5	145.5	142.75	144.25	144.25		
	5	63"	147	142	145	141.75	142.25	142.75	142	143	143.75	143.75		
	6	67"	163.5	163.5	159.5	158.25	158.25	158.75	157.25	157.75	158	158		
	7	60"	182	182	182.5	182.25	181	182	185	185.5	183	183		
	8	65"	151	147.5	146.5	146.25	149	151	150.25	152	152	152		
S C T O I N M T U R L O U S	9	59.5"	162.5	160.5	160	---	163	161	160.75	160.25	165.75	165.75		
	10	65"	155.25	155.25	151	---	153.25	154	152.5	153.5	153.5	153.5		
	11	61.5"	148.5	147.5	148	148	147.75	148.25	149	149.25	147	147		
	12	66.5"	160	163	162.5	162.75	---	---	164.25	166	166.25	166.25		
	13	67"	184	184	179	181.25	182	182.25	184.75	184.5	187.5	187.5		
	14	65.5"	159	161	160	159.25	158.75	---	160.25	164	164	164		
	15	67.5"	159	157.75	156.25	156.75	157.25	156.5	155.25	157	153.25	153.25		
	16	60.25"	129	129	127	127.75	128	---	128.5	128.25	127.75	127.75		
	17	63"	141	142.25	141.5	142	140.75	---	142.75	138.25	140.25	140.25		
	18	65.5"	194	194.25	192	189.75	195	192	192.25	193.5	192.5	192.5		
	19	63.75"	149	147.25	146.5	145	141.5	142.5	---	143.25	141.75	141.75		
	20	61"	134.5	135	135	134	133.75	133.5	133.25	130.5	128.25	128.25		
	21	62"	145.5	142.5	142	141	140	138	137	140.25	138.5	138.5		
	22	64.5"	169	167	169	166	---	168.5	168.5	170.75	169.75	169.75		
	23	61.5"	144.5	151.5	140.5	139	140	140	141	137.75	137.25	137.25		
	24	62.5"	141	141	141	---	138	138.75	---	136.75	145	145		
	25	62.5"	154	150	147.75	149	147.75	148.25	147.75	143.25	139	139		
26	63.75"	148	149.25	144.25	145.5	146	---	143.25	148	146.75	146.75			

ACADEMIC DOSSIER

Treatment of Intellectually Disabled Individuals who have Committed Sexual Offences: A Review of the Literature

Treatment of Intellectually Disabled Individuals
who have Committed Sexual Offences:
A Review of the Literature

ABSTRACT

The development of comprehensive treatment services for intellectually disabled sex offenders has been slow in comparison with mainstream sex offender treatment services which have now achieved Home Office Accreditation within the National Probation Service. The author discusses some of the reasons for this failure to keep pace focusing on the relative absence of an expertise spanning the fields of sex offender work and intellectual disabilities. Attention is focused on the particular challenges of targeting treatment, measuring change and evaluating programmes delivered to these individuals. The author reports on steps that have been taken toward overcoming these obstacles and makes recommendations about further work to be done.

INTRODUCTION

The development of comprehensive and increasingly effective treatment programmes for working with sex offenders (SO's) has predominantly come about through progressive efforts over the last twenty years (Finkelhor, 1984; Salter, 1988; Marshall, Laws and Barbaree, 1990; Maletzky, 1991; Morrison, Erooga and Beckett, 1994, Marshall, Anderson and Fernandez, 1999 and Laws, Hudson and Ward, 2000). However, specialised work with Intellectually Disabled Sex Offenders (IDSO's) has lagged well behind 'mainstream' SO treatment. In particular, there have been difficulties in terms of establishing standardised and specialised treatment programmes for ID Offenders (Parsons, 1984; Griffiths, Quinsey and Hingsburger, 1989; Swanson and Garwick, 1990; Cox-Lindenbaum, 1990 and 2001; Caparulo, 1991; Hayes, 1991; and Haaven and Schlank, 2001). Assessing risk and treatability has posed ongoing problems (McKenzie, Chisolm and Miller, 1997). Accurately evaluating therapeutic change through valid treatment measures has largely been

absent (Kolton, Boer and Boer, 2001). Appropriate resourcing of treatment services has been particularly poor (Coleman and Haaven, 1998; and Ward, Trisher and Pfeuffer, 2001) and evaluating treatment outcomes has proven difficult because of problems identifying appropriate control groups (Lindsay and Smith, 1998 and Hordell, Hill, Forshaw, Bendall, Hipkins and Robinson, 2000). Further, determining prevalence rates and more accurately defining the extent and nature of problems associated with ID individuals who commit sexual offences has been an arduous and frustrating process (Murphy, Coleman and Haynes, 1983 and O'Connor, 1996). In these areas, many mainstream SO treatment programmes have enjoyed relative success in generating funding for assessment, treatment, research and evaluation (Marshall and Fernandez, 1998).

The focus of this review article is to critically examine these impediments to the establishment of more rigorous and verifiably effective practice in the treatment of IDSO's. The literature was selectively reviewed with a principal focus on cognitive-behavioural treatment (CBT) programmes within a group therapy context. The consideration of traditional behavioural interventions was de-emphasised, as was the adjunctive role of pharmacological approaches, e.g. anti-libidinal drugs. Further, the review focused on treatment programmes for the relatively higher functioning IDSO's who are likely to come into contact with the Criminal Justice System and be referred for treatment in this way.

In the literature, many terms are used to describe intellectual disability, including mental retardation (DSM-IV, APA, 2000), mental handicap, mental subnormality, developmental disability, learning disability, etc. For purposes of clarity and consistency, the term intellectual disability will be used to refer to this condition throughout this paper. Further, the term IDSO will be employed to refer to ID individuals who have been convicted of sexual offences. The term IDSO is not intended as a label per se, but rather as an abbreviated means of conveying information about individuals with significant intellectual deficits who have committed sexual offences.

There are multiple difficulties in this area of offender work. Perhaps most importantly, the need for a unique skill mix including knowledge about intellectual disabilities and of SO treatment (Haaven, Petre-Miller and Little, 1990, Clare, 1993 and Bremble and Rose, 1999). Research on prevalence rates (O'Connor, 1997) suggests that only 10-15% of individuals convicted of sexual offences have Intellectual Disabilities. In general this refers to an IQ of less than 80 incorporating the Borderline Intellectual Functioning range (IQ = 70-80). As such, it may be judged by some that greater resources and expertise are required to treat a small minority of SO's. In the circumstances, there is perhaps little wonder why this complex area of SO practice has not kept pace with mainstream SO work. O'Callaghan (1998) noted the need for a multi-disciplinary approach, advising that no single professional group, has a monopoly on the skills required to treat this population. This may be one of the reasons why it is so difficult to get consensus/proper funding – i.e. that ID groups are dispersed – some in the criminal justice system, some in special hospitals, etc., leaving no one group with a mandate for responsibility, resources and expertise.

BRIEF HISTORY

Historically, the ID have been the subject of considerable misinformation, causing them to be regarded as major contributors to crime by some past researchers like Selling (1939) and Tutt (1971). Goddard (1920) asserted, "the greatest single cause of delinquency and crime is low grade mentality, much of it within the limits of feeble-mindedness" (p.47). However, recent research has identified general and sexual crime rates amongst the ID to be in reasonable proportion to population distribution (Lindsay, Marshall, Neilson, Quinn and Smith, 1998). It should however be noted that ID individuals are probably more likely to be apprehended since they have more limited skills in planning, deceiving, etc.

The representation of ID individuals amongst the general offender population is difficult to accurately assess because these individuals may be protected by their families or their activities may be monitored and 'processed' through Health or Social

Services instead of the Criminal Justice System (Thompson and Brown, 1997). This may conceal disproportionately higher prevalence rates amongst ID populations.

ID individuals have been variously characterised by the general public as “naïve, sexual innocents and depraved sexual deviants” (p.226) (O’Connor, 1996). As such, it is not surprising that the responses of individuals who find them engaged in inappropriate sexual activity may vary greatly. One individual who intervenes when an ID man indecently assaults a child, may ‘normalise’ this behaviour as sexual exploratory activity amongst individuals at similar developmental levels. However, someone else might report the behaviour of ‘public masturbation’ by an ID man as a criminal act without any appreciation that this individual, with limited abilities and a *normal* sex drive, may not be afforded the privacy and dignity that his non-ID peers enjoy.

Whilst there is now greater research acceptance that mainstream SO treatment works (Hanson, Gordon, Harris, Marques, Murphy, Quinsey and Seto, 2002), there have been important dissenting voices until recently. Furby, Weinrott and Blackshaw (1989) reported generally poor treatment outcomes, but on examination these findings related to interventions designed and run in the 1970’s and early 1980’s. These interventions consisted of a variety of treatments, including chemical castration, psychoanalysis and purely behavioural techniques focusing only on re-conditioning sexual arousal. In large part these programmes did not identify or address different treatment needs in an effort to tailor the interventions to the circumstances. Also, the methodologies employed in the outcome studies included in their review frequently left much to be desired (Furby et al., 1989). More recently, Quinsey (1996) continued to express considerable scepticism about treatment effectiveness, challenging the view that SO treatment work has a verifiable success record. Quinsey criticised some programmes for discounting data for men who left therapy early or failed to respond to treatment. Marshall, Jones, Ward, Johnston and Barbaree (1999) questioned whether the lack of treatment effect Quinsey and his colleagues found on their own programmes might relate to the populations he was working with; frequently

offenders in special hospital settings with dual diagnoses, and as such, perhaps more limited in their capacity for responding to treatment.

EVIDENCE OF TREATMENT EFFECTIVENESS

Abel (1999) reported on the substantial treatment improvements that have been demonstrated since CBT programmes have been introduced. An example of British research indicating treatment effectiveness is that of Allam (1999). She produced a well-controlled longitudinal study of reconviction rates comparing treated and untreated (non-ID) SO's. The purpose of this study was to primarily examine the impact of a CBT programme on short-term periods of recidivism. The subjects in this study were selected on the basis that they had all admitted to sexual offences within the course of criminal proceedings. In all instances, the assigned Probation Officer recommended a community based Probation Order with the requirement to attend a SO treatment programme. In some instances the Court accepted this recommendation and the offender was obliged to participate in a Probation SO treatment programme for periods of normally two to three years. The control group consisted of the men who had been recommended to attend a Probation treatment programme but were given a custodial sentence by the Judge. The custodial sentences for these offences were of a relatively short duration, often in the region of six months, during which time there will have been no opportunity for the offender to attend a SO treatment programme. The recidivism rates for these men were recorded over a four to five year period for both groups irrespective of quality of involvement for the treated group. Allam (1999) reported that the untreated offenders recidivated at a rate of approximately three times that of the men who engaged in the community SO groupwork programme. Other studies have also demonstrated that CBT for SO's can be effective in reducing recidivism (Dwyer, 1997; Hedderman and Sugg, 1996; Marques, Day, Nelson and West, 1994; Marshall et al., 1999). The majority of follow up studies examined relatively short period of recidivism risk (generally under five years). However, this still allows for a comparison of untreated and treated offenders, which demonstrates a positive treatment impact.

In addition to evidence from individual recidivism studies, two meta-analyses have been conducted that provide support for the effectiveness of CBT for SO's. Hall (1995) conducted a meta-analysis on a number of treatment programmes for SO's and found that there was approximately one third less recidivism (re-convictions) amongst treated offenders (19% compared to 27%). In particular, community-based programmes were found to be the most effective, as were those adopting a CBT approach. Alexander (1999) in her review of the recidivism literature found a combined sexual recidivism (re-arrests) rate of 8.1% in treated child sex abusers (CSA's) compared to a rate of 25.8% in untreated CSA's (not including incest abusers) over a five year period at risk. The data are encouraging in that such studies provide evidence that treatment development is moving in the right direction, i.e. the most recently conducted programmes (generally employing CBT groupwork techniques) have been found to be the most effective (Alexander, 1999).

Such well-designed studies have lead to increased acceptance of the efficacy of this treatment approach with non-IDSO's. However, whilst these findings offer evidence of the effectiveness of CBT programmes with mainstream SO's, it would be inappropriate to simply conclude on this basis that this is the correct treatment approach for working with IDSO's. Indeed, there is evidence that this treatment approach does not work for at least one type of Personality Disordered offender, the psychopath. Research reported by Clarke (2000) noted that psychopaths, individuals with significant aggressive, narcissistic features, were actually more likely to be reconvicted following inclusion in prison based cognitive-behavioural social skills training programmes. In view of the significant cognitive and social skill deficits found amongst IDSO's, it would therefore be most appropriate to base any assessment of treatment success on the analysis of outcome data for ID offenders exclusively. Unfortunately, relatively few such studies have been undertaken and they have often been hampered by small numbers of subjects or inadequate controls (O'Connor, 1997).

RISK ASSESSMENT

Risk assessment tools have also been developed for predicting relapse with increasing accuracy. They evaluate static, dynamic and acute risk factors associated with recidivism (Hanson and Bussiere, 1998; Thornton, 2000, Hanson and Thornton, 2000). These factors associated with reconviction may be applied to IDSO's as well as non-IDSO's. They are employed to predict the likelihood of reconviction for a further sexual offence or a violent offence. This research focused on identifying factors correlated with reconviction amongst large groups of subjects in Britain and Canada, who were convicted of sexual offences. The offender populations were normally distributed as regards intelligence and, as a proportion of them were ID, these factors associated with relapse have demonstrated utility in work with IDSO's. These factors include a range of actuarial data, e.g. age, number of sexual convictions, total criminal convictions of any kind. Other factors that increase risk include the types of sexual offences committed, aspects of the individual's history, including relationship background, substance abuse, etc. Dynamic and acute factors relate to employment, lifestyle, response to supervision, access to victims, etc.

PSYCHOMETRIC MEASURES

Specialised psychometric measures now assist in identifying therapeutic change in relation to social, cognitive and personality indices as well as attitudes and beliefs about sexual offending (Beech, 1997/98; Allam, 2000b). These measures have not, however, been normed for use with ID offenders who, clinical observations would suggest deviate from non-disabled offenders on the various indices, which include emotional loneliness, self-esteem, assertiveness, capacity for dealing with personal distress, emotional congruence with children, empathy for women, cognitive distortions, etc. Whilst some attempts have been made to modify and norm these measures (Kolton et al., 2001) for use with the ID, progress thus far has been quite limited. Indeed, in many instances, these measures are either omitted, simplified, modified or items read to the ID offender. Whilst this information may be clinically useful, the absence of normative data from ID non-offender populations means that it is not clear how the deficits/problems in question may relate to offending behaviour.

Indeed, it may be that completely different characteristics are relevant in the case of IDSO's.

THE TREATMENT MODEL

Current mainstream therapeutic programmes for SO's such as the West Midlands Probation Services, SO Unit, Community SO Groupwork Programme (2000), predominantly employ a CBT treatment model (Marshall, Anderson and Fernandez, 1999) within a groupwork setting (Allam, 2000a). The groupwork approach owes much to Social Learning Theory (Bandura, 1977), emphasising the cognitive aspects of social learning and de-emphasising more basic behaviour modification techniques (Skinner, 1953 and 1969). Within this social learning milieu attachment theory, as espoused by Bowlby (1969) and Ainsworth, Blehar, Waters and Walls (1978) has provided a helpful framework for assessing social, cognitive and personality development and informing treatment work to modify attachment styles (McGuire, 2000). Allam (2000a) provides a detailed discussion of the theoretical underpinnings of cognitive behavioural groupwork with SO's, reviewing the interplay of these intrinsic treatment elements as a vehicle for therapeutic change.

The employment of behavioural approaches (Ayllon and Azrin, 1968; Kazdin, 1975) has an extensive history in treating individuals with intellectual disabilities. Although empirically grounded and effective in many respects, it employs a rather narrow treatment spectrum which had a blanket presence for many years. Indeed, therapeutic work with lower functioning ID individuals still, appropriately, relies heavily on standard operant and respondent conditioning techniques (O'Connor, 1997).

These therapeutic strategies were primarily derived from the work of Skinner (1953, 1969). These 'Learning Theory' based approaches rely on systematically varying external environmental reinforcement schedules whilst contiguously employing various behaviour shaping techniques. Traditionally, the behavioural interventions used with ID individuals have focused little attention on the cognitive and cognitive-behavioural strategies introduced by Ellis (1962) and Beck (1970). Indeed, cognitive-

behavioural techniques were believed to be largely inapplicable to ID people but this view has changed, in particular for programmes of work with Mild to Borderline intellectual functioning individuals (Kroese, Dagnan and Loumidis, 1997).

Gradually self-control techniques began to gain general treatment acceptance e.g. (Godfried & Merbaum, 1974) in clinical work and to enhance social skills. Therapeutic work with ID individuals began to emphasise the development of wider ranging social/sexual skills and knowledge (Edmonson, McCombs and Wish, 1979; Matson, Kazdin & Esveldt-Dawson, 1980; Coleman and Murphy, 1980; Champagne and Walker-Hirsch, 1982; Craft and Craft, 1983). Robertson, Richardson and Youngson's (1984) Social Skill Training Programme for mentally handicapped people represented a good early example of a social learning, cognitive-behaviourally based approach.

CBT has facilitated the development of sex education and related counselling services for individuals with intellectual disabilities. Valenti-Hein, Yarnold and Meuser (1994) developed and evaluated dating skills in ID people specifically focusing on providing CBT based training to address social deficits. Lindsay, Bellshaw, Culross, Staines and Michie (1992) demonstrated increases in knowledge by subjects following a course of sex education in people with intellectual disabilities employing similar strategies. Further applications of CBT by Lindsay, Neilson and Lawrenson, (1997) and Lindsay and Olley (1998) have shown that this is also an effective treatment approach for addressing clinical conditions such as anxiety and depression in individuals with ID's.

TREATMENT OF INTELLECTUALLY DISABLED OFFENDERS

In the specific field of SO work there is now increasing agreement that the treatment of choice for Mild to Borderline ID men is group CBT (Haaven and Schlank, 2001). Researchers such as Coleman and Haaven (1998) have however stressed the need to modify standard CBT approaches when for example employing cognitive restructuring strategies. Coleman and Haaven emphasised the benefits of 'labelling'

attitudes and behaviour rather than relying on abstract reasoning abilities (which are almost invariably poor) amongst the ID. Coleman and Haaven advised that effective teaching is a critical though often overlooked aspect of this work if concentration and retention of information is to be maximised. They note the benefits of linking learning with active teaching and the incorporation of emotional content into the work to reinforce alternative behaviours and cognitions. The clinical practice benefits of this treatment approach has been recognised in Britain amongst early therapeutic programmes for IDSO's and supported by Leyland, Wilcox, Stait and Geach (1995), McKenzie et al. (1997), Wilcox and Leyland (1998 and 1999), Hordell, Rees and Robinson (2001) and Forshaw, Hill, Hordell, Robinson, Bendall and Hipkins (2000).

To date, most programmes have focused on modifying mainstream CBT SO programmes to address the specific needs and capabilities of ID offenders. They mirror the content and techniques with confidence and confirm that by applying these treatment principles the likely results should be similar to those obtained in mainstream programmes.

As is the case with mainstream SO treatment (and the practice of psychotherapy in general), treatment models other than CBT are also used, in particular psychodynamic methods (Cormack, 1993) and psychoanalytical groupwork (Corbett, 1996). Treatment success however is often judged by therapist perceptions and initial comparison of data (Allam and Brown, 1998) suggest that the CBT approach yields better results.

TAILORING THE TREATMENT MODEL

As practitioners and researchers have increasingly been reaching agreement about the structure of effective mainstream SO treatment programmes (Marshall et al., 1999; McGuire, 2000; and Allam, 2000a), there has been an increasing trend toward adapting these programmes to other groups of offenders, e.g. women who sexually abuse (Saradjian, 1996), adolescent offenders (Erooga and Masson, 1999), men who abuse adults as opposed to children (Marx, Miranda and Meyesson, 1999), as well as

ID individuals (Allam, Brown and Middleton, 1997). Allam et al. (1997) questioned whether different offenders have different treatment needs. They noted that “as yet, the long-term effects of tailoring treatment to suit offender characteristics is not known. Nevertheless, client and staff feedback has been positive” (P69). With the widespread use of CBT techniques in offender work (McGuire and Priestley, 1995) and in the specific area of SO treatment (Beckett, Beech, Fisher and Fordham, 1994 and Fisher and Beech, 1998), programmes have become increasingly offence-focused and the most successful programmes target the key criminogenic factors involved (Losel, 1995, Beech and Scott-Fordham, 1997 and Chapman and Howe, 1998).

Murrey, Briggs and Davis (1992) reviewed the differing assessment and treatment needs amongst psychopathic, mentally ill and ID offenders. They noted the relatively intractable nature of psychopaths in treatment, suggesting early indications of a limited potential for therapeutic change. They reported the necessity of treating mental illness in advance of most other criminogenic factors, indicating that therapeutic receptivity and effectiveness were best achieved in the absence of mental illness. They noted that agitation, mood disturbance, emotional interference and substance abuse problems can prove to be significant impediments to therapeutic progress and that the pressure associated with intensive treatment work may even exacerbate rather than alleviate the client’s mental health difficulties.

Murrey et al. (1992) reported that ID or ‘mentally handicapped’ offenders may have difficulties making therapeutic progress because of ineffective engagement and teaching methods, as well as an inadequate appreciation of mental health and lifestyle issues associated with these individuals. Borthwick-Duffy (1994) for example, reported that the ID are significantly more likely to experience concomitant mental health problems than non-ID people. Allam et al. (1997) reported on abusers whose failure to progress in treatment appeared to be linked to early life sexual trauma giving rise to unresolved emotional distress and disturbances. Brown and Barrett (1994) indicate that the ID are particularly vulnerable to such harm. Allam et al. (1997) described victim to victimiser groups as reported upon by Leyland, McKewan

and Wilcox (1995). These are adjunctive programmes designed to facilitate the mainstream SO Groupwork Programme by assisting offenders who were former victims of sexual abuse in achieving an undistorted perspective about the sexual abuse that was perpetrated upon them. Leyland et al. noted the high proportion of ID men who required this additional therapeutic input to progress more effectively in their SO treatment group.

Allam et al., (1997) also reported on specialised treatment requirements for offenders with intellectual disabilities citing the SO Unit's experience of this community-based treatment emphasis i.e., Leyland et al. (1995) and Leyland, Wilcox and Stait (1997) wherein they described the employment of varied group techniques with IDSO's to improve engagement, attention, recall ability. Leyland et al. (1995) advised wide ranging use of drama, art and other creative pursuits. They encouraged ID offenders to do relevant homework, e.g. drawings, collages, pictures, planned role plays, etc., focusing on understanding, predicting and managing their social presentation and their offending. However, they found that these techniques helped in the acquisition of new interpersonal skills and in challenging pro-offending thoughts/attitudes.

Day (2001) expressed the view that for the majority of IDSO's, "their sex offending is essentially the consequence of crude attempts to fulfil normal sexual impulses in the absence of normal outlets compounded by poor adaptive behaviour, sexual naivety, poor impulse control, and social ineptness" (p.146). Day (2001) argued that treatment for this group should focus on "increasing overall social skills and self-confidence, sex education, including the law and social codes, improving interpersonal and courtship skills, and providing opportunities for mixing with an appropriate peer group" (p.461).

TREATMENT EFFICACY

Haaven et al.'s (1990) residential programme for their community based non-residential Probation treatment programme described the importance of participative approaches to maximise the learning and change potential for these individuals. Over

time these techniques have worked with the key aims of maximising comprehension, attending to tasks and rehearsing/applying new and more adaptive social functioning strategies. (Haaven, 1993, Wilcox and Leyland 1998 and 1999, Hordell et al. 2001 and Haaven and Schlank, 2001).

Whilst specialised treatment for IDSO's is a relatively new field with unique challenges, it is nonetheless important to work toward clarifying treatment protocols and analyse relevant outcome data to properly measure success. Haaven et al. (1990) noted that recidivism rates do not give a complete picture of the impact of treatment on the frequency or severity of sexual offending. Nor do they take account of the significant under-reporting of actual sexual and violent criminal behaviour perpetrated on the public as reported by Pilkington and Kremer (1995). Furby et al. (1989) estimated that recidivism rates were unlikely to represent more than 10% of actual sexual offence occurrences. Nonetheless, recidivism rates provide some meaningful information and they are usually sought as a matter of studies of offender treatment as an answer to the question, "does the programme work?"

Haaven et al. reported that recidivism rates decreased as a function of length of time in treatment both for sexual crimes and for crimes in general, although in view of the small end size and the magnitude of change, the differences were not statistically significant. Based on these findings, Haaven et al. (1990) concluded that specialised treatment had an impact on criminal activity amongst IDSO's in their treatment programme and clients in treatment for longer periods of time recidivated at a lower rate. These data do not clarify whether high risk disruptive individuals who failed to settle in to the groupwork after a short duration of time were included in the data. Clearly, this would produce a negative bias for shorter attendance. Further, if individuals recidivated during the course of treatment and were imprisoned, they might defacto be assigned to a shorter treatment group. Lastly, this programme provided residential treatment and it may be difficult to compare results with community based programmes in terms of opportunity to re-offend (Thompson, 1997)

and the presence of positive social support networks in residence, which may well have been lacking in many independent community settings (Demetral, 1996).

Haaven et al. also reported the collection of more subjective data concluding that the majority of their treatment programme participants achieved some basic understanding that 'thinking affects behaviour' and that group members developed a capacity for understanding, predicting and controlling their pro-offending thoughts. They also improved general social competence. Such judgements and observations, whilst gathered informally, have often had a major impact on the views of clinical practitioners in this speciality (Boer et al., 1995, Wilcox and Leyland, 1998 and Hordell et al., 2000).

Lindsay and Smith (1998) identified a greater treatment effect in terms of recidivism and attitude change for IDSO's who attended a treatment programme within the context of a two-year Probation Order than for those who attended on a one year Probation Order. The subjects attended a treatment programme which addressed a range of accepted treatment issues, e.g. denial, minimisation, responsibility for offence, acceptance of harm to victim and general behaviour consistent with offending. Subjects were assessed through a standard questionnaire Lindsay developed which evaluated pro-offending attitudes. Subjects who were in treatment one year retained significantly more attitudes consistent with further sexual offending than those who attended for two years. Lindsay and Smith reported intentions of norming these attitude measures for SO and non-SO ID populations. Nonetheless, the magnitude of change measured offers cause for hopefulness about the success of CBT SO programmes with the ID. It should also be noted that the groups in the Lindsay and Smith (1998) study were small, consisting of seven subjects each.

Holden (2000) produced data that partially suggested improvement in reducing cognitive distortions, as well as social skills and sexual knowledge in a sample of ten cognitively impaired adolescent SO's who participated in a one year specialised treatment programme. However, the sample of subjects did not report significant

improvements in reducing deviant arousal. Lindsay, Olley, Baillie and Smith (1999) reported on cognitively based group treatment with four male adolescent IDSO's presenting their findings in individual case study formats and providing clinical indications that these subjects responded to treatment. Lindsay et al. concluded that an average of three and a half years had elapsed since the subjects completed the treatment programme without a known reoccurrence of an offence.

Lindsay, Neilson, Morrison and Smith (1998) reported on a further cognitive therapy treatment programme involving six men with intellectual disabilities who had been convicted of sex offences against children. Lindsay et al. reported improvements, but identified several factors that negatively impacted on the course of treatment. For example, attitude change was not uniform and subjects' views about blame and harm were quite difficult to challenge in comparison with accepting that sexual abuse is not an appropriate way to demonstrate love for a child. They acknowledged this programme to be a preliminary treatment presentation, advising that research should investigate the important relationship between attitude change and offending behaviour. Lindsay et al. noted the difficulty of employing a controlled treatment design and the key importance of gathering long-term follow up data.

Friedman, Festinger, Nezu, McGuffin and Nezu (1999) described a programme for IDSO's focusing on the development of rational and systematic problem solving skills as a means of implementing change within the context of their SO treatment programme. Working with four male clients, they provided evidence of positive changes in target behaviours, although they acknowledged that the generalisability of these results remained tentative.

McKenzie et al. (1997) described the particular difficulties in finding appropriate assessment tools for IDSO's advising that reliable and valid outcome measures are difficult to obtain. They offered suggestions about methods for evaluating progress and noted particular difficulties in identifying appropriate controls. O'Connor (1997) reported "most published studies on people with an intellectual disability with

problem sexual behaviour report on programme descriptions and outcomes based on clinical judgement. There are very few controlled studies which distinguish between the effects of various treatment components. The exception to this is a number of single case respondent and operant conditioning interventions". (p.161) Many of these behavioural interventions are reviewed by Foxx, Bittle, Bechtel and Livesay (1986).

CONCLUSIONS

There have been significant obstacles to the development of measurably effective treatment programmes for IDSO's. Whilst there are indications that CBT within a groupwork setting is superior to other interventions with SO's (Allam and Browne, 1998), the success of this approach with IDSO's is less conclusive. Treatment approaches must be modified to take account of the poor insight and abstract reasoning abilities of these individuals, whilst developing work in the core areas of Accredited Treatment Programmes, e.g. cycles, cognitive distortions, social skills, sexuality, the role of fantasy, victim empathy and relapse prevention.

Psychometric measures being piloted for the assessment of IDSO's have tended to de-emphasise 'paper and pencil' tests in favour of structured interview questions. This approach eliminates literacy barriers and enables the assessor to directly evaluate comprehension, re-framing and simplifying as needed to gain a better understanding of the client's thoughts, attitudes and beliefs. A number of measures exist including the relapse prevention questionnaire (Beckett et al., 1996) and whilst they can provide useful benchmarks for progress in the key areas addressed in treatment by being administered at intervals, it is imperative that progress be made in terms of norming these measures where appropriate, e.g. comparing the individual's scores with aggregate data for offending and non-offending ID people. Note that this is feasible for most measures like Social Functioning or offence-related attitudes and beliefs, but the relapse prevention questionnaire can not be 'normed' on non-SO's because it produces qualitative information that relates directly to offending behaviour.

Clare (1993) reported that self-report inventories conducted through interview may provide more reliable information. However, assessment work is a much more time consuming task with ID offenders and this approach has considerable, un-funded, resource implications (Boer, Dorward, Gauthier & Watson, 1995). Coleman and Haaven (1998) reported a survey of programmes for ID offenders, noting that 75% of their respondents identified a lack of resources for therapy to be a problem, whilst 85% reported a lack of funding for research in this area of SO work to be a significant impediment to progress. Nonetheless, they are "cautiously optimistic" that the majority of IDSO's, particularly those in the low risk range, could benefit from specialised SO treatment programmes.

There is considerable clinical evidence that an active, engaging and multi-sensory approach to the groupwork programme facilitates the motivation of IDSO's and improves their ability to retain information/strategies to avoid relapse. Nevertheless, research on treatment outcomes will require larger sample sizes, better control groups and appropriately normed psychometric measures in order to properly assess whether the current positive appraisal of this treatment approach is actually warranted.

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The Application of the Clinical Polygraph Examination to the Assessment, Treatment and Monitoring of Sex Offenders

The Application Of The Clinical Polygraph Examination To The Assessment, Treatment And Monitoring Of Sex Offenders

ABSTRACT

Post Conviction Clinical Polygraph Examination Testing (Lie Detector Testing) offers significant opportunities for assessing, treating and monitoring sex offenders. This article briefly reviews the historical development of polygraph techniques including the physiological measures employed, the administration of the polygraph and the interpretation of data collected. Criticisms of polygraphy are explored and information concerning the scientific acceptability of these procedures is given. The current influence of polygraphy in sex offender work is reviewed. Evidence is given of the utility of polygraphy in reducing denial, improving treatment outcomes and more effectively supervising sex offenders on probation or licence. Cost benefit considerations are examined, as well as the need for further controlled research and future regulation of the polygraph, if it is to be introduced in Britain. Planned UK Trials are described.

Key Words: polygraph testing, sex offending, sex offender assessment, sex offender treatment, sex offender community supervision, physiological assessment of sex offenders, polygraph regulation.

INTRODUCTION

The Collins English Dictionary (1993) defines the 'polygraph' as "an instrument for the simultaneous recording of several involuntary physiological activities, including pulse rate and perspiration, used especially as a lie-detector".

The scientific principles underlying the polygraph examination, relate to the recognised "fight or flight" physiological reactions produced by autonomic nervous system when an individual perceives threat. These reactions generally take the form of increases in respiration, heart rate, skin conductivity (perspiring) and blood pressure. The central premise of polygraphy is that the fear of detection, produced by

telling a lie, will activate the nervous system, producing these normally involuntary changes. When questions are given to subjects, they can be studied in relation to the physiological measures and a trained examiner can accurately evaluate this data.

The polygraph instrument uses a blood pressure cuff, skin sensors and a respiratory gauge. These measures are recorded continuously during the polygraph examination, whilst the subject is systematically asked questions.

Concerns have been raised about possible errors that might lead the polygraphist to give a 'false positive' opinion i.e. the belief that deception is indicated when this is not actually the case (or false negatives when the examinee is able to avoid detection). Trained polygraphists recognise that a subject may experience considerable anxiety and that this factor may increase the risk of error. For this reason, the polygraph subject is carefully interviewed before the polygraph examination is given in order to develop appropriate relevant and comparison questions. Comparison questions are comprised of known or probable lies, which are not directly relevant to the polygraph examination. These questions are individually established with the examinee during the pre-polygraph interview. Comparison questions are designed to produce some general doubts, uncertainty and related anxiety in the examinee. Questions like "have you ever done anything you would not want your partner to know about? have you done anything you wouldn't want your Probation Officer to know about? have you ever taken anything from the workplace that did not belong to you?" A negative response to any such question would be a probable lie and the physiological reactivity produced by responding to this item during the polygraph examination could usefully be compared with the relevant questions that have been agreed. Relevant questions are central to polygraph enquiry. Relevant questions focus on areas of specific concern to treatment or supervising staff, e.g. "have you obtained child pornography? have you masturbated to thoughts of children? have you looked at children in a schoolyard?" They are formulated to define key events in an objective and unemotional manner. Well-constructed relevant questions do not readily lend themselves to reinterpretation. For example, an acceptable relevant question might

be, “did you put your hand on (child’s) vagina?”. An unhelpful question would be “did you touch (child) in a sexual manner?”

By evaluating responses to comparison and relevant questions, variables like generalised anxiety can be factored out to form a ‘baseline’ for reactivity in each subject and not people in general. It is anticipated that some general anxiety is likely to arise in most if not all polygraph examinees even when asked irrelevant neutral questions that have been agreed beforehand. These usually relate to affirming ones age, name, address, etc. However, the relevant questions are designed to evoke more physical indications of anxiety. Therefore a ‘normal’ range can be determined and significant response differences in order to establish the probability of deception.

Holden (1999) advised that false negatives can be substantially eliminated if the examiner takes time to establish appropriate “psychological set” in the examinee. The construct ‘psychological set’ is intended to convey the necessity of making the examinee maximally aware of the purpose and possible consequences of the polygraph examination. Additionally, the examinee is reminded of the desirability of remaining attentive and able to concentrate on the interview and the tasks they are given. Holden emphasised the need to convey the importance of the polygraph examination to the referrer, e.g. Probation, Therapy Provider, etc. and the fact that the results will be disclosed fully. Holden said that examinees have the greatest opportunity to successfully deceive the polygrapher when the examinee has little reason to fear detection.

THE EARLY DEVELOPMENT OF POLYGRAPHY

Polygraph technique and practice advanced steadily during the twentieth century through significant contributions to the field by Larson (1923, 1932), Reid (1947), Reid and Inbau (1977), Backster (1963a, 1963b and 1979), Abrams (1989), Ansley (1990) and Matte (1996). However, the first and most serious challenge to the field of polygraphy occurred when Marston (1917, 1938), failed in his attempt (United States v Frye, 1923) to admit findings employing discontinuous blood pressure measurement

as evidence in Court. Although more reliable continuous measurement is now used, a precedent was set that 'polygraph' evidence would be inadmissible in Court because it lacked "general acceptance in the scientific community".

This position obtained until modern American case law rejected the 'Frye' test (United States V Piccinonna, 1989, Daubert V Merrill Dow Pharmaceuticals, 1993 and United States V Posada, 1995). These more recent cases recognised "the scientific acceptability" of polygraph testing, determining polygraphy to be both relevant and reliable. They also established that it achieves the standards of close scrutiny required by the Federal Rules of Evidence as set out by the Supreme Court of the United States.

CRITICISMS OF POLYGRAPH AND THE RESPONSE

Numerous criticisms (Lykken, 1981 and Ekman, 1985) have been raised about polygraphy that must be properly addressed if this technique is to gain professional acceptance in Britain. Steps should be taken to prevent unregulated and unethical polygraphists from damaging the field's credibility by practising outside of 'demonstrated' areas of competency or by abbreviating procedures. These kinds of practices seriously damaged the credibility of polygraphy in the USA in the 1980's.

In a personal communication, William Scheve (1999), Chairman of the Education and Accreditation Committee of the American Polygraph Association (APA), stated that The American Polygraph Association has now taken significant steps to ensure that appropriate standards of practice and procedure are adhered to by their membership. Scheve referenced the approval of the Manual of Polygraph School Accreditation (American Polygraph Association, 1997) as a key development in this regard.

In Britain, the polygraph has had little impact since the mid 1980's when its use was considered for Government personnel security screening/vetting in the wake of the Geoffrey Prime spy case (House of Commons Employment Committee, 1984, 1985a and 1985b).

Dulewicz (1984), representing the British Psychological Society (BPS) registered initial concerns about the reliability and validity of the polygraph, and the need for controlled research to be undertaken. The Scientific Affairs Board of the BPS (1986) established a Working Party and broadened its investigative remit to include ethical as well as scientific considerations.

The BPS Working Party expressed the opinion that polygraph procedures were not sufficiently standardised to be acceptable in psychometric terms. They also noted difficulties in monitoring methodology and practice employed by individual polygraphists. Particular concerns were voiced about the absence of authorised courses and licensing requirements. They expressed concerns about some published descriptions of polygraph procedures, believing they were incompatible with the BPS's Code of Conduct. Concerns were raised about public protection, the inducing of anxiety and the potential for misleading subjects.

Finally, the working party expressed grave concerns about forced compliance with polygraph examination for employment screening and, for these various reasons they opposed its use.

In the present, it is appropriate that we should take stock of the BPS's criticisms in considering the possible application of polygraphy to post conviction sex offender testing. This use of the polygraph did not come under scrutiny then and still warrants independent consideration.

The most apparent difference between conventional polygraph examination and post conviction/clinical polygraph examination is that the former asks the question "did you do it?" whilst the latter may revisit the "did you" question, but principally asks, "what have you been doing? (Morris, 1995, p.1). The post conviction polygraph focuses on the truthfulness of the offender in relation to information being obtained for treatment and probation purposes after conviction. As such, it has a much more limited relationship with the judicial system than conventional polygraphy, seeking to

effectively identify and change pro-offending attitudes and monitor compliance with the conditions of probation orders.

Whilst concerns have been raised about the accuracy of the polygraph, there has been more general acceptance of its utility (Gudjonsson, 1992). However, Gudjonsson advised that “having ‘blind faith’ in the charts can result in a miscarriage of justice” (p.247).

Investigations of the accuracy of the polygraph examination have most frequently been undertaken by comparing independent polygraph examination results with findings achieved through the use of testimony, forensic evidence, supportive documentation and judicial decisions obtained within the context of investigations and legal proceedings.

Employing these procedures, the accuracy rate reported by polygraphists has shown some variance. Levey (1988) reported relatively conservative accuracy rates of 85%, which were perhaps reflective of less rigorous procedures during the time period he reviewed.

Wilcox, Sosnowski and Middleton (1999) indicated that “in the past seventy-five years, over 250 studies have been conducted on the accuracy of polygraph testing. Since many different conditions and factors are involved in the research and since a polygraph examination is a very complex process, it is difficult to draw from the data a specific figure for the accuracy of polygraph testing in all settings”.

Holden (1996) reported published scientific validity studies over the years, documenting “polygraphic detection of deception to be an average of 90% or greater, and often in the range of 95% or better”. He also reported, “More recent studies with computerised assessment report accuracy rates, with properly conducted examinations, consistently in the high ninety’s”. Holden stated that these findings were quite robust and applied to pre as well as post conviction polygraph

examinations, including sex offender tests. He emphasised that results in this range always apply to “specific and exact applications of interviewing procedural rules”, e.g. specialised training.

Gale (1988), who chaired the BPS Working Party in 1986, further detailed objections and criticisms of the use of the polygraph. He expressed concerns that anxiety is induced to obtain compliance with the polygraph assessment. In response, it is important to recognise that the prospect of being detected of involvement in punishable activities is, by its very nature, fear producing. Where an individual may be engaging in deception, anxiety is naturally and specifically evoked as part of the examination procedure.

However, evoking anxiety for clinically and legally justifiable reasons is neither unusual nor unethical providing extraneous variables are adequately controlled. For example, suggestibility assessment (Gudjonsson's 1983, 1984) employs an anxiety-producing technique to examine the client's susceptibility to pressure from the examiner to change stated recollections. Gudjonsson's measure is both valid and ethical in clearly delineated circumstances, yet it is not possible to assess suggestibility without introducing an element of discomfort and doubt in the client to compare with their normal manner of responding. Similarly, in clinical polygraph examinations control questions are developed which evoke anxiety and then compared with relevant (offence related) questions to determine the relative anxiety produced and with this, the likelihood of deception.

Gale also expressed concerns about possible violations of the rights of individuals being polygraphed, though this argument may apply more to pre-conviction uses. Men on probation are often ordered to engage in relevant assessment and treatment. Indeed, it may be asserted that probation is more a ‘privilege’ rather than a ‘right’ and American case law supports the interpretation of “more limited rights” for individuals subject to Court orders (State v Wilson, 1974). Therefore, if the polygraph is viewed as directly pertinent to work mandated by the court, its use is valid.

Gale (1988) also expressed concerns about intrusions on the privacy of individuals. However, accepted APA guidelines prohibit irrelevant enquiries from being incorporated into polygraph examination. Questions are agreed with clients in pre-interview and should not encroach on the broader areas of 'privacy' to which individuals are entitled.

Plethysmography, developed by Freund (1963), shares with polygraphy certain ethical concerns about misuses and breaches of privacy. Penile Plethysmography (PPG) is a procedure whereby an individual's erectile responses are measured in relation to a variety of auditory and/or visual sexual stimuli. Penile tumescence is recorded as changes in penile circumference/volume and compared with specific sexual stimuli (ATSA, 1993).

There are moral and practical problems associated with eliciting possibly unwanted arousal in community based clients. In common with polygraphy, it can be anticipated that the detection of deviant interests, using the PPG, may produce anxiety/fear in the client. Further, some element of error is tolerated as, not surprisingly, the very intrusive nature of directly monitoring arousal (a mercury filled ring is placed around the circumference of the individual's penis), leads to higher numbers of 'false negatives' e.g. inadequate responses to actual deviant interests, than would be desirable. Nonetheless, the PPG is an accepted tool for breaking through denial.

Though viewed as non-voluntary and invasive, even compared to the polygraph, the value of Plethysmography is accepted in British sex offender work and it continues with some frequency.

It is important to note that the PPG is not particularly helpful for detecting whether non-paraphilic sexually abusive interests exist and may be inappropriate with under age or vulnerable (learning disabled or psychiatrically disturbed) clients. In the

author's opinion however, there is little likelihood that investigations into the deviant sexual interests of offenders can be progressed without evoking some anxiety.

DEVELOPMENTS IN POLYGRAPH APPLICATION

The first use of polygraphy for post-conviction work was introduced by several Judges in America to make decisions about probation (Partee, 1975) and to identify violations of probation (Tuttle, 1969). Both Judges found that individuals who were polygraphed admitted to other criminal activity.

Judge Tuttle believed that periodic polygraph examination could be a deterrent to further criminal involvement, making known criminals less disposed to associate with these men for fear that their activities might be detected. Schmidt (1973) described the periodic polygraph examination as an "artificial conscience" for this reason, believing it might even influence what offenders 'allow' themselves to think about.

By 1973, Judge Beatty had begun a polygraph surveillance program (Riegel, 1974) periodically testing 'high risk' with offenders who were conditionally granted probation if they agreed to participate. Teuscher (1978) reported on the four year follow-up for these one hundred and seventeen men; fifty-four failures and sixty successes among these 'career' criminals. He also reported extensive admissions to additional crimes.

Abrams and Ogard (1986) polygraphed convicted burglars, drug users and sex offenders. They reported that 69% of the men who received periodic polygraph examination whilst on probation did not re-offend and successfully completed their probation, whilst only 26% of those individuals on probation supervision (without the use of polygraph examination) refrained from re-offending. These results were statistically significant at the $<.001$ level.

Unfortunately, the number of sex offenders in the study was small, but results were encouraging and of a similar magnitude to the overall effect observed.

Referring to the polygraph's post conviction role English, Pullen & Jones (1996, p.2.11) advised that it should be viewed as one of several elements necessary to adequately control sexual offending behaviours. They assert that "the goal of the polygraph examination is not to get the offender to fail the exam but rather to pass, meaning that disclosing the offender's sexual assault pattern will increase the likelihood that an appropriate treatment and supervision plan will be developed".

Over the last 15 years the polygraph has increasingly been used in sex offender work. This has given rise to the development of different types of examinations (Holden and Abrams, 1995).

Holden, (1997a) has been instrumental in developing Clinical Polygraph Examinations as a specialism in the field of polygraphy (Joint Polygraph Committee on Offender Testing, 1998). Holden distinguished between the psychological changes that occur in subjects before and after conviction and how this influences the polygraph examination. He advised that false positive results are more common at pre-conviction stage and that at post conviction stage, false negatives are more likely. Holden purports (1997b) that this is the result of circumstances, legal status, anxiety levels, physiological reactivity etc., in the two conditions and he strongly endorses more rigorous procedures and advanced training to assist examiners.

Two distinct disclosure examinations have been advanced (Holden, 1999), one to learn more about the offender's sexual history and the other to obtain details about the index offence.

Further, periodic maintenance and monitoring examinations have been designed to address treatment and compliance issues, enabling therapists to challenge denial more successfully and to identify abusive fantasies and pro-offending cognitive distortions.

Salter (1997) reported that in the American Northwest the regular use of polygraphy has reduced resistance to treatment considerably. Denial is commonly viewed as a

significant obstacle to treatment, such that deniers may be excluded from treatment altogether. Through the use of the polygraph Salter (1997) asserts that these problems can be effectively managed.

Relatedly, the Supreme Court of the State of Washington has ruled that Trial Courts have the legal authority to subject sex offenders to polygraph examination (Spencer, 1998). The Judges ruled that “although the results of polygraph tests are generally not admissible in a trial, this Court has acknowledged their validity as an investigative tool” (p.3).

Faller (1997) noted a common view that certain personality types may be particularly resistive to effective polygraph examination. In particular, a concern was raised that individuals with high levels of psychopathy (Hare, 1991 and Hare and Cooke, 1999) may be skilled at deceiving polygraph examiners. There are however indications that the commonly held perception that psychopaths are impervious to polygraph testing is unsubstantiated. Holden (1997a, p.34) described the influence of mental factors in polygraph subjects and concluded that, “character or personality disorders generally show no significant error effect if examiner understands personality type and prepares examinee properly”. Holden also asserted “generally, drugs and alcohol have very little affect on accuracy of polygraph opinions; i.e., do not generally *cause* error to occur”. He further noted that “emotional disorders generally show no significant error effect” if examiners are appropriately prepared. Lastly, Holden asserts that “mental countermeasures (lying or attempts by the examinee at denial, rationalisation, avoidance, and other defensive positions), do not significantly impact belief systems; therefore, these behaviours will not seriously effect the outcome of a properly conducted examination”.

Sosnowski (1999), an APA Director, noted that “so long as a subject knows he is lying, i.e. has reasonable reality testing abilities; the polygraph examination can reliably identify deception”. Hare, R.D. (personal communication, November 3, 1999) expressed his belief that combining psychopathy measurement with polygraph

examination would make “a major contribution to sex offender work in Britain”. Matte (1996, p.296) cited work by Raskin, Barland and Podlesny (1978), who concluded “results were strongly contradictory to the common belief that psychopaths (sociopaths) can ‘beat the lie detector’”. However, Matte’s own conclusions did not dispel a need for caution in dealing with psychopaths as he noted, “perhaps the greatest danger is that a clever or convincing psychopath can talk a polygraph examiner into believing him, even though the polygraph charts indicate deception”.

Developments in sex offender work in Jackson County, Oregon, led to the establishment of the first formal polygraph monitoring programme for sex offenders in 1991 (Abrams and Abrams, 1993). This provided the model for polygraph use in conjunction with sex offender treatment. Jackson County even introduced legislation offering some ‘leniency’ when offenders voluntarily disclosed additional offences whilst engaging in probation/treatment work (Oregon Licensing Advisory Committee, 1990).

Importantly, sexual history disclosure interviews do not require specific names, addresses, etc. but tend to focus more on patterns of past abuse, e.g. age and sex of victim, methods of coercion employed and acts committed. As such, previous offences may be ‘disclosed’ for treatment purposes, reducing denial but not resulting in formal charges. The periodic monitoring and maintenance examination however, contrasts considerably, seeking detailed information about current offending.

In Texas, comprehensive efforts have been made to integrate sex offender work and polygraphy leading to the establishment of The Recommended Guidelines for Clinical Polygraph Examinations of Sex Offenders, (JPCOT, 1998). The document incorporates training and procedural guidance for all recognised polygraph tests in the field of sex offender work.

Holden (1999) reported routine use of polygraphy in sex offender work noting that its use is now mandatory with adolescent sex offenders and Colorado have introduced similar legislation.

COST BENEFIT

Whilst proper comparisons of custodial versus probation dispositions are required, there is little doubt that savings produced by a successful treatment programme incorporating polygraphy can be substantial. Holden (1999) recommended that maintenance and monitoring examinations should be administered about 6-monthly, stating that more frequent examination might produce an unhelpful 'habituation effect'.

Whilst offender programmes have to meet the additional costs of periodic polygraph examinations, and society must address the legal implications for those who recidivate whilst on probation, this alternative to incarceration is viewed favourably in an increasing number of criminal justice settings. Further, other benefits are achieved in relation to therapeutic outcome, possible victim assistance and public safety (Abrams and Abrams, 1993).

Edson (1991) reported on 173 sex offenders in Jackson County Oregon who received periodic polygraph examinations. His results revealed that 95% of individuals in the polygraph programme were free of new sexual convictions. 96% had no new felony convictions and 89% were 'crime free' as regards any new convictions. These data were compared with reconviction rates for sex offenders in Linn County Oregon who were not polygraphed. A statistically significant improvement in offenders behaviour was shown and maintained at three, four and five year follow-ups with reduced re-offence and incarceration rates demonstrated. This recidivism study offered additional confirmation of the value of polygraph surveillance.

English (1998) stressed the monitoring role of the polygraph examination, stating that effectiveness is maximised when close collaboration is achieved between the

probation officer, therapist and polygrapher. Increasingly, polygraphy is being employed in community based sex offender programmes (Blasingame, 1988, Baranowski 1998, Lundell and Holmes, 1999 and Wilcox, Sosnowski and Middleton, 2000). Relatedly, English et al. (1996) advised, "the polygraph is one more source of information that can flag areas of concern, and results from the test should be used in conjunction with other information when making decisions about case management of sex offenders" (p.15.11).

THE WAY FORWARD

Leading figures in the field of sex offender work have endorsed the utility of polygraphy testing. Abel (1997) described its particular benefits, noting the potential for obtaining substantial additional information.

In particular, Abel described the benefits of the polygraph in identifying non-paraphilic sexually abusive interests and behaviour. He noted that these were not readily discernible through phallometric testing (Freund, 1963, Barbaree and Marshall, 1989), or the visual reaction time procedure that he has developed (Abel, 1990, 1994, 1998). The polygraph's utility was endorsed in professional sexual misconduct cases, with non-paraphilic rapists and with many incest offenders.

Salter (1997) asserted that she had never known sex offender workers to dispense with polygraphy after having begun employing it. The polygraph has proponents in many well-respected sex offender treatment programmes (Hunter, 1997; Wolfe, 1998). The collaborative work between Wolfe, Director of the North Western Treatment Programme, and Matzke (1976), Clinical Polygraph Examiner, is an example of a well established programme employing polygraphy as one element of a comprehensive treatment package as described by Erooga (1994).

The polygraph influences offenders on a cognitive-behavioural level (Abrams and Ogard, 1986 and Harrison and Kirkpatrick, 2000). It can be employed to explore abusive thoughts, plans and fantasies, as well as actions. As such, it appears to have a

unique therapeutic potential for impacting on attitudes and beliefs that can facilitate change in the individual's lifestyle, associations and values.

The successful management of denial is one of the primary aims in any offender treatment programme (West Midlands Probation Service, 1996). Yet even when considerable information continued to apparently remain concealed, research (Allam, Browne and Middleton, 1997) indicated significant gains in treatment. Even so, group workers recognise that offenders who may continue to abuse and withhold important information are deceiving them.

Holden (1999) reported unpublished doctoral research by Michael A. O'Connell and Associates, reviewing 127 archival clinical case files of male adults who acknowledged committing sexual offences. They investigated the subject's disclosures of sexually deviant behaviour, recorded at three separate points: (a) subjects self-report on referral, (b) subjects self-report during clinical interviews and (c) subjects self-report during polygraph testing.

For the 127 cases, the mean number of incidents of sexually deviant behaviour reported on referral was 28.25. On average, an additional 65.38 incidents were reported during clinical interviews, and an additional 197.44 incidents were reported during the course of polygraph testing, a multi-variant test for repeated measures was statistically significant Wilk's Lambda = .895, $F(2, 125) = 7.316$, $p < .001$.

O'Connell also investigated the crossover rate from known offences into other sexually deviant behaviour. Subjects reported having engaged in a mean number of 3.67 different sexually deviant behaviours before and during clinical interviews. By the end of polygraph testing, subjects had reported a mean number of 7.31 different kinds of sexually deviant behaviours. A paired t-test for dependent measures yielded a high degree of significance. $t(126) = 15.41$, $p < .001$. These results provide support to Abel et al. (1987), both in terms of the number of sexual offences actually committed by offenders and the range of paraphilias that may co-exist.

A separate study by Abrams, Hoyt and Jewel (1991) also produced a significant increase in disclosures about sexual history amongst subjects who were polygraphed during sex offender treatment. More recently, Heil, Ahlmeyer and English (1998) reported that sex offenders in their study admitted to twice the number of victims as a consequence of polygraph examination.

Franklin (1995) reported polygraph results on forty-three sex offenders who were convicted of sixty-seven offences. Prior to polygraph examination these individuals admitted to 188 incidents of sexual abuse. During polygraph testing this figure increased to a total of 7,189 separate incidents of sexual offending. Franklin also reported other probation violations that were identified through the polygraph examinations.

However, in some respects post-conviction polygraph examination of sex offenders has been a victim of its own success. Clinical Polygraph Examination has tended to be adopted quickly and comprehensively because of its great treatment and assessment utility. As a result, there has been a lack of properly controlled research (Abrams and Abrams, 1993).

Nonetheless, the polygraph is being used in Britain to a limited extent now, and this writer is aware of one case (NOTA (National Organisation for the Treatment of Abusers) News, 1998) where an independent polygraph examination was administered to establish 'proof' about a convicted offender's index offence. This is worrying since, in the absence of agreed standards for training and practice, this kind of involvement can range from unhelpful to counterproductive.

The American Polygraph Association has recently recognised a sub division of the APA, the National Association of Polygraph Specialists in Sex Offender Testing/Monitoring (NAPS), as a separate organisational entity. Membership is limited to individuals who meet, and in some instances, exceed the designated APA criteria for 'expert qualifications'. These specialised requirements are being accepted as the appropriate qualification in this specialist field in some areas in the United

States. The PCSOT Sub-Committee of APA (Sosnowski, 1999) has also developed comprehensive practice criteria in this specialist area.

Earle (1998) focused on the assisting role that the polygraph examination can play within the treatment process. He noted that the polygraph examination could provide verification about the sexual offence, as well as giving an indication of the individual's willingness to comply with treatment. Earle found that the polygraph can improve openness with therapists. It can help to identify elements of the offence cycle as well as the underlying cognitive distortions. By eliciting further information, the polygraph can also aid in targeting new issues to be addressed during therapy, and can verify progress on work being done. Overall, Earle found that the polygraph examination reduced denial and minimisation.

Further research should be conducted to investigate the effectiveness of the polygraph using a population of British sex offenders. If the results bear out findings elsewhere then it may well be appropriate to establish and regulate a polygraphy training programme in Britain focusing on sex offender work.

The importance of a Board or Council to monitor the development and use of polygraphy should also be recognised. It could set standards, promote training and guard against abusive practice. Adequate controls would enable the accumulation of clinical polygraph examination data on sex offenders. This information would have research applications, and enable practitioners to gain a better understanding of offenders and offending behaviour.

It will be important to monitor any provision of polygraph services in the future, to ensure adherence to identified standards. Such a Board could provide a useful quality control function. The successful evaluation of such work will generate additional knowledge about sex offender behaviour, facilitating the further training needs of future polygraphists, as well as the range of professionals already engaging in this challenging work.

There are indications that the careful introduction of polygraphy would positively impact on the quality and success of SOTP programmes in Britain. It would also protect current practitioners by creating barriers for those without 'recognised' training in this specialised area of polygraphy.

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PROFESSIONAL DOSSIER

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British Psychological Society – ‘Statement of Equivalence’ of Overseas Qualification to Diploma in Clinical Psychology	1991
British Psychological Society Register of Chartered Clinical Psychologists	1991
British Psychological Society – Practising Certificate	1994
British Psychological Society – Associate Fellow (AFBPsS)	1994
Law Society – Directory of Expert Witnesses	1996
American Psychological Association – Member Status	1997
University of Birmingham, School of Psychology – Honorary Tutor (Former Chairman of Supervisor’s Sub-Committee, Clinical Psychology Doctoral Programme)	1997
British Psychological Society – Register of Chartered Forensic Psychologists	1998
BUPA – Approved Clinical Psychologist Practitioner	1999

British Psychological Society – Faculty for Children and Young People	1999
British Psychological Society – Special Interest Group – Learning Disabilities	2001

Related Professional Affiliations/Memberships:

The Institute of Health Services Management – Licentiate (LHSM)

British Association for Study and Prevention of Child Abuse and Neglect

British Institute of Learning Disabilities

National Organisation for the Treatment of Abusers, Midlands Branch – Vice Chair

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Educational Background:

University of Surrey School of Psychology Guildford, Surrey	Clinical Psychology Doctorate Expected Completion Date: August 2002
State University of New York Brockport, New York	Masters in Public Administration, Health Services Management Graduated: December 1982
State University at New York Geneseo, New York	Bachelors and Masters in Psychology (Clinical Emphasis) Graduated: 1978
Dansville Senior High School Dansville, New York	Regents Diploma and NYS University Scholarship

Occupational History:

Wilcox Psychological Associates 9/10 Frederick Road Edgbaston, Birmingham	Psychology Practice (Clinical and Forensic) July 1997 – Present
Strategic Alliance Probation Services Bedfordshire, Hertfordshire, Cambridgeshire, Northamptonshire	Provision of specialist psychological/ psychometric consultancy to assessment and treatment programmes. September 1999 – Present

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New York Institute of Technology
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Psychology Contract, Sex Offender Unit,
including supervision of psychology staff,
individual treatment, group therapy, and
psychological assessment work.
December 1994 – Present

Co-Owner – Directorial Board
Oversight of Business Operations
September 1989 – March 2000

Partner: Clinical and Forensic Psychology
Practice
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Contractual Psychology Services in Adult
Mental Health, Occupational Health
Counselling, Primary Care and Learning
Disabilities (Principal Psychologist)
1991 – 1998

CEO – Central Birmingham Psychiatric
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April 1986 – September 1989

Programme Manager and Clinical
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September 1982 – March 1985

Associate Professor – Psychology
Coursework – Social Psychology,
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Director of Community Placement for Long-
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Group Therapist with Psychiatric Out-Patients
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Lecturer in Behavioural Sciences
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1976 – 1977

Publications/Conference Presentations:

Wilcox, D.T. (1993) *Group Therapy for People with Challenging Behaviours and Sexual Problems*. Psychotherapy – Clinical Training for people with Learning Disability, West Midlands Psychiatry Regional Seminar. University of Birmingham

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- Wilcox, D.T. and Leyland, M. (1999) *Group Techniques for Working with Intellectually Disabled Sex Offenders*. Presentation for National Organisation for Treatment of Abusers Annual Conference. York
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- Wilcox, D.T. and Sosnowski, D. (2001) *Future Application of the Polygraph to Sex Offender Work in Europe: A Review of UK Research*. Conference Presentation. Balkbrug, Nederland

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Wilcox, D.T. (2002) 'Surviving abuse: Adaptive and maladaptive strategies'. *Sexual Offending and the Community*. National Organisation for the Treatment of Abusers Conference. Stourbridge

Wilcox, D.T. (2002) *Interviewing Psychopathic Offenders*. Presentation for Bedfordshire Probation Service. Bedford

Grubin, D., Parsons, S., Sosnowski, D. and Wilcox, D. (2002). *The Use of Polygraphy in the Management of Sex Offenders*. Presentation for the XXVII Conference of the International Academy of Law and Mental Health. Amsterdam

Forthcoming Publications/Conference Presentations:

Grubin, D., Wilcox, D.T., Marsden, L. and Sosnowski, D. (2002) *The Use of the Polygraph in the Assessment and Treatment of Sex Offenders*. Presentation for the National Organisation for the Treatment of Abusers (NOTA) Annual Conference. Lancaster, England.

Wilcox, D.T. (2002). *Treatment of Intellectually Disabled Individuals who have Committed Sexual Offences: A Review of Current Needs*. Keynote presentation Scottish National Organisation for the Treatment of Abusers (NOTA) Annual Conference. Stirling, Scotland.

Wilcox, D.T. and Sosnowski, D. (accepted for publication). 'Future European applications of the polygraph to sex offender assessment and treatment: A review of current UK research'. *Probation in Europe*, December 2002.

Training Received:

American Polygraph Association – Managing Risk in the Community, Florida

American Psychological Association - Convention Attendance 1995

Black Country Away Day Clinical Psychology Training Sessions

Clinical and Forensic Applications of the PCL-R

Clinical Psychology Departments - Attendance and participation in ongoing training with departmental meetings, Sandwell, Mid Staffordshire, Wolverhampton, Walsall, Dudley and South Warwickshire as well as the West Midlands Probation Services Regional Sex Offender Unit

Development of Innovative Care Packages for Challenging Community Cases

Diagnosis and Treatment of Aspergers Syndrome

Expert Witness Workshop – Lord Woolf Reforms

Hare Psychopathy - Training, Leicester University
 Identification of Psychiatric Disorders in Learning Disabled Individuals
 Identification and Therapeutic Support for Learning Disabled Victims of Sex Abuse
 Kingston University (Bath Penitentiary) – Sex Offender Groupwork
 Managing Aggression in Clinical Settings
 National Organisation for the Treatment of Abusers Conference Presentation 1995 - 2001
 National Probation Service, Sex Offender Treatment Programme - Interpretation of Psychometric Measures
 Post-Conviction Sex Offender Polygraph Testing Course
 Sexual Offenders – Assessment, Risk Management and Treatment: A Gathering of Leading Experts
 Southampton University - Giving Court Room Testimony
 Southampton University - Managing Risk
 Specialised Training Services – Sex Offenders: Assessing and Managing Risk, San Diego
 University of Birmingham - Annual Attendance at regularly scheduled Department of Psychology training sessions
 University of Birmingham - Ongoing Training for Honorary Clinical Tutors, School of Psychology, Clinical Psychology Doctoral Training Programme. Areas including ethical practice, neuropsychology, supervision, etc.

CASE STUDY

A Clinical/Forensic Psychological Assessment and Treatment Report on an Individual with Zoophilia

Case Study
A Clinical/Forensic Psychological Assessment And Treatment Report On An
Individual With Zoophilia

ABSTRACT

This is a case study of an individual whose index offence is zoophilia (a sexual arousal to animals). He was assessed to be high risk and high deviance on the measures employed and this case study explores the wide range of paraphilic (sexually aberrant) interests and activities with which he has been involved. The paper includes the details of his assessment as well as the treatment work he engaged in over a period of nearly three years. Although the results only suggested modest gains in terms of the acquisition of relapse prevention skills, the case study chronicles a realistic public protection problem and the steps taken to contain Mr Z's offending behaviour. Efforts have impacted on both internal processes that mediate offending attitudes and behaviour. They have also included external measures used to monitor and control his risk of re-offending.

Key words: zoophilia, public protection, sex offender assessment and treatment, polygraphy

INTRODUCTION

Mr Z is a forty-six year old single Caucasian male who was referred for an independent clinical forensic psychological assessment in relation to two offences of attempted buggery with a horse, committed in early 1998. Mr Z has an extensive history of criminal activity dating from 1977 to 1998 when he was convicted in respect of the current matters. Over this period, Mr Z has been convicted of seven sexual offences, one offence against the person and one public disorder offence, although only the sexual offences have continued during the past fifteen years. These include rape, three separate convictions for indecent assault on a female and indecent exposure with intent to insult a female. In addition, Mr Z has been convicted of assault occasioning actual bodily harm and using threatening, abusive, insulting words

or behaviour. Mr Z has also been imprisoned for breach of conditional discharge and breach of Probation Order.

Mr Z has served approximately five and a half years in prison for these offences and was first imprisoned in 1982 for the rape conviction. The police report of the rape described a particularly callous act of sexual violence, "Mr Z followed a woman into a lift on a multi-storey car park. He firstly indecently assaulted her and took her from the lift and raped her on the second storey of the car park. He then walked her along the riverbank in order to have intercourse again, but at that time she made good her escape."

Mr Z was referred at pre-sentence stage in relation to the current offence for an independent opinion about the level of risk that he may pose to the public, his amenability to treatment, the nature of any such intervention and the prognosis for positive change. It was recommended that he should be given a Probation Order with a condition to attend the Sex Offender Treatment Programme. The author provides contractual psychological consultancy to this Probation Service in the form of psychometric assessments, group and individual clinical input. As such, Mr Z's therapeutic work within the Probation Service Sex Offender Unit was supervised or directly provided by this writer throughout the period of his three year Order. Further, with Mr Z's co-operation, individual sessional input has continued on a monthly basis since the completion of his Order in the summer of 2001.

Over this period, numerous concerns have arisen about his progress and the management of offence-related activities. However, he has not been charged or convicted of any further offences, to the present date, since his last conviction. This case study provides psychometric findings at pre-treatment stage, following Mr Z's completion of the induction phase (after fifty hours of sex offender treatment) and at exit stage, following completion of his Probation Order/treatment programme involvement (please refer to Appendix 1b, 1c and 1d for raw scores). This case study references clinical impressions the author has gained through individual and group

sessions, as well as through liaison work with Mr Z's Probation Officer, the bail hostel manager where he resided for the majority of this time and other professionals, in joint efforts to contain his offending behaviour. The treatment programme Mr Z attended was the first of its kind to achieve Home Office Accreditation. The Sex Offender Groupwork Programme has been designed to impact on offence-related cognitive, personality and social functioning areas, as well as specific sex offence related beliefs, attitudes, thoughts and behaviour (WMPS, 2000).

The original assessment findings are summarised in Appendix I.

PROBATION BASED ASSESSMENT AND TREATMENT WORK

Mr Z was given a three year Probation Order with a condition to co-operate with all assessment and treatment work deemed necessary to address his sexual offending. He attended the fifty hour induction programme during the autumn/winter of 1998. "The WMPS Programme is a cognitive-behavioural programme which addresses sexual offending by adult males. Offenders are subject to an initial fifty hour induction module designed to decrease denial/minimisation of their offending and increase their acceptance of responsibility for choosing to offend. Offenders are then further assessed using clinical judgement and psychometric testing. Low risk/low deviance offenders complete a further fifty hour programme focusing on relapse prevention strategies, whereas high risk/high deviance offenders are required to undertake a one hundred and fifty hour programme which targets a wider range of criminogenic factors before completing a relapse prevention module. An offender will usually take two years to complete the full programme (200+ hours)" (West Midlands Probation Service, 2000, p.3).

Unfortunately, whilst Mr Z made some progress with this mainstream programme, his potential for progressing further in 'mainstream' was being questioned in part because of his lack of understanding and in part because of his social manner which caused him to be progressively more alienated and scape-goated. In therapy he acknowledged anger control problems and continuing fantasies about abusing women. He reported

that during his last offence against a woman he used alcohol as a disinhibitor, stalking his victim around a shopping centre, standing behind her and grabbing her breasts but there were no indications of current alcohol use.

However, there were indications that Mr Z was still withholding significant aspects of his cycle of offending as he continued to fantasise in terms of “warm, loving and romantic (without sex) encounters”. By the end of fifty hours Mr Z had apparently committed some of the groupwork to memory. However, he continued to show little accountability for his offending, in spite of expressing the belief that he accepted responsibility. His lack of insight and general reasoning ability became an obstacle to progress as he often made comments that were tangential to group discussion, demonstrating a lack of concentration and understanding. His social interactive skills remained very poor and his intermittent contributions appeared to be aimed at making self-important, narcissistic comments about his gains in self-understanding, which other group members found very irritating and disruptive to the group process.

Mr Z was quite unaware of a number of cognitive distortions that he held. However, he refused to divulge information that he believed might lead to criticism or enquires concerning current stability and level of risk. He conveyed the impression of developing more positive attitudes toward women, but evidence of underlying pathology remained. For example, in reference to the women he abused he said they are “tall, sexy and dark haired, like my mum”. At the end of induction it became apparent that Mr Z’s key triggers to offending were anger and loneliness. There were also indications that abusive fantasies made him feel better (although he rarely gave much insight about the true details of these fantasies).

Overall, Mr Z demonstrated poor understanding of his cycle of offending (Wolf, 1984). A major aim of the group is to help the offender to identify his personal cycle. The written construction of the offence cycle serves to visually demonstrate the interrelationship between thoughts, feelings and actions in the sequence in which they occur leading up to and following sexual abuse (See Appendix III). The groupwork

also focuses on the model provided by Finkelhor (1986) who identified the four sequential steps toward committing a sexual offence. These are motivation to abuse, overcoming internal inhibitors, overcoming external inhibitors, and overcoming the victim's resistance. This model is used to examine the behaviour and offence pattern of each individual engaging in the treatment programme (Appendix IV).

At the end of induction, Mr Z showed a poor ability to understand and use of these models as they applied to his offending. Particular areas targeted for further work were 1. Cycles and cognitive distortions, 2. Self-esteem/social skills and 3. Relationships/contact with women.

At the end of induction, continued individual psychological input was requested toward developing better anxiety and anger management skills and Mr Z was transferred to the intellectual disabilities group. Appendix V and VI provide information about the therapeutic focus and programme outline for the intellectual disabilities groupwork programme (Wilcox and Leyland, 1998/1999).

Motivationally, Mr Z made gains in moving to the intellectual disabilities group, his group attendance improved and based on this slower, more tailored approach, a better contribution to the group work was achieved. Although there was some evidence of inconsistency, Mr Z showed improvements in other areas as well, including hygiene and appearance (with periodic reminders and encouragement) and in terms of gaining information beneficial to his relapse prevention plan. Further, his self-esteem rose somewhat in the group as he was less likely to be scape-goated in this context, although he continued to have interpersonal difficulties in the hostel where he resided. These issues were raised in individual sessions wherein the author occasionally took a direct pragmatic involvement, liaising with the hostel manager, whilst more often efforts were focused on helping him to develop coping abilities through acquisition of anxiety management strategies (principally through the technique of re-framing thoughts) and relaxation training, which he reported finding beneficial in some instances.

In view of Mr Z's High risk of re-offending, he was monitored closely. During the course of his Order he disclosed sexually abusive fantasies about a young lady who was attending the same college class he had been enrolled in. The fantasies he revealed suggested quite advanced planning as he reported thinking about following her towards a less used building exit and assaulting her in this area. Based on this disclosure, it was agreed with Mr Z that it would be most appropriate for his Probation Officer to be advised of these matters and for him to cease attending this course. Individual and groupwork focused on helping him to accept that this was the best and most responsible action for him to take in the circumstances.

Other 'risk' situations were identified and explored within the therapeutic work undertaken. These included two incidents of sexual stalking, one disclosed in group concerned a stranger and another, which he denied, concerning a member of staff at the hostel where he was residing. Initial denial and reluctance to take responsible action hampered progress but Mr Z agreed to take appropriate action as advised. He was also observed on one occasion in a field where he was reported to have been masturbating whilst watching farm animals. He denied this stating that he had had to urinate, but he accepted that this had been a risky situation for him and agreed to avoid going there in the future.

FURTHER ASSESSMENT

In view of Mr Z's continuing difficulties in being open about his offending behaviour, a sexual history disclosure polygraph examination was planned and Mr Z agreed to participate. The polygraph results further confirmed the extent and seriousness of Mr Z's sexually deviant interests/involvements. The polygraph examination was terminated prematurely at this stage because Mr Z became both angry and distressed. Whilst he did not 'fail' the examination, it was the opinion of the polygraphist that he was likely still withholding a great deal of information in spite of acknowledging considerable further offence-related information. Of particular concern, he became emotional and refused to continue following the admissions of offences concerning children for which he had not been convicted.

Based on the polygraph examination, Mr Z made the following admissions. He indicated that he has masturbated in public on 20-30 occasions, exposed himself on 30-50 occasions, made obscene telephone calls on 2 occasions, stalked individuals on about 400 occasions and committed frottage on about 300 occasions. Regarding indecent assaults, Mr Z stated that he had approximately 700 undisclosed victims. Mr Z stated that he had exposed himself at a school, when he was younger, approximately 50-80 times and at that time masturbated approximately 10 times where children could see him. Mr Z reported that on hundreds of occasions people had told him "to stay away".

The ongoing treatment and assessment work focuses on public protection issues whilst if tenable, enabling Mr Z to be maintained in the community. As will be noted in the psychometric and clinical conclusions given below, some minimal, though important gains were made in terms of helping him to develop internal controls and significantly in terms of his willingness to accept external controls to contain his offending behaviour.

Over the last ten months, Mr Z has continued to voluntarily attend individual sessions with this writer on a monthly basis with two missed appointments, which were rather promptly rescheduled. Hygiene and grooming problems became more apparent during the period when Mr Z's attendance became poorer and he responded positively to suggestions to make improvements in these areas. Hanson and Harris (1999) indicated that a deterioration in personal appearance was an important risk factor, particularly in men who sexually abuse adult women. The focus of intervention when these issues emerge has been to help Mr Z to recognise risk factors and take appropriate steps, together with addressing underlying features associated with his mood and lack of personal direction.

Hanson and Thornton (2000) reported that acute risk factors associated with lifestyle changes and co-operation with supervision can have a dramatic impact on the immediate risk of recidivism. A comparison of Mr Z's performance on the

psychometrics that were administered in conjunction with the sex offender treatment programme are shown below.

SUMMARY

Validity and Denial

Throughout, Mr Z has suppressed the extent of his arousal to rape and denied sexual interest in children. At the end of treatment, he also moved from denying *normal* sexual drives and interests to a more extreme stance of presenting as asexual or totally uninterested in sex. His continued deceitfulness is apparent since he has paradoxically become more open about his preoccupation with and anxiety about sex than he reported during the earlier stages of assessment. There was strong evidence to suggest that Mr Z will continue to dissimulate in response to items which relate to his offending behaviour. However, there were no indications that Mr Z is attempting to portray himself in a socially desirable light.

Indeed, whilst he previously produced scores in the *normal* range, suggesting that his responses were unlikely to be motivated by any attempt to “fake good”, in the final administration his Social Desirability score was extremely low and suggestive of a level of disregard for social norms and conventions to which he had previously not admitted. This would therefore preclude him from worrying about what others thought about him in many respects unrelated to his offending. These features bore similarities to the Antisocial Personality features identified at the time of the initial assessment. Such results may constitute significantly contributing factors to recidivism (Beech, 2002). However, Mr Z still feels the need to be defensive and on all three administrations significant evidence of denial and misrepresentation have compromised test results. (Please refer to Appendix Ib, Ic and Id).

Mr Z continued throughout to show indications of low self-esteem, although this feature has improved somewhat on each re-administration. His emotional loneliness score has returned to a level that is very much above *average* having dropped at the fifty hours stage to an above *average* level. At that time, Mr Z was residing in a

hostel and now he lives on his own once again. This may account for his feelings of isolation and will be important to address in terms of advising him about social activities. Indeed, it is possible that the lack of social involvement afforded by his regular group attendance, which he regarded as a meaningful social occasion, has influenced this score too.

Mr Z's assertiveness scores have not varied much, although there are indications that under-assertiveness has reduced from above *average* to high *average* levels whilst his inclination to respond in an over-assertive manner has increased slightly from the high *average* to the above *average* range. These features may enable him to assert himself more easily in a variety of social situations, although at times, he is likely to use either aggression or hostility inappropriately to make his feelings and wishes known.

Over the course of treatment, Mr Z's locus of control measures have moved into the *normal* range, though previously his scores reflected an externalised locus of control, e.g. a general belief that events are caused by outside factors rather than internal decision making processes. Although this shift is relatively small, it is a positive one and an important requirement if an individual is to begin to demonstrate a capacity for accepting responsibility for the consequences of his behaviour. Mr Z reported relatively good perspective taking and empathic abilities, within *normal* limits. He therefore believes his ability to see events from another person's perspective has improved since the fifty hour stage and in view of his low social desirability score, it is more likely that this belief is genuine. Mr Z does not appear to suffer from high levels of personal distress and these scores have not changed over time.

Mr Z still shares features common to highly deviant and risky offenders. His feelings of inadequacy still prevail and he is feeling even lonelier than he did at both the zero and fifty hour stages. However, his profile does show some improvement since the fifty hour stage. There has been a slight increase in his feelings of self-worth and he is more likely than before to believe events are caused by his own actions. He also feels more able to assert himself, although it is concerning in view of his offence

history, that he feels it is sometimes necessary to be aggressive or hostile to achieve this.

Pro-offending Thinking and Deviant Sexual Interests

Although in interview Mr Z often reported caring feelings about adult victims, the psychometric measures revealed few distortions about his female victims, e.g. he demonstrated an accurate understanding of the victim's experience of the offence. However, there were ongoing indications that Mr Z has hostile feelings toward women in general and this is perhaps best exemplified by his repeated assertion that women see themselves as superior to men in many situations. He also displayed a 'fake good' tendency on the Empathy for Women test reporting considerably more concern about the feelings of women than the average respondent would. Mr Z also demonstrated high *average* levels of global distortions about child sexuality and indeed these scores increased from the fifty hour to exit stage. However, Mr Z was very defensive in respect of items concerning children and refused to respond to them at all on the MSI. Evidence of distortions included his assertions that "adults are not always to blame if they engage sexually with children" and his assertions that "children are not as (sexually) innocent as most people think". Mr Z's scores for emotional congruence with children were slightly lower than at the fifty hour stage and therefore below the *normal* limits. This suggested that Mr Z may be concealing his true feelings, avoiding items referencing emotional identification with children, much the way that he has systematically conveyed an asexual impression of himself with the aim of reducing people's perceptions of his true level of risk.

Mr Z still presents with very high levels of cognitive distortions and his degree of 'victim posturing' increased again at exit stage. Mr Z defensively continues to justify his offence and this is likely associated with ego protection in combination with ongoing pro-offending distortions. However, even at exit stage, Mr Z continues to show an awareness of his sexual risk, reporting a motivation to continue working on his offending behaviour. Indeed, he continues to report that he requires further input to avoid re-offending.

On the Sex Deviance Scales, Mr Z produced a slightly greater number of admissions on the rape and exhibitionism scales over the course of treatment, acknowledging that he has threatened a person in order to have sex with him and that he has had sadomasochistic interests involving "beating someone during a sexual encounter". He also admitted to more fantasy and cruising behaviours in relation to his exhibitionistic offending. However, Mr Z reported less on the Child Molest Scale than he previously has and in view of information gathered through the clinical polygraph examination, interviews and review of his assessment results, this increased tendency to withhold information is a cause for concern.

Mr Z did admit to more paraphilic interests by the end of treatment. He noted continuing frottage and voyeuristic urges and also identified becoming sexually stimulated to someone urinating. He endorsed more obscene telephone call items and notably acknowledged calling an unknown person to "frighten them with dirty words and thoughts".

There are no major differences in the responses given by Mr Z to the Sexual Dysfunction Scales, but he has endorsed more items of the Impotence Sub-Scale than at both zero and fifty hours. His knowledge of sexual anatomy and physiology was assessed to be adequate throughout.

On the Relapse Prevention Scale, Mr Z demonstrated some insight into his offending behaviour and limited strategies for preventing relapse at the fifty hour stage. He was prepared to acknowledge some risk of re-offending but did not see his risk as being as serious as others believed it to be. Significantly, Mr Z did not express any remorse or any mention of his victims and the consequences caused to others by his offending at the fifty hour stage. At the exit stage Mr Z showed some further improvements in his relapse prevention skills with slight increases in his awareness of the effects of his offending and similarly incremental gains in the development of strategies to avoid re-offending.

CONCLUSIONS

The reality is that Mr Z remains a very high risk, high deviance sex offender based on the Risk Matrix 2000 (Thornton, 2000) and other measures of risk employed. Further, his ongoing deceptiveness very likely continues to conceal important aspects of his offence cycle and deviant arousal. However, at least modest gains have been achieved. He has acquired some helpful relapse prevention skills, demonstrating an improved capacity for understanding, predicting and controlling deviant sexual urges.

During the period of Mr Z's participation in the treatment programme, there were indications that his offending behaviour was contained through collaboration between Therapists, Probation Officers and Residential Key Workers such that offence cycles may have been averted and further offending interrupted.

Further, even following the completion of Mr Z's Probation Order, he has continued to voluntarily engage with this writer in a manner which has directly impacted on significant risk factors (WMPS, 2000). He has shown adequate responsivity to voluntary supervision and agreed to continue therapeutic work, thereby achieving continuity and support in terms of lifestyle/quality of life has been achieved.

Although it is unknown whether Mr Z has re-offended during the period of his Probation Order, he has not had any further convictions over the last four years and has continued to engage in monthly therapeutic/supervision contacts since the conclusion of his Order.

IMPLICATIONS/LIMITATIONS

In terms of public protection, there will be an ongoing need to monitor Mr Z's activities and encourage his co-operation. Mr Z continues to pose a very great potential threat to women in the community and, in view of his lack of openness and co-operation in respect of possible continued arousal to children, this area of potential risk will also require supervision. Mr Z continues to communicate periodically with the manager of the Probation Hostel where he previously resided and the monthly

appointments with this writer at Probation will be encouraged. Further, the local 'beat' police officer is also part of this communication network. The various professionals involved have provided diverse inputs to improve community safety through in-depth assessment to gain a fuller understanding of Mr Z's pattern of offending and sexual arousal, to introduce better self-control through the marginal therapeutic gains introduced and through direct observation/supervision of Mr Z in the community.

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ORIGINAL ASSESSMENT FINDINGS:

Personal History

Mr Z reported that he has never been married and has had very limited relationship involvements. He said that he was the oldest of four children and reported a very conflicted relationship with his father, whom he described as very critical of him.

There were some early indications of Mr Z's rather limited intellectual abilities. Justifying his offending behaviour, Mr Z said, "I rebelled against my father and that's where my offending pattern started". Mr Z reported a close relationship with his mother stating, "she coddled me", but added that he has not been in contact with her for a long time, giving some suggestion of undisclosed tensions.

Mr Z appeared to feel socially isolated as a child, reporting that he was "picked on and bullied" at school. He said that from a young age he harboured angry feelings toward others, males and females and often fantasised about sexually aggressing towards them to 'redress injustices'. Whilst he acknowledged developing a pattern of becoming aroused to these deviant "getting even fantasies", he largely denied these associations with his offence behaviour.

Mr Z recalled that his first offence, for which he received a caution, involved an indecent assault on a woman. He stated, "I ran up to her to give her a cuddle and put my arm around her, but she said I touched her breast". This kind of denial and minimisation is not unusual in the self-reports of offenders but within this context Mr Z's comments suggested an unusual lack of self-insight and understanding of his own motivations. It was however my opinion that such implausible explanations of his behaviour could be productively explored in treatment.

During the interviews, Mr Z admitted that he has probably "gotten away with eight other (sexual) attacks" involving indecent assaults for which he was never charged. Mr Z justified his offences stating, "all the women I attacked were married". He

further appeared to query whether he hated married women or simply rationalised that they would be 'harmed' less by a sexual assault. On questioning however, Mr Z did not appear to be aware of whether or not his victims were wearing wedding rings or in any other way gave overt evidence of being married.

Mr Z also acknowledged being 'apprehended' for exposing himself on two occasions as a teenager, as well as having committed this offence on other occasions but not being caught. In general, his level of disclosure about past sexual offending, although certainly incomplete as regards detailing his offence cycle (Wolf, 1984) and the extent of his deviant activities, did suggest a potential for engaging in work focused on understanding and controlling his sexual behaviour. Whilst he minimised aspects of his abusive thinking and in particular was inconsistent in his reporting, his denial was not as pronounced as is found in many sex offenders at pre-treatment stage.

Mr Z also gave inconsistent responses to questions about past relationships and it was my impression that he had never been involved in any past significant intimate relationships. His allusion to relationships seemed aimed at 'normalising' his life or bolstering his self-esteem. Mr Z's comments about relationships both intimate and familial reflected repeating themes in his mind of inadequacy and betrayal on theirs, which appeared to fuel underlying justifications to anger on his part. He conveyed the impression that throughout his life he has been persecuted and alienated.

Exploring mental health issues Mr Z said that he had once seen a psychiatrist in relation to past offences and also saw a psychologist in prison. However, at that time, he denied that he had ever had any emotional problems such as anxiety or depression, though there were indications that he may have simply adjusted to long-term dissatisfaction with his life. Further, Mr Z later contradicted himself reporting acute depression associated with diminished responsibility at the time of his current offence. However, as Salter (1988) noted, this kind of posturing is a common means of denying responsibility.

Based on case documents available, it appeared that Mr Z has been long-term unemployed. However, he reported working as a “store-man” on a military base for about four years in his early twenties. Mr Z said that this was a period of relative stability in his life, but he indicated that this ended when he sexually assaulted a woman on the base and had to resign. Mr Z denied having any paedophilic or voyeuristic interests, although there were suggestions of both noted during the interview. The subsequent psychometric assessments administered revealed distortions and apparent omissions in both of these areas. He also reported fetish interests and arousal to odours such as leather. Mr Z acknowledged offences involving exposure and masturbating in public as well as frottage, e.g. touching someone sexually without their permission in a crowded public place. His pro-offending cognitive distortions about frottage were very concerning as he conveyed obvious annoyance, stating, “you get caught, you get dirty looks, but if you have a certain look – status, money, etc. – then it’s okay”. Sadistic ideation was also noted at times, although Mr Z often denied this.

Describing his current offence, Mr Z said, “it was a one off”. Mr Z said that the offences involved a small pony and a gelding. He stated that he was in a “very depressed state – totally out of it”. Mr Z said that when he felt this way he “switched off”. Denying volitional control and awareness Mr Z said that he was so disturbed about the end of a relationship that he was ‘not himself’.

Further work with Mr Z suggested that it was unlikely that Mr Z was in a relationship, although he may have been obsessively attracted to someone at that time. Mr Z said that he was worried about being impotent, but did not deny attempting to have sex with the animals. Mr Z gave further indications of an unwillingness to disclose information by then denying an earlier recorded admission that he had begun fantasising about sexual activity with horses whilst in prison and even collected photographs of them.

Exploring Mr Z's dissimulation further, (as he maintained that he had never had any interest in sexual activity with animals), he was asked how he would deal with this situation where he accidentally came upon two dogs that were copulating. Mr Z responded, "when you see two dogs rutting, it spooks you". He went on to say, "if someone sees you looking they might get the wrong idea and think you're a pervert". Although at times Mr Z attempted to conceal his deviant sexual thoughts, evidence of pathological preoccupation was apparent.

MENTAL STATUS EXAMINATION DURING INITIAL ASSESSMENT (1998)

Mr Z attended all four assessment appointments punctually. He was not very attentive to the details of his appearance or hygiene. His hair was unkempt and there was a notable 'musty' odour about him. He was very talkative during the initial assessment, appearing co-operative, pleasant and animated much of the time, although affectively he became notably flat at intervals. He gave the impression of trying very hard to please throughout the interviews, almost invariably choosing to speak at great length and thus requiring considerable redirection when regularly going off onto tangents. However, Mr Z's eye contact was very poor. Mr Z presented as an individual who felt misunderstood, wishing to be seen as helpful and courteous in spite of being badly treated by others.

Mr Z denied use of alcohol, tobacco, prescribed medication or illicit drugs. He reported that his weight was stable and his quality of sleep "fine". Mr Z said that his interest in sex had been about the same over recent years and that on average he masturbated twice a day. This raised questions as to whether his deviant urges were intensified further by a high sex drive, suggesting that pharmacological intervention (anti-libidinal drugs) might be an appropriate adjunct to the treatment programme (Hucker and Bain (1990)).

Mr Z did not identify any long-term aims or interests in life. He denied any suicidal ideation but reported problems controlling anger, stating that when he was young his

angry and destructive impulses “were intolerable”. However, Mr Z said that this was not much of a problem any more.

Mr Z displayed a range of Cluster B Personality Disorder traits (DSM-IV, APA, 2000). Notable features included attention seeking, emotionality and a dramatic flair. There were indications of lability and often shallowness in Mr Z’s moods. Cluster B Personality Disorders include narcissistic, histrionic, borderline and antisocial personality disorders. It was my opinion that Mr Z had a Mixed Personality Disorder with key features of each of these individual personality disturbances. Mr Z appeared to have substantial narcissistic traits associated with feelings of self-importance, ruminations about the uniqueness of his own problems, a sense of entitlement and a lack of empathy for others. The histrionic features included a highly self-centred nature accompanied by a vague manner of presentation and an attention seeking nature. The borderline personality features included impulsivity, a lack of ability to maintain stable interpersonal relationships, significant disturbance of self-image and notable affectivity. The antisocial features appeared to be related to serious irresponsibility, deceitfulness and a lack of concern for the rights of others.

Mr Z was alert throughout the assessment and his concentration was reasonably good. There were no indications of hallucinations or delusions noted, although he appeared to live much of his life vicariously through references to characters in movies, television, books, etc. as perhaps a means of managing the relative inactivity and emptiness in his own life. In addition, Schizotypal Personality features were also apparent (DSM-IV, APA, 2000). Interpersonal relationships are so difficult for these people that they appear peculiar or strange to others. They lack close friends and are uncomfortable in social situations. They may show suspiciousness, unusual perceptions and thoughts, eccentric speech and inappropriate affect.

Overall, Mr Z demonstrated poor general knowledge abilities and very limited verbal problem solving skills. There were indications that he is a very concrete thinker in

spite of his expressed interests in art, history, etc. Further, Mr Z's insight and judgement abilities were seen to be seriously deficient.

INTELLECTUAL FUNCTIONING:

On the SILS Mr Z achieved a WAIS-R equivalent IQ of approximately 80, placing him at the cut off between Borderline Intellectual Functioning and low *average* ability. Mr Z's vocabulary performance was at approximately the twenty-fifth percentile (25%) in relation to other people of his age, whilst his abstract reasoning abilities were below the tenth percentile (10%) and equivalent to the level of performance one would anticipate from an individual with a Mild to Borderline Intellectual Disability.

These performance differences were quite pronounced, suggesting the likelihood that organic pathological features play a role in the current clinical picture. Further, neurological or neuro-psychological investigation might well prove beneficial, although Langavin (1990) reported that significant organic brain pathology is a common factor in high deviance multi-paraphilic sex offenders (paraphilias are normally described as chronic, recurrent, intense inappropriate sexually arousing fantasies, sexual urges and behaviours).

In view of Mr Z's inter-score variability on the SILS sub-tests, the RCPM was also administered to compare Mr Z's non-verbal abstraction abilities with his abstract reasoning performance on the SILS. These results revealed similar performance, e.g. an RCPM IQ estimate of 80 and evidence that in this area of intellectual performance Mr Z was functioning at approximately the tenth percentile (10%). Individuals with these specific kinds of cognitive deficits are likely to be perceived as more able than they actually are, since they are often capable of disguising a lack of understanding through the construction of apparently intelligent, though usually superficial, verbal responses.

PERSONALITY FUNCTIONING:

On the Minnesota Multiphasic Personality Inventory-Second Edition (MMPI-2) Mr Z produced scores on the Validity Scales suggesting that he is a rigid individual lacking in insight and inclined to use repression and denial as his most common means of defending his ego. Validity Scales scores were in a range suggesting a naïve and unsophisticated effort to create a very favourable impression of himself. There were however indications of the likely presence of significant psychological and emotional problems.

Individuals who obtain scores in this range are likely to be described as moody, opinionated, restless, unstable, and self-critical. These individuals have limited personal resources and general coping abilities. There were indications that Mr Z is strongly dissatisfied with himself but lacks the ability to make necessary changes in his life. This is accompanied by a poor self-concept, low ego-strength and a lack of insight into his own self-motivation and behaviour. These problems are most often chronic and severe and the prognosis for psychological intervention is generally poor.

On the Clinical Scales there were indications of the presence of a Thought Disorder with some paranoid features. Such individuals often think in a way that is described as fragmented, tangential and loose. Thought content may be rather bizarre and persecutory in nature. Problems with attending and concentrating are common, as well as complaints of emotional interference characterised by complaints of tension, depression, worry or lack of support.

This MMPI-2 profile suggests that Mr Z's affective presentation is likely to be blunted and at times inappropriate. These individuals are likely to display behaviour which is unpredictable and socially/interpersonally challenging for others to manage. In general, these individuals are resentful of demands made on them by others. However, they have a strong need for support suggesting conflicted attitudes about dependency as they are confused about how to go about meeting these two different

needs. Interpersonal relationships are likely to be characterised by emotional distancing as well as significant social and intimacy deficits.

It is important to note that the personality features identified within the MMPI-2 Clinical Data interpretation was solely the result of her true or false replies on the several hundred MMPI-2 items. These items explore general attitudes, feelings, beliefs, interests, etc. but they do not involve the review of any historical data beyond the basic demographic information of age, gender and educational level. For this reason, it can be a powerful corroborative tool, along with the other psychometrics, to compare with information gathered through interview and case documentation review (Wilcox, 2000).

Pre-treatment sex offence related measures were administered focusing on social functioning, cognitions, personality traits, attitudes and behaviour associated with sexual abuse. Mr Z's scores on these measures gave indications of a High level of deviance. Based on the Structured Anchored Clinical Judgement Scale (Thornton, 1993), which suggested a High Risk of recidivism, these two findings together suggested a Very High Risk that Mr Z would be reconvicted of a sexual offence (Hanson and Thornton, 2000). It also suggested that he would require a very considerable amount of treatment work to demonstrate any reduction in risk (Allam, 2000).

The detailed findings of these measures are given in the Summary section of this paper in comparison with the re-administrations of this battery following completion of the Induction Group and after completion of the Sex Offender Treatment Programme.

The initial report concluded that Mr Z has zoophilia (deviant sexual arousal to animals), which involved attempted sexual acts on horses. It is recognised in the literature of sexual offending that people who exhibit zoophilia or bestiality have the highest crossover rate for other kinds of deviant sexual acts (Abel and Roulleau,

1990). It was further advised that assumptions should not be made that because of the nature of the current offence, there may be a lessened likelihood that further offences against woman (who appear to be the primary focus of Mr Z's sexual fantasies) would not naturally follow. Rather, it was advised that the current offence should be viewed as additional evidence of highly deviant sexualised thinking associated with a heightened risk of further sexual offending.

Further, there was evidence that Mr Z is very sexually obsessed, but does not have any effective relapse prevention skills that might enable him to exert internalised control over his offending thoughts and behaviour. Despite Mr Z's defensiveness, he provided evidence of many sexual distortions about women and children. There was also evidence of significant abstract reasoning difficulties, which may pose problems in terms of identifying an appropriate sex offender group for him to attend. His disparate abilities suggested that he would require a mainstream group to work with individuals with similar verbal ability, though his abstract reasoning skills would be best matched by attendance at an intellectual disabilities group.

Lastly, it was recommended that Mr Z should attend the full two hundred plus hour sex offender treatment programme and that the skills required to adapt the programme to meet his unusual needs and profile would probably be more readily available within the Probation Service, Sex Offender Unit rather than the Prison Service.

APPENDIX Ib

Psychometric Measures Administered to Mr Z

SCALE	STAGE		
	0 Hours (July 1998)	50 Hours (November 1998)	Exit (April 2002)
STEP QUESTIONNAIRES			
<i>Lie Scale Profiles</i>			
PRI: Social Desirability	56	56	31
SHAPS	11	9	11
Social Sexual Desirability	25	23	11
<i>Personality Inventories Profile</i>			
Self-Esteem	0	1	3
Under Assertiveness	17	15	12
Over Assertiveness	4	3	5
Emotional Loneliness	56	45	57
Locus of Control	17	19	15
Perspective Taking	16	11	15
Empathic Concern	20	22	21
Fantasy	13	17	17
Personal Distress	8	9	9
<i>Sex Inventories Profile</i>			
Victim Empathy Distortions	34.57	15.48	13.72
Global Cognitive Distortions	27	16	23
Emotional Congruence	17	4	2
<i>Empathy for Women Test</i>			
Fake Errors	24	25	25
Hostile Errors	17	17	11
Over-sexualised Errors	7	not administered	10

APPENDIX Ic

Psychometric Measures Administered to Mr Z

SCALE	STAGE		
	0 Hours (July 1998)	50 Hours (November 1998)	Exit (April 2002)
MULTIPHASIC SEX INVENTORY			
<i>Validity Scales</i>			
SSD	25	23	11
SO	4	6	8
LIE	r=8, ex=8, cm=11	r=8, ex=8, cm=9	r=7, ex=2, cm=12
<i>Accountability Scale</i>			
Cognitive Distortions/Immaturity	10	11	13
Justifications	5	5	7
Treatment Attitudes	7	5	5
<i>Sex Deviance Scales</i>			
Child Molest	1	4	1
Rape	9	8	11
Exhibitionism	8	8	12
<i>Paraphilias Scale</i>			
Fetishism	0	1 out of 9 endorsed	2 out of 9 endorsed
Voyeurism	1 out of 9 endorsed	2 out of 9 endorsed	2 out of 9 endorsed
Obscene Calls	0	1 out of 4 endorsed	3 out of 4 endorsed
Bondage/Discipline	0	1 out of 6 endorsed	0
Sadomasochism	0	0	1 out of 10 endorsed
<i>Sexual Dysfunctions Scale</i>			
Sexual Inadequacies	5 out of 8 endorsed	4 out of 8 endorsed	5 out of 8 endorsed
Premature Ejaculation	0	0	0
Physical Disabilities	1 out of 8 endorsed	1 out of 8 endorsed	1 out of 8 endorsed
Impotence	3 out of 12 endorsed	2 out of 12 endorsed	5 out of 12 endorsed
<i>Sex Knowledge & Beliefs</i>	17	19	14
<i>Relapse Prevention</i>			
Awareness	not administered	8	9
Strategies	not administered	7	8

Mr Z: Sex History Section of the MSI
(0 Hours, 50 Hours and Exit Stages)

Sex Deviance Development (0 and 50hrs)

- 151 In my growing up my parents did not show me love and affection
 203 I have been charged with a sexual offence more than once
 219 I became interested in sex after high school age
 231 As a child I was punished when I got caught in sexual activity
 247 During my adolescence I was secretly excited about sexual matters but I was too embarrassed to talk about it to my friends
 (Exit) as above, plus the following items:
 276 An older male (relative, friend, acquaintance or stranger) touched me sexually when I was a child
 284 I was not curious about sex as a child

Marriage Development (0hrs)

- 28 My wife is interested in sex much more often than I am
 32 As an adult, I have never had sex with another adult
 68 I have never been married
 89 I have never been married but I have lived with someone with whom I have had a sexual relationship
 111 I have not ever been in love
 (50hrs) as above, but minus items 32 and 28
 (Exit) as 0hrs, but minus items 89 and plus the following item:
 42 I have never taken a close look at a woman's sex organs

Gender Orientation Development (0, 50hrs and Exit)

- 99 I am strictly heterosexual

Sex Assault Behaviour Checklist (0hrs and Exit)

- 133 I have attempted rape or raped at least one time
 226 I have publicly exposed myself to an adult person(s)
 (50hrs) as above, plus the following item:
 285 A child has touched my penis in a sexual way

Assessments Administered:

Offence-related and offence-specific assessments were administered along with clinical interviews at pre-treatment stage, with the initial measures and then repeated during and at the conclusion of the treatment programme.

- Shipley Institute of Living Scale¹ (Zachary, 1996)
- The Coloured Progressive Matrices¹ (Raven, 1956)
- The Minnesota Multiphasic Personality Inventory – Second Edition¹ (Butcher et al., 1989)
- Social Desirability,^{2/3} i.e. the tendency of an individual to portray himself in an idealised manner (Greenwald and Satow, 1970)
- The SHAPS Lie Scale^{2/3}, which measures the tendency to dissimulate, i.e. conceal information (Blackburn, 1982)
- Emotional Loneliness^{2/3} (Russell, Peplau and Cutrona 1990)
- Self-Esteem^{2/3} (Thornton, 2000)
- Locus of Control,^{2/3} i.e. the extent to which events in one's life are perceived as being externally controlled (Nowicki, 1976)
- General Empathy^{2/3} which includes sub-scales of Empathic Concern, Perspective Taking Abilities and Personal Distress (Davis, 1980)
- Victim Empathy^{2/3} (Beckett and Fisher, 1994)
- Children and Sex^{2/3} with sub-scales measuring cognitive distortions about child sexuality and Emotional Congruence with Children (Beckett, 1993)
- The Multiphasic Sex Inventory^{2/3} (Nichols and Molinder, 1984)
- The Empathy for Women Test^{2/4} (Hanson, 1995). This measures the degree to which they misread situations/females responses involving both abusive and non-abusive interaction between men and women.
- The Relapse Prevention Questionnaire⁵ (Beckett, Fisher, Mann and Thornton, 1996)

¹ Administered at pre-treatment stage

² Administered at end of fifty hour induction stage

³ Administered following completion of the Sex Offender Groupwork Programme

⁴ Unfortunately this measure was inadvertently omitted at exit stage

⁵ This questionnaire was only administered at the 50hours and exit stages based on the assumption that individuals lack effective relapse prevention skills at the post-conviction/pre-treatment stage, but will have had the opportunity to acquire these skills through participation in the Sex Offender Groupwork Programme.

THE CYCLE OF OFFENDING

Wolf (1984)

Pre-Conditions to Offending

Finkelhor (1986)

General Guidelines for Therapy
With
Learning Disabled Individuals
Who Have Committed Sexual Offences

- I Key Therapy Aims**
- a) To gain a greater understanding of client’s real risk of further sexual offending.
 - b) To establish an informed support network.
 - c) To identify any current abusive sexual fantasies or plans
 - d) To protect potential victims as well as the client.
 - e) To impart skills to the client, to enable him to recognise, monitor/disclose and control sexually abusive thoughts and actions.
- II Cognitive Behavioural Framework including eclectic features: Role-Play, Family/Group Models, Art Therapy, and Dynamic elements.**

III Work with Four Pre-conditions (Finkelhor 1986)

Thoughts	Fantasies	Motivation	Permission	Opportunity	Resistance	Abuse
		Start	>	>	>	
Feelings	Experience	Want to	Decide to	Set up situation	Make (name) do what I want	

- IV Strategies**
- a) **Focus on social/adaptive skills development** rather than developing insight or theoretical understanding.
 - b) **Emphasise the development of self-control techniques** i.e. identify, predict, and control – with the aim of early intervention rather than relying on will power.
 - c) **Be supportive, facilitative and encouraging when challenging thinking errors** as opposed to being punitive or excessively confrontational.
 - d) **Employ active techniques** not passive methods in group work.
 - e) **Establish a participative, multi-sensory and engaging approach** versus a ‘cerebral’, didactic, ‘bums on seats’ approach method of working.

- f) **Use concrete examples employing the techniques of self-talk and labelling** instead of relying on abstract reasoning and generalising.
- g) **Clarify the consequences of abusive thoughts, feelings, and behaviour** rather than attempting to enhance empathic concern as a means of controlling future offending.

V Key Programme Competency Areas
Section 1 Preliminary Skills/Knowledge

- a) Cognitive Behavioural Approach – Simplified (Understanding Self Talk – Smart/Dangerous, Set Up Situations/Triggers, Stop/Go Statements, Old Me/New Me).
- b) Understanding Sexuality & Healthy Masculinity.
- c) Developing Coping Skills/Impulse Control.

Section 2 Offence Specific Skills

- a) Understanding Denial & Minimisation.
- b) Victim Harm & Consequences of Offending.
- c) Understanding Thinking Errors.
- d) Fantasies.
- e) Relapse Prevention.

Section 3 Offence Related Skills

- a) Communication Skills.
- b) Anger Management & Assertiveness.
- c) Life & Social Skills.
- d) Alcohol/Substance Abuse.
- e) Mental Health Management.

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Learning Disabilities Group Work

Introduction

Depending on the level of disability of clients involved in the group, the duration of each segment of the programme may vary. Further, since intellectually disabled individuals find it especially difficult to acquire new skills and competencies in the areas focused upon, there is need to proceed cautiously and use a wide range of techniques to reinforce learning. These include: drama, art, role-play, relaxation, and imaginal work as well as various physically engaging activities. There is a particularly strong emphasis placed on using a multi-sensorial approach to treatment and a substantial reliance on homework to confirm that positive changes are occurring and being maintained.

Module	<u>Outline Programme</u> <u>Exercises</u>
1. Introductions	* Paired introductions with feedback to group.
* Establishing Group Rules.	* Workers facilitate identification of group rules – Group Think with Flipchart.
* Group members are told that they are marked for attendance, appearance and effort.	* Work is done to clarify different ‘effort’ requirements for each group member.
2. Motivation & Risk Assessment	* Writing out and role playing offence stories.
3. Relationship Mapping	* Bring family/significant others including Probation Officer and Social Worker to session.
	* Social Atom exercise.
4. Establish contracts with clients and carers	* Agree client needs and responsibilities for all the individual contributing.
* Clarifying aims and values for Individual and group success	* Group participation, board exercise – list out purpose(s) of group.
	* Introduce TRACK strategy, Therapy is about:
(working)	<u>Together</u>
(being)	<u>Respecting</u> yourself and others
(being)	<u>Accountable</u> for your own actions
	<u>Committed</u> to change and
	<u>Keeping Track</u>

5. Understanding Self-Talk
 - * Establishing Cognitive Behavioural (C/B) Labels
 - * Develop Individual Body Tracing – Review in Group
 - * Do Body Shape Presentations
 - * Consequences of Old Me Behaviour Dangerous Self Talk Versus New Me/Smart Self Talk
6. Health Sexuality & Masculinity
 - * Pen Exercise.
 - * Paired exercise to discuss and define: Smart Self Talk, Dangerous Self Talk, Set Up Situations, Old Me and New Me.
 - * Do Body Shapes with worker input. Identify above Self Talk Labels and add Consequences, Triggers, Alternatives, Stop & Go Statements.
 - * Client's individually present their body shape exercises, adding detail to their own work as relevant information emerges from subsequent presentations.
 - * Emphasis on identifying pro-offending thoughts, Seemingly Irrelevant Decisions (S.I.D.'s) and ways to stop the Cognitive Behaviour offence chain earlier.
 - * Self fulfilling prophecy role play with group examples. Self Concept and "I like/I dislike". Body Image Exercises.
 - * Sex and Sexuality Education.
 - * Write or Draw about the characteristics of a "Good Man" and his relationships.
 - * Board Exercise re: Abuse versus Non-Abuse and Sexual versus Non-Sexual thoughts.
 - * Paired Exercises clarifying whether abuse is occurring in scenarios given to group members.
7. Finkelhor Steps
 - * Review Healthy Masculinity in relation to offending
 - * Use Chairs or Islands to review pro-offending thinking for each step in Group Exercises.
 - * Use "Good Man" exercise. Identify someone who fits client's criteria. Role-play this person through abuse steps to identify alternatives.
 - * Do Finkelhor Steps with Smart Talk and Dangerous Talk at each of the four steps. Use one group member in each chair to 'help' the individual who is doing the steps of his offence story.
8. Further Cognitive Behavioural Work addressing Self Talk patterns
 - * Coping Skills
 - * Group and paired work identifying behaviour patterns, e.g. 'poor me', 'left out', 'me first', 'bully', 'shut down', 'I can't'.
 - * Re-framing exercises involving role-play, impulse control work and assertiveness, communication skills etc. for modifying self talk patterns.
 - * Individual work as needed.
 - * Role reversal with victim to add detail to offence story. Also to get further information about empathic concern, emotional congruence, perspective taking and possible psychopathy.
 - * Exercise in pairs identify someone you would wish to protect and not take advantage of – sexual or non-sexual theme.
 - * Victim Harm – Reviews consequences to all concerned
9. Planning and pro-offending thinking
 - * Bank Robbery Exercise.

- * What did you tell yourself about your offending to make it all right to do?
 - * Review and refute distorted beliefs
- * Pairs and group work.
 - * Flipchart offence justifications.
 - * Blame cake.
 - * Paired exercised in group.
 - * Collage exercise pro-offending attitudes.
 - * Billboard homework – ‘Keeping Kids Safe’.
 - * List Self Talk statements relating to targeting, grooming and overcoming the victim’s resistance and discuss in group.
10. Fantasy and Masturbation
- * Flipchart – Misconceptions.
 - * Fantasy as the step before Finkelhor.
 - * Exercise – Is it okay to talk about secret fantasies?
 - * Why?
11. Further Work on Self Image and Social Competency
- * Identify social skills deficits and work to improve personal effectiveness
 - * Review of Pro-offending interests, moods and lifestyles
- * Group and paired work identifying personal characteristics – Self Image building exercise e.g. “Things I like about me whether I’m in a good or bad mood”.
 - * Assisted Work with Social Skills Survey.
 - * Identify key areas to work on and incorporate into specific ‘effort objectives’ for group and outside.
 - * use of Guided Fantasy/Imagery.
 - * Group and individual review of offence related problems – Alcohol/Substance Abuse, Anger Management issues, Assertiveness work and Mental Health management as they relate to each group member. Exercises “Pendulum of Responsibility”.
12. Consequences of Abuse to Self
- * Relapse Prevention
- * Demonstrate ability to effectively use Stop statements, e.g. Police, Court, Prison, Family (Shame, Harm, Break-Up) and alternative realistic Go statements.
 - * Include significant others in the last module.
 - * Exercises reinforcing ‘New Me’ self-image.
 - * Identify specific new competencies.
 - * List strategies to reduce risk.
 - * Use behavioural (bus example) exercise and evaluate response latency for hypothetical risk situations.
 - * Do Relapse Prevention Questionnaire.

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RESEARCH DOSSIER

POLYGRAPH EXAMINATION OF BRITISH
SEXUAL OFFENDERS:

A Pilot Study on Sexual History Disclosure Testing

POLYGRAPH EXAMINATION OF BRITISH SEXUAL OFFENDERS:
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Polygraph Examination Of British Sexual Offenders: A Pilot Study On Sexual History Disclosure Testing

ABSTRACT

In the UK the use of the polygraph has only recently been given serious consideration as a means of facilitating the assessment and treatment of sex offenders. This pilot study on sexual history disclosure polygraph testing was the first of its kind undertaken in Britain. The problems associated with denial, minimisation and active concealing of relevant information about sexual offending has posed ongoing problems for sex offender workers in terms of developing effective treatment programmes and adequately assessing risk to the public. This application of the polygraph examination has shown merit as a means of obtaining additional information about past sexual offending behaviours. In this study fourteen adult male sex offenders were given sexual history disclosure polygraph examinations following completion of an average of one hundred and forty one hours of Probation based sex offender groupwork treatment. Substantial increases in the numbers of admitted victims and offences were determined when comparing polygraph disclosure results with previously obtained data from all other sources available. In addition, the subjects reported much earlier onset of offending behaviour as well as a wider range of deviant paraphilic sexual interests than had previously been reported. The results suggested that polygraph examination provided a more comprehensive understanding of the offenders' sexual interests and risk areas. This suggested that collaboration amongst treatment, supervision and polygraphy professionals in UK sex offender work could help to contain offending behaviour more effectively, improve the capacity to individually tailor treatment to greater effect and enhance the protection of the public.

1.0 INTRODUCTION

In the UK the use of the polygraph or lie detector has only recently become the subject of serious professional debate as a technique for working more effectively with sexual offenders (Salter, 1997a and 1998; Wilcox, 1999a; Middleton, Wilcox and Sosnowski, 1999; Wilcox, Sosnowski and Middleton,

1999a). However, elsewhere, particularly in the United States, the polygraph has attracted significant interest amongst practitioners working with convicted sexual offenders (Abrams and Ogard, 1986; Abrams, Hoyt and Jewell, 1991; Edson, 1991; Abrams and Abrams, 1993; English, Pullen and Jones, 1996). Ahlmeyer, Heil, McKee and English (2000) noted that:

Over the last twenty-five years the polygraph has increasingly been used with adult sexual offenders for deterring re-offending behaviours, overcoming denial of offending behaviour and verifying compliance with parole supervision conditions (Ahlmeier et al., 2000, p.23).

1.1 Definitions

Wilcox, Sosnowski and Middleton (1999b) provided descriptive information about 'what the polygraph is' and 'how it works':

A polygraph instrument collects physiological data from at least three systems within the human body. Convoluted rubber tubes are placed over the examinee's chest and abdominal area to record respiratory activity. Two small metal plates are attached to the fingers, to record sweat gland activity and a blood pressure cuff or similar device records cardiovascular activity. A typical polygraph examination will include a period referred to as a pre-test interview, a chart collection phase and a test data analysis phase (Wilcox et al., 1999b, p.234).

In the pre-test phase the polygraph examiner will complete the required paperwork and talk with the examinee about the test. During this period, the

examiner will discuss the questions to be asked and familiarise the examinee with the testing procedure. A range of information is obtained in relation to each of these physiological indices. Research (English, Pullen and Jones, 1996 and Wilcox, 2000a) has indicated that when a properly trained examiner utilises an established testing procedure the decision made by the polygraph examiner is generally about 90% accurate (Wilcox et al., 1999b, p.236).

1.2 Early Use of the Polygraph

Wilcox, et al., outlined the early developments of the polygraph and reviewed its legal standing in the USA where it is most widely used:

In 1923 (United States vs. Frye, 1923), when polygraphy was still in its inception, results were ruled to be inadmissible in court because of procedural, technical and methodological limitations that existed in the field at that time. This position remained unchanged for decades in the United States. However, modern American case law has rejected the Frye test (United States vs. Piccinonna, 1989; Daubert v Merrill Dow Pharmaceuticals, 1993 and United States v Posada, 1995). These more recent 'test cases' recognised 'the scientific acceptability' of polygraph testing. They found that polygraphy offers scientific evidence that is both relevant and reliable. They also established that it achieves the standards of close scrutiny required by the Federal Rules of Evidence as set out by the Supreme Court of the United States (Wilcox et al., 1999b, p.237).

Wilcox, et al., also discussed the possible post-conviction application of polygraphy to the specific field of sex offender work in Britain and considered the kinds of safeguards that would seem most appropriate.

The earliest post-conviction use of the polygraph within the Criminal Justice System has been attributed to the innovative work of several American Judges; Partee (1975) employed the polygraph for making decisions about applications for probation whilst Tuttle (1969) used it to identify violators of conditions of probation. Abrams and Abrams (1993) reported that both Judges found that these offenders achieved greater success and admitted to other criminal activity when polygraph examinations were administered.

Schmidt, Soloman and Johnson (1973) noted Judge Tuttle believed that periodic use of the polygraph examination could also substantially reduce the likelihood of offenders engaging in further criminal activity. He thought that intermittent polygraph examinations might even impact on the choices offenders made about whom they may associate with and what they might permit themselves to think about because of their concerns about these associations and thoughts being detected. For this reason, Schmidt, et al., (1973) described the periodic polygraph examination as an 'artificial conscience'.

Riegel (1974) reported on the results of a polygraph surveillance programme for offenders in the state of Oregon, established by Judge Beattie in 1973. These men, all of whom were designated 'high risk offenders', were not granted probation if they did not agree to periodic polygraph examinations. Teuscher (1978) conducted a four year follow-up of this study and reported fifty-four failures and sixty successes amongst these 'career' criminals, referencing extensive admissions by these men to additional crimes which led to the recovery of thousands of dollars of stolen property and illegal substances. He noted that although these men had all recidivated on multiple

occasions in the past, the majority of them succeeded in avoiding further criminal convictions through the employment of periodic polygraph examinations.

1.3 Post-Conviction Polygraphy

However, the post-conviction use of polygraphy for monitoring sexual offenders has been a more recent development. Abrams and Ogard (1986) reported a 'success rate' (in terms of completing their orders without re-conviction) of 69% for men who received periodic polygraph examinations whilst on probation, as compared with 26% for those under supervision alone. These results were statistically significant at the ($p < .001$) level.

It was notable that the number of sex offenders in the study was small; but those in the 'polygraph' sub-group were 28% more successful than those in the control. This result was very encouraging and generally in a similar magnitude of change as for the other sub-groups and for total. However, because of the limited numbers of sex offenders in the study, the differences between the experimental and control sub-groups were not statistically significant.

Subsequent post-conviction sexual offender polygraph research has replicated and expanded on earlier findings demonstrating wide ranging applications of the polygraph as a tool in monitoring, assessing and treating sexual offenders (Abrams and Abrams, 1993; English, Pullen and Jones 1996 and Wilcox, 2000). Some of these studies showed increases in the number of sexual offences and victims disclosed following polygraph examination (Edson, 1991; Abrams and Abrams 1993; Franklin, 1995; O'Connell, 1998; Ahlmeyer, Heil, McKee and English, 2000 and Heil, Ahlmeyer, McCullar and McKee, 2000). These researchers also gave indications of significant crossover rates from known offences into other sexually deviant activities.

Post-conviction or clinical polygraph examination has increasingly been distinguished from conventional polygraph testing. Morris (1995) explained that conventional polygraphy asks "Did you do it?" whilst post-conviction polygraph testing focuses more central attention on the question, "What have you been doing?" Therefore, the post-conviction polygraph focuses on establishing the truthfulness of the offender in relation to information they are providing for treatment and probation purposes. As such, the post-conviction polygraph has a much more limited relationship with the judicial system than conventional polygraphy.

English (1998) stresses the importance of collaboration between the probation officer, therapist and polygraphist. English, et al., (1996) further emphasise that the polygraph is an essential component of a sex offender containment approach. This approach promotes public safety by seeking to hold sex offenders accountable through the combined use of the offenders' internal controls and external criminal justice control measures together with the use of the polygraph to monitor internal controls and compliance with external controls.

Wilcox (1999b) argued that assessment elements such as clinical interviews, review of history and appropriate psychometric/other assessments, must be used in combination if they are to properly inform an evaluation outcome. He advised that their use in isolation is of limited utility 'lacking 'contextual relevance' when they do not form part of a detailed individualised assessment'. This cautionary proviso also applies to the independent employment of physiological techniques such as the post-conviction polygraph examination as a decision making tool (Faller, 1997) and such short-sighted uses should be avoided.

1.4 Types of Examinations

Wilcox, et al., (1999b) described the different types of post-conviction polygraph examinations and their purposes. They note that *specific issue post-conviction testing* is very beneficial to the therapist when an individual is denying or substantially minimising events surrounding the index offence. There is a very high success rate in obtaining admission of wrong doing from offenders once they have undergone a polygraph examination. Salter (1997b) noted that they no longer have 'denier groups' in Oregon and Washington because of the effectiveness of the polygraph in breaking down denial.

Maintenance and monitoring testing, also known as *Compliance testing*, is also regarded as very useful for Probation Officers, treatment workers and the individual completing his Probation Order to ensure that the requirements of therapy and the Probation Order are adhered to consistently.

Sexual History Disclosure testing enables the treatment worker to understand more about the subject's general sexual history and importantly any previously undisclosed sexual interests and activities. By uncovering the details concerning past sexual history, a more focused treatment approach can be developed. Commonly, disclosure tests reveal other deviant past sexual behaviour beyond the range of the index offence. This procedure may also reveal crossing over of deviant sexual interests to include both genders or different target age groups. This knowledge may be of particular interest where child protection issues are a central concern in Care and Family Proceedings.

Ahlmeier, et al., (2000) advised that the post-conviction application of the polygraph should be seen against a broad backdrop of often intense and pervasive denial amongst sexual offenders who are extremely reluctant to disclose their offending histories for a variety of psychosocial and legal reasons. English, et al., (1996) argued that the polygraph has a significant

impact on this 'wall of denial', accruing demonstrable benefits with adult sex offenders. Indeed, they reported that this tool has shown such promise that it has gradually been applied to other sexual offending populations, including adolescents and the intellectually disabled.

Chambers (1994) and Emerick and Dutton (1993) found the polygraph a valid adjunct to their assessment and treatment programmes for adolescent offenders. Holden (1999) reported the routine use of the polygraph with sex offenders in the state of Texas in conjunction with treatment and supervision requirements, and he noted that the polygraph's application to adolescent sexual offenders is now mandatory.

Researchers Hare, R.D., (personal communication, November 3, 1999); and others (e.g. Holden, 1997; Matte, 1996; and Raskin, Barland and Podlesny, 1978) have also reported positive indications about the use of the polygraph with psychopaths (Hare, 1991). This has particular significance in Britain in light of the recently introduced Mentally Disordered and Severe Personality Disordered Offender Legislation (Department of Health, 1998 and Sex Offender Act, 1997). This legislation mirrors earlier similar laws adopted in the United States concerning Personality Disordered Sexual Offenders (Hendricks, 1997) and calls for increased powers to monitor, assess, treat and, as required, detain psychopathic sexual offenders.

Holden (1996), spoke to the American Association for the Treatment of Sexual Abusers conference in 1996 and reported that the effectiveness and accuracy of the polygraph is such that even individuals with Mood Disorders or under the influence of substances can be successfully polygraphed without compromising validity (Matte, 1996). Sosnowski (2000) provided further clarification about the essential requirements of reliable and valid polygraph testing. He noted that when the polygraph examiners are properly trained and qualified, extraneous variables have little impact on the utility and accuracy of

polygraph examination, 'providing the subject is mentally sound enough to distinguish the truth from lies'. Sosnowski, D (personal communication, July 14, 1988) advised that individuals who suffer from severe Psychiatric Disorders, which markedly impact on their perceptions of the world around them, (i.e. producing hallucinations, delusions, severe thought disorder/disturbance and other reality testing difficulties), would be the exception as they may have a genuinely reduced capacity to accurately gauge what is true because of distorted views of themselves and the world.

English (1999) set out standards for the employment of the polygraph examination with adult sexual offenders who have developmental/intellectual disabilities in the state of Colorado. She identified both procedural and professional training requirements for polygraphing individuals with special needs, indicating positive results when polygraphists are appropriately qualified.

The polygraph is being used regularly in the USA to assess compliance with other conditions of probation as well as offence-related factors such as, the use of drugs and alcohol or the presence of masturbatory/deviant sexual fantasies. Approximately one quarter of all sexual offender Treatment Programmes in the USA routinely use the polygraph in conjunction with sex offender treatment according to English, Jones, Patrick, Pasini-Hill and Gonzalez (2000).

1.5 Standards

As with any other scientific procedure, the polygraph examination should only be conducted by a properly trained polygraphist since the validity of the procedure will certainly be compromised if this common sense safeguard is ignored. Gelb (1998) advised of the particular need for specialised training and expertise in Post-conviction Sexual Offender Testing (PCSOT) to avoid polygraph errors. Advanced training requirements have now been strongly

endorsed by Dutton (2000) who chairs the PCSOT sub-committee of the American Polygraph Association (APA) and these specialised requirements have now been formally adopted by the APA.

1.6 Accuracy

In the past seventy-five years, over 250 studies have been conducted on the accuracy of polygraph testing. Since many different conditions and factors are involved in the research, and since a polygraph examination is a very complex process, it is difficult to draw from the data a specific figure for the accuracy of polygraph testing in all settings. Ansley (1990), investigated validity and reliability of polygraph testing, compiling the results of ten studies conducted between 1980 and 1990. He reported that:

Examiner decisions in these studies, were compared to other results such as confessions, evidence and judicial disposition. The ten studies reviewed considered the outcome of 2,042 cases, and the results, assuming every disagreement was a polygraph error, indicated an overall validity of 98%. For deceptive cases the validity was also 98%, and for non-deceptive cases, 97%. The studies were from police and private cases using a variety of polygraph techniques conducted in the United States, Canada, Israel, Japan and Poland (Ansley, 1990, p.171).

1.7 Cautions

However, while the polygraph technique is highly accurate, it is not infallible and errors do occur. Polygraph errors may be caused by a failure to properly prepare the examinee for the examination or by a misreading of the physiological data on the polygraph charts. Adherence to established testing protocols and stringent polygraph training requirements are the best way to

control for these errors which are usually referred to as either 'false positive' or 'false negative'. A 'false positive' error occurs when a truthful examinee is reported as being deceptive, a 'false negative' occurs when a deceptive examinee is reported as being truthful.

The American Polygraph Association has endorsed specific guidelines and procedures to identify the presence of factors which may cause false responses, and to ensure an unbiased review of the polygraph records. The polygraph examiner will ordinarily offer a finding of Deception Indicated (DI), No Deception Indicated (NDI) or No Opinion (NO) an inconclusive result which simply means that the polygraph examiner is unable to make a definite judgement. In this last eventuality, a second examination is usually conducted at a later date and in approximately 90% of those cases, the examiner is able to render an opinion at that time.

A number of protective procedures are now incorporated into polygraph testing through the increasingly rigorous guidance given by the American Polygraph Association (1997). Medical information about the subject's physical condition is routinely obtained. Specialised tests are employed to identify the overly responsive examinee and to calm the overly nervous. Meaningful comparison questions are formulated to evaluate the examinees' responses to a variety of relevant and irrelevant questions. An assessment is also made of emotional state. The pre-test interview is now given considerable attention to establish the appropriate 'psychological set', to review test questions and to establish whether any other extraneous variables are likely to adversely influence the results of the examination. Quality control and peer reviews of examination procedures and chart data have also improved polygraph practice and accuracy.

Matte (1996) noted that countermeasures can be employed to confound or misrepresent polygraph results. However, he also judged that properly trained

and experienced polygraphists can predict and control these factors, minimising the risk of this kind of manipulation.

1.8 The Use of the Polygraph in the UK

All of these polygraph research and practice developments notwithstanding, the use of this technology has not been well understood, nor has it gained acceptance in Great Britain. Whilst consideration was given in the mid 1980's to using the polygraph for security vetting and employment screening by the Government, in the wake of the Jeffrey Prime spy case (House of Commons Employment Committee, 1984/85; Gale, 1988), the Government decided not to adopt this approach at that time for these particular purposes.

A working party for the British Psychological Society (1986) raised particular concerns about the use of the polygraph for this purpose at that time. Wilcox (2000) summarised the primary issues reported by the BPS noting that polygraph procedures were not believed to be sufficiently standardised then, nor was there a readily available means of checking on practices and procedures of individual polygraphists. A method of licensing or regulation was not established or recognised either. Anxiety was induced as an integral part of the polygraph examination and the British Psychological Society were concerned about ethical implications. The BPS also believed that there was a lack of clarity concerning the polygraph's accuracy in its various uses.

Wilcox (2000) addressed these issues noting the emergence of standard procedures and specialised accredited training in the various applications of the polygraph. He explored the induction of anxiety concluding that this will inevitably occur when individuals are questioned about matters which may, in their views, have significant consequences for them. This happens in the "hot seat" in sex offender treatment programmes and may be intentionally produced with some types of psychometric testing, i.e. suggestibility (Gudjonsson, 1984). Regarding accuracy, these issues have been examined

more carefully in the polygraph's various applications such that validity and reliability is increasingly accepted in support of criminal civil and treatment matters.

In conclusion, Wilcox noted:

The Working Party's (BPS, 1986) comprehensive findings, edited by Gale (1988), reviewed the proposed use of polygraphy in Employment Screening, Security Vetting and Criminal Investigations. However, the application of polygraphy to *post-conviction* work for *assessment, treatment, supervision and monitoring* purposes was not, at that time, well recognised. As such, this use of the polygraph did not come under scrutiny. While the Government eventually decided not to adopt the polygraphy for personnel screening, its potential benefit in post-conviction offender work still warrants independent consideration (Wilcox, 2000, p.137-138)

In the field of sex offender work, British professionals began considering the polygraph's post-conviction application in the late 1990's, both in response to American influences (Salter, 1997a) and as a consequence of concerns about unregulated use of polygraphy for this purpose in Britain (Wilcox, 1999).

The first UK polygraph trial was undertaken in the West Midlands Probation Service area in the autumn of 1999. Initial findings were reported at the annual conference of the National Organisation for the Treatment of Abusers (Middleton, et al., 1999). The results suggested that workers were able to obtain more detailed information about index offences, further disclosures about past sexual offending and more information about short-term risk and non-compliance with conditions of Probation Orders.

Although this trial only involved the examination of five offenders who were participating in a sex offender group work programme, it employed the recognised types of post-conviction polygraph examinations, i.e. monitoring/maintenance, specific issue and sexual history disclosure testing (Appendix 7.15). Further, these men were selected following discussions with the Probation Services treatment workers and the volunteers were thought to be “representative” of specific types of sex offender group attendees. In the judgement of the specialist treatment team, these men could be identified with broad categories of offender types commonly found in treatment. These categories were not so much based on recognised typology of offenders in treatment as upon a pragmatic analysis of group attendees based on the extensive experience of the treatment specialists working in the programme. This categorisation included:

1. An offender who was regarded as a “model” group attendee.
2. An offender in substantial denial, even after considerable treatment.
3. An offender who was thought to be highly sexually deviant.
4. An offender whose behaviour was regarded as markedly sadistic or psychopathic.
5. An offender who was otherwise viewed as a significant worry or risk based on his group behaviour.

The polygraph questions employed in the West Midlands initiated trials (Wilcox, Sosnowski and Middleton, 2000) were developed through consultation between the polygrapher, and the relevant probation officers/treatment workers. Of particular interest, indications of deception were noted as well as the specific areas where these men disclosed new offence related information in response to the jointly formulated test questions. Some disclosures served to verify treatment concerns whilst others raised new issues to be addressed in further group and individual work. As a

result of the small number of men involved in this preliminary research, no quantitative analyses of the data were deemed appropriate.

Relevant qualitative information was however reported, including:

1. An incest offender admitted a primary sexual attraction to a further victim in the family although he had previously denied this attraction during months of treatment.
2. A second examinee who had hitherto denied substantial alcohol misuse which was thought to be a significant disinhibiting feature in his offending, admitted to continued excessive use of alcohol particularly when he was not working.
3. Another man who had begun admitting to numerous incidents of frottage (intense sexual interests that involve touching and rubbing against a person who does not consent to this behaviour – normally engaged in in crowded public areas) confirmed hundreds of such incidents as well as similar frequencies of hitherto unreported incidents of stalking, indecent assaults, and public masturbation/exhibitionism behaviour.
4. A further man acknowledged violation of his probation order involving sexual interest, contact, and sadistic fantasising about a teenage girl with whom he had been in contact. This prompted investigation and immediate steps to safeguard this youngster from very probable danger.
5. One specific issue examination was undertaken at the examinee's request to confirm that he had not attempted to abduct his victim when exposing in his car during the commission of his index offence. However, he failed to pass the polygraph test on these relevant questions. Further, although no subsequent admission was obtained, the results supported concerns raised in treatment about denial and the level of risk estimated by the group workers.

All the polygraph examination results were discussed with the relevant probation officers and there was considerable enthusiasm about the potential

for using this technique to substantiate concerns arising from the group work and to explore these matters in further detail. The few examples cited above give some indication of the polygraph's versatility as an evaluation, treatment, and case management tool.

The most significant finding of this preliminary study was the observation (Wilcox, et al., 2000) that the polygraph enabled the treatment workers to become aware of offence specific and offence related information which had not otherwise been obtainable. This is perhaps even more surprising given that four out of the five participants failed the polygraph, i.e. there was continuing evidence of deception when the examination was concluded in spite of the further information they did disclose. Edson (1991) and Almeyer, et al., (2000) reported similar findings and note that through periodic employment of the polygraph the rate of deception steadily decreased and, importantly, a more comprehensive understanding of the offenders' behavioural patterns and interests emerged. Wilcox, et al., (2000) found the disclosures to be perhaps more notable in view of the fact that these men were engaging in one of the most well established sex offender treatment programmes in Britain. The West Midlands Probation Services Sex Offender Treatment Programme was the first of its kind to receive full accreditation from the Home Office and its treatment model is now being adopted in Probation areas across Great Britain (West Midlands Probation Services, 2000).

It should be noted that the men who participated in both West Midlands Trials were volunteers and could have refused to participate. As such, they may not have been typical of individuals on Probation who are ordinarily referred for polygraph examinations. These men may well have "opted in" because they felt that the results would put them in a more favourable, (less risky) light or they may have been confident that they could conceal possibly incriminating information. Even so, the results were beneficial to the probation

officers/treatment workers involved. This would seem to bode well for future application to individuals on a case by case basis where probation officers have more specific concerns about the supervision and treatment of their clients.

The cautious optimism engendered by the earlier West Midlands trial prompted further professional interest in more comprehensive research discussed by Wilcox (2000) and Wilcox, et al., (2000). These initial findings gave rise to a decision to complete a more extensive polygraph trial specifically focusing on the Sexual History Disclosure Examination (SHDE) in 2000, which was briefly reported on at a poster session of the Annual NOTA Conference (Sosnowski and Wilcox, 2000). The detailed findings of this presentation are the subject matter of the present paper.

The SHDE is usually administered after at least three to six months of treatment has been undertaken and this procedure focuses on obtaining further information about deviance/sexualised behaviour or fantasies beyond the issues identified within the index offence for which the individual was convicted. It was believed that volunteers for this kind of examination might be more readily obtained since this test deals with issues pre-dating the index offences for which the subjects were currently on Probation Orders or Licence/Parole.

The SHDE is not designed to address issues concerning compliance with current orders. Rather, the information obtained in disclosure testing often enables a more comprehensive and individually focused therapy approach to be developed. The SHDE was thought to be potentially less threatening to would-be participants, conveying a willingness to be polygraphed. A compliance examination might create a double bind in terms of incriminating subjects fearing detection regarding any current offence related activities.

Research concerning the SHDE application of the polygraph examination has lent considerable support to sex offender research findings noted by Abel, et al., (1987) and Kaplan, et al., (1990) who both concluded that there was significant underreporting of sexual abuse, i.e. numbers of victims, offences and deviant interests amongst their samples of sex offenders when these data were sought within criminal justice settings as compared with confidential health-care settings. Obviously this level of confidentiality would not be acceptable for disclosures within criminal justice settings, but the research findings suggest a high degree of dissimulation in offenders on probation and in the general population. Many other researchers have struggled to replicate these figures, for example, believing that Abel and Kaplan had simply worked with a more deviant population of offenders. However, polygraph research findings have suggested that offence rates and ranges of paraphilias amongst offenders are often of these magnitudes.

The Diagnostic and Statistical Manual of the American Psychiatric Association (2000) identifies paraphilias as chronic (duration at least six months), recurrent, intense sexually arousing fantasies, sexual urges or behaviours involving deviant sexual activities. Appendix 7.4 provides a list of paraphilias as adapted from Abel and Rouleau (1990).

The subjects in the present study were all volunteers and the SHDE was seen to present the best opportunity to assess the polygraph's utility in this first major study in Britain, providing an opportunity to compare these results with earlier North American sexual offender polygraph findings. In particular, the British study would seek to gain information about previous victims and offences, reported age of onset of sexual offending and the full range of paraphilic interests amongst these volunteers. The SHDE offers better comparative data than the Specific Incident Examination (Appendix 7.15), although the Specific Incident Examination is particularly useful in breaking down denial (Salter, 1997b). Further, the SHDE would in all likelihood be less

threatening to offenders than the third option for post-conviction polygraph testing, the Maintenance and Monitoring Examination, which in its focus on activity since conviction, might reveal information that would be cause for revocation of current 'orders' or recall to prison. Obviously, failure to pass the polygraph on issues including compliance with the conditions of current Probation Orders, or significant post-conviction disclosures might necessarily lead to immediate further legal action and it was considered that this might seriously curtail the number of volunteers and their attendance rates in the absence of any requirement to do so. Further, Abrams, S (personal communication, December 8, 1998) reported that SHDE offers the best opportunity to demonstrate statistically significant improvements in the rates and ranges of sexual offence disclosures relative to other approaches.

It seemed probable that the highest level of co-operation, i.e. numbers of volunteers to be polygraphed, would obtain through use of the SHDE wherein the patterns and range of past sexual offence behaviour are the central focus. These data may provide a greater opportunity to produce an individually tailored treatment plan taking account of areas of sexual risk which may extend beyond those previously recognised and which can then be taken into account in the development of a relapse prevention plan (Laws, et al., 2000).

1.9 Other Behavioural and Physiological Measures

The polygraph is not however unique as a behavioural or physiological measure used to assess, treat and monitor sexual offenders (Erooga, 1993). Two other techniques in particular warrant mention because of their current widespread usage, i.e. the penile plethysmograph (Freund, 1963; ATSA, 1993 and English, et al., 2000) and the Visual Reaction Time Technique that has been developed and researched extensively by Abel et al., and his colleagues, (1990, 1994, 1998).

These techniques have all demonstrated benefits in sexual offender work Wilcox (2000). Whilst it should be noted that these techniques measure different physiological reactions, e.g the Penile Plethysmograph (PPG) records penile tumescence in response to visual/auditory stimuli and the Visual Reaction Time (VRT) records duration of visual attending. These approaches should not be seen as mutually exclusive from or in direct competition with the application of the polygraph. Indeed, the polygraph can often augment information obtained from these other sources. In addition, measures of arousal or interest tend to work most effectively in situations where it is possible to distinguish normal from deviant responses. As a result, it may be that some adult abusers and incest offenders, for example, may show little variation in their responses on the PPG or VRT from the results that non-offenders might produce. Some rapists show little evidence of arousal or interest in violent or sadistic ideation toward women, whilst intra-familial abusers often show little sexual response to children in general. These are broad classes of offenders that are difficult to distinguish via the PPG or the VRT. Other areas of sexual offending where these measures are less helpful include professional sexual misconduct and some paraphilias like exhibitionism where it is difficult to establish an appropriate stimulus set. The polygraph on the other hand, enables the therapist or Probation Officer to ask questions directly focusing on these specific kinds of sexual activities or interests (Abel, 1998).

The current study has been designed to assess the effectiveness of post-conviction polygraph testing as a tool for gathering specific additional offence related data to assist in formulating better treatment plans, as well as supervising offenders more successfully.

Specifically, it is hypothesised that subjects (offenders participating in a British Probation Services Sex Offender Treatment Programme) will report significant increases in the numbers of victims and episodes of sexual abuse

following SHDE polygraph testing. These data will be compared with all previously obtained offence/treatment related information available to the Probation Service. It is also hypothesised that significantly greater numbers of paraphilias and earlier ages of onset of sexual offending will be acknowledged by subjects through the use of post-conviction polygraph testing.

Hypotheses

1. It is hypothesised that subjects will report significantly higher numbers of victims following SHDE polygraph than data gathered from other sources and previous self-report.
2. It is hypothesised that subjects will report significantly more episodes of sexually abusive behaviour following SHDE polygraph than data gathered from other sources and previous self-report.
3. It is hypothesised that subjects will reveal significantly higher numbers of paraphilias following SHDE polygraph than data gathered from other sources and previous self-report.
4. It is hypothesised that subjects will disclose a significantly earlier onset of offending following SHDE polygraph than data gathered from other sources and previous self-report.

2.0 METHOD

2.1 Participants

Twenty-five individuals, who were attending a community based Sex Offender Group Work Programme (SOGP) volunteered for SHDE's that were administered in June 2000. One additional SOGP volunteer from the earlier October 1999 trials was included in the study as he was also given the SHDE polygraph test. These men were all on Probation Orders and had been attending SOGP for between three months and just over two years. They completed between 64 and 246 hours of group work with a mean of approximately 141 hours. All of the men were living in the community, the majority independently but some in bail hostel accommodation. For inclusion in the SHDE study, subjects had to have completed at least the induction element of the SOGP, the equivalent of 50 hours of treatment at the time of polygraph testing. All of the volunteers who attended SHDE polygraph appointments punctually in June 2000 (thirteen subjects) and October 1999 (one subject) were included in the study. It should be noted that the one subject who attended the initial small trial of five men in October 1999 was the only one in this group who was given a SHDE polygraph examination. The others took *Monitoring and Maintenance* or *Specific Incident* polygraph tests. All of the men polygraphed on both occasions were tested by the same examiner. The total number of subjects included in the SHDE study was fourteen.

The fourteen subjects were all of white/European ethnicity. Their ages ranged from twenty-one to eighty years with an average age of 42.5 years. Based on the Risk Matrix 2000, (Thornton, 2000) the average risk level was in the medium to high range. Amongst these fourteen men, four had convictions for intra-familial abuse (indecent assault) and four other men had convictions for indecent assaults on children outside of the family, two of them with multiple similar offences. Four of the subjects had convictions for indecent exposure.

All of the indecent exposers had multiple convictions with one demonstrating quite wide-ranging sexually deviant behaviour including rape, indecent assault and attempted buggery with a horse. Another indecent exposer had a history of wide-ranging non-sexual criminal activities, mostly concerned with theft of property. The remaining two men had convictions for indecent assaults on adult women. One of these adult abusers was, at the time of this study, on Probation for sending obscene mail to an elderly woman.

The Sex Offender Group Work Programme (West Midlands Probation Service, 2000) was developed in 1993 following the establishment of a specialist Sex Offender Unit in the West Midlands:

The WMPS Programme is a cognitive behavioural programme which addresses sexual offending by adult males. Offenders are subject to an initial fifty hour induction module designed to decrease denial/minimisation of their offending and increase their acceptance of responsibility for choosing to offend. Offenders are then further assessed using clinical judgement and psychometric testing. Low risk/low deviance offenders complete a further fifty hour programme focusing on relapse prevention strategies, whereas high risk/high deviance offenders are required to undertake a one hundred and fifty hour programme which targets a wider range of criminogenic factors before completing a relapse prevention module. An offender will usually take two years to complete the full programme (200+ hours) (West Midlands Probation Service, 2000, p.3).

Comparative data were collected on these subjects during the period from June 2000 to May 2001. The data gathered consisted of the numbers of individual sexual abuse victims and the numbers of offences committed. In addition, information was obtained concerning the range of deviant/paraphilic interests, the age of onset of sexual offending, age of first sexual activity, age of first masturbation and confirmation of offence related factors, i.e. use of pornography, substances, etc. in relation to offending. Treatment workers and probation field officers may have had additional knowledge or information about these individuals through direct involvement with them in supervision and group work, but only confirmed written data held in the Sex Offender Unit files were accessed for comparisons. Indeed, in our experience information disclosed or suspected within the group work process is on occasion inadequately recorded or explored because of time pressures or competing priorities within the group programme.

The twenty-five men scheduled for polygraph examination in June 2000 were assessed for risk/deviance levels, employing the Thornton (2000) Risk Matrix 2000 risk assessment measure, which is employed by the UK Parole Board for purposes of making determinations about risk of re-offending amongst prisoners. In addition, psychometric assessments were administered and scored at predetermined intervals in relation to the SOGP (West Midlands Probation Services, 2000) as a means of quantifying deviance levels obtained by offenders in the programme. Fisher, Beech and Browne (1999) have compared sex offenders to non sex offenders on these psychological measures. They determined that these measures offer substantial benefits by informing the prediction of recidivism and "dangerousness" as well as providing indications of SOGP offender needs and treatment outcomes. The assessments were administered before, during and after treatment. The battery incorporated the following tests:

Multiphasic Sex Inventory (Nichols and Molinder, 1984)
 The Kids and Sex Questionnaire incorporating a Cognitive Distortions
 Scale and an Emotional Congruence or Identification with Children
 Scale (Beckett, 1993)
 Victims Empathy Distortions Scale (Beckett and Fisher, 1994)
 Self-Esteem Questionnaire (Thornton, 2000)
 UCLA Emotional Loneliness (Russell, Peplau and Cutrona 1990)
 Assertiveness - Social Response Inventory (Keltner et al., 1981)
 Internal/External Locus of Control Scale (Nowicki, 1976)
 Interpersonal Reactivity Index (Davis, 1980)
 Relapse Prevention Questionnaire (Beckett, Fisher, Mann and
 Thornton, 1996)
 Social Desirability Scale (Greenwald and Satow, 1970)
 SHAPS Lie Scale (Blackburn, 1982)
 Empathy for Women Test (Hanson, 1995)
 Shipley Institute of Living Scale (Intellectual Functioning) (Zachary,
 1996)

This information was obtained from the Probation case files including
 available pre-sentence reports, group work progress notes, psychometric tests
 and any other available documentation. These data were gathered for the sub-
 sample only, although risk deviance profiles were obtained for all of the men
 who had been scheduled for the June 2000 trials, to consider whether this was
 a variable influencing attendance at that time. In addition to this information
 being gathered and aggregated, specific paraphilic data were aggregated, such
 as interests in frottage, voyeurism, exhibitionism, etc., as well as stalking,
 since these specific deviant activities may be underreported in relation to the
 sexual assault behaviours for which these individuals were convicted. Abel
 and Rouleau (1990) reported that these conditions are commonly under
 diagnosed in sex offender work. The aggregated data set provided specific

information relating to child and adult offending, male and female sexual abuse and along dimensions of intra and extra-familial offence categorisation.

All of the offence data that were verifiable from other sources were compared with the Sexual History Disclosure Polygraph Examination results. The sexual history structured interview form is given as Appendix 7.15 and consists of a questionnaire that covers sexual development and offending history. The polygraph examinations consisted of using a test format referred to as the mixed issue or utility test. In addition to the offence information disclosed during the polygraph examination, the results of these tests are given in terms of a polygraph finding, i.e. non-deceptive, deceptive or no opinion.

2.2 Measures

The Multiphasic Sex Inventory (MSI) developed by Nichols and Molinder (1984) is the only psychometric assessment in the battery employed for the SOGP that explores information appertaining to sexual history. The MSI is a self-report questionnaire designed to assess a wide-range of psychosexual characteristics of the sexual offender. There are twenty scales and a sexual history component to this test. Six of the twenty scales are validity scales. The other fourteen scales include three scales of sexual deviance, five scales related to atypical sexual behaviour, four scales of sexual dysfunction, a sex knowledge scale and a treatment attitudes scale.

The test is compromised of three hundred true/false items and is essentially designed to evaluate characteristics associated with sexual deviance. Thorne, Haupt and Allen (1966) found 'convincing evidence of the validity of the direct – obvious approach to the objective measurement of sexuality'. The MSI has retained this content related validity and as regards internal validation, independent raters have achieved a high level of agreement in sorting the items into the identified categories (factors) (Nichols and Molinder, 1984). Further, an independent pilot study by Wing (1983) also demonstrated

criterion related validity (empirically based evidence) correlating the child molest and rape scales with steps towards progress in treatment using subjects who had committed these types of sexual crimes. She found a correlation between their scores and the achievement of therapeutic gains. Reliability measures for the MSI have been shown to be in the moderate to relatively high range when correlations of internal item structure have been performed (Nichols and Molinder, 1984).

The only information gathered through the psychometrics that related to deviant sexual interests or past sexual offending was obtained through this measure. The other measures in the sex offender assessment battery were used to evaluate sex offence specific cognitive distortions, victim empathy attitudes and emotional congruence or identification with children as well as general offence related personality traits and social skills. Amongst these measures, only the MSI specifically addresses sexual history issues and deviant interests. As such, it is the only relevant psychometric measure that was employed to obtain further indications about sexual background following the review of offence documentation and notes relating to the groupwork programme.

These data, collectively, were with the results of Sexual History Disclosure polygraph examinations.

2.3 Apparatus

Polygraph testing was conducted by one independent examiner accredited to perform PCSOT examinations by the American Polygraph Association. The equipment utilised was the Lafayette Instrument LX-3000 Computerised Polygraph System. The examiner is an approved trainer and member of the PCSOT Sub Committee.

2.4 Procedure

Prior to each polygraph examination, the polygraphist had the opportunity to review the Probation files held on the individual at the Sex Offender Unit, focusing particularly on the pre-sentence reports for a duration of time of approximately one half hour. In the pre-test phase, subjects were individually shown how the polygraph examination apparatus worked and were given instructions concerning the test phase. This consisted of demonstrating how the offenders' cardiovascular, respiratory and galvanic skin resistance measures could be recorded and evaluated in relation to specific relevant questions agreed between the examiner and the polygraph subject. After this, the areas of enquiry raised on the Sexual History Disclosure Examination form (Appendix 7.15) were fully explored with each subject and specific questions asked about the individual's past activities in these various areas of sexual involvement/interest.

Following this, each subject was given a polygraph examination to ascertain whether they were being truthful in answering the questions agreed during the pre-test. In the post-test phase, each subject was informed about whether they had passed the polygraph examination and given the opportunity to respond if a deception indicated (DI) finding was made.

The polygraph examinations took place in a quiet office where the West Midlands Probation Services Sex Offender Unit is based. The examinations took an average of two hours to complete. Informed consent forms were completed and appropriate procedures were followed for all participants. Ordinarily, treatment workers and probation officers would have the opportunity to work closely with the examiner to develop appropriate polygraph questions concerning the Sexual History Disclosure areas to be explored. In this instance, owing to the examiner's limited availability, (having travelled from the USA for the specific purpose of conducting these trials), liaising was unavoidably rather minimal, i.e. a few minutes of

discussion with the relevant treatment worker preceding approximately one quarter of these examinations.

It should also be noted that, at least in part, offenders were encouraged to participate in the polygraph study because they were informed that potentially positive outcomes might follow their co-operation, i.e. it was suggested that if they were willing to participate and perceived to be less risky, then this might result in reduced time in the treatment programme or a lower level of supervision whilst completing their orders. In circumstances where deception or risk was indicated, attendees knew that the results would be reported to their Probation Officers but as the polygraph trials were voluntary, no formal consequences could be applied for failing to attend or for responding deceptively to the polygraph questions. The only specific consequences that were uniformly agreed for all the men who volunteered to be polygraphed was that the information gathered would be shared with their field Probation Officers and their SOGP Facilitators.

3.0 STATISTICAL METHODS

3.1 Data

The data in this study are mainly numerical, showing in general a marked tendency to positive skewness. This is particularly the case for variables which are counts (i.e. numbers of paraphilic interests). In addition, for some subjects, the number is only known to be a lower bound. When substantial skewness is indicated (i.e. for number of paraphilic interests) the data is collapsed into two or three categories. Due to the small sample size (14) the Fisher Exact Test (Bland, 1995) was used throughout for measures of association in cross-tabulations.

3.2 Statistical Tests Used

Comparisons were either on the same set of subjects (Tables, 1, 2, 3, 4, 5 and 7) for which tests of types 1,2 are used or on different sets of subjects (Table 10) for which Fisher Exact Test was used due to the small number of cases (14) in the sample. Types 1,2, are defined below. All tests are two tailed.

Type 1. Tests involving a comparison of ages. These use a paired t test (age of onset of offending as assessed by polygraph/official – probation – records (Tables 4 and 5).

Type 2. Tests involving a comparison of counts according to a further variable used a non-parametric sign test (the number of victims compared according to whether assessed by probation or polygraph records). This is done by examining the 95% confidence interval for the observed proportion (Neave, 1978). Tables involved are Tables 1, 2, 3 and 7.

4.0 RESULTS

The data for a sub-sample of fourteen subjects was examined. These included all thirteen of the twenty-five volunteers for the June 2000 trials who both attended their polygraph examination appointments and were sufficiently punctual for a SHDE to be conducted. In addition, one of the individuals polygraphed during the earlier trials (October 1999) was included in this data set, since he was given a SHDE at that time and was also attending the SOGP. The average age of the fourteen volunteers included in the SHDE study was forty-two, with a range from twenty-one years to eighty years of age.

Fifty-two percent (52%) of the individuals given appointments in June 2000 were polygraphed (thirteen out of twenty-five). This result was disappointing, but also significant in light of the fact that in the initial smaller trial conducted eight months earlier in the same location, five out of five volunteers kept their appointments and there were no failures to attend. The factors relating to this change in attendance rate and implications are considered in the discussion section of this paper. The sub-sample were Caucasian men of British origin. Whilst two men of Asian origin also volunteered, one did not attend and the second did not arrive punctually enough to be polygraphed. The sub-sample group had attended an average of thirteen months, (one hundred and twenty hours of treatment), including psychometric testing, a block week attendance and weekly sessions of two and a half hours.

The following analyses are based on a comparison of a single polygraph examination administration for each of the men reported upon with a range of other previously obtained information. These data included legal documentation, groupwork notes and correspondence between field officers and group workers. The probation record data available at the time of the polygraph examination and findings from the psychometric testing which are an integral part of the Sex Offender Group Work Programme were compared

with the polygraph findings. The psychometrics were administered pre-treatment, during treatment and at the time offenders complete their Sex Offender Group Work Programmes. The offenders all took a standard battery of tests, though the Multiphasic Sex Inventory (MSI) was the only source of further deviant sexual interests/activities amongst these measures. The MSI is helpful in terms of identifying possible additional paraphilias, but this information should at best be regarded as an ‘implied interest’, which requires further clarification through face to face work, both individually and within the group. This conservative view about possible admissions on psychometric tests is taken because individuals completing these measures can at times respond in a random way, or they may misunderstand questions owing to literacy and intellectual difficulties. As an example, some of these true/false questions are negatively worded, i.e. ‘I never . . . (behave in a certain way)’ and emotional or cognitive interference could result in an incorrect response.

4.1 Number of Victim Admissions

This data set compared the number of victims reported on the basis of probation records with those admitted during polygraph examination. Table 1 shows the mean numbers of admissions comparing probation records and polygraph examination for non-contact victims, contact victims and total number of victims reported.

Table 1. Estimated Number of Victims Comparing Probation Records with Polygraph Disclosures						
<i>Men on Probation and Attending a Sex Offender Treatment Programme (N = 14)</i>						
	Non-Contact Probation	Non-Contact Polygraph	Contact Probation	Contact Polygraph	Total Probation	Total Polygraph
Total	226	1051	447	1547	673	2598
Mean	0.9	12.6	2.8	4.3	3.7	16.9
Standard deviation	1.5	26.4	2.6	3.4	1.63	5.77
No of cases with more than 99 victims	2	3	1	5		
Number of non-tied comparisons	8		11		13	
Number for which more victims based on probation records	0		0		0	

The test of the null hypothesis that the number of victims is equal when based on probation records and based on polygraph examination used the proportion (p) of cases observed where this number was greater for probation records than for polygraph examination (Neave, 1978, figure 1.2b). There are three comparisons:

1. Within non-contact group
2. Within contact group
3. Both combined

95% confidence levels for the probability in the population of more victims when based on probation records and based on polygraph examination are, for comparison 1, (0, 0.42), for comparison 2, (0, 0.29), and for comparison 3 (0, 0.25). Thus we can reject the null hypothesis that the number of victims is equal when based on probation records and based on polygraph examination in favour of the alternative that there are more victims reported by polygraph examination findings than for probation records for each of these comparisons.

Figure 1 (below) shows the different rates of victim reporting for each condition. Following polygraph examination, subjects reported an average of 4.7 times more victims for non-contact offences than they had reported previously. For contact offences the ratio was somewhat smaller, 3.5 more victims reported further to polygraph administration than had previously been identified. Combined non-contact and contact victim figures were calculated based on probation records and an average of 48.1 victims per offender was determined. Based on polygraph examination findings, an average of 185.6 victims per offender was calculated, reflecting approximately 3.9 times more victims reported in total.

4.2 Number of Separate Episodes of Sexual Offending

Table 2 shows differences in the mean number of admissions of episodes of sexual abuse obtained from the two data sources, probation records and subsequent polygraph examination.

Table 2. Incidents of Offending		
<i>Men on Probation and Attending a Sex Offender Treatment Programme (N = 14)</i>		
	Probation Records	Polygraph Examination
Total	1285	5853
Mean	91.8	417.7
Standard deviation	124.7	686.9
Number of non-tied comparisons	13	
Number for which more victims based on probation records	1	

A test of the null hypothesis that the number of incidents of offending is equal when based on probation records and based on polygraph examination used the proportion (p) of cases observed where the number was greater for probation records than for polygraph examination (Neave, 1978, figure 1.2b).

95% confidence levels for the probability in the population of more incidents when based on probation records and based on polygraph examination are (0, 0.46). Thus we can reject the null hypothesis that the number of incidents is equal when based on probation records and based on polygraph examination in favour of the alternative that there are more incidents reported by polygraph examination findings than for probation records.

Figure 1 also presents the different rates of sex offence episodes reported for probation records and polygraph results.

The polygraph examination results gave indications of 4.5 times more incidents of sexual offending than was determined by a review of the probation records. Of particular interest, two offenders admitted to additional episodes of exposing that have taken place since their current probation order began.

4.3 Number of Paraphilic Interests/Involvements Disclosed

This data analysis examined the numbers of deviant sexual or paraphilic interests reported in the probation records, implied in psychometric test responding and disclosed during polygraph examination. The list of possible paraphilic interests is given in Appendix 7.4 and has been adapted from Abel and Rouleau (1990).

Table 3. Differences in Number of Paraphilic Interests/Involvements Reported				
<i>Men on Probation and Attending a Sex Offender Treatment Programme (N = 14)</i>				
	Probation Records	Additional Responses to Psychometric Tests – Implied Interest	Sub Total (incl. Probation and Psychometric Results)	Total Polygraph Examination Disclosures
Total	28	27	55	83
Mean	2.0	1.9	3.9	5.9
Standard deviation	0.4	1.9	2.2	2.6
Median	2	1.5	1.5-2	6
Mode	2	0	2,0	6
Number of non-tied comparisons				14 (versus probation records)
				13 (versus psychometric tests + probation records)
				0 (versus probation records)
Number for which more victims based on probation records /psychometric tests + probation records				1 (versus psychometric tests + probation records)

A test of the null hypothesis that the number of paraphilic interests is equal when based on probation records and/or psychometric tests and when based on polygraph examination used the proportion (p) of cases observed where the number was greater for probation records and/or psychometric tests than for polygraph examination (Neave, 1978, figure 1.2b).

95% confidence levels for the probability in the population of more paraphilic interests when based on probation records than when based on polygraph examination are (0, 0.23). Thus we can reject the null hypothesis that the number of incidents is equal when based on probation records and based on polygraph examination in favour of the alternative that there are more incidents reported by polygraph examination than for probation records.

Similarly, 95% confidence levels for the probability of more paraphilic interests when based on psychometric tests and probation records and than when based on polygraph examination are (0, 0.46). Thus we can reject the null hypothesis that the number of incidents is equal when based on psychometric tests and probation records on the one hand and based on polygraph examination in favour of the alternative that there are more incidents reported by polygraph examination findings.

The psychometric test responses are regarded as tentative, suggesting an implied interest and unless verification is obtained by a subsequent interview, these responses can not be relied upon and indeed are often rescinded by offenders when they are subsequently questioned about these matters on the basis that they have misunderstood the test item. As such, it is unlikely that the total of 55 paraphilic interests amongst this group of 14 men can be regarded as altogether substantiatable. The polygraph examination demonstrated a significant increase in the number of paraphilic interests amongst these men. It is likely however that the probation records plus

psychometric test findings total is a somewhat inflated figure. Of particular interest, the mean, median and modal number of paraphilic responses given by subjects during polygraph examination was 6 with a range from 2 to 10 paraphilias. The mean number of paraphilias increased to 6.5 if the two men in denial were eliminated from the N of 14 and to an 8.5 average if subjects were excluded whose polygraph results were indicative of deception.

Figure 2 shows the gain in paraphilic interest disclosures obtained through use of polygraph examination.

4.4 Age of Onset of Offending

This set of data was analysed in two ways, comparing each offenders known age at the time of onset of offending (based on official records and previous self-report) with the subjects acknowledged age of first offending reported during the polygraph examination.

Table 4 shows onset figures for any type of sexual offence, whilst Table 5 gives information about more serious offences excluding non-contact/non-invasive offences such as voyeurism or public masturbation.

Table 4. Age of Onset of Offending (Any Type)			
<i>Men on Probation and Attending a Sex Offender Treatment Programme (N = 14)</i>			
	Subject's Age (incl. official records and previous self-report)	Subject's Age (acknowledged during polygraph examination)	Mean Age Difference
Mean	27.9	13.5	14.4
Age(yrs)			
Standard	18.4	3.8	
deviation			
Range	11-80 years	6-22 years	+2 - -65 years

Two tailed paired t test is used. Reject null hypothesis of equality with value ($t=2.94$, $p=0.012$). There are significant differences between the polygraph examination findings and the probation record reports.

Twelve of the fourteen subjects reported earlier sexual offending than was determinable through a review of the records. It is notable that the remaining two subjects' polygraph examinations were in fact terminated prematurely because they were both responding in an overly emotional manner to the information they were disclosing. Indeed, for these two men a No Opinion (NO) finding was given by the polygraph examiner and by virtue of their incomplete examinations the responses obtained by them suggested that their polygraph examination disclosures concerning age of onset of offending were two years later than identified in the official records. Despite the anomalies associated with these two inconclusive polygraph examination results, the average age difference amongst these men was 14 years, between first committing a sexual offence and subsequently being identified as a sexual offender as acknowledged during the polygraph examination.

Table 5. Age of Onset of Offending (Excluding Offences where the Victim is Unaware of the Sexual Offence Occurring, i.e. voyeurism and public masturbation)			
<i>Men on Probation and Attending a Sex Offender Treatment Programme (N = 14)</i>			
	Subject's Age (incl. official records and previous self-report)	Subject's Age (acknowledged during polygraph examination)	Mean Age Difference
Mean Age (yrs)	27.9	16.3	11.6
Standard deviation	18.4	7.3	
Range	11-45 years	6-33 years	

Two tailed paired t test is used. Reject null hypothesis of equality with value (t=2.91, p=0.012). There are significant differences between the polygraph examination findings and the probation records.

Figure 3 presents age of onset data amongst the offenders who were included in this study.

These analyses demonstrate that the post-conviction SHDE polygraph test effectively elicits a greater number of sexual offence admissions and interests than have been obtained through other data sources. They also identified rates of offence disclosures comparable with O’Connell (1998).

4.5 **Polygraph Indications**

Table 5 shows admissions to more serious sexual offences and not surprisingly, the age difference between official reports and polygraph examination results is not as great. 11.5 years is compared with 14 years for any type of previous sexual offence. The data revealed is perhaps the more significant in light of the fact that 10 of the 14 subjects were found to be (DI) Deception Indicated, whilst 2 received No Deception Indicated (NDI) results and as noted previously, 2 further individuals received No Opinion (NO) findings by the polygraph examiner (Table 6).

Table 6. Polygraph Examination Results			
<i>Men on Probation and Attending a Sex Offender Treatment Programme (N = 14)</i>			
	Deception Indicated (DI)	No Deception Indicated (NDI)	No Opinion (NO)
Total	10	2	2
Percentage	72%	14%	14%

In spite of this low ‘pass’ rate, the number of victims, sexual offence episodes and paraphilic interests increased significantly further to polygraph examination and the age of onset determined by polygraph was determined to be significantly younger than official records have recorded. The polygraph examination results revealed a very high DI rate for these subjects. This may relate to cultural issues or attitudes about the polygraph in Britain, i.e. it was the polygraph examiner’s impression that a substantial number of these British volunteers believed they could ‘dupe’ the polygraph findings, though he believed that fewer Americans given polygraph tests think they can successfully deceive the polygraph test/examiner. Even so, the polygraph has produced results that are consistent with North American findings.

4.6 Individual Paraphilic Interests/Involvements Disclosed

Table 7. Paraphilic Interests/Involvements Disclosed						
<i>Men on Probation and Attending a Sex Offender Treatment Programme (N = 14)</i>						
	Exhibitionism	Voyeurism	Obscene Telephone Calls	Obscene Mail	Frottage	Other
% Probation Records	21	21	7	0	0	14
% Polygraph Examination	50	64	21	7	50	29
	Fetishism	Sadism	Masochism	Transvestism/Transsexualism	Public Masturbation	Zoophilia
% Probation Records	7	7	14	7	36	7
% Polygraph Examination	43	43	29	29	64	14
	Female Non-Incest	Male Non-Incest	Female Incest	Male Incest	Adult Rape/Indecent Assault	
% Probation Records	36	7	43	7	36	
% Polygraph Examination	64	7	43	21	43	

The number of S's was too small to employ any meaningful statistical comparisons for this table. However, actual differences are very clinically relevant and useful in respect of treatment, supervision and public protection issues. A review of the individual paraphilias reported in Table 7 enables comparisons in relation to specific types of disclosures with substantial increases in reporting based on the polygraph results as compared with probation/self-report alone. Changes in respect of exhibitionism, voyeurism, other sexually deviant interests, i.e. urolognia, copropilia, arousal to odours, necrophilia, fetishism, sadism, masochism, obscene telephone calls and public masturbation were observed. An increase in paraphilic interests in non-incest female abuse was also observed, as well as male incest abuse. Notably, 50% of the men in this study reported an interest in frottage, i.e. engaging in unwanted sexual touching in an often crowded, public place. The probation records did not reveal any indications of past convictions for frottage, although 50% of the men admitted having previously engaged in this behaviour.

The majority of subjects showed considerable evidence of crossover from one deviant sexual interest to another. Whilst probabilities of individual co-

existing paraphilic interests were not calculated, i.e. the probability that an exhibitionist might also engage in frottage, crossover between major offence divisions are shown below.

4.7 Crossover Rates

Crossover is a term which applies to sexual offending behaviour or interests which lie outside of the parameters of the index offence. In sex offender work, certain areas of crossover are of particular relevance. These include the crossover rates amongst abusers for non-contact and contact offences, intra-familial and extra-familial abuse, sexual offending against both boys and girls and the sexual abuse of adults as well as children. Where crossover exists between these major areas, relapse prevention plans and risk management strategies must be informed to maximise public safety (Wilcox, Sosnowski, Middleton, and Grubin, 2002).

Table 8. Summary Crossover Rates as Indicated by Polygraph Findings	
<i>Men on Probation and Attending a Sex Offender Treatment Programme (N = 14)</i>	
1.	93% (13 out of 14 subjects) reported that they had committed both contact and non-contact offences.
2.	50% (6 out of 12 subjects) who admitted to child sexual abuse acknowledged both intra and extra-familial offending.
3.	33% (1 out of 3 subjects) who acknowledged sexual offences against boys, also admitted to sexual offences against girls.
4.	50% (7 out of 14 subjects) reported committing sexual offences against adults as well as children.

Appendix 7.21 provides a table of information about crossover between paraphilic interests/involvements following the polygraph examination of these fourteen subjects. The table allows the reader to identify the number and percentage of men in each category of deviant sexual offending who also admitted to involvements in other paraphilic activities. As an example, eight of the fourteen men admitted to non-incestuous child abuse and amongst them five (62.5%) also acknowledged engaging in exhibitionism in the past. Whilst these comparisons may be useful, their limitations must not be overlooked. The number of subjects is small and as such, these figures should be seen to provide only crude estimates about crossover rates. In addition, the offenders

in this study, on average, were in the medium to high risk range based on the Risk Matrix 2000 (Thornton, 2000). As such, these data may be less applicable to individuals identified to be low risk, since risk is assessed in large part on the basis of past criminal convictions, both sexual and non-sexual. One might therefore reasonably assume that a group of low risk offenders, i.e. with fewer convictions, would likely be found to have fewer paraphilic involvements than individuals with entrenched histories of sexual offending. However, amongst the subjects involved in this study, this appendix offers considerable evidence of crossover of sexual offending behaviour.

4.8 Offence-Related Factors

The information presented in Table 9 is based on polygraph examination findings and was frequently not detailed in probation records. These offence-related factors are seen as precursors to relapse within the treatment model set out by Hudson, Ward and McCormack (1998).

Table 9. Offence-Related Factors	
<i>Men on Probation and Attending a Sex Offender Treatment Programme (N = 14)</i>	
	Percentage
Use of Substances	57
Alcohol	93
Use of Pornographic Magazines, Videos, Internet	86
Prostitutes/Massage Parlours	43
Adult Bookstores	43
Adultery	43
Telephone Sex	14
Nude Bars	50
Cruising/Stalking	57

Most individuals endorsed items in multiple categories. There are particular concerns that these activities may represent high-risk behaviours for offenders and as such, careful monitoring will impact considerably on the risk of the individual going into cycle (Wolfe, 1984) and relapsing. It was also noted that 57% of these men reported sexual stalking or cruising within the context of their pattern of offending.

4.9 Risk/Deviance Levels

When subjects produced scores that deviated significantly from the *average* score of non-offending British males on these measures then they can be judged to be high, medium or low deviance in respect of factors associated with offending, which relate to cognitive/social/personality functioning, as well as pro-offending thoughts, attitudes and behaviour. Thornton’s risk measure is associated with actuarial data including age of onset of risk, numbers of appearances in Court for sexual offending behaviour and general criminal background. The combining of these risk/deviance findings is regarded as the most comprehensive measure of risk of re-offending in Britain at this time. The risk level ratings vary from low to medium to high to very high and Table 10 below presents comparative for the two groups.

Table 10. Comparison of Risk/Deviance Levels		
<i>Men on Probation and Attending a Sex Offender Treatment Programme (N = 14)</i>		
	Attend	Did Not Attend
Low	3	3
Medium	4	4
High	2	3
Very High	4	2

As will be noted, the difference in risk/deviance scores for those who attended versus those who did not attend was minimal. The modal and median scores (4) for attendees and non-attendees were in the Medium Risk Range. The mean risk/deviance level was slightly higher for the subjects who attended. Comparison did not suggest that individuals who were higher risk had simply opted not to attend for polygraph examinations on the day as was initially thought likely.

However, the rate of attendance for the second set of trials in June 2000, was markedly poorer than for the first trials in October 1999, for reasons that could not be explained in terms of risk/deviance measures amongst attendees. Given that five out of five volunteers attended on the first occasion, whilst only thirteen out of twenty-five attended on the second occasion, a statistical analysis of the differences in attending rates was conducted. The differences

were not statistically significant. Nonetheless, the apparent change in attendance was pronounced and warranted additional clinical consideration. These issues are examined further in the Discussion section of this paper.

4.10 Undisclosed Victims

Although all subjects were separately questioned about previously undisclosed victims during their polygraph examinations, these data were difficult to accurately interpret. For example, there were indications that in some instances victims were 'disclosed' who had previously been reported within treatment or other settings, although perhaps not within the context of past criminal convictions. After attempting to discount these 'double-counts' or incorrect responses, attempts were made to factor out non-contact or reduced impact (frottage) victims to establish a truer estimate of undisclosed contact victims. This rough analysis revealed a total of approximately 500 previously undisclosed contact victims amongst these 14 offenders, though the individual scores were subject to great variability. These data were not analysed extensively, as it was judged that by virtue of asking more general questions as regards previously undisclosed sexual offence victims, the likelihood of obtaining accurate detailed data was much less than through the employment of questioning, focusing on a comprehensive list of deviant sexual activities/interests.

4.11 Past Sexual Behaviour

This data explored early sexual behaviour amongst the 14 subjects included in the study, producing the following results:

Table 11. Data Summary				
	Mean (standard deviation)	Median	Mode	% Under 7
Age of First Sexual Activity With Another Person (N=14)	9.5 (3.7)	8.25	6	36
Age of First Sexual Activity with Another Person (non-abuse of subject) (N = 14)	10.0 (3.6)	9.5	6	29
Age First Sexually Abused (N = 6 out of 14)	8.3 (2.5)	8	8.5	0
Age of First Reported Masturbation (N = 14)	12.5 (3.3)	12.5	12	7

Whilst these data do not reveal any significant findings in respect of risk, deviance or deception on the polygraph, the accumulation of this kind of data could enable more detailed investigation of the relationship between early sexual behaviour and later criminogenic factors.

5.0 DISCUSSION

The present study revealed significant differences in the numbers of admissions of past episodes and numbers of sexual offence episodes. Significant differences were also noted in respect of the numbers of paraphilias reported by polygraph subjects, as compared with data obtained from all other sources available. Further, subjects acknowledged that onset of offending occurred an average of 14 years before sexualised criminal activity was officially identified for any type of sexual offence and 11.5 years previously for more serious offences, excluding voyeurism and public masturbation.

Ideally, it would have been helpful to run a control group for this study, i.e. sex offenders who would not be polygraphed but instead would be given an in-depth interview covering the same areas of enquiry as those subjects who were polygraphed. However, this initial plan was not pursued, in part because there were limited numbers of volunteer subjects. The decision not to run a control group was also based on a belief by the author that the men participating in this study had been engaging in a well-recognised sex offender groupwork programme designed to assess and treat these men in a thorough, structured way. As testimony to the comprehensiveness of this programme, it will be recalled that this Community Sex Offender Groupwork Programme spearheaded the development of accredited programmes of this kind in Britain. The men who were polygraphed had engaged in intensive group and individual work as well as thorough psychometric testing on at least two occasions before the polygraph was administered. As such, it was decided that whilst a control group as conceived would be desirable, it was not critical in terms of the integrity of the study and there was sufficient evidence of the face validity of the research.

However, in these circumstances it is important to consider carefully whether the results might have been due to some other factor or factors. An assumption might be made that the higher numbers of disclosures obtained were the result of treatment rather than the polygraph effect. Whilst this is possible, it is noted that subjects regularly attended weekly groupwork sessions that were longer in duration than the single polygraph session. In every groupwork session each man was encouraged to discuss any new issues they believed might be relevant to their offender treatment work. In addition, each man attended individual supervision sessions with his Probation Officer over the duration of his Order. These contacts may vary between weekly and monthly depending on the stage of the Order. In spite of these various regularly scheduled assessment, treatment and supervision sessions, single polygraph examination produced significant increases in the reporting of offences, victims and paraphilias as well as earlier ages of first reported commission of sexual offending. It is also noted that only two out of the fourteen men in the study actually 'passed' their polygraph examination. This casts some doubt on any supposition that these men may have been motivated by a desire to disclose further information at this stage, since these results continued to suggest that subjects failed to be as open and disclosing as they might have been.

Almeyher et al. (2001) and Harrison and Kirkpatrick (2000) both noted that periodic administration of the polygraph has resulted in an increase in disclosures and ultimately in a greater percentage of offenders who 'passed' the polygraph. Harrison and Kirkpatrick (2000) also employed a structured self-report questionnaire for completion by their periodic polygraph subjects to ascertain their views about being polygraphed. Although the present study did not employ a post-test questionnaire, such a tool might have proven useful to further address the central question, 'did knowing they were being polygraphed cause them to disclose more?'

Consideration was also given to the possibility that the specific circumstances surrounding the polygraph examination may also have positively influenced disclosure levels as when Abel and Rouleau (1980) achieved higher numbers of disclosures in non-forensic, clinical research interviews that afforded full privacy and confidentiality. However, the subjects in the present study knew that the results would be comprehensively reported back to their Probation Officers and that confidentiality would not be provided. Indeed, they signed consent forms that clarified this issue. As such, it seems unlikely that any such extraneous features surrounding the administration of the polygraph examinations gave rise to further disclosures.

Ahlmeyer et al. (2000) found that disclosure rates concerning past offending were nearly three times higher for incarcerated sex offenders than for those on probation. They postulated that these differences may have been related to the offenders' perceptions of the likely outcomes or consequences of making further disclosures. Ahlmeyer reasoned that men on probation in the community may have believed they had more to lose than men in prison by being more open. These issues will be considered more fully in the next section concerning attendance issues and consequences of polygraph results.

The findings of the present study replicate the results of earlier research identifying increases in offence reporting through employment of the polygraph (Edson, 1991, O'Connell, 1998). Ahlmeyer et al., (2000) reported a 16 year gap on average between first committing a sexual offence and being apprehended.

Crossover rates were also an important area of investigation in this study. Historically, as noted by Abel and Rouleau (1990), it was believed that the offending patterns of offenders were to some degree uni-dimensional and as such, rather predictable. For example, sex offender workers held a view that incest offenders did not abuse outside of the family and vice versa. It was also

believed that individuals who sexually assaulted girls did not abuse boys and that those who commit sexual offences against adults do not commit sexual offences against children. Sex offender workers believed that non-contact offenders, like exhibitionists and voyeurs, did not commit sexual assaults and that effectively the type of sexual offence an individual was convicted of would in all likelihood encapsulate the full range of his deviant sexual interests. The research of Abel and Rouleau (1990) significantly challenged this view and the findings of this study refute this view even more comprehensively. These data are very important because they not only enable workers to establish more comprehensive treatment and relapse prevention plans, but in addition, the number of paraphilias and amount of crossover evidenced is an extremely good risk assessment indicator (Abel, 1999).

5.1 Attendance Issues

An important and obvious finding of this research was that in the absence of meaningful consequences for failure to participate in the polygraph examination, poor attendance became a significant factor. This might occur for a number of reasons and it may be predicted that individuals who have engaged in criminal activity or high risk behaviour during the period between volunteering and attending, may opt not to participate in the examination, giving an excuse or 'forgetting to attend'.

It was notable that the attendance rate for the first short trial in October 1999 was 100%, wherein five volunteers were scheduled to attend and all of them complied. In June 2000, thirteen of twenty-five scheduled volunteers attended. The attendees on the first occasion were quite sceptical about whether the polygraph examination would accurately identify deception and many believing that this was not the case. These individuals continued to be in the group work programme at the time of the second trial, eight months later and we questioned whether their views were possibly shared with other

group members, increasing anxieties about the polygraph's potential for gaining accurate, truthful information.

It should however be noted that all of these people volunteered and this may have been motivated by a wish to exonerate themselves or a perception that they could dupe the polygraph examiners. As the period of time between agreeing to be polygraphed and attending was several weeks longer for the second set of trials, the author questioned whether the non-attendance may also have related to a 'change of heart' because concerns that events they were involved in during the interim period may have been exposed to risk of detection during polygraph examination.

Further, the majority of individuals that the author would have been most interested in polygraphing did not volunteer to participate in the study. Sosnowski and Wilcox (2000) judged that unless meaningful sanctions are imposed, such as closer supervision, restrictions on activity within the community through the Sex Offender Act (1999), consideration of breach proceedings or financial liability to the polygraph examiner for non-compliance or failure to pass the examination then the polygraph's utility would be seriously compromised. In many areas in America where polygraph examinations are given at regular intervals, (averaging six monthly), the client is required to pay for each administration. This periodic monitoring and maintenance examination is a probation or licence requirement to facilitate both supervision and therapeutic work. It is recognised that many individuals have a great deal invested in continuing to conceal offence specific and offence related activity they have been engaging in and this approach may decrease reticence or non-cooperation.

English (2001) noted in her research that the majority of men serving sentences for sexual offences actually committed these current offences whilst on probation or parole/licence. As such, there is a critical need to break

through the high levels of secrecy and denial that pervade. Edson (1994) reported high failure rates initially in his work employing the polygraph for compliance purposes but as these examinations were regularly re-administered and clear immediate consequences for Deception Indicated (DI) results were applied, the majority of examinees regularly produced No Deception Indicated (NDI) results. In the interest of further increasing examinee commitment to co-operating with testing, many authorities in America not only require the offender to pay for his own periodic polygraph examinations, if he fails the polygraph or refuses to co-operate he is obliged to attend and pay for a further examination in the following month rather than six months later as would ordinarily obtain.

Whilst ethical issues and questions about the offenders financial means should be carefully considered here, if an offender is being deceptive about some aspects of his behaviour vis a vis the conditions of his order, then it seems quite reasonable to intensify polygraph and general supervision until this situation is resolved. Sosnowski (2000) indicated that many offenders in the USA even have a financial responsibility to pay for therapeutic support for their victims.

However, one US researcher (McKay, 2000) noted that in some circumstances a barrier to post-conviction sex offender polygraph testing has apparently been the cost. He stated:

This observation is interesting in light of the prevailing view that it is important to have offenders bear the expense of their own polygraph examination, thus making them more invested in passing the examination and avoiding further expenses of re-taking an examination (McKay, 2000, p.39).

This factor may have particular relevance in Britain as it may be viewed as politically, socially or economically inappropriate for offenders to provide this funding. However, it may be that a contribution toward meeting this cost would be appropriate. McKay asserts that:

Polygraph testing has become an established tool for the supervision of sex offenders in progressive community supervision and corrections departments across Texas', concluding that in this area 'the polygraph would remain a central tool of community correction agencies seeking the most effective methods of sex offender supervision (McKay, 2000, p.39).

The immediacy of the application of consequences of polygraph testing is also an important factor as noted by Matte (1996) and Cooley-Towell, Pasini-Hill and Patrick (2000). Cooley-Towell, et al., advised that 'sanctions should be certain, prompt, consistent, and linked to the severity of the behaviour detected or disclosed'. Sosnowski (2000) reported that whilst maintenance and monitoring issues are the central focus of the period examination, other concerns relating to past sexual interests/activities and full acceptance of responsibility for the index offence, may at times be agreed areas to pursue following discussions amongst group workers, probation officer and polygraphist.

5.2 Training Issues

Dutton (2000), Chair of the American Polygraph Association's Post-conviction Sex Offender Testing (PCSOT) Sub-Committee, advised of a need for rigorous professional standards in training to ensure that the quality and accuracy of the assessment is of an appropriate standard. Holden (2000) asserted that skilled polygraphists may be at significant risk of misinterpreting data without specialised training in the field. Gelb (1998) provided case study

evidence of just such errors amongst even experienced and respected polygraphists who lacked PCSOT training.

Lundell (2000) and other members of the PCSOT Sub-Committee have been influential in developing an approved APA programme for post-conviction testing of sexual offenders. The course, which requires passing a written examination, has been delivered to wide ranging private and government agencies, including the US Department of Defence. APA training provision at this level adds credibility to views that sex offender testing should be regarded as an advanced specialisation in this field. It also offers substantial indications of the rigorousness of the current post-conviction polygraph examination training course as the US Government believes that this area of polygraphy demands more refined expertise.

Edson (1991) advised that the utility of the polygraph became greater as its use became more standardised and established as part of a regular monitoring and treatment regime. He indicated that four years after its introduction, the number of DI's (Deception Indicated results) dropped from more than half to less than 25%. This may relate to an increased confidence on the part of examinees that the polygraph will accurately identify deception as well as an increased clarity of objectives shared by Therapist, Probation Officer, Polygraphist and in many instances the Client.

English, Colling-Chadwick, Pullen and Jones (1996) advise that the polygraph works best within the context of a containment approach referencing the containment triangle shown in Figure 4.

They advised that containment and risk management strategies require collaboration between professionals employing post-conviction polygraph examinations, specialised treatment and criminal justice supervision. It should be noted that this kind of close co-operative working arrangement requires ongoing dialogue and shared effort amongst professionals involved. These conditions were not achievable within the context of these British polygraph trials in 1999 and 2000 as they employed a polygraphist from abroad. Where polygraphy has become established in sex offender treatment, English, et al., (2000) strongly encouraged polygraph examiners to initiate the assembly of local teams to manage convicted sex offenders as a means of improving risk management in the community.

It is of particular interest to note that where the polygraph has been introduced with sex offenders on a regular basis in a community setting (Harrison and Kirkpatrick, 2000), the testing affected both the sex offenders' progress in treatment and their behaviour whilst on probation. Their study involved writing to twenty-eight offenders in sex offender treatment and asking them to anonymously complete an attitude survey, which incorporated some questions relating to their views about the polygraph testing element of the programme. These individuals indicated that the polygraph testing helped to clarify their

personal boundaries and values. Harrison and Kirkpatrick (2000) stated that the offenders' attitudes toward the use of the polygraph affected their behaviour in a positive direction, increasing information disclosure and helping them to keep some risky behaviours in check, such as being in contact with their victims or grooming potential future victims. Laws et al., (2000) noted that these kinds of internalised changes are particularly associated with an improved potential for remaining offence free.

5.3 Difficulties in Administration

As with any specialist intervention, it is important to employ the correct procedure in each case to enhance supervision and treatment success. This advice was particularly relevant in respect of some participants in this study who had completed only more limited induction programmes, but remained in denial at the time of testing. For such individuals the Specific Incident Examination would have been more appropriate to address denial and minimisation about their index offence first. The total denial of the index offence suggests little likelihood that an examinee would acknowledge any other past offending and this was borne out with one or two subjects who participated in this study.

We also noted that one examinee's polygraph examination was interrupted whilst his sexual history was being explored because he became too distressed to proceed. The questions created concerns in the examiner about the subject's possible involvement in a Sexual Homicide over twenty years ago. In view of the serious legal implications of such a possible admission, both for the subject and the visiting polygraphist, the session was terminated prematurely and relevant feedback given to the Probation Officer. Certainly, at this early stage of considering the possible benefits of polygraphing sex offenders on probation, the implications of a possible admission of this nature within the context of 'no admissibility' or formal legal standing for

polygraphy in Britain, suggested it would be more prudent to terminate the session and discuss this with the Probation Officer.

5.4 Recommendations for Future Use of the Polygraph

It also became apparent that less systematic attention appears to be given to the monitoring of some offence related activities in British programmes such as alcohol/substance use and use of pornography. Whilst the polygraph can be used to monitor these kinds of activities, it can also address other pre-offence related activities such as grooming behaviour, compulsive masturbation, frequenting of adult book stores, etc. These offence related factors (Marshall, Anderson and Fernandez, 1999) affect behaviour change and dynamic risk factors (Thornton, 2000) which may impact on offending in sex offenders in community settings.

Heil, Ahlmeyer, McCullar and McKee (2000) stated that:

Polygraphy is an invaluable intervention tool for enhancing the treatment and management of sex offenders in diverse criminal justice settings (Heil et al., 2000, p.30).

They advised that research and policy development can play a role in maximising the effectiveness of this tool asserting that public safety is dependent on preventing sexual offenders from concealing information that enables them to continue sexually assaulting their victims. They conclude that:

when combined with specialised treatment and supervision, polygraph testing can be a powerful tool to break this secrecy (Heil et al., 2000, p.30).

Ahlmeyer, et al., (2000) described the benefits of Sexual History Disclosure Examination in their recent research. They noted that average official records identified two sexual assault victims and seven offences per offender. Ahlmeyer, et al., (2000) found that inmates who participated in their study reported on average one hundred and eighty four (184) victims and five hundred and twenty eight offences (528). They also found that twenty-five (25) parolees (men on community orders) admitted to only seven (7) victims and twenty-three (23) offences on average by the second polygraph examination in their study of these men. They stated that these reported frequencies were likely an underestimation since the deception rate was 80% for the inmates and 74% for the parolees. It was also notable that the parolees had not participated in a prison sex offender treatment programme and they may have disclosed fewer offences because of the perception that additional disclosures might lead to restrictions being placed on their current lifestyle.

Ahlmeyer, et al., (2000) reported crossover rates in sex offending behaviour which was considerably higher using the polygraph. For example, 82% of the polygraphed men who had known histories of child molestation admitted to sexually assaulting adults. Further, 50% of the known rapists in the study admitted to sexually assaulting children. 62% of known non-relative sex offenders admitted to sexually assaulting relatives. Nonetheless, the rate of deception continued to remain high at about 80%, even with this information disclosed. Heil, et al., (2000) argued for the integration of polygraph testing with the other elements of treatment and supervision as a means of eroding this factor.

5.5 Legal Issues

Acceptance of the polygraph for sex offender assessment has increased. In 1999, the Seattle Supreme Court upheld the use of the polygraph for treatment purposes in individuals convicted of sexual offences Spencer (1998). Further, in 1998 the State of Tennessee passed a law making regular polygraph

examination of sex offenders mandatory after they have been convicted of a second offence. The tests administered may focus on specific incidents or monitoring and maintenance tests and state legislation recognised the importance of the polygraph as a deterrent to future offending.

However, Horvath, F (personal communication, October 12, 2001) reported that a recent US Court ruling in Montana held that mandatory disclosure testing can not be entered as evidence in Court Proceedings, though the polygraph's use for treatment and supervision purposes remains strongly established in many settings in the USA with some variability from state to state. The implications are somewhat unclear.

5.6 Potential Benefits

Wilcox, et al., (2000) reported a range of uses of the polygraph with sexual offenders. Table 12 describes a number of areas within which the Polygraph Examination has demonstrated its utility with men on probation or licence:

Table 12. Potential Benefits of Post-conviction Polygraph Examination	
1.	Proper polygraph supervision can help reduce prison population numbers, i.e. by providing a viable alternative to imprisonment in some circumstances through regular use of Maintenance and Monitoring Examination.
2.	The costs of housing these individuals therefore can be borne more fully by them, rather than the taxpayer.
3.	Periodic polygraph examination has a significant deterrent effect on criminal behaviour, thus reducing recidivism.
4.	Those who do re-offend have a greater likelihood of being apprehended.
5.	Community safety is increased.
6.	There is a greater probability that the names of victims can be determined more quickly and appropriate treatment provided for them.
7.	When young offenders have themselves been sexually abused, they are more likely to report the name of their abusers through employment of the polygraph and appropriate steps can be taken to apprehend these older unreported offenders through the employment of the polygraph.
8.	The different post-conviction polygraph examinations have important effects on therapeutic outcome. <u>Monitoring</u> and <u>maintenance</u> tests, discourage further criminal activity, enhancing the prospect of genuine rehabilitation and more permanent lifestyle change. Two types of <u>Disclosure Examinations</u> facilitate the therapeutic process, by breaking down denial about the <u>index offence</u> (Specific Incident testing) and about <u>deviant sexual interests</u> and involvement more generally with the Sexual History Disclosure Examination
9.	The polygraph testing provides the Probation Officer more information and flexibility to determine how to spend his or her time more effectively.
10.	Supervision of offenders can be enhanced even within current Probation resources (adapted from p.23)

In the author's view, the future of post-conviction polygraph testing in Britain and beyond is dependent upon standardisation of policies and procedures, the requirement for continuing education and a specialised requirement for post-conviction training. Abrams and Simmons (2000) have indicated that 'these steps have been initiated and they are moving the field in the direction of making polygraphists professional'. Holden (2000) has given further detailed guidelines for conducting post-conviction polygraph examinations, giving procedure and practice advice regarding the need for rigorous adherence to established structures for the different types of recognised examinations.

This preliminary research suggests that polygraphy can offer a helpful way to address denial and to contribute to the development of more tailored treatment programmes, particularly if it is introduced in a structured way with standard procedures from the outset. Without such controls, the potential for misuse remains a serious concern.

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APPENDIX 7.1

Estimated Number of Victims

Name	Non-Contact		Contact		Contact (excl. frottage)	
	Based on Probation Records	Based on Polygraph Examination	Based on Probation Records	Based on Polygraph Examination	Based on Probation Records	Based on Polygraph Examination
S1	0	0	3	4	3	4
S2	0	2	2	4	2	3
S3	200+	800+	-	1	-	1
S4 ⁺	4	4	2	3	2	3
S5	3	37	1	13	1	1
S6	-	-	411	18+	411	418
S7	0	0	1	3	1	3
S8	3	16	2	4	2	4
S9	1	5	-	201+	1	1
S10	25+	75+	10	75+	2	5
S11	-	1	4	4	4	4
S12	-	3	3	3	3	3
S13	-	18	3	109	3	9
S14	-	90	5	705+	5	5
TOTALS	226+	1051+	447	1147	440	464
MEAN	16+	75+	32	82	31	33

⁺ Session terminated early due to subject becoming distressed.

APPENDIX 7.2

Estimated Total Number of Episodes of Abuse

Name	Probation Records	Polygraph Examination
S1	26	41
S2	20+	205+
S3	200+	800+ (1)
S4	104	524+
S5	3	50
S6	411	2603
S7	1	3
S8	4	33 (1)
S9	3	206+
S10	200+	275+
S11	237+ (2)	5
S12	6	207+
S13	50	281
S14	20+	800+
TOTALS	1285	5853+
MEAN	92	418
MEDIAN	23	206.5

- (1) Subjects advised that episodes of exposing have taken place since current order began.
- (2) Figure based upon victim report of No. of incidents – subject in denial.

APPENDIX 7.3

Number of Paraphilic Interests/Involvements (1)

Name	Probation Records		Responses to Psychometric Tests – Implied Interest (2)		Sub Total	Polygraph Examination
S1	2	+	(4)	=	6	9
S2	2	+	(1)	=	3	4
S3	2	+	(2)	=	4	6
S4	2	+	(0)	=	2	6
S5	2	+	(4)	=	6	7
S6	3	+	(5)	=	8	9
S7	1	+	(0)	=	1	2
S8	2	+	(3)	=	5	4
S9	2	+	(1)	=	3	3
S10	2	+	(0)	=	2	6
S11	2	+	(0)	=	2	3
S12	2	+	(2)	=	4	5
S13	2	+	(0)	=	2	9
S14	2	+	(5)	=	7	10
TOTALS	28	+	27	=	55	83
MEAN	2		2			6
MEDIAN	2		1½			6
MODE	2		0			6 & 9
RANGE	1 – 3		0 – 5			2 - 10

- (1) List of possible paraphilic interests/involvements – Appendix 4
- (2) e.g. “I have had to fight the temptation to expose myself to someone. True or False”. Possible interests are implied but not verified as intelligence and literacy difficulties, misinterpretation and other factors may affect the veracity of item responses.

APPENDIX 7.4

List of Paraphilic Interests

Female Non-Incest Paedophilia
Male Non-Incest Paedophilia
Female Incest
Male Incest
Rape
Exhibitionism
Voyeurism
Frottage
Obscene Telephone Calls
Obscene Mail
Transexualism
Transvestism
Fetishism
Sadism
Masochism
Public Masturbation
Zoophilia
Professional Sexual Misconduct
Other (Urolagnia, Coprophilia, Arousal to Odours, Necrophilia)

APPENDIX 7.5

Age of Onset of Offending (Any Type)

Name	Subject's Age (acknowledged during polygraph examination)	Subject's Age (including official records and previous self-report)	Age Difference
S1	16½ (zoo)	35	-18½
S2	15 (voy)	80	-65
S3	9 (inc./IA)	14	-5
S4	13 (exh/voy)	11	+2
S5	15 (obs calls)	45	-30
S6	12 (voy)	15	-3
S7	22 (IA)	22	0
S8	13 (exh)	19	-6
S9	10 (voy)	42	-32
S10	13 (frot)	16	-3
S11	13 (pub mast)	29	-16
S12	15 (IA)	25	-10
S13	6 (exh)	22	-16
S14	16 (exh)	14	+2
MEAN AGE	13½	28	-14
RANGE	6 - 22	11 - 80	+2 - -65

APPENDIX 7.6

Age of Onset of Offending

(Excluding non-contact, non-victim* involved offences)

Name	Subject's Age (acknowledged during polygraph examination)	Subject's Age (including official records and previous self-report)	Age Difference
S1	16½	35	-18½
S2	33	80	-47
S3	9	14	-5
S4	13	11	+2
S5	15	45	-30
S6	14	15	-1
S7	22	22	0
S8	13	19	-6
S9	14	42	-28
S10	13	16	-3
S11	29	29	0
S12	15	25	-10
S13	6	22	-16
S14	16	14	+2
AVERAGE	16	28	11½

*** Excludes voyeurism and public masturbation (e.g. masturbating in public without the intention of being observed) as well as other 'victimless' paraphilic interests like transvestism, fetishism, etc.**

APPENDIX 7.7

Polygraph Examination Results

Name	DI / NDI or NO
S1	DI
S2	DI
S3	DI
S4	NO
S5	DI
S6	NDI
S7	DI
S8	DI
S9	DI
S10	DI
S11	DI
S12	DI
S13	NDI
S14	NO
TOTAL DI	10
% DI	72
TOTAL NDI	2
% NDI	14
TOTAL NO	2
% NO	14

APPENDIX 7.8.1

Frequency Data for Individual Paraphilic Interests/Involvements – Comparing Probation Records and Polygraph Findings

Name	Exhibitionism		Voyeurism		Obscene Telephone Calls		Obscene Mail		Frottage		Other (1)	
	Probation Records	Polygraph Examination	Probation Records	Polygraph Examination	Probation Records	Polygraph Examination	Probation Records	Polygraph Examination	Probation Records	Polygraph Examination	Probation Records	Polygraph Examination
S1	-	-	-	✓	-	-	-	-	-	-	-	✓
S2	-	-	-	✓	-	-	-	-	-	✓	-	-
S3	✓	✓	-	-	-	✓	-	-	-	-	-	-
S4	-	✓	-	✓	-	-	-	-	-	-	✓	✓
S5	-	-	-	✓	-	✓	-	✓	-	✓	-	-
S6	-	-	✓	✓	-	-	-	-	-	✓	✓	✓
S7	-	-	-	-	-	-	-	-	-	-	-	-
S8	✓	✓	-	-	-	-	-	-	-	-	-	-
S9	-	-	✓	✓	-	-	-	-	-	✓	-	-
S10	✓	✓	-	✓	-	-	-	-	-	✓	-	-
S11	-	-	-	-	-	-	-	-	-	-	-	-
S12	-	✓	-	✓	-	-	-	-	-	-	-	-
S13	-	✓	-	✓	-	-	-	-	-	✓	-	-
S14	-	✓	✓	-	✓	✓	-	-	-	✓	-	✓
%	21	50	21	64	7	21	0	7	0	50	14	29

- (1) Urolagnia, coprophilia, arousal to odours, etc.
 (2) Subject reported 2-3 incidents whilst on current order.
 Strong necrophilia interest re: child.

APPENDIX 7.8.2

Other Paraphilic Interests/Involvements

Name	Fetishism		Sadism		Masochism		Transvestism/ Transsexualism		Public Masturbation		Zoophilia	
	Probation Records	Polygraph Examination	Probation Records	Polygraph Examination	Probation Records	Polygraph Examination	Probation Records	Polygraph Examination	Probation Records	Polygraph Examination	Probation Records	Polygraph Examination
S1	✓	✓	✓	✓	✓	✓	-	✓	-	-	-	✓
S2	-	-	-	-	-	-	-	-	-	-	-	-
S3	-	-	-	✓	-	-	-	✓	✓	✓	-	-
S4	-	-	-	-	✓	✓	-	-	✓	✓	-	-
S5	-	✓	-	✓	-	-	-	-	-	-	-	-
S6	-	✓	-	✓	-	✓	-	✓	-	✓	-	-
S7	-	-	-	-	-	-	-	-	-	-	-	-
S8	-	-	-	-	-	-	-	-	✓	✓	-	-
S9	-	-	-	-	-	-	-	-	-	-	-	-
S10	-	✓	-	-	-	-	-	-	✓	✓	-	-
S11	-	-	-	-	-	-	-	-	-	✓	-	-
S12	-	-	-	-	-	-	-	-	-	✓	-	-
S13	-	✓	-	✓	-	✓	-	✓	-	✓	-	-
S14	-	✓	-	✓	-	-	-	-	✓	✓	✓	✓
%	7	43	7	43	14	29	0	29	36	64	7	14

APPENDIX 7.8.3

Paraphilic Interests/Involvements Contact Offences, Child Masturbation and Adult Rape / Indecent Assault

Name	CHILDREN						ADULTS		
	Female Non-Incest		Male Non-Incest		Female Incest		Male Incest		Rape/Indecent Assault
	Probation Records	Polygraph Examination	Probation Records	Polygraph Examination	Probation Records	Polygraph Examination	Probation Records	Polygraph Examination	Polygraph Examination
S1	✓	✓	-	-	✓	✓	-	-	-
S2	-	✓	-	-	✓	✓	-	-	✓
S3	-	-	-	-	-	-	-	✓	-
S4	-	✓	-	-	✓	✓	-	-	✓
S5	-	-	-	-	-	-	-	-	✓
S6	-	-	✓	✓	-	-	-	✓	-
S7	-	✓	-	-	-	-	-	-	✓
S8	✓	✓	-	-	-	-	-	-	-
S9	✓	-	-	-	-	-	-	-	-
S10	-	-	-	-	-	-	-	-	✓
S11	-	-	-	-	✓	✓	✓	✓	-
S12	✓	✓	-	-	✓	✓	-	-	-
S13	✓	✓	-	-	✓	✓	-	-	-
S14	-	✓	-	-	-	-	-	-	✓
%	36	64	7	7	43	43	7	21	36
									43

APPENDIX 7.9

Offence Related Factors – Derived from Polygraph Examination Disclosures

Name	Use of Substances	Alcohol	Use of Pornographic Magazines, Videos, Internet	Prostitutes/ Massage Parlours	Adult Bookstores	Adultery	Telephone Sex	Nude Bars	Cruising/ Stalking
S1	0	1	2	1	1	1	0	1	0
S2	0	1	1	0	0	1	0	0	1
S3	3	2	2	2	0	0	2	1	2
S4	0	1	0	1	0	0	0	0	0
S5	1	3	2	0	1	3	0	1	0
S6	1	2	4	3	0	1	0	0	4
S7	0	2	0	0	0	0	0	0	2
S8	0	1	4	0	1	0	0	0	0
S9	0	2	1	0	1	0	0	0	0
S10	1	2	3	1	2	1	2	2	3
S11	1	1	1	0	0	0	0	1	0
S12	1	2	2	2	1	4	0	2	2
S13	2	2	3	0	0	0	0	0	3
S14	-	-	2	0	0	0	0	2	4
MEAN	1	2	2	1	1	1	0	1	1.5
RANGE	1-3	1-3	0-4	0-3	0-2	0-4	0-2	0-2	0-4
PERCENTAGE ENGAGING	57	93	86	43	43	43	14	50	57

Scale: 0 = Denied, 1 = Infrequent, 2 = Regular Use, 3 = Excessive and 4 = Obsessional

APPENDIX 7.10

Comparison of Risk Deviance Levels
(Between group of volunteers who attended and group who did not)

Name	Attended	Name	Did Not Attend
S1	Low	S15	High
S2	Medium	S16	Very High
S3	Very High	S17	Medium
S4	Very High	S18	Medium
S5	Medium	S19	High
S6	High	S20	Medium
S7	High	S21	Medium
S8	Very High	S22	Low
S9	Medium	S23	Low
S10	Very High	S24	High
S11	Low	S25	Low
S12	Low	S26	Very High
S13	Medium	-	-
S14	Very High	-	-
AVERAGE	Medium / High	AVERAGE	Medium

APPENDIX 7.11

Age of First Sexual Activity with Another Person
(Whether this involved abuse or consensual age appropriate/equivalent sexual activity)

Name	Subject's Age
S1	6-7
S2	6-7
S3	8-9
S4	12
S5	5
S6	7½
S7*	17
S8	8
S9	6
S10	11-12
S11*	14
S12	10
S13	6
S14	14
MEAN	9½
MEDIAN	8¼
MODE	6 & 14
% UNDER 7	36%
% UNDER 9	57%

* In Denial

APPENDIX 7.12

**Age of First Sexual Activity with Another Person
(Which did not involve sexual abuse of the subject)**

Name	Subject's Age
S1	6-7
S2	12
S3	8-9
S4	12
S5	5
S6	9
S7	17
S8	8
S9	6
S10	11-12
S11	14
S12	10
S13	6
S14	14
MEAN	10
MEDIAN	9½
MODE	6 & 14
RANGE	5 – 17
% UNDER 7	29%
% UNDER 9	43%

APPENDIX 7.13

Age First Sexually Abused

Name	Subject's Age
S1	8-9
S2	6-7
S3	8-9
S4	-
S5	13
S6	7½
S7	-
S8	-
S9	-
S10	-
S11	-
S12	-
S13	6
S14	-
ABUSED	43%
MEAN AGE	8
MEDIAN AGE	8
MODAL AGE	8½
RANGE	6-13

APPENDIX 7.14

Age of First Reported Masturbation

Name	Subject's Age
S1	7-8
S2	20
S3	11-12
S4	13
S5	12
S6	14
S7	16
S8	13
S9	12
S10	11-12
S11	12
S12	13
S13	6
S14	14
MEAN	12½
MEDIAN	12½
MODE	12 & 13
RANGE	6 – 12
% UNDER 7	7%
% UNDER 9	14%

APPENDIX 7.15

Sexual History Disclosure Examination Form

TYPE OF BEHAVIOR:

1st: LAST: #TIMES:

1. Sexual play with children (playing doctor or show me games)		
2. Masturbation	Frequency ?	
Inappropriate Fantasies		
Type of Fantasy		
3. Masturbation in public (outdoors, restrooms, in vehicle)		
4. Masturbation to pornographic material (XXX films, magazines)		
5. Masturbation with under clothing/garments (stealing of clothes for masturbation)		
6. Voyeurism (peeking/watching for sexual purposes)		
7. Exhibitionism (exposing your sexual anatomy to others)		
8. Incest (any sexual activity within family)		
9. Homosexual behavior (any sexual activity with same sex, childhood or adult)		
10. Obscene phone calls, including prank or nuisance calls.		
11. Frottage (rubbing up against or touching others for sexual purposes)		
12. Molestation (any sexual contact with minors as adult)		
13. Aggravated Molestation (penetration of minor with penis, finger, or other objects)		
14. Setting fires (sexual purposes)		
15. Prostitution (either paying or being paid for sex) with Females		
15a. Prostitution	with Males	
16. Stalking (following another person without their consent)		
17. Phone sex calls (900, random, or someone known)		
18. Sodomy (mouth to penis, vagina, or anus)		
19. Transsexualism (thoughts or interest in wanting to be opposite sex)		
20. Transvestitism (activities involving dressing in opposite sex clothes)		
21. Sadism (deriving sexual pleasure from another's pain or humiliation)		
22. Masochism (deriving sexual pleasure from receiving pain)		
23. Taking photographs/videos of minors for sexual purposes.		
24. Fetishism (sexual arousal from objects, --underwear, feet, shoes, vibrators)		
25. Placing objects into anus for sexual arousal.		
26. Urolagnia (use of urine for sexual excitement--golden showers)		
27. Coprophilia (use of feces for sexual excitement--brown showers)		
28. Cruising (driving, walking searching for a sexual target)		
29. Arousal to odors (any odor associated with sexual arousal)		
30. Necrophilia (sexual contact with dead animals or people)		
31. Animal sex or cruelty to animals.		
32. Sexual victimization (if you have been sexually abused)		
33. Grooming a minor or minor's guardian/parent with sexual intentions.		
34. Contributed to the delinquency of minors--use of alcohol, drugs, shelter, porno)		
35. Visiting areas where children frequent in order to have sexual contacts/fantasies.		
36. Threesomes		
37. Nude Bars		
38. Sexual contact with fruit/vegetable		
39. Other		
40. Adultery		
41. Hurt anyone during a sexual experience		
42. Others not listed		

APPENDIX 7.16

(Letter requesting volunteers for polygraph/lie detector study given to SOGP attendees by Group Facilitators. D. Wilcox also attended each group to answer questions offenders had about the study for those expressing a willingness to participate).

West Midlands Probation Service
Selly Oak B29 6NA
Telephone:
Facsimile:

Date: 30 September 1999

Dear

We are planning polygraph examination trials with men who are currently involved in the sex offender groupwork programme. Participation is on a purely voluntary basis, but information gathered may help Probation Offices/Group Workers to decide how much group work you will need to attend and how much supervision should be given to you during your order.

The polygraph examination will involve asking you questions about your sexual offence related behaviour whilst simultaneously measuring your heartbeat, pulse and breathing. It is hoped that the information gathered will clarify issues that you and your Group Workers have been addressing in group or individual sessions.

Your Probation Office/Group Worker has been asked for the names of people who might wish to volunteer to participate in these trials. If you do attend, the polygraph questions will be reviewed with you before the examination is undertaken. These trials are not designed to 'catch you out' or 'trick' you into revealing thoughts or behaviours that will get you into current trouble or lead to a revocation of your current order. Rather, they are intended to help you and your Group Workers to develop better relapse prevention plans and understand risk issues more fully.

Let me know if you would like to participate in these trials by contacting me on the above number and if you have any questions do not hesitate to call me.

The examinations will only be administered to a small number of people at this time so the list must be finalised quickly.

Yours sincerely

Daniel T Wilcox
Chartered Clinical & Forensic Psychologist

APPENDIX 7.17

(Letter requesting volunteers for polygraph/lie detector study given to SOGP attendees by Group Facilitators. D. Wilcox also attended each group to answer questions offenders had about the study for individuals expressing a willingness to participate).

West Midlands Probation Service
Selly Oak B29 6NA
Telephone:
Facsimile:

Date: 6 May 2000

Dear

We are planning polygraph examination trials with men who are currently involved in the sex offender groupwork programme. Participation is on a purely voluntary basis, but information gathered may help Probation Offices/Group Workers to decide how much group work you will need to attend and how much supervision should be given to you during your order.

The polygraph examination will involve asking you questions about your sexual offence related behaviour whilst simultaneously measuring your heartbeat, pulse and breathing. It is hoped that the information gathered will clarify issues that you and your Group Workers have been addressing in group or individual sessions.

Your Probation Office/Group Worker has been asked for the names of people who might wish to volunteer to participate in these trials. If you do attend, the polygraph questions will be reviewed with you before the examination is undertaken. These trials are not designed to 'catch you out' or 'trick' you into revealing thoughts or behaviours that will get you into current trouble or lead to a revocation of your current order. Rather, they are intended to help you and your Group Workers to develop better relapse prevention plans and understand risk issues more fully.

Let me know if you would like to participate in these trials by contacting me on the above number and if you have any questions do not hesitate to call me.

The examinations will only be administered to a small number of people at this time so the list must be finalised quickly.

Yours sincerely

Daniel T Wilcox
Chartered Clinical & Forensic Psychologist

APPENDIX 7.18

CONSENT TO POLYGRAPH AGREEMENT

TO THE EXAMINEE: I, the undersigned, voluntarily authorize the examiner to give me a polygraph examination. I also authorize the examiner to conduct a pre-test interview with me in order to determine the facts of this case as they are known to me. I hereby grant permission to the examiner to use any equipment and methods deemed necessary for the proper administration of the examination. I also authorize the examiner to place the attachments needed to conduct the polygraph test to my body.

I do hereby specifically waive any and all rights of privacy that I have or may ever have with reference to the taking of said examination and making known the results and opinions arising from said examination. I do hereby authorize S.O.S Services, Inc., its officers and employees or its agents, to disclose both orally and in writing the said results and opinions to the person/company on whose behalf the test is being conducted, including employees and or/representatives of the client for whatever use they may determine.

I do hereby release and covenant to forever hold free from all harm, liability or damage to me as a result of the examination and opinions S.O.S Services, Inc., together with its officers, employees or its agents who may use the results and opinions of this examination. I remise, release, waive and forever discharge S.O.S.Services, Inc. from any and all action or cause of action, claim or demand, liability or legal actions which I have now or may ever have resulting directly or indirectly or remotely both from taking said examination and the oral and written opinions rendered because of said examination.

I am aware that this examination is strictly voluntary and can not be forced to take the test. I am also aware that I may discontinue the test at any time and that I am free to leave at any time. I certify that I have read the above information and that I understand its contents.

DATE: _____ **TIME:** _____ **LOCATION:** _____

Examiner _____ **Examinee's Signature** _____

POST TEST CONFIRMATION

I, the undersigned, confirm that Daniel E. Sosnowski did in fact administer to me a polygraph examination on the _____ day of _____, 2001. I further confirm that I freely and voluntarily submitted to the polygraph examination.

I was well treated during the entire period of time and was aware that I was able to terminate the test at any time if I so desired.

I was provided with the consent to polygraph examination form prior to the test which was read by me and voluntarily signed by me prior to the polygraph examination and interview.

I have been advised of the results of this examination and interview. I understand that the information provided by me to the examiner, will be relayed to the person who requested this examination. I have not been coerced, intimidated or forced to undergo this examination and interview, and I have not been intimidated into signing any consent forms, charts, documents or any paperwork associated with this examination and interview, including the signing of this document.

All statements made by me during the examination were made freely and voluntarily without threats, coercion or intimidation.

I certify that all questions asked in the examination were reviewed with me prior to the examination.

Examiner

Examinee

TIME: _____ am/pm

The Employee Polygraph Protection Act, effective December 31, 1988 requires that the polygraph procedures consume a minimum of ninety (90) minutes. Bearing witness that there be no further resolve in these proceedings, I hereby request that this interview and polygraph procedure be concluded at this time, and that I be allowed to leave the premises.

Examinee's Signature

Witnessed by:

Date

Time

(Rev.01/01/01)

APPENDIX 7.19

RISK MATRIX 2000

Family Name:

Forenames:

DOB:

Case ID:

Assessor

Date of Assessment:

RM2000/S – Risk of Sexual Offending

STEP ONE

1) Age at Commencement of Risk	Points
Under 18	0
18 to 24	2
25 to 34	1
Older	0
2) Sexual Appearances	Points
1	0
2	1
3,4	2
5 or more	3
3) Criminal Appearances	Points
Less than 5	0
5 or more	1
<u>Total Points</u>	<u>Category</u>
0	Low Risk
1,2	Medium Risk
3,4	High Risk
5,6	Very High Risk

STEP TWO: AGGRAVATING FACTORS

A) Any conviction for a contact sex offence against a male? (do not count consenting sexual behaviour involving only males aged 16 years or older)	Yes	No
B) Any conviction for a contact sex offence against a stranger? (count as stranger if the victim did not know the offender 24 hours before the offence)	Yes	No
C) "Single" (count as "single" if never lived with an adult lover for at least 2 years)	Yes	No
D) Any conviction for a non-contact sex offence? (Flashing, peeping, internet offences)	Yes	No

Put up on risk category if two aggravating factors are present and up two categories if four aggravating factors are present.

STATIC RISK CLASSIFICATION – RISK OF SEXUAL OFFENDING

Low Risk	Medium Risk	High Risk	Very High Risk
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APPENDIX 7.20

**Assessing Risk By Combining Actuarial Risk And
Deviance As Measured By Psychometric Tests**

CLIENT:

DOB:

TEST DATE/STAGE:

GROUP:

OFFENCE:

STEP 1: ASSESSING DEVIANCE

**Sexual Deviance and Dysfunction – allocate 2 points for each of the following
which are present**

	<u>Points</u>
MSI SO Scale (score of 10 or more)	_____
MSI Child Molest Scale (score of 20 or more)	_____
MSI Rape Scale (score of 19 or more)	_____
MSI Exhibitionism Scale (score of 17 or more)	_____
MSI Paraphilias Scale (score of 5 or more)	_____
MSI Sexual Inadequacies Scale (score of 3 or more)	_____
MSI Premature Ejaculation Scale (score of 2 or more)	_____
SUB-TOTAL SEX DEVIANCE AND DYSFUNCTION	_____

Social and Cognitive Functioning – allocate 1 point for each of the following which are present

	<u>Points</u>
Self-Esteem (score of 5 or less)	_____
Emotional Loneliness (score of 41 or more)	_____
Overassertiveness (score of 5 or more)	_____
Underassertiveness (score of 15 or more)	_____
Locus of Control (score of 17 or more)	_____
Perspective-taking (score of 13 or less)	_____
Empathic Concern (score of 13 or less)	_____
Personal Distress (score of 12 or more)	_____
MSI Cognitive Distortions and Immaturity (score of 4 or more)	_____
SUB-TOTAL SOCIAL AND COGNITIVE FUNCTIONING	_____

Cognitive Distortions and Victim Empathy – allocate 1 point for each of the following

	<u>Points</u>
Children and Sex Cognitive Distortions (score of 22 or more)	_____
Children and Sex Emotional Congruence with Children (score of 35 or more if offender is parent, 26 or more if not)	_____
Victim Empathy (percentage score above 27.6 or if number of “don’t know” responses exceeds 5)	_____
MSI Justification (score of 2 or more)	_____
Empathy for Women Test Hostile errors (score of 16 or more)	_____
Empathy for Women Test Over-sexualised errors (score of 19 ore more)	_____
Empathy for Women Test Total score (score of 36 or more – only allocate points here if no points allocated on Hostile or over-sexualised errors)	_____
 SUB-TOTAL COGNITIVE DISTORTIONS	 _____

Now add all sub-totals together

TOTAL DEVIANCE SCORE _____

INTERPRETATION OF DEVIANCE SCORE

0-4	Low Deviance
5-8	Medium Deviance
9 or more	High Deviance

Circle level of deviance.

DEVIANCE LEVEL: Low Medium High

If client has obtained a total deviance score of 9 or more, go straight to STEP 3. If client obtained a score of less than 9, go to STEP 2.

STEP 2: ASSESSING VALIDITY OF RESPONDING

Denial and Validity

Allocate two points for any of the following which are present

	<u>Points</u>
MSI Lie Scale* (score of 8 or more) *For obscene phone callers, use appropriate paraphilias sub-scale (score of less than 3) *For men who have indecently assaulted or raped an adult woman, use the Rape Lie scale	_____
Social Desirability (score of 66 or more)	_____
SHAPS Lie Scale (score of 8 or more)	_____

Allocate 1 point for any of the following which are present

MSI Social/Sexual Desirability (score of 23 or less)	_____
MSI Sexual Obsessions (score of 1 or less)	_____
MSI Paraphilias (score of 1 or less)	_____
Empathy for Women Test Fake Errors (score of 11 or more)	_____

TOTAL DENIAL AND VALIDITY _____

INTERPRETATION OF DENIAL AND VALIDITY SCORE

0-4	High Validity
5 or more	Low Validity

If an offender obtains 5 or more points on Denial and Validity scales, we cannot be certain that scores on other scales are reliable, i.e. that they will reveal his true level of deviance. Circle validity level.

VALIDITY: High Low

STEP 3: ACTUARIAL RISK

Calculate level of risk using Thornton's Risk Matrix 2000. Circle appropriate level.

RISK LEVEL: Low Medium High Very High

STEP 4: COMBINING ACTUARIAL RISK AND DEVIANCE

We now combine level of deviance as measured by psychometric tests with actuarial risk as measured by Thornton's Risk Matrix 2000.

If offender has a high deviance score of 9 or more (irrespective of denial and validity scores) put up risk level (as calculated by RM 2000) by one.

If offender has a medium deviance score of 5-8 (irrespective of denial and validity scores) risk level remains that calculated by RM 2000.

If offender has a low deviance score of 0-4 combined with a high validity score (0-4), lower RM 2000 risk level by one.

If offender has a low deviance score of 0-4 combined with a low validity score (5 or more) risk level remains that calculated by RM 2000.

Circle final risk level.

FINAL RISK LEVEL: Low Medium High Very High

TREATMENT DECISIONS

The following consists of suggested treatment routes for offenders according to final level of risk.

LOW RISK – Shorter programme

MEDIUM RISK – Shorter programme

However, if offender's psychometrics indicated low validity (meaning that deviance could not be assessed), final treatment decision should be reserved until he has completed Induction phase (group workers should be able to assess whether highly deviant during this period).

HIGH RISK – Full treatment programme

VERY HIGH RISK – Full treatment programme

The psychometric tests offer some indication of level of deviance. However, other indicators (particularly "panic now") factors will also need to be taken into account.

ASSESSMENT OF RISK FOR PSR/OTHER PURPOSES

Where risk needs to be assessed for purposes other than treatment planning, the validity of psychometric test responses needs to be taken into consideration, as well as the "panic now" factors.

It is suggested that if an individual's actuarial risk did not change because the validity of their responses was low (high faking), a deviance score indicating Medium Deviance is sufficient to raise his risk level by one.

Example: Mr Smith is a medium risk offender according to the RM 2000. He obtains a deviance score of 6 (Medium Deviance). However, his validity score is 7, indicating poor validity (faking). Thus, it would be reasonable to assume that he may, in fact, be highly deviant and it is appropriate to raise his level to High Risk.

Percentage Crossover between Paraphilic Interests/Involvements in Fourteen Polygraphed Sex Offenders
(Number of Subjects in each Category of Sexual Deviance followed by Percentage in Category)

	FNI	MNI	FI	MI	AR	Exh	Voy	Frot	OM	Trans	Fet	Sad	Maso	OTC	PM	Zoo	Other
FNI	8 / 100%	0 / 0%	5 / 62.5%	0 / 0%	4 / 50%	5 / 62.5%	5 / 62.5%	3 / 37.5%	0 / 0%	2 / 25%	3 / 37.5%	3 / 37.5%	3 / 37.5%	1 / 12.5%	5 / 62.5%	2 / 25%	3 / 37.5%
MNI	0 / 0%	1 / 100%	0 / 0%	1 / 100%	0 / 0%	0 / 0%	1 / 100%	1 / 100%	0 / 0%	1 / 100%	1 / 100%	1 / 100%	1 / 100%	0 / 0%	1 / 100%	0 / 0%	1 / 100%
FI	5 / 83.3%	0 / 0%	6 / 100%	1 / 16.7%	2 / 33.3%	3 / 50%	5 / 83.3%	2 / 33.3%	0 / 0%	2 / 33.3%	2 / 33.3%	2 / 33.3%	4 / 66.7%	0 / 0%	5 / 83.3%	1 / 16.7%	2 / 33.3%
MI	0 / 0%	1 / 33.3%	1 / 33.3%	3 / 100%	0 / 0%	1 / 33.3%	1 / 33.3%	1 / 33.3%	0 / 0%	2 / 66.7%	1 / 33.3%	2 / 66.7%	1 / 33.3%	1 / 33.3%	3 / 100%	0 / 0%	1 / 33.3%
AR	4 / 66.7%	0 / 0%	2 / 33.3%	0 / 0%	6 / 100%	3 / 50%	4 / 66.7%	4 / 66.7%	1 / 16.7%	0 / 0%	3 / 50%	2 / 33.3%	1 / 16.7%	2 / 33.3%	3 / 50%	1 / 16.7%	2 / 33.3%
Exh	5 / 62.5%	0 / 0%	3 / 37.5%	1 / 12.5%	3 / 37.5%	8 / 100%	4 / 50%	3 / 37.5%	0 / 0%	2 / 25%	3 / 37.5%	3 / 37.5%	2 / 25%	2 / 25%	7 / 87.5%	1 / 12.5%	2 / 25%
Voy	5 / 55.6%	1 / 11.1%	5 / 55.6%	1 / 11.1%	4 / 44.4%	4 / 44.4%	9 / 100%	6 / 66.7%	1 / 11.1%	3 / 33.3%	5 / 55.6%	4 / 44.4%	4 / 44.4%	1 / 11.1%	5 / 55.6%	1 / 11.1%	3 / 33.3%
Frot	3 / 42.9%	1 / 14.3%	2 / 28.6%	1 / 14.3%	4 / 57.1%	3 / 42.9%	6 / 85.7%	7 / 100%	1 / 14.3%	2 / 28.6%	5 / 71.4%	4 / 57.1%	2 / 28.6%	2 / 28.6%	4 / 57.1%	1 / 14.3%	2 / 28.6%
OM	0 / 0%	0 / 0%	0 / 0%	0 / 0%	1 / 100%	0 / 0%	1 / 100%	1 / 100%	1 / 100%	0 / 0%	1 / 100%	1 / 100%	0 / 0%	1 / 100%	0 / 0%	0 / 0%	0 / 0%
Trans	2 / 50%	1 / 25%	2 / 50%	2 / 50%	0 / 0%	2 / 50%	3 / 75%	2 / 50%	0 / 0%	4 / 100%	3 / 75%	4 / 100%	3 / 75%	1 / 25%	3 / 75%	1 / 25%	2 / 50%
Fet	3 / 50%	1 / 16.7%	2 / 33.3%	1 / 16.7%	3 / 50%	3 / 50%	5 / 83.3%	5 / 83.3%	1 / 16.7%	3 / 50%	6 / 100%	5 / 83.3%	3 / 50%	2 / 33.3%	4 / 66.7%	2 / 33.3%	3 / 50%
Sad	3 / 50%	1 / 16.7%	2 / 33.3%	2 / 33.3%	2 / 33.3%	3 / 50%	4 / 66.7%	4 / 66.7%	1 / 16.7%	4 / 66.7%	5 / 83.3%	6 / 100%	3 / 50%	3 / 50%	4 / 66.7%	2 / 33.3%	3 / 50%
Maso	3 / 75%	1 / 25%	3 / 75%	1 / 25%	1 / 25%	2 / 50%	4 / 100%	2 / 50%	0 / 0%	3 / 75%	3 / 75%	3 / 75%	4 / 100%	0 / 0%	3 / 75%	1 / 25%	3 / 75%
OTC	1 / 33.3%	0 / 0%	0 / 0%	1 / 33.3%	2 / 66.7%	2 / 66.7%	1 / 33.3%	2 / 66.7%	1 / 33.3%	1 / 33.3%	2 / 66.7%	3 / 100%	0 / 0%	3 / 100%	2 / 66.7%	1 / 33.3%	1 / 33.3%
PM	5 / 55.6%	1 / 11.1%	4 / 44.4%	3 / 33.3%	3 / 33.3%	7 / 77.8%	5 / 55.6%	4 / 44.4%	0 / 0%	3 / 33.3%	4 / 44.4%	4 / 44.4%	3 / 33.3%	2 / 22.2%	9 / 100%	1 / 11.1%	3 / 33.3%
Zoo	2 / 100%	0 / 0%	1 / 50%	0 / 0%	1 / 50%	1 / 50%	1 / 50%	1 / 50%	0 / 0%	1 / 50%	2 / 100%	2 / 100%	1 / 50%	1 / 50%	1 / 50%	2 / 100%	2 / 100%
Other	3 / 75%	1 / 25%	2 / 50%	1 / 25%	2 / 50%	2 / 50%	3 / 75%	2 / 50%	0 / 0%	2 / 50%	3 / 75%	3 / 75%	3 / 75%	1 / 25%	3 / 75%	2 / 50%	4 / 100%

LEGEND:

FNI	Female Non-Incestuous	OM	Obscene Mail
MNI	Male Non-Incestuous	Trans	Transvestism/Transsexualism
FI	Femal Incestuous	Fet	Fetishism
MI	Male Incestuous	Sad	Sadism
AR	Adult Rape/Indecent Assault	Maso	Masochism
Exh	Exhibitionism	OTC	Obscene Telephone Calls
Voy	Voyeurism	PM	Public Masturbation
Frot	Frotage	Zoo	Zoophilia (Beastiality)
		Other	Unusual Paraphilias incl. Urolognia, Coprophilia, Arousal to Odours