PERSONALITY AND CRIMINAL BEHAVIOUR: THE ABILITY OF THE MCMI-11 TO DISTINGUISH OFFENDER GROUPS

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By

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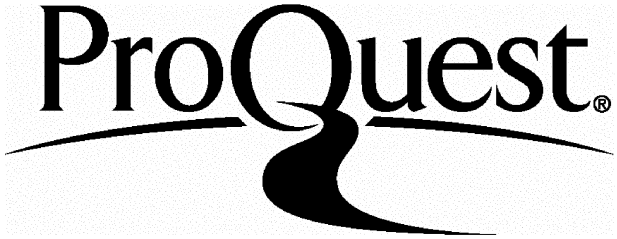

TABLE OF CONTENTS

Tables

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ABSTRACT

This study aimed to explore the relationship between personality (MCMI-11, Millon, 1987) and offending behaviour. More specifically, to investigate if sexual offenders could be differentiated from violent offenders. It was predicted that violent offenders would report personality profiles characterised by Passive-Aggressive, Antisocial and Aggressive-Sadistic traits. Conversely, sex offenders will have elevated levels of Avoidant, Dependent and Schizoid Traits. The relationship between index offence and forensic history was explored to determine the degree of concordance between offences.

Sixty eight offenders were recruited from three location sites (Probation Service, Inpatient and Outpatient). Within this group there were 45 participants who had been convicted of a sexual offence and 19 for violent offences. Comparisons were made between offender groups and site of recruitment on personality scores. Further, a series of discriminant analyses were performed to determine the ability of personality scales to predict offender groups. Statistical analyses, indicated that the two groups were similar on personality profiles, although high levels of personality disturbance and response bias was observed. Furthermore, there was a suggestion of a degree of correspondence between index offence and previous convictions. Possible explanations for the results are discussed, and the clinical and theoretical implications explored.

Introduction

Overview

The assumption of a significant role for 'personality' in explaining deviant social behaviour has received considerable support by both academics and lay persons. However, such a contention has often been difficult to document, and a review of the literature suggests a number of difficulties in reliably reporting an offender profile. In part, this is as a result of methodological problems inherent in forensic research. However, they also reflect limitations of existing research inventories. The development of theory based personality measures, demonstrating good psychometric properties, has given a new lease of life to research and clinical practice. This study, utilising a new measure of personality (MCMI-11) aims to investigate the role of personality in offending behaviour. In particular, the ability to differentiate offenders grouped by their index offence, on personality scales.

Definitions of Personality

"Personality traits are alive and well", stated the title of an article written by Deary and Matthews in the July 1993 edition of the Psychologist (Deary & Matthews, 1993). Prior to this date, the authors suggest that the concept was mortally wounded, failing to recover from the celebrated attack by Mischel (1968).

Although there are many definitions of personality (reviewed in Fonagy & Higgitt, 1984; Millon & Davis, 1996), they all assume an enduring set of behaviours and

response sets which are relatively stable over time. Mischel (1968) claimed there to be little consistency or predictability of behaviours across situations or time, thus rendering the concept of personality flawed.

Millon and Davies (1996) outline that historically, the word personality derived from the Greek term persona. It originally represented the theatrical mask used by dramatic players. As a mask, it suggests the pretence of appearance, or the possession of traits other than those actually characterised by the individual behind the mask. Over time, persona lost its connotation of illusion, and began to represent the real person's apparent, explicit and manifest features. The final change to the term occurred when personality was seen to delve beneath the surface, with the focus on the inner, hidden qualities of the individual. Thus, it has moved from external illusion, to surface reality and finally rested on hidden or opaque traits. The third meaning comes closest to modern understanding of personality, characterised by largely unconscious, relatively stable traits which are difficult to alter and largely automatic in their expression. They affect every facet of the individual's functioning.

Allport (1937) was one of the first to highlight problems in the definition and use of personality. His comments, while written 60 years ago have relevance today. He stated:

> "The term 'personality' is a perilous one for (the psychologist) to use unless he (or she) is aware of its many meanings. Since it is remarkably elastic, its use in any context seldom is challenged. Books and periodicals carry it in their titles for no apparent reason other than its cadence, its general attractiveness and everlasting

> interest. Both writer and reader lose their way in its ineffectual vagueness, and matters are made worse by the description of the word in the hands of journalists, beauty doctors and peddlers of gold bricks labelled 'self improvement'. 'Personality' is one of the most abstract words in our language, and like any abstract word suffering from excessive use, its connotative significance is very broad, its denotative significance negligible. Scarcely any word is more versatile". (p 12)

Despite these problems, there has been a resurgence of interest in personality, with new well validated measures being developed e.g. Neo-PI (Costa & McCrea, 1985), SIDP-R (Pfohl, Blum, Zimmerman & Stangl, 1989) and the SNAP (Tellegen, 1985). There is of course a plethora of established measures such as the EPQ (Eysenck, 1975) and the Minnesota Multiphasic Personality Inventory (MMPI). In addition to the importance of personality in research (Deary & Matthews, 1993), its assessment is seen as having clinical importance, as there has been the development of models to explain enduring patterns of maladaptive behaviour, in patients who present to mental health workers (Beck & Freeman, 1990). However, critics of such assessments remain (Bentall, 1993).

The Millon Clinical Multiaxial Inventory (MCMI)

While there are a multitude of personality measures, Van Velzen and Emmelkamp (1996) state the most widely used self-report questionnaire is the Personality Diagnostic Questionnaire [PDQ-R] (Hyler, et al, 1990) and the MCMI (Millon, 1987). The MCMI has become increasingly recognised as an instrument of differential diagnosis (Millon, 1987;

McCann & Dyer, 1996). It has been applied in several clinical settings and increasingly deployed as a research tool. One reason for the increasing popularity of the MCMI is its anchorage in a comprehensive theory of personality and psychopathology. This is not to say that other measures are not linked to theory, but an advantage of the MCMI is its close association to DSM models of personality disorder and clinical symptoms.

Millon's Theory of Personality and Psychopathology

A brief overview of Millon's theory is provided below. For a comprehensive review see Millon and Davis (1996). Millon (1969) conceptualised personality using a biosocial learning model. Although this somewhat differed from DSM models of personality disorder, his later revisions were more comparable. A central theme in his work, was an interplay between organismic and environmental factors. These interactions begin at the time of conception and continue throughout life.

Individuals with a similar biological profile and potential can develop radically different personalities and symptomatologies as a result of environmental factors. Biological factors determine the way in which the individual interprets and interacts with their environment. For example, temperamental disposition and information processing abilities can influence the way in which environmental conditions are interpreted and responded to. However, such biological factors can be shaped by the environment, particularly in early development. For example, the recognition of 'developmental delays' can be rectified by psychological interventions (Herbert, 1991).

Naturally there is an interaction between biology and environment. While each individual has their own unique pattern of sensitivities and response sets, infants and children play an active role in shaping their environment. In addition, biological pre-determinants evoke reactions from others. For example, a child with a difficult temperament (characterised by problems in sleeping, feeding and excessive crying) may elicit anger and frustration, hence facilitating poor early attachment from the primary care taker. In this example, maladaptive biological traits can be reinforced. Of course it is possible that these can be modified. For example, an experienced and sensitive parent can react adaptively to such a 'difficult' infant, hence influencing and possibly modifying biological predispositions.

Adaptive behaviours such as independence and sociability can be reinforced by primary caretakers. Conversely, aversive environments characterised by dysfunctional family patterns, abuse or early trauma, can detrimentally effect otherwise 'normal' development. Gonsiorek, Bera and LeTourneau (1994) have highlighted the consequences of early sexual abuse on subsequent personality development.

A second major theme running through Millon's theory is that of a threefold group of dimensions (developed from the work of earlier writers). These are seen as the 'raw materials' for personality construction (Millon & Davis, 1996):

The active - passive dimension. In this dimension, behaviours and responses can be grouped as to whether the individual takes the initiative in shaping events and their surroundings, or whether a more detached, or reactive style is adopted. Active individuals

are characterised as employing alertness, vigilance and persistence in their goal directed behaviours. Such strategies are employed to avoid pain and obtain positive reinforcements. By contrast passive individuals appear inert, engaging in few manipulative strategies.

The pain - pleasure dimension. This refers to the direction of motivation and behaviours. At one polar they are directed towards positively reinforcing consequences. At its polar opposite, aversive or negatively reinforcing consequences are the source of attainment. Millon and Davis (1996) also detail personality types which are unable to distinguish between pain and pleasure. They demonstrate an abnormal response to pleasurable and painful stimuli. Millon and Davis (1996) call this a *deficit capacity* or detached pattern of response.

The self - other dimension. This dimension acknowledges that of all of the environmental stimuli available to the individual, two are most important: the self or others. The dependent individual has recognised that pleasure and the avoidance of pain is best provided by others. By contrast, the independent character is reliant on the self as primary reinforcer. However, not all individuals show such a clear cut preference. These so called ambivalent personalities remain uncertain of the source of reinforcement.

From this threefold framework, personality coping patterns which correspond closely to DSM-111-R and DSM-1V, Axis 11 personality disorders were developed. They reflected what reinforcement strategies the individual sought or avoided (pain - pleasure), where they were obtained (self - others), and how individuals behaved to obtain or avoid them

(active - passive). Millon (1987) extended his classification to ten pathological personality variants, organised in a 5 x 2 matrix. Included within it were three more serious or dysfunctional variants which reflected lower levels of internal structural cohesion and organisation. These are expressed behaviourally in a more pathological form. Each of these 13 maladptive personality types are represented in Table 1.

Table 1 Millon's Theory Based Framework for Personality Pathology

Pathology Domain	**Self - Other**		**Pain - Pleasure**		
Reinforcement source	**Other + Self -**	**Self + Other -**	**Self <-> Other**	**Pain <-> Pleasure**	**Pleasure Pain + / -**
Instrumental coping style/ interpersonal pattern	Dependent	Independent	Ambivilant	Discordant	Detached
Passive variant	Dependent	Narcissistic	Compulsive	Self -defeating	Schizoid
Active variant	Histrionic	Antisocial	Passive-Aggressive	Aggressive (sadistic)	Avoidant
Dysfunctional variant	Borderline	Paranoid	Borderline or Paranoid		Schizotypal

Forensic Psychology - An Introduction

Blackburn (1993) provides an excellent introduction to the role of the forensic psychologist. He dates its origin to 1879, where the first use of a psychologist was in a memory falsification court case in Germany. Although a somewhat vague term, he defines forensic psychology as "the provision of psychological information for the purposes of facilitating a legal decision" (p20, Blackburn, 1993). Within this wide definition, personality testing has an important role in the assessment of sex offenders, perpetrators of domestic violence and child custody applicants. In addition, it is important in the assessment of deception and malingering in personal injury cases. A knowledge of personality may also be important in evaluating defendants' fitness to plead, and where the competence of professionals to practice has been questioned (McCann & Dyer, 1996).

Aggression and Violence - Definitional Considerations

In a review of the literature 'aggression', 'violence' and 'criminal violence' are often interchangeable. Hollin and Howells (1989) discussed issues of definition. Aggression refers to the intention to hurt or gain advantage over others without necessarily resorting to the use of physical injury. Violence involves the use of physical force against another person, often as the result of aggressive motivation. Criminal violence involves injurious behaviour which is forbidden by law.

Although the occurrence of violent crime is infrequent, it is a topic which receives considerable media space and is of great concern to the public. The Home Office (1985) revealed 173 convictions for murder, 35 for attempted murder, and 1254 for wounding or

life endangering acts. However, these are an under-representation of the true figures, as many acts will go unreported, unsolved, or fail to reach court (Blackburn, 1993).

Theories of Violent Offending

There are numerous theories to explain violent and aggressive behaviour. These include biological, sociological, feminist and environmental theories. It is not within the scope of this thesis to detail them. Excellent reviews can be found in Blackburn (1993), Hollin (1996) and Howells & Hollin (1989).

A number of psychological explanations for violent offending have been put forward. Some of the earliest were psychoanalytic, emphasising the notion of drives (Dollard *et al*, 1939; Fromm, 1973). Social learning theories propose that aggressive behaviour is learnt. Bandura et al (1973) demonstrated that violent behaviour can be directly observed and modelled. Additionally, violent behaviour can be positively reinforced (Hayes *et al*, 1980; Patterson, 1982). Social cognitive approaches, while focusing upon social influences, give primacy to individual variables. Social cognitive theories have argued that aggression is best understood in terms of impression management (Felson, 1978), or valuing a norm for aggressive behaviour (Wolfgang & Ferracutti, 1967).

Considerable debate concerns the role of the media (Geen, 1983) and alcohol / drug use (Taylor & Leonard, 1983) in violent behaviour. There are problems in establishing the cause and effect relationship of media / substance abuse to violent behaviour. A simple causal relationship would be that passive consumption of media violence and / or

substances lead to violence. While there are examples where this is the case, probably acting as disinhibitors, an alternative hypothesis is that individuals seek out media violence or excessive alcohol / substance use. Hence, these are related only *indirectly* to violent acts. One possibility is that personality factors may explain preferences for both disinhibitors and violence.

Personality and Violent Offending

Violence appears to be a relatively stable trait over time and across situations (Olweus, 1979; Huesmann, 1984; Farrington, 1989). A typology of violent offenders has been proposed by Megargee (1966). The under-controlled individual has few inhibitors, hence frequently acting in a violent manner. The over-controlled person has strong inhibitors and violence is the result of prolonged and intense provocation. Blackburn (1971) using the MMPI with convicted murderers reported four clusters within Magree's (1966) typology. These are represented in Table 2.

Table 2 Typology of Violent Offenders (Blackburn, 1971)

UNDERCONTROLLED	OVERCONTROLLED
Psychopathic	Controlled - Repressor
Paranoid - Aggressive	Depressed - Inhibitor

The 'psychopathic' group is characterised by: poor impulse control, high extroversion, outward-directed hostility, low anxiety and few psychiatric symptoms. The 'paranoid-aggressive' group display high impulsivity and aggression. In addition, they experience high levels of psychotic symptoms. They can be further categorised as Primary and Secondary psychopaths. The 'controlled- repressor' group demonstrate a high degree of impulse control, defensiveness, dependent and compulsive traits. They exhibit few psychiatric symptoms, and have low levels of hostility. The second overcontrolled group, 'depressed inhibited', are characterised by low levels of impulsivity, extroversion and self directed hostility. In addition, avoidant, schizoid and passive aggressive traits are evident. However, they report high levels of depression. There has been general success in replicating this finding (Blackburn, 1975; McGurk, 1978; & Henderson, 1982). Although, Holcomb, Adams and Ponder (1985) found somewhat different typologies using the MMPI in pre-trial murderers. Attempts to distinguish the personality traits of violent men has not always meet with success. Sutker and Allain (1979) in a review of studies attempting to identify a personality profile of extremely violent men reported "there is little consistent evidence that assaultative and nonassaultative men significantly differ on trait or type dimensions" (p120).

There is a role for the psychologist in carrying out personality assessment with aggressive individuals. This could be in understanding why an offence took place and in the prediction of future risk in hospital or prison. Similarly, in preparation for discharge to less secure settings or into the community (Blackburn, 1993; Blackburn, 1996; Brown & Howells, 1996).

There has been some debate concerning the nature of 'psychopathy' or psychopathological personality disorder. While it's definition has changed over time (including sociopathy and antisocial personality), it essentially means 'socially damaging' individuals (Blackburn, 1989). The term psychopath no longer appears in DSM-111-R or DSM 1V categories, being replaced by Antisocial Personality Disorder (APD). DSM conceptions of APD were influenced by Robins (1978), whose definition largely relied on delinquent acts (e.g. damage to property and theft), although personality traits referring to irritability, aggressiveness, impulsively and recklessness were also highlighted. The main problem with this conceptualisation, is that APD is defined by behaviour rather than by traits. Personality disorder and socially delinquent acts are not mutually exclusive. The individual may display either, neither or both. Millon (1981) argues for a focus on an aggressive coping pattern, corresponding to the active maintenance of independence, with a narcissistic personality representing the passive form. The dominant traits of the aggressive personality are hostile affectivity, social rebelliousness, vindictiveness and a disregard for danger.

The MCMI and Violent Offending

Using the MCMI, Blackburn et al (1990) reported that mentally disordered offenders with unspecified offences, detained in a maximum security hospital, showed high levels of personality disorder. Prevalence rates of 68% for at least one personality disorder were observed. The most frequent personality disorders were Dependent, Avoidant, Schizoid, Histrionic and Passive - Aggressive. Borderline, Compulsive. Surprisingly, Antisocial personality disorders had a low frequency. Blackburn (1996) conducted a cluster analysis on a sample of mentally disordered offenders, detained in a maximum security hospital.

Five clusters were identified. Three of the groups corresponded to the primary psychopath, controlled and inhibited groups. The other two groups were variants of the secondary psychopath.

Hart, Forth and Hare (1991), examined the relationship between the MCMI-11 and the Psychopathy Checklist (PCL-R - Hare, 1980) in a sample of 119 male inmates who had mostly committed violent offences. PCL-R total scores significantly correlated with Antisocial, Narcissistic, Aggressive / Sadistic, Borderline, Paranoid, Drug Dependence, Thought Disorder, and Delusional Disorder scales of the MCMI-11. The PCL-R Factor 2 scale correlated with the above measures and with Schizotypal, Alcohol Abuse and Disclosure score. PCL-R Factor 1 correlated moderately only with the Aggressive-Sadistic scale.

Murphy, Myer and O'Leary (1993) examined the MCMI-11 scores of partner assaultative men, non violent men in dysfunctional relationships and well-adjusted men. The violent men reported significantly higher mean levels of Aggressive-Sadistic, Antisocial, Passive - Aggressive, Paranoid, Narcissistic, Borderline, Self-defeating, Avoidant and Schizotypal traits. With reference to Axis-1 disorders, partner assaultative men reported higher levels of Bipolar: Manic, Alcohol Dependence, Drug Dependence, Thought Disorder and Major Depression. The authors covaried Desirability and Debasement scores on personality scales. Significant differences between the groups were maintained for Aggressive and Antisocial traits: Aggressive / Sadistic, Passive-Aggressive, Antisocial and Drug Dependence.

Hart, Dutton and Newlove (1993) administered the MCMI-11 to a series of wife assaulters (court and self-referred). Using a Base Rate (BR) >74 cut-off score for personality disorder, 90% of both court and self referred men reached this criteria. While using a BR >84 criteria, 75% of court referred and 85% of self referred were classified as personality disordered. The most commonly observed were: Avoidant, Antisocial, Aggressive-Sadistic and Passive - Aggressive. The authors also examined the validity measures for both groups. They found self referred patients were more open (Disclosure), had slightly lower Desirability scores and greater Debasement scores, compared to court referred men.

Hamberger and Hastings (1986) administered the MCMI to 99 perpetrators of domestic abuse. They conducted a factor analysis on the personality profiles. Three profiles were identified: Schizoid / Borderline, Narcissistic / Antisocial, Dependent / Compulsive. In a related study, Hamberger and Hastings (1996) made a comparison of the personality characteristics of spouse abusers who completed counselling treatment to those who dropped out. Completers demonstrated overall lower levels of personality disturbance and in particular fewer schizoid and borderline traits.

There is evidence that social desirability and other test taking biases exist in aggressive populations. Hart, Dutton and Newlove (1993) found self referred patients more open and less likely to present themselves in a positive light, compared to state referred patients. Reporting biases may be a factor in the complex results obtained from Blackburn's (1990) special hospital sample, as surprisingly he reported low levels of antisocial and borderline personality traits.

Using the MCMI, high prevalence of personality disorder have been identified in mentally ill violent offenders (Blackburn, 1990) and in partner assaultative men (Hart et al, 1993; Hamberger & Hastings, 1986). Despite a framework for describing violent offenders being proposed by Magaree (1966) and Blackburn (1971), a clear pattern of offending profiles has not been adequately demonstrated (Sutker & Allain, 1979). However, Blackburn's series of studies (Blackburn, 1990; 1996) do show relative consistency. Violent offenders display a range of personality disorders, although these vary depending upon the particular study. Antisocial, Aggressive-Sadistic, Avoidant and Passive-Aggressive appear to be common. Less frequently reported personality disorders include Borderline, Schizoid, Dependent, Histrionic, Narcissism, and Self-defeating traits. One clear finding is the relative lack of compulsive personality traits in this sample. This is not surprising as these refer to a perfectionist, rule conforming behaviour pattern.

Sexual Offending - Definitions and Classifications

Sex offending must be regarded as one of the most horrific crimes against the person. Debate concerning the definition and prevalence of sexual offending has been outlined elsewhere (Hollin & Howells, 1991). It is defined mainly by the use of force, disparities in age, violations of close relationships and violations of public order (Blackburn, 1993). A more formal typology to explain sexual offending has been proposed by Perkins (1991):

Compensatory: Motivation for the offence is primarily sexual, with the offender seeking sexual satisfaction. Force is used to attain such gratification. There may be

social / sexual relationship difficulties which block the attainment of normal sexual pleasure.

Displaced aggression: The offender is motivated by anger or hatred, with the sexual aspect of the offence being a means of hurting or degrading the victim. Typically, more force is used than necessary, and it may be directed at a particular type of victim: prostitutes, older or successful women. These offenders have a history of poor relationships with women.

Sadistic: Although the motivation for the offence is sexual, the offender obtains sexual gratification from inflicting pain or fear on the victim. There will be an excess of aggression, although unlike the displaced aggressive offender, the violence will appear more cold and deliberate.

Impulsive/opportunistic: These offenders have a long history of antisocial actions. Obtaining sex by force is an example of general impulsively and deviant lifestyle. Sex offences may occur in conjunction with non sexual violence or burglary.

With reference to sex offences specifically against children, Groth (1978) specifies two types of offender:

Fixated: The fixated individual has always been attracted to younger people. In general they have not developed appropriate age related sexual and social relationships.

Regressed: These individuals have developed age appropriate relationships but develop attractions to younger people when they experience stress, or their sense of adequacy or self esteem is threatened.

Theories of Sexual Offending

A number of frameworks have been provided to explain sexual offending. These include feminist (Baron & Straus, 1987), sociological (Burt, 1980) and sociobiological (Thornhill & Thornhill, 1992; Wilson, 1987) theories. It is not within the scope of this thesis to outline them in detail, and the reader is referred to Polaschek, Ward & Hudson (1997); Hollin & Howells (1991); Blackburn (1993) and Morrison, Erooga & Beeckett (1994) for a comprehensive account. With the level of explanation moving to the individual, a number of psychological theories have been proposed to explain sexual offending. These include behavioural theories (Abel et al, 1977), psychodynamic (Groth et al, 1977) and social cognitive theories (Johnston & Ward, 1996).

Two models popular in the U.K for explaining sexual offending are Wolf (1984) and Finkelhor (1984). They incorporate personality as a *contributing* factor, with clear implications for assessment and treatment of sexual offenders. According to Wolf's (1984) model, early histories lead to the development of deviant sexual interest. Sex offenders have a history of early experiences of victimisation. These can be sexual, physical or emotional abuse; neglect; sexualisation or experience of dysfunctional families. The child learns inappropriate ways of behaving and develops maladaptive

cognitions of himself and others. Most notably, that adult males have power to do whatever they want. These lessen inhibitions against sexual deviance such as fear of discovery, harm to others or sexual taboo. These early experiences lead to personality development which is characterised by poor self image, egocentricity, defensiveness and distorted thinking. Obsessions in thought and behaviour concerning sexual matters, social alienation and sexual pre-occupations may also be present.

Finkelhor (1984) developed a four factor framework to explain the development and maintenance of sexual interest in children. Today these four factors are seen as a single model, although they were originally seen as separate (Morrison, et al, 1994). Factor one concerns the emotional congruence that child abusers appear to have with children. They have a special meaning for abusers, often as weak and non-threatening. Overcoming childhood trauma, through repetition and identification with the aggressor are likely to be important factors leading to emotional congruence with children.

Factor two describes how an abuser comes to identify the child as sexually arousing. Often sexual offenders have themselves a history of sexual abuse. Attraction to deviant stimuli is thought to be conditioned through such early experiences. However, it does not explain why some who have not been abused offend, and why not all children who have been abused later offend (Morrison et al, 1994).

Factor three addresses why some sex offenders experience difficulties in their ability to meet their sexual and emotional needs from appropriate consenting adult

relationships. Two sorts of blockage are described: developmental blockage where offenders have a lifetime history of problems in developing peer relationships. Secondly, situational blockage occurs when an appropriate relationship exists but sexual activity is not present. In this case, it is assumed there is a prior deviant interest, which has been abated until situational blockage occurs.

Factor four examines why normal inhibitions against sexual contact are overcome or were never present. Impulsivity may be one factor. However, there is considerable evidence of planning in many offences (Morrison et al, 1994; Howells & Hollin, 1991; Howells, 1979). Senility and learning difficulties may be a factor in increasing impulsivity, although these probably account for only a small percentage of the total offences against children.

Alcohol and sexually arousing materials may also serve as disinhibitors (Morrison et al, 1994). However, as with the relationship between media / substances and violence, they may serve as disinhibitors, but they do not explain initial motivation to offend. With regard to incestuous relationships, an 'incest avoidance mechanism' may be in operation. Stepfathers may be less inhibited to have sexual feelings towards their children than natural fathers, either because of different norms or lack of exposure to the child at an early age. The incidence of abuse by step fathers is considerably higher than by natural fathers (Morrison et al, 1994), and may be explained by such a mechanism.

Finkelhor (1984) developed a further four-stage model to describe the necessary preconditions for offending to occur. Again, within this personality may have a contributing role:

Motivation to sexually abuse: In order for any sexual offence to occur, motivation must be present. This can vary according to the experiences of the individual. Many offenders report being sexually abused themselves or come from families characterised by abuse or neglect (Howitt, 1995).

Overcoming internal inhibitions: Although some find deviant sexual activity arousing, not all offend. This would suggest a degree of internal control. The majority of offenders know their acts are illegal, and must overcome these internal inhibitions. Morrison et al, (1994) suggest that the development of cognitive distortions and justifications, serve as disinhibitors. The use of sexually arousing pictures may also be a disinhibiting factor.

Overcoming external inhibitions: Once internal inhibitions have been overcome, the situation to offend must be set up (often refereed to as grooming and planning). While there is opportunistic offending, the majority of offences have some degree of planning (Morrison et al, 1994; Howells & Hollin, 1991; Howells, 1979). An example of planning may involve engineering a situation where the mother is not present when the offence occurs.

Overcoming the resistance of the child: As with setting up an abusive situation, much effort is spent in overcoming the resistance of the victim. Grooming may involve becoming the child's friend, giving presents, showing them pornography or supplying alcohol. Some children, especially those who are vulnerable or have

previously been abused may be targeted (Morrison et al, 1994). To ensure the co-operation of the child, or to prevent them informing, threats can be made.

Understanding Sexual Offences Against Adults - The MMPI

Levin and Stava (1987) conducted a review of studies utilising the MMPI in sex offender research. Their search of the literature indicated that it was the most popular instrument in the assessment of personality with this group. Okami and Goldberg (1992) confirmed the supremacy of the MMPI in a later review of the literature.

Levin and Strava (1987) suggest that the MMPI may not be the most appropriate measure to use in assessing personality. They quote Butcher and Tellegen's (1978) paper which suggests that the MMPI is essentially a measure of symptoms and not personality. Further, they argue that the test was originally developed to distinguish various groups in terms of psychiatric diagnosis, from a healthy sample and from each other. The results were a set of scales measuring psychopathology with the exception of the Social Introversion scale. Hence, there has been a shift away from using the MMPI as a measure of symptoms to employing it as a measure of personality, using the highest codes to fit personality prototypes. The MMPI has spurned a host of personality measures from its original format, to the point where there are more auxiliary scales than items on the MMPI (Graham, 1990).

Levin and Strava (1987) identified seven studies applying the MMPI to rapists. They highlight similar methodological problems associated with sex crimes against children

(reported below). Rader (1977) reported MMPI profiles of rapists, men who exposed themselves and non sexual assault. Rapist reported higher scores on the Psychopathic deviance and Schizophrenia scales than the other two groups. In addition, they reported rapists having elevated Paranoia, Conversion hysteria, Depression and F (infrequency) scales compared to men who exposed themselves. A number of studies have failed to find MMPI differences between rapists and other offender groups (Panton, 1978; Quinsey et al., 1980; Anderson et al., 1979).

Where the MMPI has been applied to populations of 'other' sex offenders (fetishists, exhibitionists and those who make obscene telephone calls), results are unclear (Swenson & Grimes, 1958; Carroll & Fuller, 1971; Hartman, 1967). Methodological problems, particularly in not establishing homogeneous offence categories may explain this uncertainty.

Understanding Sexual Offences Against Children - General Problems and the MMPI.

In reviewing the personality profiles of perpetrators of sex offences against children, a series of difficulties in interpretation is evident. The literature provides a multitude of interchangeable terms (Okami & Goldberg, 1992). These include: pedophile offender, abuser, perpetrator, rapist and molester. Some studies have used a victims up to the age of 18 (Hall et al., 1986). Others provide no definition of a child (Briere & Runtz, 1989). In addition, the research often fails to distinguish a preference for children and actual behaviour towards them. As most personality profiles relate to convicted (or suspected)

offenders who have already entered the criminal justice system, they may constitute a biased sample. Only one study using a non forensic, non clinical sample of professed pedophiles has been identified (Wilson & Cox, 1983).

Levin and Stava (1987) identified eight studies where the MMPI was applied to pedophiles. They highlight, as do Okami and Goldberg (1992) that many of these suffer methodological limitations including the assumption of heterogeneity with respect to key factors: age of victim, sex of victim, whether force was used, the relationship of the victim to the offender, and whether there is a history of offences against children. In addition, problems often occur when the control group is examined. Often these 'other sex offences' are heterogeneous, including those who exposure, fetishists and voyeurs (Armentrout & Hauer, 1978).

Okami and Goldberg (1992) suggest that there is repeated mention in the literature of a pedophilia personality type. Pedophiles are characterised by a passive, dependent, unassertive nature. They are felt to be isolated, anxious and depressed. They often have poor social skills, a preoccupation with religious beliefs, and have ignorant or puritanical attitudes towards sex. Additionally, they have high levels of narcissism; are psychosexually immature; have an aversion to women and have low levels of aggression. However, it is possible that these assumptions are based more on clinical impression, than research (Langevin et al, 1983).

There is weak evidence of social inadequacy in this group. Wilson and Cox (1983) reported higher levels of shyness and social anxiety, although noting no significant lack of social skills or confidence in a sample of self confessed pedophiles recruited from a self-help organisation. Although Howells (1979) reported themes of dominance in the repertory grids of pedophiles (seeing adults as overbearing and demanding), this finding was not subsequently replicated by Horley (1988). A review of the MMPI data relating to social inadequacy finds no evidence for the hypothesis that they have marked deficits. Similarly, Langevin (1985) reported no difference between pedophiles and adult sex offenders using Alberti and Emons' Assertion Inventory or Rathus' Assertiveness Schedule. Indeed it is possible, that poor social skills and feelings of social inadequacy are characteristics of offenders in general (Blackburn, 1993).

As there has been difficulty in demonstrating social inadequacy in pedophiles, it has similarly been difficult to demonstrate higher levels of affective disorder. In a review of 9 studies, Okami and Goldberg (1992) found little evidence for either anxiety or depression in this population. Where these have been found (Wilson & Cox, 1983), methodological problems in measuring affective disorders has been noted. Peters (1976) even reported lower levels of anxiety and depression in pedophiles compared to other sex offenders.

Toobert, Bartelme and Jones (1959) reported that the two most frequently endorsed items by incarcerated pedophiles were 'I read the Bible several times a week' and 'I go to church every week'. These,they suggest indicate pedophiles are preoccupied with religion (and

may generally hold conservative attitudes). An alternative view is that they reflect social desirability and should be viewed within the context of these men preparing for parole.

Another personality trait attributed to pedophiles is that they are non aggressive. Popular in myth (Okami & Goldberg, 1992) and typologies such as Groth et al (1982), the pedophile is portrayed as non violent. They are assumed to be passive, employing tricks and subtle methods of cohersion. There has been some empirical evidence for this (Toobert et al, 1959). However, Christie et al (1979) reported 58% of her sample used force against their child victims.

In general results are mixed, showing no clear personality profile of offenders against children. Social introversion has not been found to be a distinguishing factor (Langevin et al., 1978; Panton, 1978). Other studies have found that Paranoia, Schizophrenia, Hypomania, Lie and Conversion hysteria distinguished forceful and non forceful offences against children. While the Hypochondriasis, Conversion hysteria, Psychopathic deviance and Schizophrenia distinguished those with a history of offences compared with those with none (McCreary, 1975). Quinsey, Arnold and Pruesse (1980) found the MMPI unable to distinguish pedophiles from offenders in general.

Sexual Offending and the MMPI - Some Conclusions

Levin and Stava (1987) concluded their review of the MMPI data by saying:

"Given the amount of MMPI research performed, the yield regarding the personality profile of the sex offender seems rather sparse. In general, negative or inconsistent findings outweigh those of a positive nature" (p204).

However, they conclude that the Schizophrenia scale is more prominent in those who use force with children. Indeed, rapists and forceful pedophiles may share characteristics of social alienation, chronic hostility and distorted cognitions. Men who expose themselves, Levin and Stava (1987) suggest may be within normal limits using the MMPI.

Personality and Sexual Offending - Other Measures

Problems in using the MMPI have been noted (Butcher & Tellegen, 1978), although it is a widely used measure in sex research, others have been utilised. In their review of other measures applied to assess the personality of sexual offenders (including the Edwards' Personal Preference Schedule EPPS, Catell's 16PF, Eysenck Personality Questionnaire and projective tests: Draw-a-Person Test, Rorschach), Levin and Stava (1987) highlight methodological problems similar to studies utilising the MMPI. Despite this, they suggest that rapists and pedophiles may have greater abasement and lower scores on aggression than non sex offenders. However, due to a scarcity of studies, and the lack of replication these must be interpreted with some caution.

Personality and the Sex Offender - Findings From the MCMI

There have been a number of attempts to define the personality characteristics of sex offenders using the MCMI. In a sample of 99 men referred to a sexual disorders clinic

with a range of presenting problems, Lehne (1994) reported that 67% of his sample showed evidence of personality disorder (BR > 85). Of this group, 28% had more than one elevated scale, 23% had 2 or 3 elevated scales, and 15% had more than 4 elevated scales. Dependent and Passive Aggression were the most frequent personality disorders. Anxiety and Depression were the most frequently reported Axis 1 disorders.

Perhaps the benchmark study utilising the MCMI in forensic psychology is that of Chantry and Craig (1994). They administered the MCMI to a sample of 603 American incarcerated offenders. Respondents were grouped according to the nature of their offence: child molesters (n=201), rapists (n=195), and non sexually aggressive felons (n=205). The results suggest that child molesters reported significantly higher mean scores than the other two groups on Passive Aggressive personality, and Anxiety and Dysthmic symptoms. They also reported higher mean scores than non sexually aggressive inmates on Schizoid, Dependent, Borderline, Psychotic Thinking, and Major Depression scales.

Both of the sexual offending groups reported higher mean scores for Avoidant personality than the violent felons. Rapists reported higher scores for Passive Aggressive traits than violent inmates. Rapists and violent offenders reported higher scores for Narcissism, Compulsive and Paranoid traits than child molesters. When the authors conducted a group profile, comparing profile high peaks, the child molesters' highest peak was the Dependent scale. The other two groups did not show a modal peak, although high scores were obtained for Dependent (rapists) and Histrionic (aggressive offenders) scales.

Lagevan et al (1988) reported a study comparing the differences between sex offenders and controls. The offender group comprised felons with mixed offences while the control group consisted of non sexual offenders, police trainees and community volunteers. The offender population reported significantly higher levels of Schizoid, Avoidant, Dependent and Aggressive personality. In addition they reported greater symptoms of anxiety and depression. Controls however reported higher levels of Narcissism and Compulsive personality. This study must be interpreted with some caution as the control group can be seen as too heterogeneous.

Wales (1995) applied the MCMI to a forensic outpatient population in the West Midlands, UK. Of a total number of 726 outpatient referrals, 139 (19%) were administered the MCMI. Of this sample, 24 were discarded for reasons of validity. The index offence of the outpatients were mixed including violence, sexual, property related and 'other' crimes. A cluster analysis was performed on the final BR scores. Four clusters were identified: Cluster 1 was characterised by high Schizoid, Avoidant and Dependent scores. Additionally, moderately high scores on Passive Aggressive, Compulsive, Schizotypal and Borderline scales were observed. This may be similar to Blackburn's 'controlled group' (Wales, 1995).

Cluster 2 was characterised by high Schizoid, Avoidant, Dependent and Passive-Aggressive scales, and moderate scores on Antisocial, Schizotypal, Borderline and Paranoid scales. They also report low scores on the Compulsive scale. The main

distinguishing scale was Antisocial. This is akin to Blackburn's 'secondary psychopath' (Wales, 1995).

Cluster 3 was characterised by very high Schizoid, Avoidant and Passive-Aggressive scales. They also had high Borderline and Paranoid scores. They reported very low Histrionic, Narcissistic, and Antisocial traits. Wales, (1995) suggests this may be similar to Blackburn's 'inhibited group'. The final factor was characterised by high scores on Histrionic, Narcissistic and Antisocial scales. This is similar to Blackburn's 'primary psychopath' group (Wales, 1995).

There was a significant difference between personality clusters and index offence committed. Members of cluster 2 were more likely to have committed a violence related offence than the other clusters. They were also less likely to have committed a sexual offence. Cluster 3 contained the greatest number of sexual offences, and were less likely to have committed violent acts.

Personality and Sexual Offending - Some Conclusions

As with establishing a consensus on the personality profiles of violent offenders, there has been considerable difficulty in establishing traits associated with sexual offending. Some of this may be attributed to methodological problems in reported studies, in particular the application of the MMPI (Levin & Strava, 1987; Okami & Goldberg, 1992). Other problems, notably the heterogeneous nature of offending groups are present. Although high prevalence rates for personality disorder exists in this

population (Blackburn, 1993; Howitt, 1996; Lehne, 1994), specifying a particular pattern that exists has proved problematic.

Studies utilising the MCMI have similarly failed to produce a consensus. However, there appears to be a trend for Schizoid, Avoidant, Dependent, Passive-Aggressive and Borderline personality traits in this sample compared to non sexual offenders. Surprisingly, there is little consistent evidence for Antisocial and Aggressive-Sadistic personality disorders in this population. With reference to Axis 1 disorders, there is some suggestion of elevated levels of anxiety and depression in this population.

A Note on Language and Conceptions of Personality

There has been much use of the term personality disorder, in the literature and in this thesis. A few notes need to be made concerning this. According to a medical model, problems in personality functioning would be akin to disease entities, such as bacterial, fungal or viral infections. However, personality is a social construction, which has no existence outside of a set of shared meanings, held by medical and lay people. Personality is best seen as existing on a continuum rather than categorical dimensions (Millon & Davis, 1996).

Any distinction between normality and abnormality is by definition socially derived. In general, behaviours which are uncommon are seen as deviant or pathological. Such behaviours are culturally defined, and are subject to change over time and between cultures. For example, homosexuality was seen as a psychiatric condition until the

1970s (Gonsiorek & Weinrich, 1991). Similarly, aggression and ruthlessness may be seen as psychopathy in one culture or signs of a great leader in others.

Millon and Davis (1996) assert that personality disorders may be assessed but not diagnosed. There are many arguments against a diagnostic classification of personality disorders. Many of these centre around the arbitrary nature of making a diagnosis, including the type and number of traits needed to meet diagnostic criteria.

The discretionary nature of cut-off criteria is a problem that applies to the MCMI-11. The criteria of BR75+ is in many ways similar to DSM-111-R diagnosis, and carries with it similar criticism (Millon & Davis, 1996). The most useful way to use MCMI-11 cut-off points is that they provide a useful indication that 'excessive' levels of any one particular trait is present. The degree to which it can then be seen as personality disordered is within the context of the individual's social circumstances. Essentially, there has to be a fit between individual functioning and social / environmental demands. The reserved disciplined, conscientious and rule bound individual (Compulsive) would be able to function adequately in a job which was able to meet those demands (e.g. accountancy). Similarly, individuals with narcissistic and histrionic traits may be able to function in an environment such as the performing arts, where such behaviours are not seen as abnormal and may even be desirable. In this study, cut-off criteria were used as well as mean scores.

Response Bias and the Sex Offender

In clinical practice a common feature of working with sex offenders is their minimisation of offences (Morrison et al, 1994; Howells & Hollin, 1991; Howells, 1989). Many will simply deny that the offence took place while others will use a series of justifications to explain their offences (Fisher & Thornton, 1993). This has applications for research. It is conceivable that many of the inconsistencies reported in research outlining the personality profiles of offenders may be attributed to the attitude taken towards test taking.

Grossman and Cavanaugh (1989) reported that sex offenders who denied their offences were distinguished from those who admitted it on 6 of the seven MMPI validity scales. On the clinical scales, the non admitters reported less psychopathology than the admitters. There were significant differences on the Depression, Psychopathic deviance, Masculinity-femininity, Paranoid, Schizophrenia and Social introversion scales.

Haywood, Grossman and Hardy (1993) administered the 16PF to a sample of sex offenders (mixed offences, largely towards children). Those who denied their offence were significantly more likely to 'fake-good', while the admitters were more likely to have a 'fake-bad' profile. This could be explained by the experience of guilt and remorse, following acceptance of offending. In addition, deniers were more likely to minimise their deviant interests. Faking good was significantly correlated with 9 of the 16PF's 16 scales. Those faking good presented themselves as emotionally stable, happy go lucky, venturesome, trusting, genuine, untroubled, group dependent, controlled and composed.

An advantage of the MCMI- 11 is the inclusion of four measures of validity. This study aims to examine the nature of faking in offender populations.

The Relationship Between Current and Previous Offending

Assumptions concerning the repetitive nature of offending vary between two extremes. Some hold that following conviction sex offenders hardly ever repeat their offences (West, 1987), while others see sex offenders as committing many offences against a large number of victims (Wolf, 1984). Early studies reported relatively low recidivism rates in offending populations (Blackburn, 1993). However, this may have been an underestimation as often follow up periods were too short (Soothill, Way & Gibbens, 1978). A longer follow up period, often as long as 20 years indicate higher recidivism rates (Soothill et al, 1978; Grunfeld & Noreik, 1986).

A further examination of sexual re-offending rates suggest that the range of crimes committed is somewhat consistent. In other word, there is a tendency for multiple criminal acts to be similar in nature (Groth, 1977; Grunfeld & Noreik, 1986; Hall & Proctor, 1989; Fisher & Thornton, 1993). However, Soothill et al (1978) compared the criminal careers of those convicted and acquitted of rape. Both groups were similar in terms of the number of previous offences committed and sexual and violent crimes were predominant in their forensic histories. Similarly, Hall and Proctor (1989) found that a previous conviction for a sexual offence was predictive of a non sexual violent offence in incarcerated offenders, as well as later sexual offending. However, no relationship was found with child molesters. These studies suggest that offenders have committed a variety of crimes, with no evidence

of 'crime preferences'. The examination of the relationship between current and prior offending will lead to some support for examining personality differences between offender groups. If there is evidence of crime preference, then personality variables may distinguish those who commit violent offences against those where a sexual component is present.

The Development of the MCMI

The MCMI was based on Millon's theory of psychopathology described above. The instrument has been developed along with the authors' evolving theory of personality. There have been two subsequent versions of the MCMI. These have been developed in conjunction with changes in Axis I and Axis 11 syndromes in DSM-111 and DSM-111-R. An MCMI-111 version has been published to reflect changes in DSM-1V.

The MCMI was published in 1977. It is not within the scope of this review to detail its extensive use, psychometric properties or applications. A revised version of the MCMI (MCMI-11) was published in 1987 (Millon, 1987; Millon & Davis, 1996). McMahon (1993) reports that the revision was to incorporate changes in Millon's underlying theory. It was also designed to improve its psychometric properties. In addition, scales were developed to measure Aggressive and Self-defeating personalities.

A major advancement in the MCMI-11, over its earlier version was the development of a weighting system. Items were assigned a weighting of 1, 2, or 3. This was designed to reflect the polythetic structure of the model. It acknowledged that patients vary in the

degree to which they resemble a prototype. Members of one prototypical category manifest features of others, as elements that define one category are found to overlap with others. The weighting system is reviewed in Millon (1987) and Craig and Weinberg, (1993). Retzlaff, Sheehan and Lorr (1990) reported correlations in the high .90s between weighted and unweighted scores, thus casting statistical doubt on the usefulness of this procedure, despite its theoretical interest.

A third version of the MCMI was developed in 1994. This again was a reflection of the evolving nature of Millon's theory and changes in the conceptualisation of DSM-IV Axis 1 and 11 disorders. A detailed description of the development of the MCMI-111 is given elsewhere (Millon & Davis, 1996; McCann & Dyer, 1996).

This study used the MCMI-11. In part this was a reflection of the availability of the scale. McCann and Dyer (1996) recommended its use for forensic and research purposes, rather than the later version. Compared to earlier versions, Millon (1994) provides few details of the psychometric properties of the MCMI-111 in the manual.

The Present Study

There has been considerable interest in profiling the personality of offenders. While it makes intuitive sense that there are differences between offenders and non offenders, and in particular between different types of offenders, the ability to demonstrate this empirically has been less successful. Methodological problems have been highlighted, in particular the problematic application of the MMPI Butcher and Tellegen (1978). Reviews (Armentrout

& Hauer, 1978; Langevin et al., 1985; Quinsey 1983) have generally failed to discriminate sex offenders from other offender groups. Other studies have produced mixed and often inconclusive results. The resurgence of an interest in personality, has lead to the development of theoretically based models of personality. One of the most influential, has been the bio-social model proposed by Millon (1969). The MCMI-11 has been devised in accordance with Millon's model of personality, and has the advantage of a close association with DSM models of personality disorder. In forensic populations, using the MCMI, high levels of personality disorder have been observed. However, attempts to distinguish personalities profiles according to the type of crime committed have met with limited success. A notable limitation to this has been the Chantry and Craig (1994) study, utilising a large sample of non mentally ill incarcerated offenders. The application of the MCMI-11, with its statistical advantages over its earlier version may help in clarifying the situation. The application of the MCMI-11 to a mixed population of offenders will address its ability to discriminate not only offender groups but the source of from which these offenders have been recruited (inpatients, outpatients, probation service). The lack of research using the MCMI-11 with a mixed sample of forensic patients is noted, and its ability to distinguish offender groups is uncertain.

Research Questions

The personality profiles of offenders who have been convicted of a sexual offence will be compared to those who have received a conviction for a violent offence. It is hypotheised that:

1. The prevalence of personality disorders using Millon's cut-off criteria will be comparable to previous research. In particular, Antisocial and Passive-Aggreressive personality disorder will be noted in the sample as a whole.

2. Differences between the two offender groups will be observed. Specifically, violent offenders will report higher levels of Passive-Aggressive, Antisocial and Aggressive-Sadistic traits. Although the profiles of sex offenders is less certain, they are likely to report significantly higher levels of Avoidant, Dependent and Schizoid traits.

3. Differences between the groups on personality scores will be independent of Axis-I pathology.

4. Response bias will be observed within this population. Specifically, sex offenders will show a greater response bias than violent offenders, particularly in demonstrating higher levels of social desirability.

5. Significant differences will be observed between the index offence committed by the participant and type of offence previously committed (sexual, violent, theft, 'other'). This will support the idea of criminal preferences and support the aim of identifying personality profiles of offending groups.

Method

Overview

This study aimed to investigate the personality profiles of offenders. In particular, differences between violent and sexual offenders were examined. Sexual offenders were compared to violent offenders on the MCMI-11. The relationship between symptoms and personality was examined, as was the source of recruitment. The acknowledgement of response bias in this population was examined. The relationship between current index offence and history of offending was explored. The methodology used in order to accomplish these aims is described here.

The Setting

Participants were recruited from the North West Thames Forensic Psychiatry Service, Three Bridges Regional Secure Unit, West London Healthcare NHS Trust (NWTFPS). Between September 1996 and July 1997, inpatients who were detained under the Mental Health Act (1983) were approached to participate. Participants were also approached from the Outpatient Department of the NWTFPS. In addition, members of the Middlesex Probation Service Sex Offender Programme were asked to participate.

Participants and Recruitment Procedures

Recruitment procedure: Ethical Permission to conduct the study was applied for. Verbal consent was obtained from the West London Healthcare Trust Ethical Committee on 27 September 1996.

The five psychologists employed in the NWTFPS were approached and asked to identify individuals they thought suitable to participate in the study. Participants in all three groups met the following inclusion criteria:

1. They were free from active symptoms of mental illness.
2. In the psychologists' opinion, they did not have a learning difficulty and would be able to complete the questionnaire.
3. Participation would not interfere with ongoing assessment or treatment.
4. The assessment could be conducted in English.

A letter outlining the study was sent to psychologists employed in the NWTFS (see Appendix 1). All of the psychologists were followed up with direct contact on several occasions. Once suitable participants had been identified, the consultant psychiatrist who had medical responsibility for the patient was approached, and their permission to approach the patient gained. Once this was obtained participants were approached. Participants were either administered the questionnaire as part of thier assessment / treatment or were asked to participate in the study. All were provided with

instructions on completing the questionnaire. Where appropriate, written consent was obtained (appendix 2).

Inpatient population: Inpatients who were detained under conditions of varying degrees of security at the Regional Secure Unit were approached (either by the researcher, or the consultant psychiatrist) and asked to participate. Participants were given the option to complete the MCMI-11 with the investigator (either supervising or reading the questions) or in their own time. Individual feedback on results were provided to the participant, and a report or oral feedback was provided to the consultant psychiatrist and his/her medical team (if completed as part of assessment). Demographic and control data was obtained from case notes.

Outpatients: Outpatients attending the NWTFPS Outpatients Department were approached by the psychologist involved in their assessment or treatment. Participants, who agreed to participate were given the MCMI-11 to complete in their own time, usually returning it at their next appointment. A report was written, or feedback was provided to the therapist which could be used for clinical purposes and / or relayed to the participant. Demographic details were taken from case notes.

Middlesex Probation Service (MPS): There are close links with the NWTFPS and the MPS. An assessment service is provided by the Psychology service in the NWTFPS to the MPS. The Sex Offender Treatment Programme (SOTP) has been outlined by Lord (1996). The four SOTP group leaders were approached and agreed

to administer the MCMI-11 to group members. An individual report was written on each MCMI-11 profile for use by the probation service. Feedback was relayed to participants, by probation officers. Demographic and background details were provided by the MPS.

Measures

Background details on participants were collected to provided a description of the study population and to address the research hypotheses. Information was collected from case notes.

Demographics:

1. Sex.
2. Age.
3. Employment status - this was recorded at the time of the offence.
4. Marital status - this was recorded at the time of the offence.
5. Living arrangements at the time of the index offence.
6. Highest educational qualification.
7. A prior psychiatric / psychological contact with services.

Ethnicity data was not collected. This information was not readily available from Probation Service reports, so it was not collected on the other participants.

Forensic details:

The nature of the index offence and forensic history was categorised as follows: Sexual offences, violent offences, theft and property related offences and 'other' offences. There is considerable difficulty in the categorisation of offences into discreet groupings (Blackburn, 1993) , although this classification is based on Wales (1995).

The MCMI-11

The theoretical foundations of the MCMI have been described above. Similarly, changes in the questionnaire have also been outlined. The MCMI-11 is a 175 item, true / false format self administered questionnaire. Thirteen of the twenty two clinical scales are proported to measure basic and pathological personality styles (DSM-111-R, Axis 11). The remaining nine, are designed to assess common DSM-111-R, Axis 1 symptoms. The separation is designed to emphasise traits which are seen as more enduring, from more transitory and circumscribed symptoms.

Description of MCMI-11 Scales.

The first 10 scales (1, 2, 3, 4, 5, 6a, 6b, 7, 8a, and 8b) measure maladaptive personality styles (Schizoid, Avoidant, Dependent, Histrionic, Narcissistic, Antisocial, Aggressive-Sadistic, Compulsive, Passive-Aggressive and Self-defeating). The next three (SS, CC, and PP), measure more severe personality disorder (Schizotypal, Borderline, and Paranoid). These differ from the first in their degree of disturbance. Both sets of scales reflect DSM-111-R Axis 11 disorders.

The next six scales (A, H, N, D, B and T) assess less severe clinical syndromes (Anxiety, Somatoform, Bipolar: Manic, Dysthmia, Alcohol Dependence, and Drug Dependence). The final three (SS, CC, and PP), assess more severe symptom disorders (Thought Disorder, Major Depression, and Delusional Disorder). Both sets of scales reflect DSM-111-R Axis 1 disorders. A brief description of the MCMI-11 scales are attached as Appendix 3.

Scoring the MCMI-11.

Manual scoring of the MCMI-11 is a time consuming (approx. 40 minutes per questionnaire) and complex procedure. The scoring protocol is attached as Appendix 4.

Psychometric Properties

The psychometric soundness of a personality instrument is paramount. McCann and Dyer (1996) highlight the importance of this with regard to court testament. In addition, they have an important bearing on treatment and research. For reasons of brevity, this review will limit itself to the MCMI-11. Millon & Davis, 1996; McCann & Dyer, 1996; Craig & Weinberg, 1993 provide a comprehensive account of the psychometric properties of the MCMI-11 and the earlier version.

In reporting the criterion validity of the MCMI-11, Widger and Corbitt (1995) found moderate validity between the MCMI, the MMPI (range .50 - .87) and clinical ratings (.56 - .78). They also highlight that superior convergent validity was obtained for the

MCMI-11 than for the earlier version. The MCMI-11 manual provides evidence of the validity for the MCMI-11. Strong correlations (.75 and above) were observed between it and (blind) clinical ratings. Hollis (1995) found somewhat moderate correlations (.18-.48) with the MMPI. In addition, it correlated as would be predicted with the NEO-PI (Costa & McCrae, 1990; Hyer et al, 1994) suggesting further convergent validity. Hart, Forth and Hare (1991) suggested that the Antisocial scale was a strong predictor of antisocial behaviour but not the affective and interpersonal characteristics of psychopathy, as measured by the PCL-R. However, Renneberg et al (1992) reported poor correlations (.18 - .28) between the MCMI-11 and clinical interview (SCID-11) in an anxious outpatient population.

The MCMI-11 demonstrates stability over time. In a non clinical population, stability coefficients of .79-.89 were observed for a 4 week period (Millon, 1987). The stability was however somewhat lower in a psychiatric outpatient population (.49-.75). Timing of administration appears to be a critical factor, as test-retest correlations are reduced from admission to release (Priesma, 1987). This would suggest that the mental health state effects are present, although this is likely to apply to all other self-report measures.

Craig and Weinberg (1985) conclude "our review of the research would suggest that it is unlikely that any (other measure) will clearly provide a more valid and/or a more reliable assessment than the MCMI-11" (p198).

RESULTS

Overview

The results of the descriptive analyses relating to sexual and violent offending groups are presented here. A detailed description of the categorisation of offences (index offence and previous offences committed) is provided. Differences between the groups were explored. This is followed by an examination of a number of factors which may have influenced the results. Specifically, the response style of the offending groups was examined, in light of the results obtained. In addition, the effects of the location where participants were recruited and the contribution of symptoms on personality profiles was investigated. Finally, the effects of a prior forensic history on present offending was explored.

The presentation of the results follow this order of analyses:

1. On determining the acceptance and validity rates for the sample, the demographic characteristics of the participants were summarised in terms of: sex, age, highest educational qualification, employment status (at the time of the offence), marital status (at the time of the offence), living arrangements (at the time of the offence) and recorded psychiatric history.

2. The descriptive analyses investigated differences in demographic variables and observed personality scores. These were examined in relation to the location where

participants were recruited (inpatient, outpatients and probation service) and index offence (violent and sexual).

3. The prevalence of personality disorder, using three cut-off criteria (proposed by Millon, 1987) was examined in relation to index offence and source of recruitment.

4. The mean scores for personality scales were examined with regard to the index offence and source of recruitment.

5. The effects of social desirability in this population was examined in light of the results obtained. Correlations between the validity indices (disclosure, desirability and debasement scores) and personality scales were examined. The reports obtained were classified as 'acceptable', 'marginal - over-reporting' and 'marginal - defensive' using McCann and Dyer's (1996) criteria (attached as Appendix 5). Differences between these groups were examined on the personality scores obtained.

6. To determine the effects of Axis-1 disorders and personality reporting, a series of analyses were performed to determine differences in symptom reporting and site of recruitment.

7. A discriminant analysis was performed to determine the ability of personality scales to distinguish index offence was present.

8. The relationship between current index offence and forensic history was examined. This was to determine the degree of concordance between index offence and previous convictions.

Acceptance Rates

The response rate for offenders who were contacted about the study are presented for each of the three locations in Table 3.

Table 3 Acceptance Rates of Participants for Site of Recruitment

	Inpatients	Outpatients	Probation Service	Total
Population	56	153	34	243
Contacted	28	26	34	88
Refused	4	3	0	7
Interviewed	24	20	33	77
Invalid Reports	4	3	3	10
Reports Used	20	17	31	68
Percentage	35.7	11.1	91.1	36.2

The protocol for identifying suitable participants in the inpatient and outpatient groups has been outlined above. Of the five psychologists employed in the NWTFPS, four (80%) identified suitable participants. The percentage of patients who were

identified as suitable to participate in the study was variable, depending upon the site of recruitment. Reasons for not approaching participants were not recorded, but they reflected the psychologist's opinion regarding the suitability of the offender to participate in the study. This was based on their level of intellectual functioning, mental health and impact upon assessment and treatment. Probation service completion rates were higher than those for the inpatient and outpatient groups. These reflect the uniformed assessment procedure employed by the MPS and the lower levels of psychiatric disturbance in this population.

Descriptive Analyses

The demographic composition of the sample appears in Table 4. No demographic data (other than the type of offence committed) was provided on 1 Outpatient and 2 Probation Service participants.

The majority of offenders were male (98.5%), with only one female included in the sample. The range of ages were 18-66 years, with a mean of 37 years recorded. The majority of the sample were single (51.5%), with 21 (30.9%) categorised as married or cohabiting. A minority of the sample (9, 13.8%) were divorced, separated or widowed. There was evidence of poor scholastic achievement in this sample as 47.7% of the sample left school with no formal qualifications. The index offences recorded were sexual n=45, (66.2%), violent n=19, (27.9%), theft or property n=3, (4.4%) and 'other' n=1, (1.5%). Due to the relatively small number of theft and 'other' offences these were not included in further analyses.

Table 4 Demographic Description of the Sample

Variable	N	(%)
Sex		
Male	67	98.5
Female	1	1.5
Marital Status		
Single	35	52.9
Married/cohabiting	21	30.9
Separated/divorced/widowed	9	13.8
Employment		
Unemployed	36	52.9
Employed	25	36.8
Missing data	7	10.3
Educational level		
No qualifications	31	47.7
CGSE/O level	23	35.4
A level	8	12.3
Some university	3	4.6
Index Offence		
Sexual offence	45	66.2
Violence	19	27.9
Theft / property	3	4.4
Other	1	1.5

A wide variety of offences were committed, and are presented in Table 5. Information was taken from a variety of sources including police, psychiatric, social work and probation service reports.

Table 5 Categorisation of Offences

Offence Type	Current	Previous
Sexual		
Indecent assault - female child	12	5
- male child	4	3
- female adult	10	8
Indecent exposure	3	4
Abduction and rape of a female adult	1	0
Incitement to gross indecency with a child and possession of indecent child photographs	1	0
Sending indecent letters and telephone messages	2	0
Attempted rape, indecent assault, robbery and theft	3	0
Rape and Buggery	3	0
Attempted Rape	6	1
Violent		
Armed Robbery carrying a weapon / firearm	2	0
Grievous bodily harm (GBH)	3	1
Actual bodily harm (ABH)	2	11
Attempted murder	1	0
GBH with intent to murder	1	1
Assault	3	6
Unlawful imprisonment and threats to kill	1	0
Manslaughter with diminished responsibility	3	0
Physical assault on a child	2	0
Threatening behaviour	0	2
Arson with reckless intent (to endanger life)	1	0
Shooting a policeman with an air rifle	0	1
Carrying an offensive weapon	1	5
Murder	4	0

Table 5 Categorisation of offences (Cont.)

Offences	Current	Previous
Property and Theft		
Shoplifting	0	6
Taking and driving away (TDA) motor vehicles	1	4
Theft from an employer	1	1
Handling stolen goods	1	2
Burglary	0	1
Arson	0	2
Fraud	0	2
Criminal damage	0	6
Theft	0	18
Other offences		
Drug smuggling	1	2
Drink driving offences (repeated offences)	0	7
No Forensic History	-	16

With regard to differences amongst the offender groups, there was no significant differences between the groups with regard to age (t (63) = 1.07, n.s.). Similarly, there was no differences in marital status (χ^2 (1) = 4.1, n.s.) or educational level (χ^2 (1) = 1.0, n.s.). However, a significant difference in living arrangements at the time of the offence being committed (χ^2 (1) = 7.7, $p < .05$) was observed. Violent offenders were more likely to be living alone at the time of the offence than sex offenders.

To determine differences in demographics and the site of recruitment, a series of analysis were performed. There was no significant difference in age noted between the groups (F (2,64) = 2.0, n.s.). Significant differences were observed in marital status (χ^2 (2) = 21.0, p <.001) employment status (χ^2 (2) = 21.9, p <.001) and living arrangements (χ^2 (2) = 31.0, p <.001). Inpatients were more likely to be single and living on their own at the time of the offence. In addition they were more likely to be unemployed than either the probation or outpatient groups.

For inpatients detained under the Mental Health Act (1983), the section under which they were detained is reported in Table 6.

Table 6 The Section Under Which Detained Patients Were Held

Section	N	Percentage
37/41	16	23.5
38	2	2.9
47/49	2	2.9

Sixteen of the sample were detained under section 37/41. This is a hospital order of 6 months duration (extensions can be applied for) where patients are suffering from a mental disorder. There is a restriction order in place so as to protect the public from serious harm. Two patients were detained under section 38, an interim hospital order where the individual is suffering from a mental disorder. Two participants were

detained under Section 47/49. In these cases, patients were removed from prison to hospital as they were suffering from a mental disorder. The duration of the order is as long as the sentence or until there is a return to prison.

The psychiatric diagnosis of inpatients and outpatients is reported in Table 7. It may be observed that no data was available for 32 subjects (including MPS participants). No psychiatric diagnosis was reported in 10 participants. In the remaining sample, Schizophrenia (N= 14) and Psychosis (N= 7) were the most frequently observed psychiatric diagnosis. Less frequently diagnosis included Episodic dyscontrol, Psychopathic disorder, Schizotypal personality disorder, and Depression.

Table 7 Current Psychiatric Diagnosis in the Sample

Psychiatric Diagnosis	**N**	**Percentage**
None	10	14.7
Schizophrenia	14	20.6
Paranoid psychosis	7	10.3
Episodic dyscontrol	1	1.5
Psychopathic disorder	1	1.5
Schizotypal personality disorder	1	1.5
Depression	2	2.9
Missing data	32	47.1

Prevalence of PD in the Offender Groups

To determine the number of patients with clinically significantly elevated levels of personality disorder a series of cut-off criteria were adopted (Millon, 1987). Base rate (BR) cut-off points of 75, 85 and 95 were used for each of the 13 scales, and are reported in Table 8. A BR score of 75 - 84 suggests the presence of the disorder, while a BR score between 85 - 94 indicates strong evidence for the presence of the disorder. A BR score of 95 or over suggests a decompensated personality pattern. The adoption of such cut-off criteria has been utilised elsewhere (Blackburn et al, 1991; Lehne, 1994; Hart et al, 1991).

Using a BR cut-off score of 75, the most frequently reported personality disorder was Dependent, observed in 45.6% of the population. Clinically significant levels of Passive-Aggressive personality disorder was noted in 39.7% of the population. Aggressive-Sadistic personality disorder was observed in 36.8%, while Antisocial was observed in 35.3% of the population. Although 20.6% of the sample reported significant levels of Borderline personality, the other severe personality pathologies were less frequently observed (Schizotypal, 8.8%; Paranoid, 8.8%).

Taking a BR cut-off score of 95+ (indicating extremely high levels of pathology) the most frequently observed personality disorder observed was Passive-Aggressive (N=16, 23.5%). Antisocial personality disorder was noted in 13 participants (19.1%). Relatively low rates of severe personality pathology at the BR 95 cut-off was observed. However, 6 (8.8%) participants reported clinically significant levels of

Borderline personality, 3 participants (4.4%) had evidence of Schizotypal and 1 (1.5%) had significant levels of Paranoid personality disorder.

Table 8 Number and Percentage of the Population Reporting P D According to BR cut-off rates

Personality scale	BR 75+	BR 85+	BR 95+
Schizoid	18 (26.5%)	12 (17.6%)	7 (10.3%)
Avoidant	22 (32.4%)	14 (20.6%)	10 (14.7%)
Dependent	31 (45.6%)	19 (27.9%)	4 (5.9%)
Histrionic	15 (22.1%)	5 (7.4%)	2 (16.2%)
Narcissism	19 (27.9%)	13 (19.1%)	8 (11.8%)
Antisocial	24 (35.3%)	18 (26.5%)	13 (19.1%)
Aggressive	25 (36.8)	17 (25%)	11 (16.2%)
Compulsive	15 (22.1%)	4 (5.9%)	2 (2.9%)
Passive-Aggressive	27 (39.7%)	19 (27.9%)	16 (23.5%)
Self-defeating	18 (26.5%)	13 (19.1%)	7 (10.3%)
Schizotypal	6 (8.8%)	3 (4.4%)	3 (4.4%)
Borderline	14 (20.6%)	9 (13.2%)	6 (8.8%)
Paranoid	6 (8.8%)	1 (1.5%)	1 (1.5%)

Table 9 presents the number of personality disorders recorded in this population. It can be observed that the range was 0 - 9. Twelve patients (17.6%) reported no

personality disorder defined as a BR cut-off of 75. One personality disorder was observed in 11.8% of the sample. The modal number of personality disorders was 3, reported in 14 (20%) of the sample. There is some evidence of high levels of pathology in this population, as 6 (11.8%), 7 (2.9%), 8 (1.5%) and 9 (2.9%) personality disorders were observed.

Table 9 The Number of Personality Disorders Recorded in the Total Population

The number of personality disorders recorded	Number	Percentage of population
0	12	17.6
1	8	11.8
2	5	7.4
3	14	20.6
4	7	10.3
5	9	13.2
6	8	11.8
7	2	2.9
8	1	1.5
9	2	2.9

Differences in Personality Amongst Offender Groups

To determine differences in absolute rates of PD amongst the offender groups a Chi square was performed on 'sex offenders' and 'violent offenders'. Using a BR 75 cut-off, no significant differences between the cells were observed for any of the clinical personality or server pathology scales. It was decided not to use other cut-off criteria as cell sizes would be unacceptably small.

The arbitrary cut-off criteria for personality does not acknowledge the range of scores observed. Table 10 reports the means (standard deviations) as well as the range of scores for the population on each of the personality scales. To determine differences between sexual and violent offenders a series of t-tests was performed on the observed score. Means, standard deviations and t-values for both offending groups are presented in Table 11. No significant differences between the groups were observed. As a possible violation of the principles underlying the t-test, a series of Mann-Whitney tests were performed. Results confirmed those of the t-tests.

Table 10 **The Range of Scores Observed for Personality Scales**

Personality scale	Mean	(SD)	Range	
			Minimum	Maximum
Schizoid	65.35	(23.84)	0	121
Avoidant	63.37	(27.68)	6	118
Dependent	61.99	(30.64)	0	105
Histrionic	57.28	(24.16)	6	99
Narcissism	60.24	(25.62)	0	119
Antisocial	69.35	(27.56)	0	120
Aggressive	62.88	(26.61)	5	113
Compulsive	57.88	(21.25)	3	108
Passive-Aggressive	65.04	(32.74)	0	119
Self-defeating	66.16	(24.74)	0	119
Schizotypal	60.94	(18.07)	7	113
Borderline	62.90	(22.56)	7	116
Paranoid	56.78	(16.36)	10	101

Table 11 Means and (SD) for Personality Scales and Index Offence

	Offence		
Personality scale	**Sexual**	**Violent**	**t value**
Schizoid	62.5 (25.8)	67.7 (16.3)	.98
Avoidant	60.6 (28.6)	63.5 (23.2)	.42
Dependent	64.4 (30.9)	54.0 (30.1)	1.25
Histrionic	59.3 (22.3)	54.4 (29.3)	.65
Narcissism	60.1 (24.0)	62.8 (28.0)	.36
Antisocial	64.9 (26.9)	78.5 (23.0)	1.8
Aggressive	61.0 (25.3)	67.7 (26.5)	.92
Compulsive	59.0 (22.4)	54.3 (20.1)	.82
Passive-Aggressive	66.7 (30.4)	59.7 (34.7)	.76
Self-defeating	66.2 (24.8)	61.3 (23.1)	.75
Schizotypal	59.8 (19.1)	60.2 (11.0)	.09
Borderline	60.0 (20.8)	63.7 (22.6)	.61
Paranoid	55.3 (17.4)	59.6 (14.6)	1.0

The Effects of Location on Personality Scores

To determine if the location in which participants were recruited biased personality scores, a series of analyses were performed to determine the effects of site of recruitment on personality disorder. A BR cut-off 75 criteria was adopted. Using chi square analyses, those recruited from the probation service were more likely to have a Passive-Aggressive (χ^2 (2) = 7.7, p<.02), Self-defeating (χ^2 (2) = 7.1, p <.02) and

Schizotypal (χ^2 (2) = 12.0, p<.001) personality disorder. To determine differences between the three groups on mean personality scores, an ANOVA with Tukey post hoc analysis was performed. The means (SD) and statistical significance for the three location groups are presented in Table 12. The only observed difference was that outpatients reported significantly greater levels of Passive-Aggression than inpatients (F (2,67) = 5.5, p <.01). No significant differences in mean scores were observed between the groups on Self-defeating (F (2,67) = 2.5, n.s.), or Schizotypal (F (2,67) = 1.3, n.s.) personality.

Social Desirability in Offending Populations

The effects of response bias has been highlighted in offender populations (Grossman & Cavanaugh, 1989; Haywood et al, 1993; Fisher & Thornton, 1993). It was appropriate to examine it in this study. No significant differences were observed in the validity measures (Disclosure, Desirability or Debasement) for location or index offence. To determine the relationship between the three validity indices, a correlation was performed on disclosure, debasement and social desirability scores. Table 13 reports the correlation coefficients and level of statistical significance.

Table 12 Means and (SD) for Personality Traits and Site of Recruitment

Personality scale	Location		
	Inpatient	Outpatient	Probation
Schizoid	58.9 (23.7)	72.0 (19.7)	65.5 (25.4)
Avoidant	55.7 (23.3)	66.2 (31.8)	66.7 (27.6)
Dependent	60.5 (31.1)	60.1 (26.1)	63.9 (33.3)
Histrionic	57.0 (27.7)	59.8 (22.6)	56.0 (23.2)
Narcissism	63.1 (25.2)	64.9 (30.0)	55.7 (23.3)
Antisocial	70.9 (25.1)	74.6 (32.4)	65.4 (26.4)
Aggressive	58.1 (23.7)	74.0 (24.3)	59.8 (28.4)
Compulsive	61.6 (21.5)	53.7 (19.6)	57.7 (22.1)
Passive-Aggressive	47.7 (27.9)*	80.7 (36.2)*	67.6 (29.1)
Self-defeating	56.0 (18.4)	69.9 (29.4)	70.6 (24.3)
Schizotypal	59.4 (10.1)	64.5 (24.3)	59.9 (18.3)
Borderline	55.3 (16.0)	70.1 (32.6)	63.7 (18.3)
Paranoid	61.1 (13.0)	59.6 (15.5)	52.3 (18.0)

* $p<.05$

Significant associations were observed between disclosure and debasement scores, suggesting that those who were more open in their reporting were more likely to do so in a negative way ($r = .68$, $p<0.001$). No relationship was observed between social

desirability and level of disclosure (r = .22, n.s). Surprisingly, no significant relationship was observed between debasement and social desirability scores.

Table 13 Correlation Between Validity Indices (Disclosure, Debasement and Social Desirability)

Validity measure	Disclosure	Social desirability
Disclosure		
Social desirability	.22	
Debasement	.68***	-.09

*** $p < .001$.

To determine what role response style played in this sample, correlation coefficients for the three validity scales (Disclosure, Desirability and Debasement) and personality traits were performed. These are presented in Table 14. Significant associations were observed between Desirability and Compulsive (r = .44, p<.001), Dependent (r = .52, p<.001), Histrionic (r = .47, p<.001) and Paranoid (r = .36, p<.002) personality. While Debasement scores positively correlated with Antisocial (r = .30, p<.01), Avoidant (r = .71, p<.001), Paranoid (r = .28, p<.02), Passive-Aggressive (r = .45, p<.001), Self-defeating (r = .71, p<.001), Schizoid (r = .42, p<.001) and Schizotypal (r = .68, p<.001) personality.

Table 14 Correlations between Personality Scales and Validity Measures (Disclosure, Desirability and Debasement).

Personality scale	Disclosure	Desirability	Debasement
Schizoid	.40***	.10	.45***
Avoidant	.66***	-.09	.71***
Dependent	.23*	.52***	.21
Histrionic	.24*	.47***	-.01
Narcissism	.39***	.27*	-.08
Antisocial	.55***	-.14	.30*
Aggressive	.51***	-.07	.21
Compulsive	-.08	.44***	-.19
Passive-Aggressive	.68***	-.11	.45***
Self-defeating	.70***	.12	.71***
Schizotypal	.66***	.10	.58***
Borderline	.77***	.03	.63***
Paranoid	.68***	.36**	.28*

* $p < .05$ ** $p < .01$ *** $p < .001$

The profiles obtained contained 14 of 'marginal validity' using McCann and Dyer's (1996) criteria (attached as Appendix 5). Of these, 3 were designated 'defensive' and eleven 'over-reporting'. To determine differences in personality scores and the categorisation of the report, a series of ANOVAS with Tukey post hoc analyses were performed . These are presented in Table 15.

Table 15 **Acceptable and Marginal Reports and Personality Scores**

	Report		
	Acceptable	**Over reporting**	**Defensive**
MCMI Scale	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**
Disclosure	54.1 (21.5)*	88.7 (9.3)*	76.3 (4.0)
Desirability	52.8 (22.0)*	50.8 (21.7)*	93.3 (2.8)*
Debasement	51.0 (18.4)*	80.1 (11.4)*	48.0 (19.4)*
Schizoid	61.1 (21.4)*	85.4 (27.7)*	68.0 (17.5)
Avoidant	56.9 (25.2)*	96.3 (16.9)*	57.3 (12.4)
Dependent	60.5 (31.1)	60.1 (26.1)	63.9 (33.3)
Histrionic	57.9 (23.8)	47.4 (24.2)	81.6 (10.5)
Narcissism	60.1 (23.3)	53.0 (31.6)	87.6 (33.0)
Antisocial	65.5 (27.1)	85.0 (24.0)	81.1 (32.3)
Aggressive	72.4 (30.4)	72.4 (30.4)	59.8 (28.4)
Compulsive	57.5 (21.9)	52.5 (14.8)	83.0 (10.5)
Passive-Aggressive	59.6 (33.2)*	91.6 (19.3)*	64.3 (9.9)
Self-defeating	60.2 (22.8)*	94.6 (15.3)*	69.0 (4.0)
Schizotypal	56.2 (14.7)*	81.3 (20.5)*	70.6 (3.0)
Borderline	57.5 (19.4)*	88.1 (23.2)*	67.3 (3.5)
Paranoid	54.0 (16.3)*	62.4 (9.7)	77.0 (20.8)*

* $p < .05$

There were significant differences between the three groups on the validity measures. Those who over reported, disclosed significantly more than the other groups ($F(2,65) = 14.9$, $p<.001$), and such disclosure was in a more negative way ($F(2,65) = 12.8$, $p<.001$). However, there was no significant difference between those faking good and acceptable reports on amount disclosed, although items disclosed was in a positive light ($F(2,65) = 5.45$, $p<.01$). In order to determine the effects of the type of report produced and personality scores a series of ANOVAs with Tukey post hoc analysis were performed. Those who over-report or 'fake bad' showed significantly higher Schizoid ($F(2,65) = 5.4$, $p<.001$), Avoidant ($F(2,65) = 12.5$ $p<.001$), Passive Aggressive ($F(2,65) = 4.8$, $p<.01$), and Self-defeating ($F(2,65) = 11.7$, $p<.001$) personalities compared to those with 'acceptable' reports. The significant difference in Schizotypal ($F(2,65) = 12.4$, $p<.001$) and Borderline ($F(2,65) = 11.1$, $p<.001$) suggest a relationship between response style and more severe personality pathology. Those who showed excessive defensiveness, surprisingly reported significantly greater Paranoid traits than acceptable reports ($F(2,65) = 3.7$, $p<.05$).

The Relationship Between Subject Group and Symptoms

The population for this study were drawn from a diverse sample. To ensure bias from Axis I disorders was not a possibility, the relationship between subject group and DSM Axis 1 disorders was examined. Table 16 represents the means and SD for the groups (inpatients, outpatients and probation service) and clinical symptoms. No significant differences between the groups on Axis 1 symptom scores were observed.

In addition, the results produce no clear trend in levels of pathology between groups. There is no evidence to suggest that inpatients have higher levels of psychological problems than the other groups. This would suggest comparability of the groups in terms of mental health at the time of completing the MCMI-11. It was decided not to examine the relationship between symptoms and index offence, as these scales are less reliable and would not suggest the presence of symptoms *at the time* of offending.

Table 16 Mean (SD) Symptom Scores and Site of Recruitment

Personality scale	Location		
	Inpatients	**Outpatients**	**Probation**
Anxiety	51.8 (37.7)	56.1 (28.8)	56.6 (29.6)
Somatoform	58.7 (16.7)	54.0 (21.1)	52.3 (17.4)
Bipolar: Manic	50.1 (18.1)	55.7 (13.2)	48.3 (17.8)
Delusional Disorder	53.6 (33.2)	53.8 (29.6)	58.6 (28.5)
Alcohol Dependence	55.1 (16.5)	61.0 (20.6)	58.8 (15.1)
Drug Dependence	63.5 (15.9)	65.2 (22.6)	57.7 (18.2)
Thought Disorder	47.4 (24.6)	58.1 (18.7)	48.2 (24.6)
Major Depression	51.2 (20.9)	57.0 (23.4)	53.6 (16.3)
Delusional Disorder	51.3 (12.5)	51.0 (20.8)	43.8 (21.0)

Discriminant Analysis

To determine the ability to predict the participant's index offence (sexual and violent) from the MCMI-11, a discriminant analysis was performed using the 10 basic scales, 3 severe variants and validity measures (debasement, disclosure and social desirability). Results of the discriminant analysis are reported in Table 17 and indicate that this combination of variables was unable to predict index offence committed (χ^2 (2,65) = 23.2, $p < .05$).

Table 17 **Discriminant Analysis and the Ability to Predict Index Offence**

MCMI-11 scale	F value	Significance
Disclosure	.0035	n.s
Desirability	3.25	n.s
Debasement	.52	n.s
Schizoid	.67	n.s
Avoidant	.15	n.s
Dependent	1.5	n.s
Histrionic	.52	n.s
Narcissism	.15	n.s
Antisocial	3.6	n.s
Aggressive	.89	n.s
Compulsive	.61	n.s
Passive-Aggressive	.63	n.s
Self-defeating	.53	n.s
Schizotypal	.005	n.s
Borderline	.39	n.s
Paranoid	.88	n.s

The Relationship Between Forensic History and Index Offence

As there was an inability to detect personality differences in the index offence committed, the relationship between forensic history and current offence was examined, using a series of chi square analyses. The relationship between index offence and a history of sexual offences are presented in Table 18. A significant difference was observed, with sexual offenders significantly more likely to have a history of previous sexual offending (χ^2 (1) = 10.6, p <.001).

Table 18 **Index Offence and a History of Sexual Offending**

	Forensic history	
Index offence	**No**	**Yes**
Sexual	25	18
Violent	18	0

To determine whether differences in current offence and a history of violent offending was observed, a chi square was performed on index offence and a reported history of violent offending. Results suggest that those with a current violent index offence were more likely to have a history of violent convictions. Results are presented in Table 19.

Table 19 **Index Offence and a History of Violent Offending**

	Forensic history	
Index offence	**No**	**Yes**
Sexual	32	11
Violent	4	14

To address the question of whether current offending was committed within a context of general offending, 'theft' and 'other' previous offences were examined in relation to the index offence. The relationship between current index offence and a history of theft is reported in Table 20. A significant relationship between index offence and a past history of theft was observed (χ^2 (1) = 8.7, p <.01). Violent offenders were more likely to have had a history of theft and property related offences than sex offenders.

Table 20 **Index Offence and a History of Theft**

	Forensic history	
Index offence	**No**	**Yes**
Sexual	25	18
Violent	3	15

An examination of the relationship between current index offence and a history of 'other' offences is reported in Table 21. Violent offenders were more likely to have a conviction for 'other' offences than sex offenders. It should be noted that there were relatively few 'other' offences and related to drug possession and motoring offences (drink driving and driving without a licence or insurance).

Table 21 Index Offence and History of 'other' Offending

	Forensic history	
Index offence	**No**	**Yes**
Sexual	40	3
Violent	12	6

Discussion

Overview

The primary aim of this study was to investigate the personality profiles of offender populations. This discussion examines these findings in the light of the study's aims, and the methodology employed. This is followed by a consideration of the findings with regard to clinical practice. Finally, the implication of the results will be considered within the wider theoretical context, with recommendations for further research proposed.

The Main Findings

Prevalence of PD in this Population

The study aimed to explore the relationship between personality types and offending behaviour. Personality was assessed by examining the cut-off criteria for personality disorder proposed by Millon (1987) and employed by others (Blackburn, 1991, Hart et al, 1991, Hart et al, 1993, Lehne, 1994). In addition, mean personality scores were utilised.

The percentage of patients classified as having a personality disorder was observed to be high. Eighty two percent of the sample reported at least one personality disorder. Two or more personality disorders were reported by 70.6% of the sample, and 63.2% reported three personality disorders. There were high levels of disturbance in this

sample, indicated by 42.6% reporting four or more personality disorders. The range for observed personality disorders were 1- 9. This is somewhat higher than previous reports with sexual and violent offenders, using the MCMI, although the predominance of Dependent, Passive-Aggressive, Antisocial and Aggressive-Sadistic personality traits is consistent (Blackburn et al 1990; Murphy, et al, 1993; Hart et al, 1993; Lehne, 1994).

Ability to Distinguish Offender Groups on MCMI-11

There has been considerable debate concerning the ability to differentiate offending groups on personality measures, despite the theoretical desirability of such an approach. Chantry and Craig (1994) were able to distinguish three groups of incarcerated offenders using the MCMI-11. In particular they reported that child molesters were characterised by Passive-Aggressive and Dependent personalities. There were some similarities between rapists and violent offenders who scored higher on Narcissism, Compulsive and Paranoid traits than child molesters. Although, violent offenders reported low levels of Avoidant personality than the other groups.

Despite this, a number of reviews have suggested that it is difficult to make such a distinction (Langein et al 1988, Okami & Goldberg, 1992; Levin & Stava, 1987). Such reservations have largely been on methodological grounds: the lack of adequate controls, the heterogeneous nature of offender groups, and problems of dependent measures (most notably, the problematic use of the MMPI - Butcher and Tellegen, 1978). This is not to say that research has not demonstrated differences between

offender groups, but an overview has suggested these differences are somewhat inconsistent.

This study failed to report significant differences between the offending groups, on either absolute rates of personality disorder or on mean scale scores. This may reflect the heterogeneous nature of the population or real difficulties in distinguishing the groups. The problem of heterogeneity may be common in forensic research. Reviews (Okami & Goldberg, 1992; Levin & Strava, 1987) have noted this in previous studies. This may be overcome by using offender typologies and a more narrow definition of offending behaviour. For example, Perkins (1991) has provided a typology of sex offenders. Within each of these groups, further classifications could be made: the orientation of the offender, previous convictions, the number of victims, age of victim, and relationship of victim to perpetrator. The list is somewhat endless, and finding suitably matched offender groups in sufficient numbers is difficult. Similarly, violent offences can be grouped in terms of the relationship of the victim to the offender, if it was in pursuit of other goals (e.g. theft or property related offending), the nature of the offence (murder verses assault), including premeditation and degree of force used, or evidence of sadism. To overcome these problems, meta-analyses (Smith & Glass, 1977) may be usefully employed in determining personality profiles.

However, there is perhaps nothing inherent in crimes that would lead to differences in personality types being observed. Considerable overlap between offences may make the distinction between sexual and violent offending problematic. Rape and attempted

rape have been designated in this study as sexual offences, although they can also be seen as crimes of violence. Sex offences where there is some degree of contact can be seen as violent and antisocial, as there is resistance by the victim. Non-contact sexual offences may be seen as somewhat different in so far as they may not involve violence towards the victim but are surely aggressive and antisocial.

The offences committed were taken from official records. A major problem with this approach is that they are not value free. For example, the term 'assault' includes a wide range of behaviours, as would 'carrying an offence weapon'. Blackburn (1993) states:

> "crime is measured by counting criminal events or offenders, although it will become apparent that whether an event qualifies as a crime, or a person a criminal, depends on a complex decision process" (p35).

These include whether the individual is identified by the legal system, the crime for which they were charged and whether a conviction is secured. Social factors are also involved in whether a custodial sentence or treatment order is made.

Faking, Social Desirability and Response Bias

The use of questionnaires has been a controversial area in psychology. While they offer the researcher and clinician an easy and hopefully well validated tool in which to assess an individual, they are not without criticism. This problem applies not only to the use of personality assessments but to other constructs - e.g. symptoms, social support and dispositional styles. In particular, subjects may be poor judges of

questionnaire items, e.g. 'do you have a lack of empathy or warmth for other people'. Such items may need a degree of external validity. However, the problem of bias in the observer (often a family member or nursing staff) is a possibility. A consistent bias may be observed in patients' responding. The most notable being social desirability (although this is assessed in the MCMI-11). Other biases may be a dichotomous thinking pattern which minimise or maximise traits. While this is not so problematic in inventories with a Y/N format, it may be a concern for questionnaires with a likert type scale.

Previous research in forensic populations suggest that patients tend to minimise the consequences of their offence and deny the degree of planning involved (Morrison, et al, 1994; Howells & Hollin, 1991; Lang, 1993). Fisher and Thornton (1993), commenting on the problems of risk assessment state:

> " Risk assessment is also subject to two particular complications: the adversarial nature of the assessor's interaction with the offender and the variable amount of information on which the assessment has to be based. The adversarial element derives from a conflict of motives: the offender naturally wishes to give away as few indications of risk as possible whereas the professional conducting the assessment wishes to elicit accurate information about the presence or absence of risk factors. Offenders may opt for a number of strategies in order to minimise the extent to which they appear to present a risk. Thus some will actively refuse to co-operate with the assessment, some will try to maintain the appearance of co-operating while seeking to conceal crucial bits of information, and others will actively co-operate with a treatment programme, and then

present their evidence of 'openness' as evidence that they are now a different person. The variation in the self-presentational strategies adopted by offenders means that information available for risk assessment may differ greatly from case to case" (p106).

In addition, those who deny their offences minimise psychiatric symptoms (Grossman & Cavanaugh, 1989) and fake good on personality measures (Haywood, Grossman & Hardy, 1993). An advantage of the MCMI, compared to other personality measures (notably the Neo-PI) is the inclusion of validity measures. In this study, while effects of social desirability were low, a surprisingly high number of reports were classified as 'over-reporting'. It may be that these patients were motivated for treatment, and were more open in their reporting. Alternatively, it may be as an attempt to portray themselves as more open, and having changed. Such a high percentage of marginal reports is likely to have distorted the overall results obtained.

Although there were no differences between validity measures (Disclosure, Desirability and Debasement) and site of recruitment or index offence, social desirability was seen to correlate with dependent, histrionic, compulsive and paranoid traits. Items assessing dependent traits may be interpreted as signs of helplessness and the opposite of aggressive or antisocial traits. Histrionic items may be interpreted as the need to draw attention to themselves and a presentation as attractive and worthwhile (which is the opposite of their underlying sense of worthlessness). Compulsive traits measure compliance and orderliness which may be interpreted as

socially positive behaviours. Paranoid traits by definition are linked to social desirability as they denote a mistrust and wariness of others, where a coping strategy of hypervigilence, and a searching for hidden motives in others is characteristic. This may well explain the association observed between social desirability and paranoid personality.

Despite this problem, response style is of considerable use in the clinical management of offenders. Low levels of disclosure and high social desirability suggest a defensive patient, who does not admit to difficult and troublesome aspects of their personality. Such a profile would suggest that a gradual and gentle approach to treatment is needed. Defences will be high, for intra-psychic need, or more practical ones e.g. preparation for mental health tribunal or release. The over reporting patient may present in an anxious and troubled state, with a multitude of interpersonal and intra-psychic difficulties. Alternatively, there is always the possibility that such over-reporting is a crude attempt to present as evidence of change.

The Relationship Between Index Offence and History of Offending

The results of this study suggest that there was a relationship between index offence and previous offending. In this sample, 23.5% did not have any previous convictions, with the majority having a police record. Specifically, sexual offenders were more likely to have a history of sexual offending, while violent offenders were more likely to have violent offending backgrounds. There was evidence to suggest that for violent offenders a history of general antisocial behaviour was present. They were more likely

to have a history of theft and 'other' type offences, compared to sex offenders. There is general acceptance for a high recidivism rate amongst offenders (Fisher & Thornton, 1993; Soothill et al, 1977; Hall & Proctor, 1989), although debate concerns the degree of similarity between crimes.

An implicit assumption here, is of a 'career criminal'. This suggests an involvement in crime sufficiently intensive and exclusive over time to constitute a way of life. Gibbons' (1988) review, highlighted problems in attempting to create taxonomic classifications for offenders. He concluded that such typing was a "barren vein", since behavioural diversity rather than career specialism characterised most offenders. He used as evidence a study by Abel et al (1987), who reported that thier community based sample of sex offenders had committed considerably more offences than were officially recorded. These crimes were also diverse in their nature (Abel et al, 1988) Similarly, official statistics underestimate the number of crimes committed. The British Crime Survey (Mayhew, Elliots & Davids, 1989) estimate four times more household crimes (burglary, car theft, vandalism) and five times more personal crimes (assaults, robberies, interpersonal theft and sexual offences) occur, than are recorded by the police. A detailing of offences committed where detection did not take place, would have been useful. However, it is unlikely, due to the secretive nature of this population that true figures would ever have been established.

If there is a degree of similarity, it is conceivable that those categorised as violent offenders are less likely to commit offences with a sexual component, as such

offending is morally repugnant. Similarly, amongst child molesters, there is a predominance of deviant attitudes towards children, which reflecting distorted cognitions relating to the sexual education of children, and sexual relationships between adults and children as 'natural'. Other deviant attitudes may not be present. An evaluation of sexual attitudes and cognitions may prove to distinguish these groups and predict repeat offending.

Methodological Considerations

The Small and Uneven Sample Obtained

The most notable limitation to this study was the relatively small sample size obtained. Difficulty was observed in the collection of data, producing somewhat uneven cell sizes. Specifically, there were relatively few inpatients recruited. By definition, this is a highly disturbed population. They suffer mental illness, often with low intellectual functioning. Their dangerousness is such that a degree of security is needed to protect themselves and the public (Blackburn, 1993; Briggs, 1994; McDougall, 1996; Lang, 1993).

This population produces a number of challenges in terms of therapeutic management and opportunities for research. Patients are very vulnerable, subject to outbursts of hostility and mood swings. Therefore, research in such settings is problematic. An additional problem working with mentally disordered patients is that they are undergoing continual assessment and treatment. This may result in undue suspicion of research, especially in the area of personality.

Other studies carried out in the U.K (Wales, 1995) and in the USA (Lehne, 1994; Herkov et al, 1996) with forensic populations have reported relatively small numbers of patients. Such small sample sizes may be a factor common in forensic studies (a notable exception being Chantry and Craig (1994), who detailed the personality profiles of 603 non mentally ill prison inmates in the USA). This may be as a result of finding suitable patients and in gaining their co-operation in participation. It is notably that many studies have used data collected as part of *routine* assessment protocols (Wales, 1996; Charntry & Craig, 1994). This is likely to increase the size of the sample as refusal rates will greatly be reduced. It will also eliminate patient selection bias.

An additional difficulty with recruiting inpatients was that a major reorganisation was underway at the time of data collection. Patients were changing therapeutic teams, which resulted in elevated levels of distress in an already vulnerable population. As the NWTFPS does not have a standard assessment procedure, unlike other secure settings (e.g. Broadmoor), the sudden application of a personality measure not routinely administered may have produced specific problems. It can be hypothesised that clinicians did not see the value of personality testing, with regard to their clinical practice. In particular the application of such a measure, where feedback is presented to the patient, may cause problems in the therapeutic relationship, especially where already established. This may be an explanation of the relatively low levels of existing outpatients that were administered the MCMI-11. This is likely to be a common problem in research with any clinical population. Higher numbers of participants were

recruited from the probation service, where routine questionnaire assessments already take place.

Personality assessment may be viewed with suspicion by participants. While many non clinical populations enjoy completing such inventories and relish feedback, forensic populations may view such inventories with suspicion, consistent with their general defensiveness (Grossman & Cavanaugh, 1989; Haywood et al, 1993). Evidence for this was the relatively high refusal rate and the number of invalid reports. In addition, 20.5% of 'marginal validity' reports were found. In clinical experience, patients who produce marginal reports, feedback that they have answered as truthfully as they could, and do not generally accept that they have reported in a biased way. Thus, it is conceivable that the stage at which the MCMI-11 is administered, is a determinant of producing a questionable profile. It could be hypothesised that the likelihood of producing a valid report is based upon an established relationship, where threat is minimised and the openness of the respondent is maximised.

The Heterogeneous Nature of Offences Committed

The index and previous offences committed in this sample were somewhat variable. This methodological problem has already been highlighted (Okami and Goldberg, 1992; Levin and Stava, 1987). For the sake of economy subjects were grouped according to broad categories of offending: sexual, violent, theft and property related and 'other'. This is not a neat separation, as overlap between offences can occur. For example, sexual offending within the context of burglary. Feminist conceptualisations

of sexual offences have seen them as primarily violent offences (reviewed in Polaschek et al, 1997). Indeed, rapists have been found to be similar to general offenders on a number of characteristics including previous convictions for violent and theft related offences (Grubin & Gunn, 1990; Scully, 1990). There is also evidence for sexual offenders having committed a variety of offences against adults and children. Abel et al (1988) reported 44% of 126 rapists had also abused non-familial female children, with 14% molesting a male child.

Further examination of the criminal careers of offenders is needed, and a clinical formulation needs to incorporate all types of offences committed. The issue of a simple categorisation of clients has treatment implications. Cognitive behavioural treatments of sexual offenders (Beckett, 1994; Howitt, 1995, Lord, 1996) and violent offenders (Browne & Howells, 1996; Novaco, 1975) tend to treat offenders as if they were meaningfully distinct subgroups. Whereas, evidence from the literature suggests diversity, which would suggest a more integrative approach to treatment is required.

The Influence of Mental Illness on Personality

One limitation to this study was the inclusion of offenders with a diagnosed mental illness and those without. This study did not find a relationship between Axis 1 symptoms and personality scores. All three location groups were comparable on prevalence of personality disorder and mean scores. Although there is some evidence of greater Passive-Aggressive traits in Probation Service participants, this must be

interpreted with some caution due to the larger number of analyses conducted. This raises the question of the relationship of mental illness and personality. In general Axis-1 disorders are seen as acute or transient, while Axis-11 are viewed as more enduring.

Fundamental to the validity of an MCMI-11 analyses, is temporal stability. Although a number of studies have demonstrated higher test-retest validity for the MCMI-11 compared to its earlier version (reviewed in Widger & Corbitt, 1993), Prirsma (1989) demonstrated a significant reduction in self reported personality disorders during psychiatric hospitalisation. He reported significant decreases in Schizoid, Avoidant, Dependent, Passive-Aggressive, Self-defeating, Schizotypal, Borderline and Paranoid scores. He surprisingly found a significant increase in Histrionic and Narcissistic scores. These results may be interpreted as an over reporting of personality disorder when an individual was *acutely* unwell. In this study, participants were recruited who were not suffering active symptoms of mental illness. While this led to a reduction in the number of participants who were eligible to participate, it is hoped that it resulted in increased validity.

The Influence of Therapy on Personality

A further limitation of this study was the assumption of stability of behavioural traits and the ability to predict future behaviour; in particular to the recurrence of violent or sexual offending. Debate concerning the reliability and stability of personality is set to continue (Deary & Matthews, 1993). Controversy surrounds the ability of individuals

to fundamentally change their personality (Heaterton & Weinberger; 1994). While there is considerable evidence for the stability of personality throughout the lifespan (Costa & McCrae, 1994; Buss, 1994), significant events can have quantum effects (Helson & Stewart, 1994; Miller & C'deBaca, 1994). It is impossible to determine the extent to which the profiles obtained, relate to personality *at the time* of the index offence. Judicial, custodial and therapeutic input could all have effects upon personality, observing such quantum changes. It was not possible to determine these effects.

A number of authors have detailed the difficulty in treating personality disorders (Beck et al, 1990; Young, 1990). It is unlikely that brief and global interventions will address underlying personality pathology. They are more likely to treat symptom manifestations, rather than underlying structure. In theory, personality should change if interventions address them directly and not simply their manifestation. Studies conducted in therapeutic communities have mixed results. Ravndal & Vaglum (1991) reported significant changes in MCMI personality scores in an alcohol dependent population, while Copas, O'Brien, Roberts and Whitleley (1991) found positive but non significant changes in personality disordered patients treated in a therapeutic community. Valliant and Antonowicz (1991) reported a significant change in self-esteem, aggressive traits and anxiety but no change on MMPI scales following a 5 week CBT and social skills package in a prison. Clearly, treatment studies of personality disordered offenders could utilise the MCMI-11 as a measure of change, providing invaluable information on the success of treatment and the stability of the MCMI-11.

A Knowledge of Personality will Help in the Treatment of Offenders.

The growing academic interest in personality is set to continue, despite debate over its utility (Deary & Matthews, 1993, Mischel, 1968; Costa & McCrae, 1994; Buss, 1994). One of the growing areas of cognitive behavioural therapy has been the development of treatments aimed at persons with long standing, chronic problems (Beck et al, 1990; Young, 1990; Millon & Davis, 1996). A high prevalence of personality difficulties were noted in the study group. Eighty six percent reported at least one personality disorder, and several personality disorders were noted in many participants. It would seem useful to examine the therapeutic implications of this study.

As a first stage, an assessment of the personality of the offender / client would be needed. There are advantages to using a structured questionnaire over unstructured personality assessments. While it is possible to ask certain types of questions, e.g. Do you cry a lot? Did you run away from home as a child? Others are more difficult., e.g. are you vain and demanding? Are you manipulative? Assessment with structured measures provide an advantage over simple interview, as the interviewer may have a 'blindspot' to certain traits. For example, there may be a searching for traits such as conformity and conservative attitudes in sex offenders (Okami & Goldberg, 1984). Ambiguous answers or leading questions may elicit these traits, to the exclusion of others. Alternatively, random error may occur. For example, clinical pressure results in less time to carry out an intensive interview, or simply having a bad day. An

advantage of a structured questionnaire is that such systematic and random error should be eliminated, increasing validity.

The configuration of profiles is the 'meat' of the assessment. Several protocols for interpretation have been detailed elsewhere (Millon, 1987; Millon & Davis, 1996). An advantage of the theory led personality model proposed by Millon, is that predictions of behaviour and affect can be made depending upon the nature of personality. Millon makes predictions concerning, the expressive behaviour, regulatory mechanisms, morphological organisation, interpersonal conduct, self image, object representations, cognitive style, and mood/temperament. In patients where only one personality disorder is observed, such a formulation is easier than where multiple personality difficulties are present. This raises the question of reliability in the interpretation of reports.

With such a structure to understand the individual, treatment can be prescribed depending upon the nature of offending. Briefly, cognitive therapy for personality disorder, assume that maladaptive affect and behaviour is the result of 'schemas'. These tend to produce consistently biased judgements of the self, other people and the world in general. Schemas lead to the development of a set of beliefs (dysfunctional assumptions), negative automatic thoughts and information processing biases. Such cognitive processes relate to behaviour and mood. With reference to this study, a number of personality disorders were identified. However, the most frequent was

Dependent. In working with an offender with Dependent personality disorder, an analysis could be:

View of Self: These passive - dependent individuals see themselves as primarily inept. They view themselves as weak, fragile and fundamentally inadequate. A lack of confidence, with a belittling of their own achievements and abilities will be present. The dependent will also see themselves as needy and helpless, needing to rely upon a caring and nurturing other.

View of others: In their interpersonal relationships, the dependent personality will seek strong and caring relationships. Once these have been established, functioning can be quiet normal, although there will be concerns about abandonment. The dependent will have a somewhat over idealised view of 'caretaker' figures. In interpersonal behaviour the dependent will take a submissive role, subordinating themselves to others' demands and wishes. They will be compliant and placating, usually to avoid real or imagined abandonment.

Main beliefs: The dependent will express concerns about needing other people. These may manifest as beliefs such as 'I need other people, especially a strong person to survive'. Happiness will depend upon it being provided by others. They may hold beliefs that they need support and reassurance in order to be fulfilled. This may translate into 'I cannot live without a partner' or 'I can never be happy until I am loved' type beliefs. Core beliefs are likely to centre around their own worthlessness

and incompetence. They may hold core beliefs such as 'I am completely helpless' or 'I am worthless'. Conditional beliefs centre around needing support from others. Specifically, they may be 'I can function only if I have somebody capable' or 'if I am abandoned, I will die'. The dependent is likely to hold imperatives such as 'Don't offend others', or 'cultivate as intimate relationship as possible'.

Threat: The main source of threat to the dependent is abandonment or rejection from others, in particular caretaker figures.

Cognitive biases: The dependent is likely to have as their main cognitive bias the interpretation of events as leading to abandonment. As a consequence, they will demonstrate a Pollyanna attitude to interpersonal conflicts. They will also tend to be uncritical and somewhat gullible, in their processing of information of others. A minimisation of their own abilities, and a halo effect of others will be present.

Coping strategy: The dependent's main coping strategy is to develop nurturing and supportive relationships. This will be done by subordinating their own needs and desires.

Affect: Unexpressed anxiety is the main affect, noted in the dependent personality. Due to beliefs concerning abandonment, conflict is not expressed, as the main aim is to cultivate and maintain relationships.

Therapeutic considerations: The main consideration with the dependent patient is the therapist - patient relationship. The client may have a particular fear that they are about to be abandoned, or will not be able to live independently without the therapist. Dependent behaviour such as clinginess and the need for support and reassurance will be prominent. Cognitive-behavioural approaches emphasise the teaching of models with an active approach in setting therapeutic goals and homework assignments. These feed into the belief such patients have, that they can only survive with the help of a strong and competent caretaker. Counter transference raised by patient's helplessness and neediness may involve feelings of wanting to rescue. This would clearly be counter therapeutic, if the main goal is autonomy. Alternatively, such helpless behaviour may generate a sense of frustration in the therapist. Beck et al (1990) suggest the use of Socratic questioning and a collaborative approach with such clients. Due to the tendency to develop dependent relationship, firm boundaries with regard to finishing of sessions and terminating treatment are needed. In order to minimise dependency, Beck et al (1990) recommend limited physical contact with patients (including hand shaking and showing comfort).

In general, developing the therapeutic alliance will occur by demonstrating empathy and an understanding of the patient. This can be facilitated by the feedback of MCMI-11 profiles in a positively connoted way. In particular, the themes of schemas, dysfunctional assumptions and negative automatic thoughts, can give the patient confidence in the therapist having an empathetic understanding. The positive re-phrasing of problems can de-stigmatise maladaptive personality traits.

The Contribution of this Study to our Understanding of Personality - An Alternative Model for Explaining Offending Behaviour

Many more questions are raised by this study than have been answered. Putting aside the methodological problems already highlighted, there was a failure to demonstrate differences between sexual and violent offenders on personality measures, although high levels of disturbance was noted. It is conceivable that the MCMI-11 is not sufficiently able to differentiate offending groups, despite good statistical properties having already been highlighted (Millon, 1997; McCann & Dyer, 1996). It also has the advantage of close links to theory and a recognised classification measures of personality disorder (DSM-111-R). It is unlikely that other measures of personality would meet such specifications. One possibility is that response styles of participants in forensic research, distort the overall picture, so results are rarely consistent. While the MCMI-11 has the distinct advantage over other well accepted and theory based personality measures (Neo-PI), for having validity measures, the degree of bias is likely to distort overall results.

The ability to establish a typical offender profile is a somewhat simplistic assumption on two accounts. The first is the overemphasis on personality, to the exclusion of other known risk factors. The results suggest difficulty in making a distinction between personality styles and offending. There is some evidence for offenders to have previous convictions similar to the index offence, although prevailing evidence is that there is no specification (Gibbons, 1988). Focusing on personality excludes other factors.

Offences occur within a framework of numerous social factors. Typologies for violence (e.g. Megargee, 1966; Blackburn, 1971; Perkins, 1991) and sexual offending (Groth, 1978; Wolf, 1984; Finkelhor, 1984) provide a framework for explaining offending. Within these, personality types *may* have prominence. The assumption is that personality predisposes an individual to a host of other risk factors, leading to criminal activity. These may include the development of deviant beliefs, negative attitudes, cognitive distortions and information processing biases. However, the reverse may be true. Psychological factors, such as peer group norms for offending, a lack of negative consequences, may be better predictors of offending behaviour than personality. Similarly, social factors such as unemployment, poverty, opportunities to offend may be more closely associated with criminal behaviour. For example, in relation to alcohol and drug abuse, availability and cost appear to be the biggest factor in use and change in consumption (Robson, 1994).

A multiple model to explain offending would need to encompass these factors. Regression analyses should determine the contribution personality makes in predicting offending behaviour, where other factors are considered. Although such attempts (Prentky et al, 1997) have found that personality factors often account for a small percentage of the variance in predicting future offending.

Instead of tying to determine a personality profile of offenders, a more fruitful way of explaining deviant behaviour may be in the identification of risk factors, with the development of a cycle of deprivation. Of this sample, 52.9% were unemployed at

the time of their index offence. While, 47.7% had poor scholastic achievement (as defined by no qualifications). Only a minority of the sample were either married or cohabiting. Within this cycle, personality difficulties such as impulsivity, low self-esteem and dependency may in the presence of stress and the absence of protective factors (e.g. social support) lead to criminal behaviour.

The second consideration is the problem of conceptualising personality. Certain personality traits, may be common to all offending behaviour. For example antisocial, passive aggressive and sadistic traits may explain a general predisposition toward offending, possibly explaining internal disinhibitions to criminality. Any individual differences in relation to other traits may only make a limited contribution to a formulation of offending.

However, a more fundamental problem is the search for traits that predict offending behaviour. In part, this is a problem where attempts at making categorical decisions regarding personality are made. The over representation of personality disorders may be a reflection of the disadvantage of using a such an approach. Having an easy understanding of a person on the basis of a personality disorder categorisation is appealing. However, such an approach does not provide the richness to describe the individual. A simple categorisation does not provide a true understanding of the complexity of behaviour leading to a diagnosis. Widger and Francis (1994) highlight that there are 848 different ways to reach DSM-111-R criteria for antisocial personality disorder, thus actually not describing the individual at all.

Similarly, McGlashan (1987) in attempting to research the co-morbidity of depression and borderline personality disorder found that his depressed group (without a Borderline diagnosis) shared on average three of the Borderline criteria. In other words subjects who were not categorised as Borderline, had Borderline traits. Therefore in this study, the inability to differentiate offending groups, probably occurred because many offenders share similar characteristics. So in conclusion, it is perhaps too reductionist to expect that personality will predict specific criminal activity. However, this problem is not unique to forensic clinical psychology, as a similar problem has been observed in other areas of psychology, notably in health, where attempts at demonstrating a role for personality in health has been debated (Deary, Clyde & Frier, 1997).

REFERENCES

Abel, G. G. Becker, J. W., Mittleman, M., Cunningham-Rathner, J., Roulea. J., & Murphy, W. D. (1987). Self-reported crimes of non-incarcerated paraphilacs. *Journal of Interpersonal Violence*, **2**, 3-25.

Abel, G. G. Becker, J. W., Mittleman, M., Cunningham-Rathner, J., & Roulea. J. (1988). Multiple paraphilic diagnosis among sex offenders. *Bulletin of the American Academy of Psychiatry and the Law*, **16**, 153-168.

Abel, G. G., & Osborn, C. A. (1996). Behavioural therapy treatment for sex offenders. In I. Rosen (Ed.), *Sexual Deviation (3rd Ed)*. London: Oxford University Press.

Abel, G. G., Osborn, C. A., Anthony, D. & Gardos, P. (1992). Current treatments for paraphiliacs. *Annual Review of Sex Research*, **1**, 255-290.

Abel, G. G., Barlow, D. H., Blanchard, E. B. & Guild, D. (1977). The components of rapist's sexual arousal. *Archives of General Psychiatry*, **34**, 895-903.

Alford, A. & Beck, A. T (1994). Cognitive therapy of delusional beliefs. *Behaviour Research and Therapy*, **32**, 369-380.

Allport, G. (1937). *Personality: A Psychological Interpretation.* New York: Holt.

Anderson, W. P., Kunce, J. T. & Rich, B. (1979). Sex offenders: Three personality types. *Journal of Clinical Psychology*, **35**, 671-676.

Armentrout, J. A. & Hauer, A. L. (1978) MMPIs of rapists of adults, rapists of children and non rapist sex offenders. *Journal of Clinical Psychology*, **34**, 330-332.

Bandura, A. (1973). Social learning theory of aggression. In J. F. Kautson (ed.), *The Control of Aggression: Implications from Basic Research*. Chicago, IL: Aldine.

Barlow, D. H. (1993). *Clinical Handbook of Psychological Disorders*. New York: Guildford Press.

Baron, L. & Straus, M. A. (1987). Four theories of rape: A macro-sociological analysis. *Social Problems*, **34**, 467-489.

Beck, A. T. (1952). Successful outpatient psychotherapy of a chronic schizophrenic with a delusion based on borrowed guilt. *Psychiatry,* **15,** 305 -312.

Beck, A. T. et al (1990). *Cognitive Therapy of Personality Disorders*. New York: Guildford Press.

Bentall, R. P. (1993). Personality traits may be alive, they may even be well, but are they really useful? *The Psychologist*, **July**, 307.

Blackburn, R. (1971). Personality types amongst abnormal homicides. *British Journal of Criminology*, **11**, 14-31.

Blackburn, R. (1975). An empirical classification of psychopathic personality. *British Journal of Psychiatry*, **127**, 456-60.

Blackburn, R. (1989). Psychopathy and personality disorder in relation to violence. In K. Howells & C. R. Hollin (Eds.), *Clinical Approaches to Violence*. Chichester: John Wiley & Sons.

Blackburn, R. (1993). *The Psychology of Criminal Conduct: Theory, Research and Practice*. Chichester: John Wiley and Sons Ltd.

Blackburn, R. (1996). Mentally disordered offenders. In C. R. Hollin, (Ed.), *Working with Offenders: Psychological Practice in Offender Rehabilitation*. Chichester: John Wiley & Sons.

Blackburn, R. (1996). Replicated personality disorder clusters among mentally disordered offenders and their relation to dimensions of personality. *Journal of Personality Disorders*, **10**, 68-81.

Blackburn, R., Crellin, M. C., Morgan, E. M. & Tulloch, R. M. B. (1990). Prevalence of personality disorders in a special hospital population. *Journal of Forensic Psychiatry*, **1**, 43-52.

Bradfird, J. M. W. & Pawlak, A. (1993). Double-blind crossover study of cyproterone acetate in the treatment of paraphilias. *Archives of Sexual Behaviour*, **22**, 383-402.

Briere, J. & Runtz, M. (1989). University males' sexual interest in children: Predicting potential indices of 'pedophilia' in a non forensic sample. *Child Abuse and Neglect*, **13**, 65-75.

Briggs, D. (1994). The management of sex offenders in institutions. In T. Morrison, M. Erooga, & R. C. Beckett, (Eds.), *Sexual Offences Against Children: Assessment and Treatment of Male Abusers*. New York: Routledge.

Browne, K., & Howells, K. (1996). Violent Offenders. In C. R. Hollin, (Ed.), *Working with Offenders: Psychological Practice in Offender Rehabilitation.* Chichester: John Wiley & Sons.

Burt, M. R. (1980). The cultural myths and support for rapes. *Journal of Personality and Social Psychology*, **38**, 217-230.

Buss, D. M. (1994). Personality evoked: The Evolutionary psychology of stability and change. In T. F. Heaterton & J. L. Weinberger (Eds.), *Can Personality Change?* Washington: American Psychiatric Association.

Butcher, J. & Tellegen, A. (1978). Common methodological problems in MMPI Research. *Journal of Consulting and Clinical Psychology*, **46**, 620-628.

Christie, M., Marshall, W. L. & Lanthier, R. (1979). *A Descriptive Study of Incarcerated Rapists and Pedophiles.* Report to the Solicitor General of Canada.

Chantry, K. & Craig, R. J. (1994). Psychological screening of sexually violent offenders with the MCMI. *Journal of Clinical Psychology*, **50**, 430-435.

Copas, J., O'Brien, M., Roberts, J. & Whiteley, S. (1991). Tereatment outcomes in personality disorder: The effect of social, psychological and behavioural variables. *Personality and Individual Differences*, **5**, 565-573.

Costa, P. T. & McCrae, R. R. (1985). *The NEO Personality Inventory Manual.* Odessa, Fl: Psychological Assessment Resources.

Costa, P. T. and McCrae, R. R. (1994). Set like plaster? Evidence for the stability of adult personality. In T. F. Heaterton & J. L. Weinberger (Eds.), *Can Personality Change?* Washington: American Psychiatric Association.

Craig, R. J. & Weinberg, D. (1993). MCMI: Review of the literature. In R. J. Craig (Ed.), *The Millon Multiaxial Inventory: A Clinical Research Information Synthesis.* Hillsdale, New Jersey: LEA.

Deary, I. J. & Matthews, G. (1993). Personality traits are alive and well. *The Psychologist*, **July**, 299-311.

Deary, I. J., Clyde, Z., & Frier, B. M. (1997). Constructs and models of health psychology: The case of personality and illness reporting in diabetes mellitus. *British Journal of Health Psychology*, **2**, 35-54.

Dollard, J., Doob, L. W., Miller, N. E., Mowrer, O. H., & Sears, R. R. (1939). *Frustration and Aggression*. New Haven, CT: Yale University Press.

Evans, M. C. (1990). The Needs of a Blue-eyed Arab: Crisis Intervention with Male Sexual Assault Survivors. In M. C. Hunter, *The Sexually Abused Male, Prevention, Impact and Treatment*, New York: Lexingham.

Eysenck, M. W. & Eysenck, S. B. G. (1975). *The Eysenck Personality Inventory.* London: University of London Press.

Farrington, D. P. (1989). Early predictors of adolescent aggression and adult violence. *Violence and Victims*, **4**, 79-100.

Felson, R. B. (1978). Aggression as impression management. *Social Psychology*, **41**, 205-213.

Finkelhor, D. (1984). *Child Sexual Abuse: New Theory and Research.* New York: Free Press.

Fisher, D. & Thornton, D. (1993). Assessing risk of re-offending in sexual offenders. *Journal of Mental Health*, **2**, 105 - 117.

Flynn, R. (1996). Breaking the Cycle. *New Law Journal*, **146**, 1662.

Fonagy, P. & Higgitt, A. (1984). *Personality Theory and Clinical Practice*. New York: Methuen.

Fromm, E. (1973). *The Anatomy of Human Destructiveness*. New York: Holt, Rinehart & Winston.

Furnham, A. (1986). Response bias, social desirability and dissimulation. *Personality and Individual differences*, 7, 385-400.

Geen, R. G. (1983). Aggression and television violence. In R. G. Geen & E. I. Donnerstein (Eds.), *Aggression: Theoretical and Empirical Reviews*, **2**, New York: Academic Press.

Gonsiorek, J. C., Bera, W. H. & LeTourneau, D. (1994). *Male Sexual Abuse: A Trilogy of Intervention Strategies*. Thousand Oakes, CA: Sage publications.

Grillo, J., Brown, R. S., Hilsabeck, R., Price, J. R., & Lees-Haley, P. R. (1994). Raising doubts about claims of malingering: Implications of relationships between MCMI-11 and MMPI-2 performances. *Journal of Clinical Psychology*, **50**, 651-655.

Grossman, L. S., Cavanaugh, J. L. (1989). Do sex offenders minimise psychiatric symptoms? *Journal of Forensic Sciences*, **4**, 881-886.

Groth, A. N. (1978). Patterns of sexual assault against children and adolescents. In A. W. Burgess, A. N. Groth, L. Holstrom & S. M. Sgrol (Eds.), *Sexual Assault of Children and Adolescents*. Toronto: Lexingham Books.

Groth, A. N., Burgess, A. W., & Holmstrom, L. L. (1977). Rape: Power, anger and sexuality. *American Journal of Psychiatry*, **134**, 1239-1243.

Groth, A. N., Hobson, W. F., & Gary, T. S. (1982). The child molester: Clinical observations. *Journal of Social Work and Human Sexuality*, **1**, 129-144.

Gruben, D. & Gunn, J. (1990). *The Improvised Rapist and Rape*. London: Institute of Psychiatry.

Grunfeld, B., and Noreik, K. (1986). Recidivism rates among sex offenders: A follow up study of 541 Norwegian sex offenders. *International Journal of Law and Psychiatry*, **9**, 95-102.

Hall, G. C. N. & Proctor, W. C. (1987). Criminological predictors of recidivism in a sexual offender population. *Journal of Consulting and Clinical Psychology*, **55**, 111-112.

Hamberger, L. K. & Hastings, J. E. (1986). Personality correlates of men who abuse their partners: A cross validation study. *Journal of Family Violence*, **1**, 323-341.

Hamberger, L. K. & Hastings, J. E. (1988). Characteristics of male spouse abusers consistent with personality disorders. *Hospital and Community Psychiatry*, **39**, 736-770.

Hamberger, L. K., & Hastings, J. E. (1989). Counselling male spouse abusers: Characteristics of treatment completers and dropouts. *Violence and Victims*, **4**, 275-286.

Hare, R. D. (1980). A research scale for the assessment of psychopathy in criminal populations. *Personality and Individual Differences*, **1**, 111-119.

Hare, R. D. (1986). Twenty years of experience with the Cleckley psychopath. In W. H. Reid, D. Dorr, J. Walker, & J. W. Bonner (Eds.), *Unmasking the Psychopath: Antisocial Personality and Related Syndromes*. New York: W. W. Norton.

Hart, S. D., Dutton, D. G., & Newlove, T. (1993). The prevalence of personality disorder among wife assaulters. *Journal of Personality Disorders*, **7**, 329-341.

Hart, S. D., Forth, A. E. & Hare, R. D. (1991). The MCMI-11 and psychopathy. *Journal of Personality Disorders*, **5**, 318-327.

Hayes, S. C., Rincover, A., & Volosin, D. (1980). Variables influencing the acquisition and maintenance of aggressive behaviour: Modelling verses sensory reinforcement. *Journal of Abnormal Psychology*, **89**, 254-262.

Haywood, T. W., Grossman, L. S. & Hardy, D. W. (1993). Denial and social desirability in clinical evaluations of alleged sex offenders. *The Journal of Nervous and Mental Disease*, **181**, 183-188.

Heaterton, T. F. & Weinberger, J. L. (1994). Can Personality Change? Washington: American Psychiatric Association.

Helson, R. & Stewart, A. (1994). Personality change in adulthood. In T. F. Heaterton & J. L. Weinberger (Eds.), *Can Personality Change?* Washington: American Psychiatric Association.

Hemsley, D. R. & Garety (1996). The formation and maintenance of delusions: A Bayesian analysis. *British Journal of Psychiatry*, **149**, 51-56.

Henderson, M. (1982). An empirical classification of convicted violent offenders. *British Journal of Criminology*, **22**, 1-20.

Herkov, M. J., Gynther, M. D., Thomas, S. & Myers, W. C. (1996). MMPI differences among adolescent inpatients, rapists, sodomites and sexual abusers. *Journal of Personality Disorders*, **66**, 81-90.

Holcomb, W. R., Adam, N. A., & Ponder, H. N. (1985). The development and cross validation of an MMPI typology of murders. *Journal of Personality Assessment*, **49**, 240-244.

Hollin, C. R. & Howells, K (1989). An introduction to concepts, models and techniques. In K. Howells, & C. R. Hollin (Eds.), *Clinical Approaches to Violence*. Chichester: John Wiley & Sons.

Hollin, C. R. (1996). *Working with Offenders: Psychological Practice in Offender Rehabilitation*. Chichester: John Wiley & Sons.

Home Office (1986). *The Sentence of the Court*. London: HMSO.

Horley, J. (1988). Cognitions of child sex abusers. *The Journal of Sex Research*, **25**, 542-545.

Howells, K. & Hollin, C. R. (1989). *Clinical Approaches to Violence*. Chichester: John Wiley & Sons.

Howells, K. & Hollin, C. R. (1991). *Clinical Approaches to sex offenders and their victims*. Chichester: John Wiley & Sons.

Howells, K. (1979). Some meanings of children for pedophiles. In M. Cook & G. Wilson (Eds.), *Love and Attraction: An international Conference*. Oxford, UK: Pergamon Press.

Howitt, D (1996). *Paedophiles and Sexual Offences Against Children*. Chicester: John Wiley.

Huesmann, L. R., Eron, L. D., Lefkowitz, M. M. & Walder, L. O. (1984). Stability of aggression over time and generations. *Developmental Psychology*, **20**, 1120-1134.

Hyer, S. E., Skodal, A. E., Oldham, J. M., & Doidge, N. (1990) Validity of the personality diagnostic questionnaire - revised: A replication in an outpatient sample. *Comprehensive Psychiatry*, **33**, 73-77.

Jenkins, C. D., Zyzanski, S. J. & Roseman, R. H. (1978). Coronary-prone behaviour: One pattern or several. *Psychosomatic Medicine*, **40**, 25-43.

Joffe, R. T. & Regan, J. J. (1988). Personality and depression. *Journal of Psychiatric Research*, **22**, 279-286.

Johnston, L. & Ward, T. (1996). Social cognition and sex offending. *Sexual Abuse: A Journal of Research and Treatment*, **8**, 55-80.

Klerman, G. L. (1973). The relationship between personality and clinical depressions: Overcoming the obstacles to verifying psychodynamic theories. *International Journal of Psychiatry*, **11**, 227-233.

Lang, R. A. (1993). Neuropsychological deficits in sexual offenders: Implications for treatment. *Sexual and Marital Therapy*, **8**, 181- 200.

Langevin, R. (1983). *Sexual Strands: Understanding and Treating Sexual Anomolies in Men*. Hillsdale, NJ: Lawrence Earlbaum Associates.

Langevin, R. et al. (1988). Personality and sexual anomalies, an examination of the Millon Clinical Multiaxial Inventory. *Annals of Sex Research*, **1**, 13-32.

Langevin, R., Handy, L., Russon, A. E. & Day, D. (1985). Are incestuous fathers pedophilic, aggressive or alcoholic? In R. Langevin (Ed.), *Erotic Preference, Gender, and Aggression in Men*. Hilsdale, NJ: Erlbaum Associates.

Langevin, R., Paitich, D., Freeman, R. Mann, K. & Handy, L. (1978). Personality characteristics and sexual anomalies in males. *Canadian Journal of Behavioural Science*, **10**, 222-238.

Lanyon, R. I. (1993). Validity of MMPI scale offender scales with admitters and non admitters. *Psychological Assessment*, **5**, 302-306.

Lehne, G. K. (1994). The NEO-PI and the MCMI in forensic evaluation of sex offenders. In P. T. Costa & T. A. Widiger (Eds.), *Personality Disorders and the Five Factor Models of Personality*. Washington DC: American Psychological Association.

Levin, S. M. & Stave, L. (1987). Personality characteristics of sex offenders: A review. *Archives of Sexual Behaviour*, **16**, 57-79.

Libb, J. W. et al. (1990). Stability of the MCMI among depressed psychiatric outpatients. *Journal of Personality Assessment*, **55**, 209-218.

Lord, A, (1996). *The Treatment of Imprisoned Sex Offenders*. H. M. Prison Service Publication.

Machon, R. C. (1993). The Millon Multiaxial Inventory: An introduction to the theory, development and interpretation. In R. J. Craig (Ed.), *The Millon Multiaxial Inventory: A Clinical Research Information Synthesis*. Hillsdale, New Jersey: LEA.

Marshall, W. L. & Barbaree, H. E. (1990). Outcome of cognitive - behavioural treatment programmes. In: W. L. Marshall, D. R. Lawes (Eds) *Handbook of Sexual Assault*, New York: Plenum.

McCann, M. & Dyer, J. (1996). *Forensic Assessment with the Millon Inventories*. New York: Guildford Press.

McCreary, C. P. (1975). Personality differences among child molesters. *Journal of Personality Assessment*, **39**, 591-593.

McDougall, C. (1996). Working in secure settings. In C. R. Hollin (Ed), *Working with Offenders: Psychological Practice in Offender Rehabilitation.* Chichester: John Wiley & Sons.

McGurk, B. J. (1978). Personality types among normal homicides. *British Journal of Criminology*, **18**, 146-61.

Megargee, E. I. (1966). Undercontrolled and overcontrolled personality types in antisocial aggression. *Psychological Monographs*, **80**, (3, Whole No. 611).

Miller, W. R. & C'deBaca, J. (1994). Quantum change: Towards a psychology of transformation. In T. F. Heaterton & J. L. Weinberger (Eds.), *Can Personality Change?* Washington: American Psychiatric Association.

Millon, T. & Davies, R. D. (1996). *Disorders of Personality: DSM-IV and beyond.* New York, John Wiley and Sons.

Millon, T. (1969). *Modern Psychopathology: A Biosocial Approach to Maladaptive Learning and Functioning.* Philadelphia: Saunders.

Millon, T. (1981). *Disorders of Personality: DSM-111, Axis 11.* New York: Wiley.

Millon, T. (1987). *Millon Clinical Multiaxial Inventory.* Minneapolis: National Computer Systems.

Millon, T. (1994). *Millon Clinical Multiaxial Inventory.* Minneapolis: National Computer Systems.

Mischel, W. (1968). *Personality and Assessment.* New York: Wiley.

Morrison, T., Erooga, M. & Beckett, R. C. (1994). *Sexual Offences against Children: Assessment and Treatment of Male Abusers.* New York: Routledge.

Murphy, C. M., Meyer, S. & O'Leary, K. D. (1993). Family of origin and MCMI-11 psychopathology among partner assaultative men. *Violence and Victims*, **8**, 165-176.

Novaco, R. W. (1975). *Anger Control: The Development and Evaluation of an Experimental Treatment. Lexington*, MA: D. C. Heath.

Okami, P. & Goldberg, A. (1992). Personality correlates of pedophilia: Are they reliable indicators? *The Journal of Sex Research*, **29**, 297-228.

Olweus, D. (1979). Stability of aggressive reaction patterns in males: A review. *Psychological Bulletin*, **86**, 852-875.

Panton, J. H. (1958). MMPI configurations among crime classification groups. *Journal of Clinical Psychology*, **14**, 305-308.

Panton, J. H. (1978). Personality differences appearing between rapists of adults, rapists of children and non-violent sexual molesters of female children. *Research Community Psychology, Psychiatry and Behaviour*, **3**, 385-393.

Patterson, G. R. (1982). *Coercive Family Process.* Eugene, Or: Castalia.

Perkins, D. (1991). Clinical work with sex offenders in secure settings. In C. R. Hollin and K. Howells (eds.), *Clinical Approaches to Sex Offenders and Their Victims.* Chicester: John Wiley and Sons Ltd.

Peters, J. J. (1976). Children who are the victims of sexual assault and the psychology of offenders. *American Journal of Psychotherapy*, **30**, 398-421.

Pfohl, B., Blum, N., Zimmerman, M. & Stangl, D. (1989). *Structured interview for DSM-III-R personality (SIDP-R).* Iowa City: University of Iowa, Department of Psychiatry.

Piersma, H. L. (1989). The MCMI-II as a measure of of DSM-III Axis II diagnosis: An empirical comparison. *Journal of Clinical Psychology*, **43**, 478-483.

Polaschek, D. L. L., Ward, T. & Hudson, S. M. (1997). Rape and rapists: Theory and treatment. *Clinical Psychology Review*, **17**, 117-144.

Prentky, R. A., Knight, R. A., & Lee, A. F. S. (1997). Risk factors associated with recidivism among extrafamilial child molesters. *Journal of Consulting and Clinical Psychology*, **65**, 141-149.

Quinsey, V. L. (1983). Prediction of recidivism and the evaluation of treatment programs for sex offenders. In S. N. Verdon-Jones & A. A. Keltner (Eds.), *Sexual Aggression and the Law*. Criminology Research Centre: Simon Fraser University.

Quinsey, V. L., Arnold, L. S. & Prusse, M. G. (1980). MMPI profiles of men referred for a pre-trial psychiatric assessment as a function of offence type. *Journal of Clinical Psychology*, **36**, 410-417.

Rader, C. M. (1977). MMPI profile types of exposers, rapists and assaulters in a court service population. *Journal of Consulting and Clinical Psychology*, **45**, 61-69.

Ravndal, E. & Vaglum, P. (1991). Changes in antisocial aggressiveness during treatment in a hierarchical therapeutic community: A prospective study of personality changes. *Acta Psychiatry Scandanavia*, **84**, 524-530.

Rezlaff, P. D. Sheehan, E. P. & Lorr, M. (1990). MCMI-11 scoring: Weighted and unweighted algorithms. *Journal of Personality Assessment*, **55**, 219-223.

Robins, L. (1978). Sturdy predictors of adult antisocial behaviour: Replications from longitudinal studies, *Psychological Medicine*, **2**, 487-99.

Robson, P. (1994). *Forbidden Drugs: Understanding Drugs and Why People Take Them*. Oxford: Oxford University Press.

Scully, D. (1990) *Understanding Sexual Violence: A study of Convicted Rapists*. Boston: Unwin Books.

Smith, M. L. & Glass, D. V. (1977). Meta-anaysis of psychotherapy outcome studies. *American Psychologist*, **32**, 752-760.

Soothill, K. L. & Gibbens, T. C. N. (1978). Recidivism of sex offenders: A re-appraisal. *British Journal of Criminology*, **18**, 267-276.

Sutker, P. B. & Allain, A. N. (1979). MMPI studies of extreme criminal violence in incarcerated women and men. In C. S. Newmark (Ed.), *MMPI Clinical Research and Research Trends*. New York: Praeger.

Swenson, W. M. & Grimes, B. P. (1958). Characteristics of sex offenders admitted to a Minnesota state hospital for pre-sentence psychiatric investigation. *Psychiatric Quarterly, Supp.*, **32**, 110-123.

Taylor, S. P. & Leonard, K. E. (1983). In R. & G. Donnerstein (Eds.), *Aggression: Theoretical and Empirical Reviews*, **2**, New York: Academic Press.

Tellegen, A. (1985). Structures of mood and personality and their relevance to assessing anxiety, with an emphasis on self-report. In A. H. Tuma & J Maser (Eds.), *Anxiety and the Anxiety Disorders*. Hillsdale, NJ: Erlbaum.

Thornhill, R. & Thornhill, N. W. (1992). The evolutionary psychology of men's coercive sexuality. *Behavioural and Brain Sciences*, **15**, 363-421.

Toolbert, S., Bartemele, K. F. & Jones, E. S. (1959). Some factors related to pedophilia. *International Journal of Social Psychiatry*, **4**, 272-279.

Valliant, P. M. & Antonwicz, D. H. (1991). Cognitive behavioural therapy and social skills training improves personality and cognition in incarcerated offenders. *Psychological Reports*, **68**, 27-33.

Van Velzen, C. J. M. & Emmelkamp, P. M. G. (1996). The assessment of personality: Implications for cognitive and behavioural therapy. *Behaviour Research and Therapy*, **34**, 655-668

Wales, D. (1995). Personality disorder in an outpatient offender population. *Criminal Behaviour and Mental Health*, **5**, 85-94.

West, D. (1987). *Sexual Crimes and Confrontations. Cambridge Studies in Criminology*. Aldershot: Gower.

Widger, T. A. & Corbitt, A. E. (1993). Personality disorder scales and diagnosis. In R. J. Craig (Ed.), *The Millon Clinical Multiaxial Inventory: A Clinical Research Information Synthesis*. Hillsdale, NJ: LEA.

Widger, T. A. & Frances, A. J. (1987) Interviews and Inventories for the measurement of personality disorders. *Clinical Psychology Review*, 7, 49-75.

Wilson, G. D. (1987). An ethnological approach to sexual deviation. In G. D. Wilson (Ed.), *Variant Sexuality: Research and Theory*. Baltimore: John Hopkins University Press.

Wilson, G. D. & Cox, D. N. (1983). Personality of pedophile club members. *Personality and Individual Differences*, **4**, 323-329.

Wolf, S. C. (1984). *'A Multifactor Model of Deviant Sexuality'* Paper presented at Third International Conference on Victimology, Lisbon.

Wolfgang, M. E. & Ferracutti, F. (1967). *The Subculture of Violence*. London: Tavistock.

Young, J. (1990). *Cognitive Therapy for Personality Disorders: A Schema-Focused Approach*. Sarasota: Professional Resource Exchange.

Appendices

Appendix 1 Letter to Psychologists

Dear (name of psychologist)

As you are aware, for my final year project, I am attempting to determine differences in personality profiles of inpatient and outpatients, using the MCMI.

I would be grateful if you could provide me with a list of suitable patients to complete the MCMI. Suitable participants should have a good command of English, be able to understand the questions and be free of active symptoms of mental illness. I will then contact the relevant consultant to obtain their written consent.

Where you think appropriate, could existing and new outpatients also be given the questionnaire to complete. If the MCMI is completed for research purposes, then I can only provide feedback to the patient, unless their consent that the information can be shared with the therapist. If the questionnaire is administered as part of their clinical assessment or care, then I will be happy to provide feedback.

Please do come and discuss any part of the project further with me.

Many thanks in anticipation of your help.

Dr Rob Flynn
Psychology Trainee

Appendix 2 Consent and Information Sheet

An Investigation of the Personality Profiles of Individuals Assessed and Treated by the Regional Forensic Services Using the Millon Clinical Multiaxial Inventory -11.

We are conducting a study exploring the personality profiles of users of the Regional Forensic Services.

We would be grateful if you could complete the attached questionnaire, which should take you no longer than 30 minutes.

Your responses are confidential, being seen only by the researchers involved in the study. Results will not influence your clinical care.

If you have any questions regarding the study please feel free to ask the investigator.

Dr. R Flynn
Trainee Clinical Psychologist

Mr David Kirkby
Chief Psychologist

I confirm that the investigator has explained fully the nature and purpose of the procedures and I understand that the procedure is for research purposes.

I give my agreement that the procedure be carried out.

Signature (participant) ..... Date .....
Name (participant) .....

Signature (investigator) ..... Date .....
Name (investigator) .....

Signature (witness) ..... Date .....
Name (witness) .....
Status of witness .....

Signature (consultant)..... Date .....
Name of consultant .....

Appendix 3

DESCRIPTION OF MILLON'S SCALES

Basic maladaptive personality styles (1 - 8B)

Schizoid (Scale 1): Passively detached personality types typically display a limited capacity to experience painful or pleasurable emotions. These individuals are characterised by a poverty of cognitive processes and interpersonal relationships. They also demonstrate emotional inactivity. This scale reflects characteristics of Schizoid personality disorder as described in DSM-111-R.

Avoidant (Scale 2): This actively detached personality type is acutely sensitive to punishment. Primarily they are motivated to avoid social situations. While seeking supportive relationships, a poverty of coping strategies, chronic social anxiety and vigilance ensures failure to attain this goal. This scale reflects DSM-111-R Avoidant personality disorder.

Dependent (Scale 3): A passively dependent personality, characterised by their need for support and approval. These individuals avoid conflict and appease others in social interactions. They readily subordinate their own demands infavour of others. This scale assesses features of DSM-111-R Dependent personality disorder.

Histrionic (Scale 4): These actively dependent personalities are similar to passive dependents in their reliance upon attention from others to maintain their self esteem. However, they differ in the active nature to which they try to meet this need. They are characterised by dramatic and attention seeking behaviours. They appear to others as ostentatious and theatrical. This scale reflects features of DSM-111-R Histrionic personality disorder.

Narcissistic (Scale 5): These passively independent personalities derive a need for satisfaction from their overvalued sense of self. They are characterised by a grandiose and egocentric view of themselves, extreme confidence and arrogance. They tend to be exploitative in interpersonal relationships. Features of this scale reflect DSM-111-R Narcissitic personality disorder.

Antisocial (Scale 6A): Actively independent personalities rely upon themselves to meet intrapsychic needs. This is because of a fundamental mistrust of others, anticipating exploitation from others. While seeing themselves as tough minded, others will view them as argumentative, manipulative and exploitative. A lack of empathy and sympathy for others will be evident. They also reject societal values and norms, often engaging in destructive, deviant and illegal acts. This scale reflects features of DSM-111-R Antisocial personality disorder.

Aggressive - sadistic (Scale 6B): These actively discordant individuals experience a reversal in the pain - pleasure polarity. Pleasure is derived from hostile and abusive

relationships. While seeing themselves as aggressively independent, others will view them as cruel and intolerant. This personality type has been deleted from DSM-111-R, although it's use in forensic settings is valuable.

Compulsive (Scale 7): This passive ambivalent personality type experiences conflict over whether needs should be meet by themselves or others. Such individuals lead a restrained, perfectionist existence. Compulsives have moralistic and ordered thinking. They are conformist and compliant in the acceptance of social rules. Their interpersonal relationships are characterised by docililiy and compliance. Items on this scale reflect DSM-111-R Obsessive Compulsive personality disorder.

Passive aggressive (Scale 8A): Passive aggressive personalities also experience ambivalence concerning the source of reinforcement. High scoring on this scale however is characterised by sulking, fretful moodiness and swings between passive dependence and active independence. This scale reflects items of DSM-111-R Negativistic personality disorder, subsequently deleted from DSM-1V.

Self defeating - masochistic (Scale 8B): This passive discordant personality is characterised by a reversal of the pain pleasure polarity. They view themselves as primarily inadequate and defective. Such individuals frequently engage in self defeating and self sacrificing behaviours. They find comfort in physical suffering and believe they deserve pain and humiliation. This scale reflects features of DSM-111-R Self-defeating personality disorder, subsequently deleted from DSM-1V.

Severe Personality Disorders (S, C, P)

These three scales reflect a more severe and maladaptive level of personality functioning:

Schizotypal (Scale S): The schizotypal personality represents a more sever form of schizoid or avoidant personality. They tend to be socially isolated, experiencing paranoid and confused thinking. Brief psychotic episodes may be present under severe levels of stress. Items on this scale reflect features of DSM-111-R Schizotypal personality disorder.

Borderline (Scale C): The borderline experiences a range of ambivalent behaviours across all three polarities. This is reflected by lability of mood, self destructive behaviours and vacillating views of the self and others. Items in this scale reflect features of DSM-111-R Borderline personality disorder.

Paranoid (Scale P): These independent personalities display a mistrust of others, while seeing themselves as independent. They are characterised by hostile and controlling interpersonal behaviour, with an overvalued sense of self.

Clinical syndromes scales (A, H, N, D, B, T)

These scales are proported to measure symptomatology. They are designed to measure DSM-111-R Axis disturbances. The reliability and stability of these scales are somewhat lower than the personality scales, and reflect the transitory nature of clinical symptoms.

Anxiety (Scale A): This scale is designed to assess symptoms of anxiety. High scores reflect tension, worry and nervousness. Individuals may ruminate over social fears and discomfort. Physical symptoms such as muscular tightness and nausea may also be present.

Somatoform (Scale H): These individuals express psychological concerns through physical channels. Such expression may be through generalised weakness, fatigue and tension. Actual physical complaints, where present, may be exaggerated.

Bipolar - manic (Scale N): Patients high on this scale exhibit periods of impulsivity, and irritability. They may also demonstrate an inflated sense of self worth. It is possible that at extreme levels hallucinations and delusions may be present.

Dysthymic (Scale D): This scale measures depressive symptomatology. It assesses a relatively chronic state of poor self worth, depressed mood and suicidal ideation.

Alcohol dependence (Scale B): High scores on this scale indicates difficulty in controlling alcohol use. It denotes the likelihood of alcohol related problems in work and personal relationships.

Drug dependence (Scale T): This scale measures a history of drug addiction or abuse. It also assesses common characteristics of drug abusers: impulsivity, resistance to limits and self centred traits. There is also an assessment of their effects on family and work.

Severe Clinical Syndromes (SS, CC, PP)

In keeping with the MCMI's focus on distinguishing between severity of pathology three severe clinical syndromes are measured.

Though disorder (Scale SS): High levels on this scale indicate severe levels of pathology such as schizophrenia or other psychotic disturbance. High scoring patients exhibit delusions, hallucinations and disorders of thought.

Major depression (Scale CC): This measure is an indication of severe levels of depression. They measure severely depressed mood, suicidal ideation, loss of appetite and sleep disturbance.

Delusional disorder (Scale PP): This scale measures acute paranoid ideation, which may reflect formal delusional content. Individuals scoring high on this scale will have ideas of reference and feelings of persecution.

Validity and correction indices.

The MCMI-11 has attempted to reduce factors leading to distortions in profiles and subsequent interpretation. They assess test taking attitudes and response biases.

Validity measure: This is a measure of the extent to which a patient is disturbed, uncooperative or approaches the test in an erratic manner. It consists of four highly improbable items (e.g. I flew across the Atlantic 40 times during the last year).

Disclosure level (Scale X): This scale is composed of the raw scores of the basic personality scales. It assesses openness to disclose psychological difficulties. High scoring patients will be open about such difficulties, while low scoring ones are seen as secretive and reticent.

Desirability (Scale Y): This scale consists of items which are sensitive to social desirability. High scorers tend to portray themselves in a positive light, while minimising more negative traits.

Debasement (Scale Z): This scale measures the tendency of the individual to report negative traits and personal faults. The scale is useful in assessing malingering (for example, in compensation claims) and 'psychological cries for help'.

Appendix 4

Scoring the MCMI-11.

1. The first procedure is to apply the weighted templates to obtain raw scores for the 22 scales. Once these have been obtained Base Rate (BR) scores are obtained from Millon's table.

2. The next step involves a complex set of adjustments to the scales depending upon disclosure levels and the configuration of Y and Z scores:

3. A denial - compliant adjustment (DC adjustment) is made where patients have scored highest on the Histrionic or Narcissistic scales, or have the Compulsive scale as the first or second highest scale (DC adjustment - part one). A second adjustment (DC adjustment - part two) is made when the Self defeating scale is highest, or the Avoidant scale is the first or second highest scoring scale.

4. A Depression - Anxiety adjustment is made when scores on the Dysthymic and Anxiety scores reach a critical point (BR >85).

5. The setting (in-patient or outpatient) is the final consideration for adjustment.

Appendix 5

McCann and Dyer's (1996) Validity criteria

Validity indicator	Acceptable	Marginal	Unacceptable
A. **Item omissions**	<8	8-11	12+
B. **Consistency of endorsement**			
1. Validity	0	1	1+
2. BR Y and BR Z ≥ 75	No	Yes	Yes
C. **Accuracy of endorsement**			
3. Overreporting			
Scale Z	BR <75	BR 75-89	BR ≥ 90
2. Defensiveness			
Scale Y	BR <75	BR 75-89	BR ≥ 90