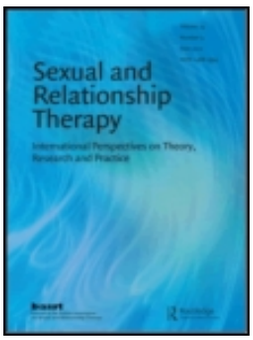

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ORIGINAL RESEARCH

Themes and risk of sexual violence among the mentally ill: implications for understanding and treatment

PAUL VINCENT GREENALL[1] &
LORNA JELLICOE-JONES[2]
[1]*Department of Investigative Psychology, University of Liverpool, UK,* [2]*Guild Lodge Secure Services, Preston, UK*

ABSTRACT *This study examined the files of 11 men from a regional forensic service who committed acts of sexual violence in the context of a mental disorder. The aim was to identify what factors other than a mental disorder may be relevant when considering acts of sexual violence by the mentally ill and what treatment implications this might raise. Several men experienced troubled childhoods, involving abuse in the home and outside and adulthoods were marked by employment difficulties, psychiatric morbidity and criminality. Static-99 found most men presented a medium-high or higher risk of re-offending and risk was mostly linked to sexual deviance and range of victims. Thematic analysis suggested sexual violence was primarily motivated by factors such as anger/violence; psychotic drive; sexual disinhibition and paedophilia. However, medication was the primary treatment intervention, with no treatments aimed at addressing other motivational or risk factors. Although men with a mental illness exhibit similar psychiatric features, this study found they commit sexual violence for a variety of reasons. However, whilst anti-psychotic medication is an important treatment, there is a need to consider others if the nature and level of their future risk is to be effectively managed.*

KEYWORDS: *sexual offending; mental illness; risk assessment; individual therapy*

Introduction

Research into sexual offending and mental illness has mostly focused on the role of psychosis. However, research into sexual violence generally suggests many such crimes are fuelled by, or are a reflection of, psychological and historical factors

Correspondence to: Paul V. Greenall, Centre for Investigative Psychology, University of Liverpool, Eleanor Rathbone Building, Bedford Street South, Liverpool L69 7ZA, UK.
Tel.: +44 (0)151 794 1403. E-mail: paulvgreenall@yahoo.co.uk

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relevant to the offender. To date, few studies have sought to investigate the actions of mentally ill sex offenders by reference to these concepts. Consequently, by examining 11 sex offenders from a regional forensic service, this study sought to address this omission.

Sexual offending and mental illness

The focus of this paper is sexual offending and mental illness, as within our regional forensic services, mental illness appears to be the most common diagnosis amongst patients in general (Coid *et al.*, 2001; Edwards *et al.*, 2002) and sex offenders in particular (Chesterman & Sahota, 1998; Craissati & Hodes, 1992). Several authors have explored the role of mental illness in the aetiology of sexual offending. For example, Jones *et al.* (1992) found sexual offending occurred in response to command hallucinations, a factor which they suggest must be taken very seriously, because "some patients do as they are told" (Jones *et al.*, 1992, p. 47). Craissati & Hodes (1992) found sexual offences were impulsively executed with little thought given to potential capture and they were primarily triggered by feelings of sexual disinhibition. They suggested mental illness broke down a person's normal inhibitory controls and left them unable to look beyond their immediate aim, to the nature and consequences of their actions. Phillips *et al.* (1999) supported this by finding disinhibition important in 13 out of 15 patients who sexually offended. Although positive symptoms of psychosis were present, Phillips *et al.* (1999) found they did not directly relate to offending in most cases, rather they occurred within the context of the personality damage, such as impairment of normal inhibitory controls integral to schizophrenia.

Sexual violence: motivation and risk

The wider literature on sexual violence has generally concentrated on motivation and risk. For example, several authors have found that various acts of sexual violence can be indicative of issues like power, anger, hatred or sexual desire (Groth & Birnbaum, 1979; Knight & Prentky, 1990). Additionally, research on risk suggests that apart from being young and single, factors related to sexual deviancy (e.g. prior sexual offences, stranger victims, early onset of sexual offending etc.) and antisocial criminality (e.g. prior non-sexual offences, antisocial personality disorder etc.) are reliably associated with sexual violence (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2004). Indeed, Powis (2002) reports sexual offenders are generally young single sexually deviant men, with previous sexual or violent convictions, who are poorly educated and unemployed, who abuse substances, target strangers, have low victim empathy, a personality disorder and who drop out of treatment programmes. In an attempt to capture these risk factors, several risk assessment tools now exist (e.g. Boer *et al.*, 1997; Hanson & Thornton, 1999; Hart *et al.*, 2003; Quinsey *et al.*, 1998; Thornton *et al.*, 2003).

The present study

Research suggests many mentally ill sex offenders originate from dysfunctional backgrounds that continue into adulthood (Baker & White, 2002; Chesterman & Sahota, 1998; Craissati & Hodes, 1992; Phillips *et al.*, 1999) and once in hospital, anti-psychotic medication is the dominant treatment approach (Smith, 1999b). Given the focus of the literature in this area, this treatment may appear appropriate. However, research suggests the motivations (Smith, 2000) and cognitions (Sahota & Chesterman, 1998a) of mentally ill sex offenders, plus the reasons why they might re-offend (Bonta *et al.*, 1998; Phillips *et al.*, 2005) are similar to those without such an illness. Consequently, further research is required to identify what factors beyond a mental disorder, may be relevant when considering acts of sexual violence by the mentally ill and what treatment implications this may raise. This study therefore examined the files of 11 sex offenders from a regional forensic service, to identify the most appropriate explanation for their offending, their recidivism risk and what treatments were provided whilst in hospital.

Research question: How can the actions of those who engage in sexual violence in the context of a mental disorder, be most appropriately explained and what treatment implications does this raise?

Method

Chiswick (1983) argued mentally disordered sex offenders are a small and distinct group and understanding their offending requires an overall view of the offence and the offender, rather than being constrained by rigid psychiatric nosology. This ideographic aspiration requires a qualitative investigation, which concentrates on the meaning of an individual's actions, when viewed in their subjective context. This study therefore utilised a retrospective case record analysis of each participant's hospital files, followed by a content and thematic analysis of this material.

Participants and selection criteria

Participants were all current or ex-patients of Lancashire Care NHS Trust. This Trust includes Guild Lodge medium secure unit near Preston, plus other 'satellite' units around Lancashire. Participants were selected according to three factors. Firstly, all had been convicted of a sexual offence or had engaged in antisocial sexual conduct that placed others at risk. Secondly, all were suffering from a mental disorder as per the Mental Health Act 1983. Thirdly, all had received treatment from Lancashire Care's forensic psychiatric service during 1998–2002 inclusive. Because the Trust's computer system did not record index offences, participants were selected with the assistance of the consultant psychiatrists at Guild Lodge, who were requested to supply a list of their patients who satisfied the criteria. This process yielded 11 cases and in accordance with instructions from the local research ethics committee written permission was obtained from each psychiatrist before any files were accessed.

Procedure

All documentation contained in each patient's file was consulted. Whilst they constituted the only data source, these files did contain numerous pre- and post-admission reports compiled by a variety of forensic professionals. Using this information, the procedure progressed as follows:

Firstly, detailed information on the participants' previous history (see Table I), their conduct and treatment pathway whilst in hospital (see Table II) and their index offence was gathered using content analysis. This is an approach to the analysis of documents that seeks to quantify content in terms of predetermined categories and in a systematic and replicable manner (Bryman, 2004). Secondly, to provide an estimation of the level of risk that these men presented upon admission, a risk assessment of each man was undertaken using Static-99. This actuarial tool estimates the probability of sexual or violent recidivism among adult male sex offenders, based on the absence or presence of ten items pertaining to sexual deviance, range of potential victims, persistence in offending, antisociality and age (see Figure 1). Scores range from 0–12 and are used to place individuals into a low, medium–low, medium–high or high-risk category (Hanson & Thornton, 1999). Static-99 was

TABLE I. Historical background.

	n=	%
Childhood		
Poor relationships with parents	8	*73*
Physically/sexually abused	7	*64*
Parental loss/separation	4	*36*
Family mental disorder	4	*36*
Social isolation	4	*36*
School failure	4	*36*
Adulthood		
Further education	6	*55*
Psychiatric history	11	*100*
Irregular/unstable employment	7	*64*
Drink/drug abuse	6	*55*
Socially isolated	5	*46*
No long-term relationships	6	*55*
Deviant sexual fantasies	7	*64*
Forensic		
Any previous conviction	7	*64*
a) Sexual offences	3	*27*
b) Violent offences	4	*36*
c) Other offences	5	*46*
Previous custodial terms	5	*46*
Previous probation terms	4	*36*
Antisocial (unconvicted) conduct	8	*73*

TABLE II. Risk and treatments.

	n =	%
Static-99 risk predictions		
Low	–	–
Medium – Low	3	*27*
Medium – High	6	*55*
High	2	*18*
In hospital		
Risk linked to disorder	9	*82*
Violent thoughts/behaviour	5	*45*
Sexually inappropriate	4	*36*
Absconded	1	*9*
Medication	11	*100*
SOTP	0	*0*
Other therapies	3	*27*

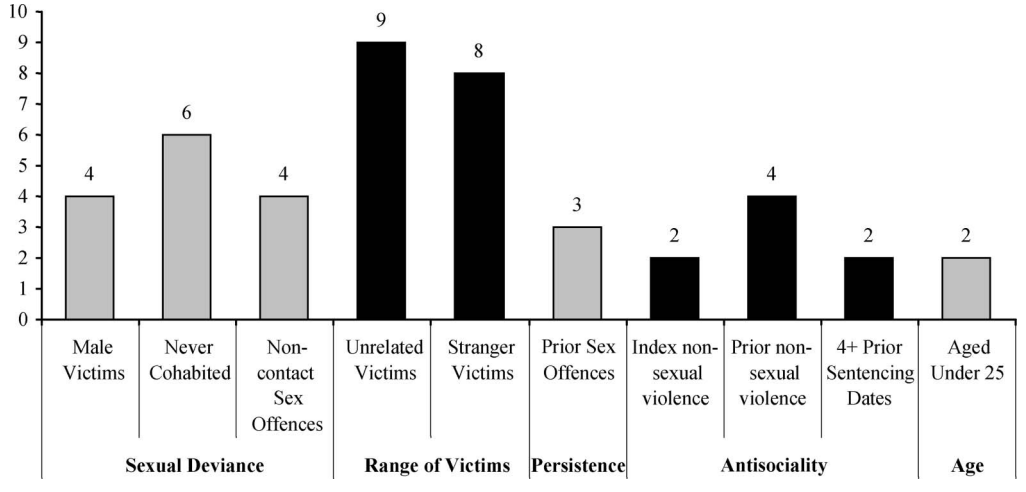

FIGURE 1. Static-99 risk items.

chosen because it can be scored on file information only and it was developed on samples of forensic psychiatric patients (Harris *et al.*, 2003), and because of its predictive accuracy (Barbaree *et al.*, 2001; Sjöstedt & Långström, 2001; Stadtland *et al.*, 2005). Finally, in order to understand the rationale behind each man's index offence, thematic analysis of each case was undertaken. Thematic analysis is a process of encoding qualitative information from which relevant themes can be identified. Boyatzis defines a '*theme*' as "a pattern found in the information that at minimum describes and organizes the possible observations and at maximum interprets aspects of the phenomenon" (Boyatzis, 1998, p. 4). Themes can be identified at the manifest (i.e. directly observable in the information) or latent (i.e. underlying the phenomenon)

level and they can be generated inductively from raw data or deductively from theory or prior research (Boyatzis, 1998). In this study a combined approach was used as themes were generated from raw data (i.e. information obtained from the content analysis, about the index offence and their mental state at the material time) and from prior research.

Results and analysis

The ages of the 11 men in this study at the time of their index offence ranged from 23–72 (mean 40, S.D. 16), with most ($n = 6$) being under 40. Most men were single ($n = 7$) and from a white UK ethnic background ($n = 10$). Three men were in hospital on an informal basis; two were diagnosed as primary paedophiles and the other with schizotypal personality disorder and schizophrenia. Eight men were detained under the mental illness category of the Mental Health Act 1983; seven had a psychotic illness and the other PTSD.

Previous history

As children, most men ($n = 8$) had poor relations with their parents, who were reportedly cold, unaffectionate, domineering or punitive. Additionally, most ($n = 7$) were physically and/or sexually abused, although not all of this occurred at home. By contrast, a minority experienced parental separation/loss ($n = 4$), had a family history of mental disorder ($n = 4$), were described as socially isolated as children ($n = 4$) or experienced school failure ($n = 4$) by truanting and/or leaving without any qualifications (see Table I).

After school, six men attended further education including four who went to university, where one man obtained a Masters Degree and another a PhD. However, several other aspects of their adult lives were problematic: All 11 men had previous psychiatric histories, with most ($n = 9$) having been in-patients as a result; seven had never had regular/stable employment and ten were unemployed when they committed their index offence; six had a history of drug and/or alcohol abuse; five were described as socially isolated; six had never had a long-term relationship and seven evidenced sexual fantasies of a deviant nature (i.e. involving children, expressions of anger and resentment at women or acts of rape and murder).

Finally, most ($n = 7$) men had previous criminal convictions. Of these, three had a previous sexual conviction, four had previous convictions for violence and five had convictions for 'other' types of crimes, including burglary, theft, criminal damage, fraud, possessing an offensive weapon, breach of the peace, deception, drunk and disorderly and bail/probation violations. Consequently, these men had received the full range of official sanctions. In particular five had previously been in prison and four had been on probation. However, in addition to officially recorded offences, eight men had histories of engaging in antisocial conduct that would normally have resulted in conviction if apprehended. Examples include fighting in public, serious violence involving knives, criminal damage, indecent exposure, indecent assault and numerous acts of child sexual abuse.

Index offences

Seven men engaged in sexual conduct, which resulted in arrest and/or prosecution; six men committed indecent assault and one abducted three children and massaged them. The remaining four men engaged in antisocial sexual conduct that did not receive official sanction, as they were diverted into the forensic psychiatric service instead; one man engaged in indecent exposure, one was found masturbating outside a school, one was stalking women to fuel his masturbatory fantasies and another complained of hearing voices instructing him to rape and murder. Excluding one victim aged 84, the known ages of the victims ranged from 8 – 15 (mean 12, S.D. 2.3), meaning victims were significantly younger than their assailants ($t = 5.2$, df = 9.3, two-tailed $p = 0.000$). Just under half the victims were strangers with the remainder being relatives, neighbours and other acquaintances.

Thematic analysis

At the time they offended, nine men were experiencing poor mental health and the remaining two appeared to have equally complex, albeit different, psychiatric presentations. However, thematic analysis suggested that within this group of men, four sub-groups existed whose behaviour could best be understood in terms of a range of psychological and historical factors, as the following cases illustrate. These groups are not mutually exclusive and overlaps exist.

Theme 1: 'Anger/Violence'. Sub-group one consisted of three men. Although they experienced several psychotic symptoms at the material time, the emerging theme suggests they primarily offended with angry, violent intent, albeit exacerbated by their psychosis:

- Case 1 was experiencing bizarre paranoid beliefs, delusions and auditory hallucinations. He was socially isolated, angry and had deviant sexual fantasies. He claimed his sexual assault upon a girl in a park, which included violence, was a revenge attack as she had angered him by her taunts.
- Case 2 was hearing voices and thought the radio was talking to him. He was angry, irritable and hostile, and spoke of violent intentions towards others. He could not remember sexually assaulting two girls on public transport, but recalls drinking heavily beforehand.
- Case 3 was feeling low in mood, anxious, uptight, socially isolated, paranoid, and was hearing voices. He spoke of having violent fantasies and wanting to act on them. He denied his indecent exposure had a sexual motive. Rather, he stated it was an expression of anger and frustration, following an argument.

The 'anger/violence' theme was supported by the antisocial criminal backgrounds of these men, which for two was quite extensive. All three had previous violent convictions and/or had engaged in other acts of (in some cases, serious) violence and

one had a previous sexual conviction. All three had previously been in prison and had a history of substance abuse.

The offences of the remaining eight men appeared more sexually motivated. This was supported by the fact that compared to group one, they were less antisocial, had fewer previous convictions and most of their previous convictions and antisocial behaviour was of a sexual nature. However, the combination of motive and illness produced three thematic sub-groups:

Theme 2: 'Psychotic Drive'. Sub-group two consisted of four men who appeared to be 'psychotically driven' (Smith & Taylor, 1999) to offend by the positive symptoms of their psychosis:

- Case 4 claimed his sexual urges came from God. He was convinced he was receiving signals from girls who wanted him to follow and look at them and he acted on these signals to fuel his masturbatory fantasies, until arrested. Later in hospital he believed female staff sent him signals that made him masturbate.
- Two men had delusions that drove them to engage in inappropriate sexual conduct with boys. Case 5 thought his actions would provide them with good mental health, which his 'special powers' of massage would bring and he enticed three children into his house for this purpose. Case 6 indecently assaulted a boy in a park as he was driven by his pseudo-religious beliefs in the special status of boys, who were there to be loved by all men.
- Case 7 sat in a car armed with knives waiting for a particular type of woman to rape and murder. He had been acting like this for several weeks. This behaviour was apparently driven by voices in his head that instructed him to find rape and kill a woman. The thought of this excited him and had become incorporated into his sexual fantasies.

Theme 3: 'Sexual Disinhibition'. Sub-group three consisted of two men who appeared to be sexually disinhibited by, but not actually driven by their psychosis:

- Case 8 followed some girls and then indecently assaulted another girl he had just met, after which he followed her home and waited for her outside. His explanation was he was looking for love and he felt that he loved his victim as she was nice.
- Case 9 was found with his trousers down masturbating outside a school. Police stated he fitted the description of a person involved in several such incidents over the previous months. He explained his actions by the fact that he fancied the girls in the playground and was trying to frighten them. In hospital he talked a lot about sex and his various 'sexual conquests'.

Theme 4: 'Paedophilia'. Sub-group four consisted of two men receiving aftercare following release from prison. Although they were not (officially) mentally disordered at the time, they nonetheless appeared to have complex psychiatric presentations.

However, their indecent assaults appeared primarily motivated by a sexual attraction towards boys:

- Case 10 indecently assaulted a boy after grooming him for this purpose. He confirmed this act was for self gratification and it formed part of his masturbatory fantasies, both before and after the assault. He reported a compelling attraction towards boys and was afraid of re-offending. Psychiatric reports made reference to auditory hallucinations, low mood impairing his judgement, depression, command hallucinations instructing him to re-offend and a narcissistic personality.
- Case 11 indecently assaulted three children over several years. These assaults were reportedly related to periods of depression, low self esteem and self pity, deviant sexual fantasies of grooming and being alone with children, plus powerful rationalisations that his actions would not harm his victims.

Recidivism risk and treatments received

Table II displays the global Static-99 risk predictions for these men upon admission. As shown, all 11 presented at least a medium risk of re-offending and eight presented a risk that was medium-high or higher.

An alternative way of considering the risk presented by these men is to illustrate the factors that produced these predictions. Figure 1 displays the frequency of the ten items within the five domains of Static-99. This illustrates that although collectively these men were not particularly antisocial or persistent in their offending, sexual deviance and offending against a range of victims were important risk factors. However, had the eight men with histories of antisocial conduct actually been convicted of these crimes, then levels of sexual deviance, range of victims, persistence and antisociality would have been elevated, as would their global risk score.

Table II also shows that whilst under the care of this regional forensic service, the risk posed by nine men was considered to be related to deterioration in their mental state. However, during their stay in hospital five men were either violent towards staff and/or fellow patients, or had violent thoughts/fantasies; four engaged in sexually inappropriate conduct, such as making sexual comments towards staff and/or having deviant sexual fantasies and one successfully absconded. Therefore, there was ongoing evidence of risk behaviours as predicted by Static-99 and consistent with their histories and index offences. All 11 men were prescribed medication of some kind and no formal sex offender treatment was provided. Three men did receive other types of therapy such as social skills training to address anxiety and cognitive behavioural therapy to modify delusional thought content. However, this did not appear to focus on all of the factors identified by the thematic analysis or the areas of risk identified by Static-99.

Discussion

Research into sexual violence committed in the context of a mental illness is limited (Sahota & Chesterman, 1998b) and primarily focussed on the role of psychosis.

This study however, builds upon previous research to suggest factors other than a mental illness are important when understanding the actions of mentally ill sex offenders (Smith, 2000) and when assessing their future risk (Bonta *et al.*, 1998; Phillips *et al.*, 2005).

Pre-offence histories

Collectively, the pre-offence histories of these men appeared problematic, deviant and antisocial, similar to other studies of mentally ill sex offenders (Baker & White, 2002; Chesterman & Sahota, 1998; Craissati & Hodes, 1992; Phillips *et al.*, 1999; Sahota & Chesterman, 1998a; Smith, 1999a) and of sex offenders in general (Grubin & Gunn, 1990; Scully, 1990; Smallbone & Dadds, 1998). Indeed such is the similarity between mentally ill and non-mentally ill sex offenders in this regard, that their illness may be the only discriminating feature. However, this study found mental illness did not interact with sexual offending in a consistent way.

Themes of sexual violence

The finding that three men offended with angry/violent intent, is supported by the wider literature as several 'typologies' accommodate the presence of this theme in their explanations of sexual violence (Groth & Birnbaum, 1979; Knight & Prentky, 1990). Indeed, given the antisocial criminal backgrounds of these men, they appear similar to Drake & Pathé's (2004) group whose deviant sexuality is a manifestation of a more generalised antisocial behaviour. The finding that six men offended due to their psychosis receives support from the literature cited earlier, especially as their psychosis manifested itself in two ways: Firstly, four men were driven to offend by their psychosis. However, unlike Jones *et al.*'s (1992) participants whose assaults appeared to have an underlying sexual motive, the secondary motives of the four men in this sub-group included sexual desire, paedophilia and violence. So a clear within-group difference existed between these men. Secondly, two men were sexually disinhibited by their psychosis, with little thought given to the implications of their actions (Craissati & Hodes, 1992). However, once again there was a difference as whilst one appeared to act impulsively, the other appeared to have been sexually exhibiting himself for several months. It may be that the between and within group differences among these six men are due to elements of pre-morbid sexual deviancy becoming incorporated into their psychosis (Smith & Taylor, 1999) and producing a decrease in judgement, social skills, or impulse control that lead to unusual sexual behaviour (American Psychiatric Association, 2000). Regardless of this, these men appear similar to Drake & Pathé's (2004) group whose deviant sexuality arose in the context of mental illness or its treatment. Finally, the finding that two men offended because of paedophile tendencies holds no surprises, given the youthful age of most victims in this study and the fact that such a motivation is well supported within the literature (Grubin, 1998; Howitt, 1995). Although these two men went to prison rather than hospital for their crimes, mental illness still appeared to play a role in their actions. However, this illness appeared to be

secondary, making them similar to Drake & Pathé's (2004) group with a pre-existing paraphilia.

Treatment implications

The finding that treatments received by these men mostly consisted of medication with no sexual offence focussed treatment provided, accords with previous research (Smith, 1999b). As mental illness was a factor not only in the sexual offending of several men but also their perceived future risk, this treatment may appear appropriate. However, although many men were ill when they offended, their illness manifested itself differently and factors like sexual desire, impulsivity and anger were arguably of equal importance. Additionally, Static-99 suggested these men had varying degrees of risk that were not necessarily related to their illness. Indeed, whilst in hospital and receiving medication, some men were sexually inappropriate, harboured violent thoughts or were actually violent and one successfully absconded. Given these findings, plus others linking mental illness to violence (Walsh *et al.*, 2002) and suggesting factors other than a mental illness are required to explain future recidivism risk (Bonta *et al.*, 1998; Phillips *et al.*, 2005), perhaps a gap in treatment existed for these men? This point is illustrated by reference to 'case 1'.

During his teens, 'case 1' developed the habit of staring at attractive women. Sometimes he would follow them and run past them to obtain a better view and this behaviour became incorporated into his masturbatory fantasies. Several years later he was convicted of attempted rape, after he ran up to a woman in an isolated location and sexually attacked her. Shortly after his release from prison for that crime, he committed his index offence, which was a very similar sexual assault. However, he later conceded this assault only ''turned sexual'' when he punched his victim in the face. Using Static-99, his recidivism risk was calculated as being high.

'Case 1' appears to evidence two important aspects that are not necessarily related to mental illness. Firstly, his actions involving staring at, following and then running past women that culminated in two sexual assaults, are very similar to the developmental process described by MacCulloch *et al.* (1983). This process of rehearsal, behavioural try-outs and masturbatory reinforcement was found by MacCulloch *et al.* to have preceded acts of sadistic sexual violence. Although MacCulloch *et al.*'s study was of psychopaths, they did refer to two schizophrenics whose offences originated out of a similar process and other research has found sadistic fantasy among psychotic sex offenders (Smith, 1999a). Secondly, his admission about when his index offence became arousing is also important. Had this attack not been terminated by the intervention of a passer-by, it might have progressed to rape. If so, the apparent gratification that he received from the use of violence could lead us to believe that his assault contained sadistic undertones (Groth & Birnbaum, 1979; Knight & Prentky, 1990). If correct, then simply prescribing 'case 1' medication to address his mental illness would miss the apparent fantasy driven developmental aspect to his offence and its possible underlying sadism; factors that increase the likelihood of re-occurrence. However, as Marshall &

Kennedy (2003) report, there are problems applying the label of sadism. But even if this label has been misapplied in this case, this assault would still be indicative of an extensive antisocial/criminal history and behaviour pattern (Drake & Pathé, 2004) that requires additional intervention in order to reduce its repetition.

Sex offender treatment

When considering the treatment of mentally ill sex offenders, Jones *et al.* suggested "a whole package should be offered including social skills training, problem solving therapy and possibly cognitive therapy" (Jones *et al.*, 1992, p. 49) and Phillips *et al.* that "treatment of patients such as these is complex and necessarily involves not only treatment of positive psychotic symptoms but also individual and group work related to sexual issues, interpersonal relationships, more general social skills, anger management, and so on" (Phillips *et al.*, 1999, p. 174). Such treatments could be provided by a Sex Offender Treatment Programme (SOTP) similar to that within HM Prison Service. SOTP aims to increase motivation to avoid re-offending and to develop the necessary skills to achieve this. SOTP also aims to address anger management, relationship skills, fantasy modification, victim empathy and relapse prevention, plus repeated failures in coping with everyday problems that may be important in producing low mood states, that are frequent precursors to offending (Beech *et al.*, 1999). Whilst mental illness once prevented participation in SOTP (Beech *et al.*, 1999), it is now recognised that offenders whose illness is stabilised may be suited for treatment and benefit from it, because "mentally ill offenders also exhibit other risk factors related to sexual offending that could be addressed via SOTP" (Beech *et al.*, 2005, p. 117).

Research suggests sex offender treatment in general (Hall, 1995; Lösel & Schmucker, 2005) and SOTP in particular (Beech *et al.*, 1999; Friendship *et al.*, 2003) reduce recidivism. The importance of this is illustrated by research that suggests sex offender recidivism may be of a non-sexual nature (Soothill *et al.*, 2000), may progress to more serious sexual offending (Sugarman *et al.*, 1994) or even to homicide (Francis & Soothill, 2000). Clearly, for several men in this study, this was a possibility and not necessarily because of their illness. Consequently, providing a more comprehensive treatment beyond medication should ensure their risk is more suitably managed when they are no longer in the care of a regional forensic service.

Methodological considerations

The fact that mentally ill sex offenders are a small and distinct group means large-scale quantitative methodologies are not always possible. The methodology employed in this study however, had one or two limitations. Firstly, the data source was arguably limited and a degree of 'triangulation' (Coolican, 2004) in the form of interviews with the participants would have enhanced this study. Unfortunately, time constraints, ethical considerations and the fact that most participants had left the hospital prevented this. Secondly, the small sample size may limit the generalisation of the findings. However, other studies have used similar (Craissati & Hodes, 1992;

Phillips *et al.*, 1999) or even smaller (Jones *et al.*, 1992) sample sizes and still made a contribution to this area. Thirdly, the actuarial approach to risk assessment is limited by its focus on static events. Whilst other risk assessment protocols consider dynamic factors (Boer *et al.*, 1997; Hart *et al.*, 2003), such an approach was beyond the scope of this research. Finally, the usage of and the first author's role in thematic analysis could be questioned. This was arguably a subjective undertaking and another researcher might have determined other themes. However, those themes would reflect that researcher's input and thus, be subjected to the same critical reflexive analysis. Boyatzis suggests ''a good thematic code is one that captures the qualitative richness of the phenomena. It is usable in the analysis, interpretation, and presentation of the research'' (Boyatzis, 1998, p. 31). Consequently, as the identified themes in this study are all supported within the literature and have helped illustrate the offending behaviour of the participants, a degree of external validity might be ascribed to them.

Conclusion

This study has examined the complex area of sexual violence committed in the context of a mental illness. Sexual offences were found to have various themes and the perpetrators presented with varying degrees of risk. However, mental illness was not always related to these factors and so this study raises important issues regarding the need for and benefit of, access to a fuller treatment regime similar to SOTP.

Drake and Pathé found ''there is a paucity of research on the mentally ill who engage in other deviant sexual practices, particularly child molestation and non-contact paraphilias such as exhibitionism'' (Drake & Pathé, 2004, p. 115). Although the nature of the offences reported in this study were probably due to methodological and institutional artefacts, by making a useful contribution to this fascinating area, this may prove fortuitous.

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Contributors

PAUL VINCENT GREENALL, BSc (Hons), MSc, *Forensic Psychologist & Research Assistant, Centre for Investigative Psychology, University of Liverpool, UK.*

LORNA JELLICOE-JONES, *Consultant Clinical Psychologist and Head of Psychological Services at Guild Lodge Secure Services, Lancashire Care NHS Trust, Preston, UK.*