CHECKLIST OF OFFENCE PATHWAYS FOR RAPISTS: A CLINICIAN’S GUIDE TO INFORMED INTERVENTION

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Abstract

The violent sexual assault of women and the rehabilitation of its perpetrators is an area of crime that has been scarcely researched. The problem of sexual aggression is multi-dimensional and accordingly a comprehensive assessment needs to address a wide range of psychological vulnerabilities and offence process characteristics to enhance treatment customisation. The purpose of this study was to create a clinician rated measure for the treatment classification of rapists – Checklist of Offence Pathways – Rapist Version – and to assess the measure’s reliability and validity. The 15-item measure was created using the framework of the pathways model (Ward & Hudson, 1998; Ward, Hudson, & Keenan, 1998). The measure was divided into two subscales measuring approach vs. avoidant goals and active vs. passive strategies. Both subscales demonstrated significant interrater reliability ($r = .53$ and $r = .46$, respectively) as well as internal consistency ($\alpha = .50$ and $\alpha = .60$, respectively). The majority (80%) of the inter-item correlations were uncorrelated or weak indicating that the test items were measuring separate constructs. Validity analysis indicated that a number of test items displayed convergent and discriminant validity with established psychometric scales. Overall these results suggest that this measure provides a useful framework for understanding sexual aggression and selecting treatment strategies for rapists, while avoiding some of the pitfalls associated with dissimulation in self-report measures.
Declaration of Authorship

I, Qusai Hussain, declare that this thesis comprises only my original work, except where due acknowledgement has been made in the text to all other material used. This thesis is approximately 30,000 words in length, exclusive of tables, figures, bibliography, appendices and footnotes.

Qusai Hussain

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CHAPTER ONE

Review of the Literature

1.1 Introduction

The infliction of sexual aggression on adult women, although frequent, is an area of crime that has been inadequately researched. One of the consequences of this omission is that there is surprisingly little research to guide how rapists can be rehabilitated effectively (Polaschek & King, 2002). In contrast, recent years have seen an increased interest by clinicians and researchers in the area of child sex offenders. There may be a number of convincing reasons for this focus on child sex offenders. Some may be pragmatic, with over 80% of sexual offenders entering treatment programmes having offended against children (Beech & Fisher, 2002); others may be based on our values, as children are considered to be one of the most vulnerable groups of our society (Polaschek & King, 2002). Perhaps child sexual abuse is more readily recognised as a social problem because the victims are more clearly identifiable. A zero-tolerance attitude to any kind of sexual contact with a child sits well within the social conscience. However, the rules of sexual engagement between adults are still quite nebulous and vary from culture to culture. Determining what constitutes appropriate and inappropriate sexual contact between adults has direct implications for delineating the boundaries between rape and non-criminal sexual practices and, therefore, is reflected in the incidence and prevalence of rape (Gilbert et al., 1997).

Substantial evidence indicates that sexual aggression in general, and rape in particular, are determined by a multiplicity of interacting variables (Malamuth,
and that rapists constitute a markedly heterogenous group (Knight & Prentky, 1987). The diverse nature of sexually assaultative behaviours displayed by these offenders vary from comparatively minor instances of unwanted gestures and verbal behaviour, to heinous sexual assaults resulting in the victim’s death (Ward, McCormack et al., 1997). This has resulted in a variety of nosological and conceptual problems (Hudson & Ward, 1997). Given the significant implications this heterogeneity has for the assessment, treatment and rehabilitation of rapists, it seems appropriate that this complex sexual behaviour be explored in greater detail in order to develop intervention strategies that are tailored to target the specific needs of these offenders.

Until recently, treatment programmes have relied on essentially categorical and hierarchical models for the classification of rapists, using a number of empirically derived risk factors to assess and determine treatment needs. Unfortunately, treatment outcome studies of rapists have demonstrated a less than adequate success rate in reducing recidivism which has prompted researchers to develop what is being now known as the offence chain or pathways model of sexual offending (Ward & Hudson, 1998; Ward, Hudson, & Keenan, 1998). Although this model was originally developed on a sample of child molesters it has been validated with rapists (Polaschek & Hudson, 2004; Polaschek, 1997; Polaschek et al., 2001; Webster, 2005). One of the key contributions of the pathways model is that it outlines four distinct pathways to offending and describes the offence process as the unfolding of a sequence of events over time, culminating in the commission of the offence. The proponents of this model suggest that placing emphasis on the temporal context of an offence provides an intuitively useful way to structure the assessment process and takes into account
various cognitive, affective, behavioural and volitional aspects of the offence process that could constitute successful targets for intervention.

In order for any treatment strategy to be effectively developed, a thorough assessment that integrates an offenders’ risk factors and treatment needs is essential. It is therefore the scope of this thesis to develop a clinician-rated assessment measure for rapists utilising the framework of the Ward and Hudson Self-Regulation Model of sexual offending (Ward & Hudson, 1998; Ward, Hudson, & Keenan, 1998). The focus of this thesis will be on men who have been convicted for penetrative sexual assaults of adult women. For purposes of convenience, the offence committed by these men will be referred to as rape and the perpetrators will be referred to as rapists.

This introductory chapter begins by briefly examining the legal and social definitions of rape and the prevalence research, with particular reference to the Australian context and the extant literature on conviction trends within the Department of Corrections. This information is included in order to provide a context for the sample of rapists on which this research was conducted. This is followed by a brief discussion of early taxonomic systems of rapists followed by a detailed discussion of the Pathways model and a critical analysis of the supporting literature. Finally, a detailed review of the assessment measures frequently utilised with rapists is presented, and their limitations are discussed, underscoring the rationale for the current study. Chapter 2 is devoted to a description of the first study, which focuses on the development of the Checklist of Offence Pathways-Rapist Version (COP-RV: Appendix A) from the theoretical and empirical literature. The second study is discussed in Chapter 3, which aims to assess the reliability and validity of the COP-RV and contains a description of the participants, casefiles, methodology and summary of the results. Finally, Chapter 4
integrates the information presented during the course of this thesis and provides a discussion of the results, elaborates the strengths and limitations of the current study, and outlines directions for future research.

1.2 Rape Defined: Diagnostic and Legal Implications

1.2.1 Clinical definition of rape

It would seem appropriate to begin a discussion about the problem of rape with the relevant nosological system, however, rape is not included as a paraphilia in the Diagnostic and Statistical Manual of Mental Disorders – IV (DSM-IV: American Psychiatric Association, 1994). A paraphilia is defined as intense sexually arousing fantasies, sexual urges, or behaviour generally involving unusual objects, activities or situations, lasting for a period of at least 6 months and causing significant distress to the individual or impairment in functioning (American Psychiatric Association, 1994). Although there may be a variety of motivations for sexually aggressive behaviour, Abel and Rouleau (1990) have noted that “clinical interviews with rapists provide support for the classification of rape as a paraphilia, because many individuals report having recurrent, repetitive and compulsive urges and fantasies to commit rape” (p.18). Other paraphilias such as exhibitionism, frotteurism and voyeurism have been listed in the DSM-IV and are described as conditions that are characterised by compulsive urges and fantasies but which are rarely self-referred, thereby implying a lack of personal distress or impaired functioning. This is also true for rape, and hence, its absence from the list of paraphilias is puzzling (Hudson & Ward, 1997). Interestingly, research studies have shown a close relationship between these paraphilias, indicating a high co-occurrence between exhibitionism, frotteurism,
voyeurism and rape (Abel et al., 1988; Bradford, Boulet, & Pawlak, 1992). Studies also demonstrate that the content, frequency and intensity of sexual fantasies have important implications for the identification and treatment of rape (for a review see Prentky & Knight, 1991), and Marshall and Barbaree’s (1989) study suggests that deviant sexual fantasies are not only responsible for deviant sexual behaviour, but also impede normal sexual adaptation. Furthermore, lack of impulse control (Hanson & Morton-Bourgan, 2004; Prentky & Knight, 1991) and problems with sexual self-regulation, whereby, rapists perceive themselves to have strong sexual urges which cannot be controlled (Hanson & Bussiere, 1998) have been consistently linked to sexual offending. While these studies demonstrate that rapists share a number of common features with paraphiliaes, the non-inclusion of rape as a paraphilic disorder still remains unclear.

1.2.2 Legal definition of rape

In Australia, for pragmatic purposes, the act of rape is determined by legal statute, and although clinically there still exists an ambiguity about its definition, legally it is defined by the nature of the sexual assault as well as the age of the victim (Hudson & Ward, 1997). The latter criterion is most commonly set by legal statute at 16 years of age (Waller & Williams, 2001). Not surprisingly, offenders are sometimes unaware of this age criterion and, in such cases, the discrepancy in age between the victim and the offender and the nature of the sexual acts are examined (Seghorn, Prentky, & Boucher, 1987).

Australia is regarded as a common law country and as such has incorporated many of the values, principles, procedures and rules developed initially in England (Kapardis,
The law can be made in a number of ways and these have been set out below, in order to provide clarity when the terms are used throughout this section:

1. Common law: Refers to the fact that the courts create much of the law, which is through judicial decisions and case law. Judge-made law is based upon tradition and precedent and uses previous decisions to adjudicate the present.

2. Statutory law: These are laws that are made in parliament and are referred to as ‘acts’ or ‘statutes’.

3. Delegate legislation: Some bodies such as universities or local government councils are delegated the authority to make laws and by-laws within a prescribed range.

The relationship between common law and statutory law is close, because parliaments have periodically set common law into specific legislative frameworks (statutes), while courts play a significant role in making law through interpreting parliamentary legislation (Waller & Williams, 2001).

From a historical perspective the concept of rape under common law was taken to mean “the carnal knowledge of any woman….against her will” (Waller & Williams, 2001, p.89) and was restricted to penile-vaginal penetration. With a growing body of research (Muehlenhard et al., 1992), the complexity of sexual assault started to become apparent and increasing awareness of the proliferation and depth of the problem of rape prompted a wave of global reforms starting with the United States. Law reform in the United States sought to use gender neutral language in statutes so as to encompass homosexual rape (i.e. male victims raped by other males) and to broaden the term *sexual penetration* to include not only penile-vaginal intercourse but
cunnilingus, fellatio, anal intercourse and other bodily intrusions (Searles & Berger, 1987). Following such progressive developments in the United States, commonwealth countries like England and New Zealand began to initiate legal reforms to their rape laws, and broadened the scope of rape to include a wide range of sexual behaviours (Polaschek, Ward, & Hudson, 1997).

Over recent years in Australia, each of the common law states have amended the law relating to rape and other sexual offences in quite a fundamental fashion (Waller & Williams, 2001). In South Australia, New South Wales and Victoria the crime of rape has been greatly increased in scope. In South Australia this was achieved by the Criminal Law Consolidation Amendment Act (1976). In New South Wales, the Crimes (Sexual Assault) Amendment Act (1981) abolished the crime of rape, replacing it with categories of sexual assault such as aggravated sexual assault, assault with intent to have sexual intercourse, indecent assault, aggravated indecent assault, acts of indecency and aggravated acts of indecency. In Victoria, reform was first achieved by the Crimes (Sexual Offences) Act (1980). The Victorian legislation was further amended by the Crimes (Sexual Offences) Act (1991) and then by the Crimes (Rape) Act (1991), which introduced a purely statutory crime of rape and abolished the common law offence. Section 38 of the Crimes Act (Vic) (1958) defines rape as being the non-consensual sexual penetration of a person above the age of 16 years. Through these reforms, sexual penetration has been widened to include homosexual rape, vaginal, anal and digital rape as well as cunnilingus, fellatio and the insertion of other objects.
1.3 Incidence and Prevalence of Rape

1.3.1 Victim surveys

Measurements of the incidence and prevalence of rape can be divided into two categories – those assessing its occurrence over a lifetime, and those examining its incidence within more limited time periods, typically a year (Kelly, Lovett, & Regan, 2005). The complex nature of these methodological differences makes the task of establishing accurate prevalence rates for rape far more formidable.

In one of the most comprehensive studies in the United States focusing on women’s self-reported experiences of sexual victimisation, Russell (1982; Russell & Howell, 1983) reports a 24% victimisation rate of rape. This is comparable to a figure of 24.5% found in a national sample of American university women reporting having experienced rape or attempted rape since the age of 14 years (Koss, Gidycz, & Wisniewski, 1987). The study also reports that the victimisation rate for women peaks in the 16 to 19 year old age group, with the second highest rate occurring in the 20 to 24 year old age group. An American study (Saunders et al., 1999) investigating the experience of childhood rape of adult women found that more than one fifth (20.2%) of the first child rapes occurred at ages 16 and 17. A similar rate of 25.3% for rape and attempted rape was found in a study of New Zealand university students (Gavey, 1991).

Comparisons between different national data show significant variations in the prevalence and reporting of rape such that the possibility of differential national levels of sexual violence within different societies needs to be explored (Kelly, Lovett, & Regan, 2005). An International Crime Victims Survey (ICVS) in 1996 (Mayhew &
van Dijk, 1997) of females aged 16 and over from eleven industrialised countries (Austria, Canada, England, Wales, Finland, France, the Netherlands, Northern Ireland, Sweden, Switzerland and the United States) reported that although the rates of sexual victimisation (including rape and attempted rape) are highest in Switzerland (4.6%), Austria (3.8%) and the Netherlands (3.6%), these countries generally have lower levels of reporting of incidents to the police. In over half of the cases involving rape and attempted rape, the women knew the offenders, which may explain the low levels of reporting. In New Zealand, the Victimisation Survey Committee which commissioned the first comprehensive national survey of crime victims in 1996 (Young et al., 1997), found an average victimisation rate (including rape and other forms of penetration) of 6.1 per 100,000 women, with 26% of women reporting having been sexually assaulted at least once in their lifetime. Approximately 4% of women had been forced by a partner to have sex. Although there has been no dedicated national random sample study of either the incidence or prevalence of rape in the UK, Kelly and colleagues (2005), in a review of independent survey studies, found high prevalence rates of rape, where one in four women had experienced rape or attempted rape in their lifetime. This study had comparable results to the International surveys with findings that the most common perpetrators of rape are current partners (54%) and ex-partners (29%), and a considerable proportion involves repeat assaults by the same perpetrator (50% in the same 12 month period). However, the vast majority of victims (91%) told no-one at the time.

Researching unreported rape and sexual assault is more complex than many other forms of violence research against women, as the use of the word ‘rape’ in survey questionnaires greatly decreases the reporting of non-consensual sex (Schwartz,
1997), an approach which could be helped by providing a description of the acts that constitute the offence (Koss, 1992). Koss and colleagues (Koss, 1993, 1996; Koss, Gidycz, & Wisniewski, 1987; Schwartz, 1997) have noted several features of the methodologies used by both researchers and statutory authorities that serve to heighten inconsistent findings and underestimation in official surveys: the sample; the number and content of questions asked; the format (questionnaires, telephone or face-to-face interview); and the definition of rape used by the researchers. The re-design of questions in the US National Crime Victimisation Survey (NCVS) in 1992 for instance, resulted in findings four times higher than previous versions (Greenfeld, 1997). Koss (1992) suggests that the true incidence of rape is likely to be 6 to 10 times the NCVS estimates with approximately a 20% lifetime prevalence of rape victimisation of women (Koss, 1993).

1.3.2 Official reports

An alternative approach to the measurement of the prevalence of rape as reported in victimisation surveys is to review the incidence of complaints, prosecutions and convictions (Hudson & Ward, 1997). Although estimates of convictions resulting from incidents reported to authorities range from 7% to 25% (Carrington, 1996; Grace, Lloyd, & Smith, 1992), these are of little value as it has been estimated that 40% to 50% of rapes are not reported to authorities (Koss, 1985). The number of reported rapes is lower than both incidence and prevalence rates (Walby & Allen, 2004) and there is a gradual shrinkage between the number of sexual assaults that occur and those that are reported to police, recorded by them, proceed to trial and finally result in a conviction (Lievore, 2004).
One of the explanations for the low reporting of rapes and attempted rapes is the nature of the relationship of the victim to the offender. A large number of crimes occur within relationships and families and are never brought to the attention of law enforcement agencies (Lievore, 2004). The Australian Bureau of Statistics (1999) reports that a majority of women are sexually assaulted by men they know and trust, with an 85% victimisation rate by perpetrators who are friends, family, partners, ex-partners, acquaintances, neighbours or colleagues of the victim. Koss (1992) notes that a woman is four times as likely to be raped by someone she knows than by a stranger. The close nature of the relationship between the offender and the victim may create personal barriers to reporting and sexual assault research indicates that the odds of a victim reporting to police decreases as the relational distance between the victim and the offender decreases (Lievore, 2004). Clearly, women find it difficult to reconcile intimate partner sex with criminality. Survey results show that a large proportion of women’s experiences that can be categorised as rape according to legal parameters, do not classify themselves as rape victims and even those who describe an incident as sexual assault hesitate to define it as a crime (Fisher, Cullen, & Turner, 2000; Myhill & Allen, 2002).

1.3.3 The Australian position

The Australian Bureau of Statistics (ABS) has conducted three major surveys that have reported on the incidence and prevalence of sexual assault. The *Women’s Safety Australia* survey conducted by the Bureau of Statistics in 1996 involved a random sample of 6,300 women aged 18 and over and focused on the nature and extent of violence against women (Australian Bureau of Statistics, 1996). It reports a prevalence rate of 17.9% for sexual assault since the age of 15 years and an incidence
of 1.9% for women aged 18 years and over in the year prior to the survey. *Recorded Crime Australia*, which presents annual statistics on a range of offences recorded by police in all states and territories, reports an incidence rate of 0.86 per cent (Australian Bureau of Statistics, 2002b). The prevalence of sexual assault is more likely to be in the younger age group (18-24) with *Crime and Safety Australia* reporting a rate of 3.3% (Australian Bureau of Statistics, 1999) and *Women’s Safety Australia* reporting a rate of 4.6% (Australian Bureau of Statistics, 1996). This age group is twice as likely to be victimised by sexual assault than those who fall in the age range of 35 to 44 years - who have a reported victimisation rate of 2.3% (Australian Bureau of Statistics, 1996). In sharp contrast, a more recent independent study conducted in Queensland (O'Donovan, Devilly, & Rapee, In Submission), attempted to measure the antecedents to women’s fear of rape, collecting survey data on its respondents (n = 411) with a finding that almost 18% of women above the age of 18 years had reported being raped (defined as vaginal, anal and/or oral sexual contact involving force or threat of injury), with almost 20% of rape victims having identified themselves as being professionals. The wide disparity in the reported figures of the incidence of sexual assault among these surveys may be due to methodological differences such as the use of different populations and varied collection and counting methodologies. However, they underscore the general risks for and characteristics of sexual assault.

While comparing the incidence and prevalence rates of rape in Australia to other countries, the Australian results from the 2000 International Crime Victims Survey are similar to those from other countries taking part (for details see van Kesteren, Mayhew, & Nieuwbeerta, 2000). Results from Australian surveys are also congruent with those from surveys conducted in England and Wales, Canada, New Zealand and
the United States. These survey results which indicate the relatively uniform international risks for rape for different groups of women, and the high prevalence rates of these sexual assaults, highlight the need for a more focused attention on this insidious and growing problem.

1.4 Australian Rapists: Apprehension and Conviction

Trends

Surveys of sex crime victims do not provide estimates of the prevalence of sex offenders but indirectly shed light on the number of sex offenders who may never be brought to the attention of the criminal justice system because of their relationship to the victim (Lievore, 2003). Closer approximations can be made of the number of potential sex offenders by using police apprehension records in Australia. Police services in Victoria, Queensland, South Australia and the Western Australian Crime and Research Centre publish statistics on apprehensions of alleged sex offenders who have committed offences of rape and indecent assault against adult women. Data published by other jurisdictions was not available at the time of writing this thesis, nor was it available from the Australian Bureau of Statistics (ABS), who are currently developing a collection of Offender Based Statistics which will include details of persons apprehended for sexual assault (Lievore, 2003).

It is evident, however, that rape constitutes a small but significant proportion of all sexual offences, with the majority of rapists in Australia likely to be adults. In Victoria, South Australia and Queensland the proportion of juvenile sex offenders has been stable since 1996, with young offenders (17 years or younger) comprising only
eight per cent of the sex offender population in 2001 (Australian Institute of Criminology, 2002).

1.4.1 Prevalence of rapists across jurisdictions in Australia

There are noticeable differences amongst the states in the commission of rape offences. For instance, in Victoria for the 2001 fiscal year, Victoria police processed 3,439 alleged sex offenders of whom 15.4% were alleged rapists (Victoria Police, 2002). In contrast, South Australia Police cleared 740 sexual offences between 1st January and 31st December 2001 of which over half of the alleged offenders (59%) were apprehended for rape and indecent assault (Attorney-General's Department, 2002). Both jurisdictions reflect similar age groups for rapists: In South Australia 65% of the alleged rapists were aged between 25 and 59 years at the time of apprehension and in Victoria 90% of the alleged rapists were adults (Attorney-General's Department, 2002; Victoria Police, 2002). Interestingly, each of the jurisdictions witnessed an age-related decline in offending behaviour such that the peak age range was between 20 to 34 years. During the same fiscal year Queensland Police recorded 1,076 rapes and attempted rapes, which constitutes approximately 19% of all the sexual offences in the state. This jurisdiction saw twin peaks in age categories with males aged between 30 to 34 and 45 to 49 being most likely to be proceeded against (Queensland Police Service, 2001). In Western Australia, 407 rapists were released into the community after having served a prison sentence between 1987 and 2000. This represents 26% of the total sex offender population during that period (Greenberg, Da Silva, & Loh, 2002). Conviction and sentencing data in Australia reflect a similar pattern. In the year ending 30th June 2001, out of a total sentenced prison population of 18,123, eleven per cent (11%) of offenders had
committed a serious sexual offence comprising of rape, attempted rape or the indecent assault of an adult woman (Australian Bureau of Statistics, 2002a). The proportion of males sentenced for sexual assault was highest in Western Australia (16%) and lowest in the Northern Territory (just under 8%).

1.4.2 International prevalence of rapists

Similar trends in the base rate of rape offences have been found internationally. In the U.K. although rape constitutes a very small proportion of all violent crime (1% in 2002/03), it makes up a quarter (25%) of all recorded sexual offences (Ruparel, 2004). The United States Department of Justice (Greenfeld, 1997) reported a total of 94,500 arrests in 1995 for sexual offences of which rape constitutes 37%. Interestingly when these figures are compared to penetrative sexual offences against children (under the age of 16), the majority of offences (55.3%) are against adult women (Greenfeld, 1997). A Home Office study in the U.K. (Kelly, Lovett, & Regan, 2005), comparing convictions for rape offences of adult victims and children under the age of sixteen, found that between 1998 and 2002 an average of 54.6% of convicted rapists had committed offences against adult victims.

It appears that globally, and notwithstanding the attrition in the prosecution and conviction of rape cases, rapists account for approximately a quarter (25%) of the sexual offender population, and constitute a majority when compared to sexual offenders who engage in sexually penetrative offences against children. Yet very little attention has been given to offenders who commit serious sexual assaults against adult victims. It is possible that too much reliance has been placed on early research, which suggested prevalence rates of rape were too low to justify dedication of scarce
resources. This is not surprising if it is assumed, as national and international figures suggest that a rapist is unlikely to be convicted and those that are ultimately convicted are a small subset of those that actually offend (Barbaree et al., 1994). However, with more dedicated research studies uncovering the true prevalence of rapists in our communities, the serious sexual assault of adults is beginning to be viewed more seriously by the criminal justice system (Victorian Law Reform Commission, 2004) than it was in the recent past, and with more rapists now entering treatment programmes the targeted assessment and treatment of these offenders poses an even greater challenge.

### 1.5 Taxonomic Systems for Rapists

Descriptive studies of rapists indicate that they are quite dissimilar to other sex offender populations (see Knight & Prentky, 1990; Marx, Miranda, & Meyerson, 1999 for a review), and while they exhibit considerable variability among themselves, attempts have been made to differentiate more homogenous groups within this population. Since the early 1950’s a number of taxonomic systems have been developed from established theoretical models, and have had some utility for assessment, evaluation of treatment, and prediction of risk (Polaschek, Ward, & Hudson, 1997). These early typological systems have attempted to delineate descriptive features of the offence or the offender into rationally derived subcategories. An understanding of these subcategories is considered to be important as they guide assessment and treatment planning and have considerable implications for outcome studies. Despite differences between these theoretical models in the manner in which these subtypes are derived and sorted, there appears to be sufficient
conceptual similarity in the way in which these groups have been structured. The most influential of these theoretical models will be discussed briefly below clustered as three distinct systems, and will provide a conceptual backdrop for a discussion of the development of the Pathways model of sexual offending (Ward, Hudson, & Keenan, 1998).

1.5.1 Categorical models

Categorical classificatory systems define types as discrete or mutually exclusive and internally consistent classes (Knight, Rosenberg, & Schneider, 1985). The earliest categorical typology of rapists was proposed by Guttmacher and Weihofen (1952) using psychoanalytic theory, and differentiated three subtypes on the basis of motivational components in the offence.

Kopp (1962) classified rapists as ego-dystonic or ego-syntonic based on the offenders characteristic style. Here, the ego-dystonic rapist is seen as one for whom the behaviour is dissonant with his character and is described as likely to feel guilty after the offence, whereas the ego-syntonic rapist is described as a psychopathic individual who is cold, calculating and unempathic.

In models that have high qualitative differences between types such as that of Kopp (1962), the distinctive features that characterise cohesiveness within groups are of importance to the clinician. In contrast Gebhard and colleagues (1965) posit a typology of rapists’ in which type 1 exhibit instrumental violence (aggression during the commission of the offence is a means to an end), and type 2 exhibit gratuitous violence (violence is an end in itself). These authors, much like Guttmacher and
Weihofen (1952), view the quality of aggression in the offence as fundamental to distinguishing between rapist subgroups. Whilst the authors abandon this simple dichotomy in favour of seven classes of “heterosexual aggressors against adults” (Knight, Rosenberg, & Schneider, 1985, p.248), the aggression as means and aggression as end dichotomy can still be inferred in most cases. Thus, although Gebhard and colleagues (1965) classificatory system appears to be derived based on descriptive features of observed cases, it is less formally structured than other systems. Knight, Rosenberg and Schneider (1985) suggest that since such a high degree of overlap between types fails to show homogeneity and distinctiveness between types, its validity and utility may be correspondingly reduced.

1.5.2 Hierarchical models

In the 1970’s researchers introduced a refinement to the classificatory systems, which posits a hierarchical relationship between types – classes at higher levels are further broken down and rarefied into subgroups (Knight, Rosenberg, & Schneider, 1985). This appears to be a natural development of the systems, which began by defining types as extreme positions along a theoretical dimension and has grown into their division into more cohesive subgroups with enhanced homogeneity. Perhaps the best-known typologies developed in this system are those by Groth and colleagues (1979; 1977) and researchers at the Massachusetts Treatment Centre (Cohen, Seghorn, & Calmas, 1969; Cohen et al., 1971; Knight, 1999; Knight & Prentky, 1990; Prentky & Knight, 1991).

The model proposed by Groth and colleagues (1977) is similar to those mentioned earlier in its emphasis on underlying motivations that constitute the act of rape, but it
differs to the extent that it utilises a socio-cultural interpretation of rape focusing on masculinity and issues of power, aggression and dominance in the commission of rape. Using the accounts of 133 offenders and 92 victims, the authors identified two dominant types of rapists. The *power rapist* who intimidates his victim into submission using aggression and force is further classified on the aggression continuum as *power-reassurance* where the rape is committed to resolve feelings of sexual inadequacy, and *power-assertive* where the rape is committed through the expression of dominance and control. In contrast, the *anger rapist* vents his rage and contempt for his victim through sexual assault, often engaging in gratuitous physical and sexual violence to soothe perceived affronts. This category has been further divided into the *anger-retaliation* rapist who is primarily motivated by revenge and the *anger-excitation* rapist who is sexually aroused by the infliction of violence. The authors report that the predominant class of rapes are power-rapes (65%) with thirty-eight percent (38%) of the offender sample being classified as power-assertive rapes and forty percent (40%) as anger-retaliation.

A more robust taxonomy, which has been subjected to rigorous empirical analysis in recent years is the one proposed by the Massachusetts Treatment Centre. Although this model is similar to that proposed by Groth and colleagues (1977) in that it emphasises motivational components of the sexual behaviour, it differs by concentrating on the underlying sexual and aggressive nature of these motivations as opposed to only power and anger suggested by Groth (Knight, Rosenberg, & Schneider, 1985). The earliest version, the MTC-R1 (Massachusetts Treatment Centre - Rape 1) was developed by Cohen and colleagues (1969) and described four rapist
sub-types: The *impulsive* rapist, the *sex-aggression-diffusion* rapist, the *displaced-aggressive* rapist and the *compensatory* rapist.

The first revision of the MTC-R1 system was prompted by an unsatisfactory interrater agreement in the classification of the rapists into the four types (Prentky, Cohen, & Seghorn, 1985). The majority of the disagreements in classification were restricted to distinguishing between compensatory and impulsive types. This lead to the formulation of the MTC-R2 typology in which lifestyle impulsivity evolved from a single type discriminator (impulsive type) to a generic discriminator among multiple types. Thus each of the four rapists types were further sub-divided into low and high impulsivity giving rise to a hierarchical decision tree model assessing a pervasive pattern of poor impulse control and behavioural problems. While follow-up studies (Prentky et al., 1995) of rapists revealed that high-impulsivity offenders were at a hazard rate of twice that of low-impulsivity rapists in all four categories, indicating that lifestyle impulsivity was a robust predictor of reoffence risk, reliability studies of the taxonomic system were not altogether promising. These studies suggested that the low-high impulsivity construct suffered reliability problems, especially for offenders who engaged in instrumental aggression (Prentky, Cohen, & Seghorn, 1985). Further, the model did not provide effective group discrimination to be optimally reliable (Rosenberg et al., 1988).

The latest version, the MTC-R3 sought to address these limitations in the earlier model and substituted the construct of lifestyle impulsivity with a broader one of social competence (Prentky & Knight, 1991). Admittedly deficits in social skills have received weak support as a discriminator between rapists and other criminals, but the
construct of social competence as assessed by the stability and durability of an offender's interpersonal relationships, as well as employment history, has shown promise as a discriminator among subgroups of rapists (Prentky & Knight, 1991). Nine groups have evolved within the MTC-R3, and cluster analytic studies have demonstrated the potential utility of social competence in discriminating among groups of rapists, identifying valid sub-types within compensatory (Rosenberg et al., 1988), exploitative (Prentky, Knight, & Rosenberg, 1988) and displaced anger groups (Knight & Prentky, 1990). However, more recent analysis of the MTC-R3 sub-types indicate that although the classificatory system has some validity there may be critical dimensions that underlie these constructs and as a result their complex interrelationships need further investigation (Knight, 1999).

1.5.3 Dimensional Models

The dimensional model departs from traditional classificatory schemes in that it assumes that differences among types are continuous and quantitative in nature. Although this model of structuring relations among types has seen frequent application in psychiatric and criminal populations, it has been less commonly used in sex offender typologies (Knight, Rosenberg, & Schneider, 1985). One of the reasons for this could be that the rationally-derived schemes that are so popular for the categorical and hierarchical models are more difficult to apply to the quantitative assumptions inherent in the dimensional models (Prentky & Knight, 1991). Thus, dimensional models usually adopt classifications based on psychological tests and inventory data. The earliest dimensional classification of sex offenders was based on an MMPI study by Anderson and colleagues (1979) in which three prototypic profile configurations were developed. More recently, researchers in the United Kingdom
have developed deviancy classifications of child abusers using a statistically devised system of weighting psychometric scores (Beech, 1998; Beech, Fisher, & Beckett, 1999).

Since quantitative assumptions have limited the spread of dimensional models, the qualitative bases of these typological differences have been considered. For example Cohen and colleagues (1969) did not rule out the possibility that the differences between types in their system may fall along a continuous dimension. In more recent times there has been an increasing interest in classifying offenders based on their offence chain (Hudson, Ward, & McCormack, 1999; Ward et al., 1995). Using grounded theory analysis (Strauss & Corbin, 1990) the offence process of the offender is systematically classified in terms of pathways. This descriptive model of sexual offending is built from the bottom up using qualitative research techniques to summarise the information provided by the offenders about their own offence process. These pathways in combination with the self-regulation theory (Baumeister & Heatherton, 1996) have given rise to four pathways organised around the nature of sexual offence goals (approach vs. avoidant) and the types of strategies employed to achieve these goals (active vs. passive).

It is therefore possible that one strategy for developing this system could be through a combination of models with dimensional differences characterising groups at one level and hierarchical relations existing between groups at another level, much like the pathways model. Such complex systems are becoming more common in the general classification literature, as exemplified by the adoption in the DSM-IV (American Psychiatric Association, 1994) of the categorical and at times hierarchical
structuring of symptoms and personality disorders. The utility of the classificatory system will ultimately depend on its scope for practical application. At this stage, categorical and hierarchical models of sexual offending assist police in narrowing down suspects from a pool of inferred behaviours at a crime scene and are less helpful for treatment providers. Undoubtedly, models designed to assist with risk prediction may need to differ in important ways from those intended to assist with the development of more relevant and powerful treatment strategies. A dimensional model embracing pathways to offending offers promising treatment strategies for rapists, and will be discussed in more detail in the following chapter.

1.6 The Pathways Model

A significant contribution to the problem of effective treatment delivery to rapists is a limited conceptual understanding and incorporation of, treatment approaches to address the heterogeneity of men who sexually offend against adult women. Not surprisingly, this heterogeneity has caused a “variety of conceptual and nosological problems” (Hudson & Ward, 1997, p.332), and has generated confusion concerning a number of issues, most importantly the prevalence and incidence of rape and factors associated with it. There have subsequently been multiple attempts at classification of rapists and the establishment of sub-types. However, due to the enormous diversity in the histories, personalities, and offending behaviours of the men who commit rape, no simple classification system is able to adequately inform treatment needs (Ward, McCormack et al., 1997). Accordingly, both assessment and treatment need to address a wide range of psychological vulnerabilities and offence characteristics to effectively modify the sexually deviant behaviour of each offender.
With the advent of behaviour therapy in the 1950’s and 60’s, treatment providers began using behaviour modification in the treatment of sexual offenders, to suppress deviant sexual arousal and increase social competence (Laws, 2003). This approach to treatment was dominant throughout the next decade, until the evolution of cognitive approaches in the 1970’s turned the attention to thought processes in sexual offenders and targeting pro-offending attitudes and beliefs (Marshall, Anderson, & Fernandez, 1999). By the 1980’s the concept of relapse prevention began to proliferate as an organising framework for cognitive-behaviour therapy for sexual offenders (Polaschek, 2003) and until recently continued to be the most widely accepted treatment approach for sex offenders around the world.

1.6.1 Relapse Prevention: Here Today Gone Tomorrow?

Relapse Prevention (RP) was developed in the early 1980’s by Alan Marlatt and his colleagues for the treatment of alcohol and drug addiction (Marlatt & Gordon, 1985). The premise of RP is simply that if the determinants of relapse can be identified and adequate coping skills developed, these can act as buffers against threats to abstinence. With interventions for sexual offending still in their infancy, the practical potential of RP was soon recognised and adapted for use with sexual offenders (Pithers et al., 1983). The RP approach in essence requires the sexual offender to identify ‘high-risk situations’ and other threats in order to avoid re-offending. Once these have been effectively identified, self-management skills are developed in treatment to prevent relapse (Pithers et al., 1983). Apart from providing a treatment framework RP also outlined a model of the offence process identifying a sequence of cognitive, affective and behavioural elements leading to relapse. It is, therefore, not surprising that such a treatment approach quickly became popular as an organising
framework for treatment programmes world-wide. Polaschek (2003) argues that the rapid spread of RP can be attributed to three causes: First, there was no evidence prior to the 1980’s that treatment was effective in reducing recidivism, and the acknowledgement of ‘lapses’ within RP provided clinicians with optimism by confirming the difficulties of working with offenders. Second, it provided a common language to all clinicians by being organised within a cognitive-behavioural framework and third, it came with explicit guidelines for what to do in treatment.

However, with a growing interest in evidence-based practices, the uncritical acceptance of RP has received vigorous criticism. In a review of the literature Polaschek (2003) found very little evidence for the empirical analysis of RP. The only study with extensive external RP supervision – SOTEP – failed to demonstrate a significant treatment effect (Marques et al., 2000). Marshall and Anderson (2000) conducted a comparative review of treatment programmes without RP, to those with internal RP (skills taught during the treatment programme) and external RP (structured RP based follow-up after completing the treatment programme). This study similarly found that RP did not add any significant value in comparison to non-RP programmes in reducing recidivism after treatment (Marshall & Anderson, 2000).

Concern has also been raised about the acceptance of the way in which RP perpetuates the notion of a single pathway to the commission of a sexual offence (Laws, 2003). Studies have indicated that some offenders may consciously decide to engage in sexually abusive behaviour and engage in careful systematic planning accompanied by positive emotional states (Ward & Hudson, 1998). In a detailed critique, Ward and colleagues (Laws, Hudson, & Ward, 2002; Ward, 2000; Ward & Hudson, 1996) outline a number of theoretical difficulties with the RP model. First,
the adaptation by Pithers (Pithers, 1990; Pithers et al., 1983) of the original model (Marlatt & Gordon, 1985) for sexual offenders places reliance on a number of diverse theoretical sources leading to confusion in its application. For example, the original model’s use of various psychodynamic and behavioural treatments for the reduction or elimination of alcohol and drug abuse (Laws, 2003). Second, the articulation of covert planning and negative affective states proximal to the offence fails to account for offenders who engage in detailed planning and offend to accentuate positive emotional states (Ward & Hudson, 1998). Third, the model does not cover all possible pathways in reoffending, and the emphasis on skills deficits fails to include situations in which offenders consciously decide to offend. It has become increasingly apparent that a single pathway proposition such as the RP model not only lacks evidence of efficacy but also fails to recognise the heterogeneity in sexual offenders. As a result of the questionable applicability of the RP model to the treatment of sexual offenders a growing body of research has started to emerge investigating multiple pathways to offending known as the self-regulation or pathways model.

1.6.2 Evolution of the Pathways Model

One of the most serious shortcomings of the traditional relapse prevention model is its inability to account for all the possibilities involved in reoffending (Ward & Hudson, 1996). That is, its scope is too limited given that offenders are a heterogeneous group that adopt distinct offence pathways (Marshall, 1999b). Since the mid 1990's, Ward and his colleagues (Polaschek et al., 2001; Ward et al., 1995) set out to derive empirically grounded models of the offence chain of child molesters and rapists. Through a number of studies, the authors have provided evidence for the existence of diverse offence pathways containing a number of distinct phases which
suggest that offenders vary in their goals, their capacity to plan offences, and in the kinds of emotions they experience throughout the offence process.

The very first model developed was the offence chain of child molesters (Ward et al., 1995). Eight stages were identified which accounted for several distinct offence pathways for this offender type. Stage one, contained proximal background factors, either positive or negative. Stage two, was labelled ‘distal planning’ and involved covert planning, chance contact or explicit planning. Stage three constituted a high risk situation which involved establishing non-sexual contact with the victim. Stage four, involved the cognitive and arousal processes which turned contact with the potential victim into an explicit intention to offend. Stage five was the proximal planning, which pertained to the specific intention to offend and was hypothesised to have one of three foci: self, victim, or mutual. Stage six was the offence. Stage seven described the post-offence evaluation. Stage eight involved a resolution to either repeat the behaviour in the future or not.

The most important contribution of the Ward-Louden model described above was its recognition of two distinct offence pathways for offenders. The first pathway included negative affect, covert planning and negative evaluations post-offence, and resembled the RP model. The second pathway was markedly different and captured offences committed with a positive affect, explicit planning, cognitive distortions about children and a resolution to commit further offences (Ward et al., 1995). Subsequently, Hudson, Ward, & McCormack (1999) expanded the diversity of offence pathways by mapping 86 new offence descriptions on the Ward-Louden model. A similar pattern of eight stages was found in this study but was clustered into three pathways. The first two resembled the pathways in the Ward-Louden model and
the third involved negative affect but with explicit planning, focus on both the victim and self and resolutions to avoid offending. Although this study provided some support for this model with child molesters, its validity with rapists was questionable given the small sample size (14 rapists).

Further work by Polascheck, Hudson, Ward and Seigert (2001) developed a similar model for rapists with some notable differences to prevailing rape taxonomies (Prentky, Cohen, & Seghorn, 1985; Prentky & Knight, 1991). First, offender goals were not restricted to those temporal to the offence but rather appeared at several points in the offence chain. Second, nonsexual goals were made salient and distinguished from sexual goals. Third, the model was etiological and, while its primary purpose was to provide a description of the offence process, it was also capable of subsuming a classic relapse pathway. Subsequent research (Polaschek & Hudson, 2004) supports this model and has delineated three pathways. The first is a positive affect pathway in which the goal is casual sex to enhance a pre-existing positive mood. The second pathway is characterised by sexual gratification to alleviate personal distress and the third pathway reflects nonsexual goals in which the offender seeks to redress perceptions of harm to self by sexually assaulting and degrading the victim.

The most recent contribution to the offence pathways literature has been an addition to the earlier descriptive model of the offence process (Hudson, Ward, & McCormack, 1999; Polaschek et al., 2001; Ward et al., 1995) using self-regulation theory (Baumeister & Heatherton, 1996; Carver & Scheier, 1990; Karoly, 1993). The self-regulatory model (Ward & Hudson, 1998; Ward, Hudson, & Keenan, 1998) of
the sexual offence process consists of nine phases in which the offender engages in goal directed behaviour (approach vs. avoidant) and select strategies to achieve these goals (active vs. passive).

Goals are key constructs in theories of self-regulation, and are concerned with not only inhibiting or suppressing behaviour but can include the enhancement, maintenance or elicitation of behaviour as well. Ward and Hudson (1998) postulate two kinds of goals in the sexual offence process:

- **Approach goals** concern the gaining or increase of a skill or situation, and essentially involve approach behaviour. For example some sex offenders may crave excitement and seek to enhance or sustain positive emotional states such as sexual arousal. The type of goal is often related to the affective state - positive or negative – and depends on the aims of the offender. So for example, a desire for sexual gratification may be accompanied by a positive affective state, while the intention to humiliate and degrade a person may be evoked by strong negative emotions. Once a goal has been formed, any failure to achieve such goals tends to increase a person’s effort to succeed.

- **Avoidance goals** by way of contrast, are concerned with the decrease or inhibition of a behaviour or situation, and involve avoidance behaviour. For example, the inability to cope with difficult negative emotions may lead offenders to engage in avoidance behaviours by offending sexually. This goal requires more effort to implement and if unsuccessful focuses an offender’s attention on failure, interpreted in an all or nothing manner. More often than
not the affective state in this pathway is negative and high levels of psychological distress is experienced in anticipation of an unwanted event or action occurring.

Once these offence-specific goals have been established, a strategy to achieve the desired goal is activated (self-regulation style). This may be an explicit decision with the active use of strategies to bring about the desired state, or alternatively, strategies may be selected automatically as a result of well-learned behaviours (Ward & Hudson, 1998):

- **Passive Self-Regulation**: Those individuals who follow a passive route to offending by way of under-regulation fail to control their behaviour and behave in a disinhibited manner. Evidence of passive coping styles suggests a lack of self-regulatory capacity. In this view, impulses have a certain strength or intensity, and overcoming them therefore requires a corresponding form of strength or self-control. Consequently, under-regulation is associated with a difficulty in restraining impulsive behaviour and delaying gratification and additionally having an external locus of control that has been found to be related to high levels of impulsiveness. Therefore, individuals who follow a passive route to offending by way of under-regulation or disinhibition are more likely to present as unassertive, have an external locus of control and lead an impulsive lifestyle.

- **Active Self-Regulation**: Effective self-regulation requires cognitive preparations such as planning and rehearsing as well as the ability to monitor
and evaluate one’s behaviour. Therefore, an active self-regulatory style enables the delay of gratification and the restraint of impulsive behaviour in favour of a more valuable but remote goal. Offenders adopting an active self-regulatory style may either be effective in moving in a goal directed manner (e.g. ‘grooming’ their victim) or through the selection of inappropriate strategies misregulate. A commonplace example of misregulation is masturbating to deviant fantasies in an attempt to reduce urges, thereby paradoxically increasing the likelihood of re-offending. In this pathway, unlike passive self-regulation, offender’s make explicit attempts to cope with the selection of either goal.

1.6.3 Validation of the Pathways Model

The pathways model presents with considerable theoretical and practical departure from previous approaches to sexual offending and provides a potentially enhanced model for intervention with sexual offenders. That being said it has been the subject of limited empirical validation, an issue that the authors readily acknowledge (Hudson & Ward, 1996). Of the preliminary testing that has been undertaken, Proulx, Perreault and Ouimet (1999) examined the offence pathways of a cohort of extra-familial child molesters and discovered that they could be allocated to either a “coercive” or “non-coercive” pathway (Proulx, Perreault, & Ouimet, 1999, p.127). The authors conceptualise the coercive pathway as relating to avoidance goals, and the non-coercive pathway as relating to approach goals. This finding provides some support for Hudson, Ward and McCormack’s (1999, p.785) suggestion of “self focus” avoidant offenders displaying intrusive and violent behaviours, with “victim or
mutual focus” (Hudson, Ward, & McCormack, 1999, p.785) approach offenders displaying less intrusion and less physical coercion.

A second evaluation by Bickley and Beech (2002) also found a degree of support for the model. Eighty-seven child abusers were examined in terms of their pathway membership using psychometric and offence demographic data. Preliminary validation of the model was supported with differences across the groups being highlighted. Approach goal offenders were found to have more cognitive distortions about children than avoidance goal offenders. Approach goal participants were also more likely to have offended both inside and outside the family, and against both genders, than avoidance goal offenders. Passive pathway men were also more likely to blame external circumstances for their offending than those within an active pathway. These findings have implications for treatment with the authors suggesting that interventions be tailored to the type of goal the offender activates and the means by which he regulates this behaviour to achieve the desired goal. Thus, assessment of these factors is all the more critical to accommodate greater treatment customisation. In a treatment outcome study of the pathways model, Bickley and Beech (2003) demonstrated that there were differential treatment effects for the reduction of cognitive distortions among approach and avoidant goal child sexual abusers. Although there was a significant reduction in distorted beliefs about children in the approach group, the avoidant group did not display such a change as they were within the normal range prior to treatment. This suggests that treatment effects can be optimised if clinical interventions are tailored to the needs of different groups, thereby reflecting the heterogeneity of the offending process. A similar examination of group differences by Mann and colleagues (2004) in a sample of 47 sexual offenders
receiving treatment using the traditional relapse prevention model, indicated that approach group offenders were more engaged in treatment than the avoidance group. The approach group offenders were also more likely to identify ‘risk factors’ and reported their behaviours in a more active way, while avoidance group offenders were more likely to have an external locus of control. These findings are consistent with the model’s (Ward & Hudson, 1998) proposition that approach goal offenders activate behavioural scripts that are appetitive in function, and allude to a possible differential in therapeutic process while engaging in group therapy with approach and avoidant goal offenders.

Some preliminary research on this model also suggests that specific pathways vary with respect to risk and criminogenic need. In one study using a mixed sample of sex offenders, offenders in different pathways were found to differ significantly from each other on their static risk to re-offend, with offenders who followed an approach pathway being at greatest risk of reoffending (Yates, Kingston, & Hall, 2003). Additionally, pathway membership also differentiated between types of sexual offenders. Rapists were more likely to follow the approach pathway with fifty-eigh percent following the approach-automatic pathway and thirty-six percent following the approach-explicit pathway. Child molesters with male victims were more likely to follow an approach-explicit pathway (83% of the sub-sample) while child molesters with female victims were equally likely to follow either an approach-automatic or approach-explicit pathway. Half of incest offenders followed an approach-explicit pathway. This study offers a preliminary validation of the pathways model with two risk assessment measures. It also demonstrates that different groups of offenders have
varying pathways to the commission of the offence and supports the best practice principles of risk, need and responsivity in treatment (Bonta, 1996).

Finally, the most recent evaluation of the pathways model examined the validity of the model in allocating offenders into one of the four pathways (Webster, 2005). Twenty-five sexual offenders who had participated in HM Prison Service Sex Offender Treatment Programme, and had committed a further sexual offence upon their release from custody participated in the study. Results indicated that although there was some ambiguity in certain phases of the model, on the whole there was “strong support for the content validity of the model across the nine phases” (Webster, 2005, p.1192). The predominant pathway for this sample was approach-explicit with a majority of the participants being reliably classified. However, four participants could not be reliably allocated a pathway either pre- or post-treatment as they were characterised as having multiple concurrent pathways throughout the nine phases. Findings from this study suggest that although most offenders can be allocated a pathway, this model does not account for a small number of concurrent pathways. Furthermore this data support earlier findings (Ward & Hudson, 1998) that approach-explicit men are the most difficult to treat and that further research is necessary to delineate their specific treatment needs.

While there has been minimal research to date on the application of the pathways model to sexual offending, research has provided some support for the various pathways and their differential relationship to static and dynamic risks to re-offend. This is more than can be said for the relapse prevention model and although more evidence is required, focusing on various cognitive, affective, behavioural and
volitional aspects of the offence process could delineate different pathways that could be targets for intervention. Of course, this has implications for clinical assessment and Ward and Hudson (1998) argue that the pathways model provides an intuitively useful way to structure the clinical assessment and guide the clinician through the offence process. Recognition of an offender’s pathway will help highlight the kinds of treatments that are most important for him and allow for greater treatment customisation.

1.7 The Assessment of Rapists

Sexual aggression by rapists is a multi-dimensional problem (Hudson & Ward, 1997), and both assessment and treatment need to address a wide range of psychological vulnerabilities and offence characteristics to effectively modify the sexually deviant behaviour of each offender (Nugent & Kroner, 1996). The accurate assessment of rapists is therefore quite complex requiring highly skilled and resourceful clinicians.

The assessment of rapists can occur in a number of contexts. These include diagnostic appraisals pursuant to an arrest for an alleged rape (Laws, 1984), assessment of an offender’s strengths and deficits, treatment amenability and motivation after conviction as necessary prerequisites to effective treatment planning and implementation (Dougher, 1995; McGrath, 1991), an evaluation of an individual’s progress through therapy at the conclusion of treatment (Hanson, Cox, & Woszczyna, 1991), and finally an assessment of the individual’s risk of re-offending.
This last assessment has implications for the safety of the community and the future resumption of offending behaviour (Hanson, 1998; Marshall & Barbaree, 1989).

Irrespective of the purpose of assessment, it is imperative for a clinician to examine a wide range of information that includes not only the offender’s own report of the offence and its antecedents, but also available psychometric test results and ancillary collateral information such as police reports, victim statements and court records (Ward, Hudson, & McCormack, 1997). The assessment of important empirically derived content areas enables clinical decisions to be based on scientifically accurate information, and facilitates the optimal development of a treatment plan and concomitant intervention strategies (Ward, McCormack et al., 1997). Currently, there are two methods which complement the clinical interview and assist the clinician in determining an offender’s treatment needs: a clinician-rated multi-component assessment of need comprising of actuarial and dynamic assessments of risk; and self-report psychological measures which assess for specific, single construct needs.

1.7.1 Actuarial and Dynamic assessments of risk

The purpose of the assessment phase of treatment is to identify the most critical antecedent factors that have contributed to the current offence. Sometimes these antecedent factors constitute core treatment issues, but are more commonly utilised as predictors of risk for future re-offending (Prentky & Burgess, 2000).

In recent years there has been an increasing interest in the development of actuarial risk predictors for sexual offenders. In contrast to unaided clinical predictions of future offending, which have been found to be unreliable (Hanson & Bussiere, 1998),
actuarial procedures constitute a more objective, valid and reliable approach to risk prediction. Using risk factors that have been empirically identified in the research literature, explicit rules for combining these variables into probability estimates have been generated which provide an individual’s probability of reconviction within a specified follow-up period (Quinsey et al., 1995). The majority of clinician-rated actuarial risk predictors rely exclusively on historical variables that cannot be changed or static risk factors, such as previous offence history, characteristics of the victim, lack of long-term relationships and general criminality (Hanson & Morton-Bourgan, 2004).

A number of clinician-rated actuarial instruments have been developed during the 1990’s and have been widely adopted by sex offender programmes for evaluations of risk and treatment planning. The actuarial measures most commonly used with sex offenders are the Static-99 (Hanson & Thornton, 2000), the Rapid Risk Assessment for Sexual Offence Recidivism (RRASOR: Hanson, 1997), the Violence Risk Appraisal Guide (VRAG: Quinsey et al., 1998), the Sex Offender Risk Appraisal Guide (SORAG: Quinsey et al., 1998), and the Minnesota Sex Offender Screening Tool – Revised (Epperson, Kaul, & Hesselton, 1998). What these instruments have in common is their advantage in being easy to score and interpret, and a degree of predictive validity which has been established through previous research (for a detailed review of these instruments see Prentky & Burgess, 2000). However, Beech, Fisher and Thornton (2003) have identified a number of limitations of using actuarial risk predictors: First, since these instruments typically contain unchangeable risk factors which cannot be addressed in treatment, they are of little value in treatment programmes. Second, these instruments only yield a probability of future recidivism
and as they are based on underestimations of true offence rates there is potential for false negative error rates. Third, these instruments are developed from aggregate quantitative data, and reliance by clinicians on these instruments may preclude the identification of unique risk factors that can be treated in individual cases. Finally, these instruments estimate long-term risk of re-offending, usually within 5 or 10 years, and fail to identify an imminent risk of re-offending.

As a result of these deficits in actuarial instruments, the second generation of research into risk of re-offending amongst sex offenders identified “dynamic risk factors” (Hanson & Harris, 1998, p.2) or “criminogenic needs” (Bonta, 1996, p.23). These authors suggest that in addition to conducting risk assessments of sex offenders, both “stable” and “acute dynamic factors” (Hanson & Harris, 1998, p.2) should also be assessed to determine an offender’s treatment needs. Stable dynamic factors are those that are changeable, but typically enduring features, and are often considered to be treatment targets, such as intimacy deficits, attitudes supportive of sexual offending, problems with emotional/sexual self-regulation as well as general self-regulation (Beech et al., 2002; Hanson & Harris, 2000b; Hudson et al., 2002). Acute dynamic factors on the other hand change and fluctuate, such as substance abuse and mood states, and are typically more immediate risk factors that create high-risk situations and signal the onset of offending. Hanson and Harris (2000b), in a study of sex offenders under supervision, found that the best acute risk predictors were found to be access to a victim, lack of cooperation with the supervision conditions and shifts in mood leading to hostility and anger.
Following the research in the late 1990’s into dynamic risk factors (Hanson & Bussiere, 1998; Hanson & Harris, 1998, 2000b), Hanson and Harris developed a structured approach to dynamic risk assessment in North America known as the Sex Offender Need Assessment Rating (SONAR: 2000a; 2001). This measure contains six stable dynamic predictors and eight acute predictors. Overall, the scale shows adequate internal consistency and a moderate ability to differentiate between recidivists and non-recidivists ($r = .43$; ROC area of .74). The SONAR is substantially correlated with static measures of risk such as the VRAG (Hanson & Harris, 2000a) and therefore the added contribution of the dynamic factors remains questionable. The extent to which these factors contribute to changes in recidivism, if targeted in treatment, will only be borne out by prospective studies. Nonetheless, the instrument has greater utility as a supervision-monitoring tool, with limited applications for treatment planning. Since a number of the items are selected based on their correlations with sexual recidivism, it does not include all the factors that are often treatment targets in sex offender programmes (McGrath, Livingston, & Cumming, 2002). Furthermore, the majority of the sample consists of child abusers, and the utility of this instrument in accurately identifying and predicting dynamic risk variables for rapists is still uncertain.

Researchers in the United Kingdom have further developed methods to assess stable dynamic/criminogenic needs that are currently being used by the Probation Services. One method is the deviancy classification for child abusers developed by Beech (1998) from the Sex Offender Treatment Evaluation Project (STEP) test battery (Beech, Fisher, & Beckett, 1999). The STEP battery is made up of a number of scales that measure deviant sexual interests, pro-offending attitudes and socio-affective
problems, and using a statistically devised method of weighting the scores on these scales, child abusers can be divided into high deviancy and low deviancy. High deviancy child abusers are characterised as having high levels of distortions about children, high levels of sexual obsessions and deviance, greater emotional identification with children and greater socio-affective difficulties. Low deviancy offenders on the other hand have marked social competence problems, and poor empathy for their victims (Beech, 1998). Although the predictive accuracy of this method has been shown to be enhanced in comparison to the static methods (Beech et al., 2002) its applicability to other sex offender populations, namely rapists, has not been tested. One of the other methods utilised by the U.K. Prison Service is the Structured Risk Assessment model developed by Thornton (2002). This model covers static assessment based on unchangeable, historical risk markers, an Initial Deviance Assessment (IDA) measure based on changeable psychological risk factors that are stable, evaluation of progress in treatment and risk management of acute risk factors. The IDA assesses four dynamic risk domains: deviant sexual interests, distorted attitudes, socio-affective functioning and self-management problems. An offender’s deviancy classification is determined by the dominance of these risk factors in their pattern of offending. An offender is classified as demonstrating high deviance if there are problems in at least three domains, moderate deviance when risk factors are present in one or two domains, and low deviance when no dynamic risk factors are present. The study (Thornton, 2002) indicates that these classifications accurately discriminate between child abusers who have been convicted on one occasion from those who have been convicted of such offences on more than one occasion. However, this model has not been tested on rapists and, with over sixty per cent of the sample comprised of child abusers, its applicability with rapists is questionable. In
addition, even though the study suggests that combining static and dynamic risk enhances predictive accuracy, the author has acknowledged that there is no evidence to indicate that the dynamic factors identified in this study can actually change and it may be “possible that the IDA domains mark enduring propensities to offend” (Thornton, 2002, p.150).

One of the most promising instruments identifying changes in criminogenic needs has been developed in the United States and is known as the Treatment Needs and Progress Scale for Adult Sex Offenders (TPS: McGrath, Livingston, & Cumming, 2002). This clinician rated instrument was developed to assess and track treatment changes for offenders attending sex offender treatment programmes in Vermont. The scale consists of 22-items scored on a 4-point Likert-type scale (0 = minimal or no need for improvement, 4 = very considerable need for improvement) and measures the following domains: responsibility, sexual deviancy, criminality, self-regulation, treatment and supervision cooperation, lifestyle stability and social supports. Initial analysis indicates a satisfactory interrater reliability ($r = .83$) and good internal consistency ($\alpha = .90$). Although, the scale revealed adequate validity when compared to established risk assessment instruments, long-term follow-up studies will be required to determine whether the TPS has predictive validity. Changes in the total score of the measure were indicated prior to, during and upon completion of treatment, and suggests that the criminogenic needs identified in the measure are indeed amenable to change over an extended period of treatment. However, since a number of the instrument’s items consist of historical and acute dynamic factors and results are reported for the total score, it is unclear if the greatest reduction in scores is a result of changes in the dynamic risk predictors.
Collectively, the development of these instruments demonstrates that stable and acute dynamic risk factors provide unique information not captured by static, historical factors. However, these instruments have been developed with the predominant purpose of classifying the risk of re-offending. Research is therefore yet to determine which of these criminogenic risk factors are most important in reducing recidivism among rapists and how best these clinician-rated multi-component assessments of risk can address the heterogeneity of rapists and identify their specific treatment needs.

1.7.2 Self-report instruments

Self-report measures are routinely used in sex offender treatment programmes to assess for rapists’ deficits in primary areas of intervention, because their standardization allows systematic comparisons and they make for efficient use of resources and time (Marshall, 1999a; Nugent & Kroner, 1996; Ward, McCormack et al., 1997). Many treatment programmes frequently use self-report instruments to plan appropriate treatment strategies for rapists and evaluate post-treatment change across various domains: cognitive distortions, victim empathy, social and interpersonal competence, deviant sexual arousal and emotional regulation (Hudson et al., 2002; Marshall, 1999a; Marshall, 1999b; Marshall & Moulden, 2001; Ward, Hudson, & McCormack, 1997). A list of frequently used instruments to assess these domains is provided in Table 1.
Table 1: Frequently used self-report instruments to measure specific areas of intervention with rapists.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Assessment Measure</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>COGNITIVE DISTORTIONS</td>
<td>Multiphasic Sex Inventory (Select Scales)</td>
<td>(Nichols &amp; Molinder, 1984)</td>
</tr>
<tr>
<td></td>
<td>Rape Myth Acceptance Scale</td>
<td>(Burt, 1980)</td>
</tr>
<tr>
<td></td>
<td>Hostility Towards Women</td>
<td>(Check, 1985)</td>
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<tr>
<td></td>
<td>Attitudes Toward Women Scale</td>
<td>(Spence, Helmreich, &amp; Stapp, 1973)</td>
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<tr>
<td></td>
<td>Bumby Rape Scale</td>
<td>(Bumby, 1996)</td>
</tr>
<tr>
<td>SEXUAL BEHAVIOURS</td>
<td>Multiphasic Sex Inventory (Select Scales)</td>
<td>(Nichols &amp; Molinder, 1984)</td>
</tr>
<tr>
<td></td>
<td>Sexual Experiences Survey</td>
<td>(Koss &amp; Gidycz, 1985; Koss &amp; Oros, 1982)</td>
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<tr>
<td></td>
<td>Clarke Sexual History Questionnaire</td>
<td>(Langevin et al., 1990)</td>
</tr>
<tr>
<td>VICTIM EMPATHY</td>
<td>Interpersonal Reactivity Index</td>
<td>(Davis, 1980, 1983)</td>
</tr>
<tr>
<td></td>
<td>Rape Empathy Scale</td>
<td>(Deitz et al., 1982)</td>
</tr>
<tr>
<td></td>
<td>Rape Empathy Measure</td>
<td>(Fernandez &amp; Marshall, 2003)</td>
</tr>
<tr>
<td>INTERPERSONAL AND SOCIAL</td>
<td>Relationship Questionnaire</td>
<td>(Bartholomew &amp; Horowitz, 1991)</td>
</tr>
<tr>
<td>COMPETENCE</td>
<td>Fear of Intimacy Scale</td>
<td>(Descutner &amp; Thelen, 1991)</td>
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<tr>
<td></td>
<td>Waring Intimacy Questionnaire</td>
<td>(Waring &amp; Reddon, 1983)</td>
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<tr>
<td></td>
<td>Social Self-Esteem Inventory</td>
<td>(Lawson, Marshall, &amp; McGrath, 1979)</td>
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<tr>
<td></td>
<td>Social Avoidance and Distress Scale</td>
<td>(Watson &amp; Friend, 1969)</td>
</tr>
<tr>
<td></td>
<td>Fear of Negative Evaluation</td>
<td>(Watson &amp; Friend, 1969)</td>
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<tr>
<td></td>
<td>Revised UCLA Loneliness Scale</td>
<td>(Russell, Peplau, &amp; Cutrona, 1980)</td>
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<tr>
<td></td>
<td>Self-Efficacy Scale</td>
<td>(Sherer et al., 1982)</td>
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<tr>
<td></td>
<td>Assertion Inventory</td>
<td>(Gambrell &amp; Richey, 1975)</td>
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<tr>
<td>DEVIANT SEXUAL AROUSAL</td>
<td>Wilson Sex Fantasy Questionnaire</td>
<td>(Wilson, 1978)</td>
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<tr>
<td></td>
<td>Multidimensional Assessment of Sex and Aggression</td>
<td>(Knight, Prensky, &amp; Cerce, 1994)</td>
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<tr>
<td></td>
<td>Attraction to Sexual Aggression</td>
<td>(Malamuth, 1989a)</td>
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<tr>
<td>EMOTIONAL REGULATION</td>
<td>State Trait Anxiety Inventory</td>
<td>(Spielberger, 1983)</td>
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<tr>
<td></td>
<td>Beck Depression Inventory</td>
<td>(Beck et al., 1961)</td>
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<tr>
<td></td>
<td>State Trait Anger Expression Inventory - II</td>
<td>(Spielberger, 1999)</td>
</tr>
<tr>
<td></td>
<td>Symptom Checklist-90-R</td>
<td>(Derogatis, 1992)</td>
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</table>

Some authors suggest that offenders typically represent themselves in an exculpatory manner and that many deny outright that they ever committed an offence (Kroner & Weekes, 1996b; Marshall, 1994; Tierney & McCabe, 2001). Since much of the information in the assessment process is gleaned from self-report measures completed by offenders, denial and desirable responding often act as impediments to the accurate
gathering of information. Relying solely on official records is not always ideal as offender motivations (Marshall & Barbaree, 1989), affective states and current stressors (Ward & Haig, 1997), the individual's strengths and weaknesses (Ward & Stewart, 2003), attitudes, beliefs, and cognitive processes (Ward, Hudson, & Marshall, 1995), sexual knowledge and preferences, and substance abuse (Ward, Hudson, & McCormack, 1997) are necessary information for building a conceptual model of the client in order to inform treatment goals. However, since denial and favourable self-presentation is high among rapists (Barbaree, 1991) the benefits of using self-report measures are quickly offset by the deceptive response patterns of these offenders.

1.7.3 Limitations of self-report instruments

Social desirability is a construct that refers to an individual's tendency to respond to a self-report questionnaire in a manner the presents the respondent in a favourable light rather than to respond in an honest and accurate manner (Holtgraves, 2004). Research demonstrates that the operation of social desirability is widespread, and over-reporting of desirable behaviour and under-reporting of undesirable behaviour is quite frequently engaged in by the general community in a number of situations (Hadaway, Marler, & Chaves, 1993; Mensch & Kendel, 1988). It is therefore, not surprising, that given the approbation that offenders face for their criminal activity they engage in similar behaviours. Studies show that offenders in general can alter scaled scores when motivated to do so, and Walters (1988) reports changes in self-report scores in high-demand situations like application for release and placement in a single cell. Similar self-report differences occur with exaggeration of psychiatric symptomatology in evaluations for competence to stand trial (Wasyliw et al., 1988)
and in inmate populations (Walters, White, & Greene, 1988). Posey and Hess (1984) identify a number of possible motivations for socially desirable responding among an offending population, ranging from embarrassment at being given the label of a mental disorder, to the presentation of ‘masculine’ attitudes and beliefs exhibiting personal strength and self-sufficiency. Schretlen and Arkowitz (1990) even suggest that a large number of prisoners exhibiting antisocial personality traits are more skilled than the general population at deception. As a consequence, response biases in correctional and forensic settings assume all the more importance when offenders are administered self-report inventories.

Some self-report measures used with sex offenders incorporate validity scales to measure social desirability responding such as the Minnesota Multiphasic Personality Inventory-2 (Armentrout & Hauer, 1978; Lanyon, 1993; Schlank, 1993), the Multiphasic Sex Inventory (Nichols & Molinder, 1984), the Self-Appraisal Questionnaire (Loza et al., 2000) and the Psychological Inventory of Criminal Thinking Styles (Walters, 1995). However, other measures more commonly used to assess rapists’ sexual deviance, cognitive distortions, deviant attitudes and beliefs, hostility and aggressive temperaments do not possess these in-built validity scales and run the risk of non-detection of socially favourable presentation biases (Kroner & Weekes, 1996b). Few treatment programmes supplement their test batteries with independent measures of social desirability, malingering or denial (Crowne & Marlowe, 1960; Edwards, 1957; Paulhus, 1984; Rogers, Bagby, & Dickens, 1992; Schneider & Wright, 2001; Wiggins, 1964). Some authors (e.g., Kroner & Weekes, 1996b; Marshall & Hall, 1995; Nugent & Kroner, 1996) suggest that results from these measures should guide the interpretation of data taken from other self-report
questionnaires and should be substantiated with collateral information when writing treatment reports. However, these measures do not correlate very highly with each other, suggesting that these researchers have different conceptualisations of these constructs (Holtgraves, 2004). Along these lines some researchers (Klein & Loftus, 1993) suggest that responding to self-report items involves a sequence of stages and that these will not be the same for all types of items and for all people in all situations. Sudman and colleagues (1996) have delineated the following sequence of stages as being implicated in responding to self-report questionnaires: (a) interpretation of the question, (b) retrieval of the information, (c) generation of an opinion or representation of the behaviour (depending on what the question is soliciting), (d) response formatting, and (e) response editing. The authors argue that social desirability could operate at any of these stages and the activation at particular stages suggests either an automatic or a more deliberate response process. In a series of experiments conducted to determine the operation of socially desirable responding while completing self-report questionnaires, it was found that the process by which this occurs was activated in the “response editing phase” (Holtgraves, 2004, p.165). The author explained that respondents in the study had longer reaction times when considering socially desirable responses than when not. High impression management and self-deception participants were consistently found to have responded in a socially desirable manner and the participants were more likely to endorse ‘yes’ on positive responses than ‘no’ on negative responses. Thus, it is reasonable to expect that given the context of the assessment of rapists, these offenders may be more likely to employ impression management strategies and be more deceptive, leading to more socially desirable responses in self-report measures.
Within a sex offender population, the transparency of test items and the influence of social desirability on responding are considered major impediments to an accurate assessment when self-report measures are administered (McGrath, Cann, & Konopasky, 1998). Because rapists are in uniquely challenging contexts and are frequently asked to complete self-report inventories in a variety of settings and for multiple purposes (e.g. security classification, needs identification, assessment of psychopathology, amenability to treatment and risk assessment) their responses may be tainted by a socially desirable presentation bias in order to achieve specific outcomes (Kroner & Weekes, 1996a). This, coupled with the difficulty in admitting responsibility for actions which harm others, raises questions about whether the responses of sex offenders reflect their actual opinions and attitudes, or their desire to present themselves in a positive light (Tierney & McCabe, 2001). Lanyon’s study (1993) comparing admitting and non-admitting sex offenders with an admitter/non-admitter control group who were not known to be sex offenders found that non-admitting sex offenders had higher scores on sexual deviance scales than the control group, suggesting that the presence of denial has direct implications for obtaining accurate assessment information. Scully and Marolla (1984) found that rapists who deny their offences justify their behaviour by focusing on the victim and her role in the event, whereas rapists who admit their offence view themselves as ‘nice guys’ but minimise their responsibility by focusing on more socially acceptable personal difficulties such as having emotional and substance abuse problems. In a study conducted by Nugent and Kroner (1996) rapists were reported to constitute a greater number of partial deniers in comparison to child molesters. The authors suggest that while the rapists admit their offences they deny their role in the offence and the degree of force alleged to have been used. Interestingly, partial admitters and non-
admitters are just as likely to have a defensive response set. Typically rapists, while admitting their offending behaviour, minimise the intrusiveness of their actions, minimise their coerciveness, minimise the frequency of their offending and minimise the responsibility and impact that the abuse has on the victim (Ward, McCormack et al., 1997). While engaging in these denials and minimizations, Scully (1988) reports that rapists utilize self-serving distorted perceptions of their victims behaviour which assists in justifying their behaviour. All of these rationalizations and distortions reflect the refusal to take personal responsibility for the offence. Maletzky (1996) suggests that an admission of responsibility within a correctional or forensic setting is seen as an admission of weakness and personal fault. This provides strong social pressure to deny or minimise sexually deviant behaviour. Since an assessment is conducted upon request of an authority interested in the results, the rapist is frequently motivated to present the most favourable image of himself and his actions (Taylor, 1972). It is therefore unlikely that self-report measures can be totally free of response bias. In fact in an evaluation of self-report measures of cognitive distortions and empathy among Australian sex offenders, Tierney and McCabe (2001) found that adult sex offenders have higher scores than child molesters on the denial subscales and are just as likely to deny deviant sexual behaviour. While using the Sexual Social Desirability Scale, the authors (Tierney & McCabe, 2001) found that responses on the self-report measures were tailored to provide a favourable picture of the rapists sexual fantasies and behaviour. A key issue that influences the acceptance of responsibility and hence the minimisation of the offence is the presentation of the positive aspects of disclosing the deviant sexual behaviour (Ward, McCormack et al., 1997). The largest differences between admitting and non-admitting rapists occur in the context of denying negative characteristics rather than trying to improve their overall image to others. Thus, self-
reports are useful in the context of assessing global denial (Lanyon, 1993; Weinrott & Saylor, 1991) but not when the focus is on the admission or acceptance of undesirable characteristics such as hostility towards women, deviant cognitions, deviant sexual fantasies, sexual components of aggression, lack of empathy, and social and intimacy deficits, which are frequent areas of intervention in sex offender treatment programmes.

1.8 Rationale for the Thesis

As discussed in the preceding pages, the assessment process with rapists typically relies on self-report measures in combination with clinical interviews and file information to determine the type, intensity and duration of treatment provided to the offender. The evidence regarding the validity of self-report information is circumspect, and while the goal of assessment is to collect data systematically and accurately, there is currently no clinician-rated measure available that provides clinicians with assessment information to suitably classify rapists and identify offence-specific needs.

The purpose of the current investigation was to contribute to the extant pathways literature by developing a clinician-rated, culturally relevant and psychometrically sound measure to assess the treatment needs of rapists. Thus, the current thesis consists of two interrelated studies designed to create and assess the interrater reliability of the measure, assess its internal consistency and demonstrate its convergent and discriminant validity.
The aim of Study 1 was to develop a clinician-rated instrument for the assessment of rapists using a rational/deductive approach (Knight, 1999). Ward and his colleagues (Ward & Haig, 1997; Ward, Hudson, & McCormack, 1997) suggest that clinicians can play an important role in motivating the offender during an interview to disclose cognitive, affective and emotional states prior to and after the offence. This method of self-disclosure can minimise the tendency towards a positive self-presentation. It was therefore, hypothesised that a measure using a clinician-rated method of information gathering, corroborated by other file and historical information would have far greater utility for clinicians in assessment and treatment planning than interpretation of self-report measures. The second hypothesis was that the constructs selected for inclusion in the measure would have content validity in delineating rapists into approach vs. avoidant goals and active vs. passive self-regulation strategies as proposed by the pathways model (Ward & Hudson, 1998; Ward, Hudson, & Keenan, 1998). The final hypothesis related to the structure and format of the assessment measure being developed. As discussed earlier, Ward and Hudson (1998) suggest that structuring the assessment process on the offence pattern of the sexual offender provides the clinician with a useful framework for understanding sexual aggression. It was therefore expected that an expert panel of sex offender specialists would structure the items in the measure so as to complement the pattern of the offence process and select a scale that would appropriately capture the degree of presentation of the constructs selected.

The aim of Study 2 was to assess the reliability and validity of the measure developed in Study 1 (COP-RV: Appendix A). Once offenders were assigned to one of the model’s typologies, the measure was assessed for interrater reliability, internal consistency, convergent validity and discriminant validity.
Previous research with child abusers has demonstrated that clinicians can reliably classify offenders into one of the four pathways (Bickley & Beech, 2002, 2003). In this study it was hypothesised that clinicians would similarly be able to reliably classify rapists into either approach vs. avoidant goals and active vs. passive strategies. The second hypothesis related to a comparison of interrater reliability between global categorical classifications of rapists into the pathways and subscale score classifications. It was expected that the interrater reliability for subscale score classifications using the 18 items in the test would be better than global categorical classifications made by the clinicians. It was also hypothesised that there would be more agreement between clinicians on the dominant goals of the rapists than there would be for the self-regulation strategies utilised in pursuit of these goals. Furthermore it was predicted that the teams of raters (homogenous and heterogenous raters) could explain differences in agreement between clinicians on different items of the measure as well as classifications into the pathways. Finally, as a result of the development of the content, structure and format of the measure in Study 1, it was hypothesised that an analysis of the internal reliability of the measure would reveal adequate consistency of the subscales. Since it was expected that each of the items would be measuring separate constructs, it was hypothesised that there would be weak interitem correlations for most of the items on the measure.

The second phase in the assessment of the psychometric properties of the measure consisted of a validity analysis of each of the items in the test. This was achieved by comparing the individual items in the COP-RV (Appendix A) to scores on other psychometric scales purporting to measure either related or unrelated constructs (Nunnally & Bernstein, 1994). As this was an exploratory study it was hypothesised
that the majority of the constructs in the COP-RV would demonstrate convergent or
discriminant validity to those constructs to which they were theoretically related or
unrelated, respectively. As a result, *a priori* assumptions were made about the
convergent and divergent validity of each item to other psychometric measures used
for this analysis.

Finally, specific hypotheses were made about the extent of socially desirable
responding among this sample of rapists. Previous research with sex offenders has
established that when self-report measures are administered in forensic contexts, the
responses are tainted with socially desirable presentation biases in order to achieve
specific outcomes (Kroner & Weekes, 1996b; Scully & Marolla, 1984). Given the
context in which this sample of rapists have been asked to complete the psychometric
test battery, it was hypothesised that the majority of rapists would try to present
themselves in a favourable light. More specifically, it was expected that the rapists
would deny their offending behaviour and minimise and ‘fake good’ their interest in
sexual deviance.
CHAPTER TWO

Study 1

2.1 Design

The purpose of this first study is to create a measure that appropriately classifies rapists based on their treatment needs and to assess the content validity of the derived measure. Applying a rational/deductive strategy (Knight, 1999) to the Ward and Hudson (Ward & Hudson, 1998; Ward, Hudson, & Keenan, 1998) self-regulation model, items supported by the theoretical and empirical literature were generated and operationalised based on expert agreement. The items were designed and structured to delineate four treatment pathways for rapists: Approach-Active, Approach-Passive, Avoidant-Active and Avoidant-Passive. The first two pathways above have been re-named to maintain symmetry, and avoid confusion throughout these studies, but correspond to the initial conceptualisation by Ward and Hudson (1998) of the Approach-Explicit and Approach-Automatic pathways, respectively. The conceptualisation and development of the COP-RV (Appendix A) involved a multi-stage process that included a literature review, consultation with experts in the field, and feedback from sex offender clinicians.

Item generation for the COP-RV has been based on the following four methods: (a) reviewing the literature on assessment and treatment practices with sexual offenders in general and rapists in particular; (b) identifying constructs that are considered pertinent to the classification of offenders into the four pathway groups identified by Ward and Hudson (1998); (c) extracting and modifying items relevant to rapists from the offence pathway checklist used to classify child abusers in a study conducted by
Bickley and Beech (2002) (for which permission was obtained); and, (d) consulting with clinicians at the Sex Offender Programme about the relevance, cohesion and ease of comprehension with respect to the items included in the COP-RV.

The purpose of the literature review is two-fold: First, it provides a theoretical basis for the selection of items considered to be important in the development of the measure, and second, it provides empirical support for variables considered to be important during the assessment and treatment of rapists.

For the following review, a literature search was conducted in January 2004, August 2004 and March 2005 so that the most recent literature could be identified and incorporated into this study. The search consisted of three phases, namely on-line database searches such as PsycInfo and related electronic journals, web-based searches such as Sage Online and specific web-site searches. The searches were guided by three content areas of studies:

1. The pathway and offence chain models of sexual offending;
   (Key phrases included “sex offender AND self-regulation”, “sex offender AND offence process”, sex offender AND pathways”).

2. Treatment interventions for sexual offenders in general and rapists in particular;
   (Key phrases included “sex offender AND treatment”, “rape”, “rapist”, “sex offender AND recidivism”).

3. Static and dynamic risk factors in sexual re-offending;
   (Key phrases included “sexual reoffending”, “sex offender AND static risk”, “sex offender AND dynamic risk”, “rape AND recidivism”).
Once articles were collated and screened for relevance to this study, the development of the COP-RV was guided in the main, by the Ward and Hudson Self Regulation Model of the offence process of sexual offenders (Hudson, Ward, & McCormack, 1999; Ward & Hudson, 1998; Ward, Hudson, & Keenan, 1998), descriptive models of the offence chains of rapists (Polaschek, 2003; Polaschek et al., 2001), social cognitive theory (Fiske & Taylor, 1991) and stable and acute dynamic risk factors identified in the scientific literature (Hanson & Bussiere, 1998; Hanson & Morton-Bourgan, 2004).

2.2 Test Development

As detailed in the earlier chapters, the authors of the pathways model have identified discrete points of individual differences which give rise to the possibility of four different pathways: Approach-Active, Approach-Passive, Avoidant-Active and Avoidant-Passive (Ward, Hudson, & Keenan, 1998). The overarching mechanisms by which these pathways are distinguished are firstly, through the identification of goal-directed behaviours, which are divided into approach and avoidant goals, and, secondly, through the accompanying strategies that are activated in pursuit of these goals, and have been classified as being either active or passive strategies.

The initial strategy in developing a framework for the COP-RV was to divide the test into two parts as discussed by the proponents of the model (Hudson, Ward, & McCormack, 1999; Ward & Hudson, 1998; Ward, Hudson, & Keenan, 1998). The first part of the test was designed to assess the goals of the offender and the second part to assess their self-regulation strategies. Each construct was defined clearly, and
then items were developed that fit that definition. Once the constructs were established, they were allocated to each of the goals and strategies. Figure 1 provides a diagrammatic representation of the allocation of each item and the process by which each of the pathways were determined.

Figure 1: Construct-item allocation and pathway determination.
2.2.1 Theoretical and empirical basis for the development of the COP-RV

The inclusion of the constructs within the test was based on an analysis of the theoretical and empirical literature, which is detailed below. First, each fundamental construct is analysed and explained (i.e. Goals and Self-regulation strategies). Within each overarching construct, the theoretical evidence is presented which supports the inclusion of each of the individual items within the framework of the test. A summary of the supporting evidence is provided in Table 2 for the Goals and in Table 3 for the Self-regulation strategies.

A. PART I: GOALS

The self-regulation or pathways model has been developed using the assumptions of goal theory (Carver & Scheier, 1981) which postulate that goals contain cognitive representations that guide the interpretation of others’ actions and enable the implementation of one’s behaviours. Theorists argue that goals function to guide the “planning, implementation and evaluation of behaviour” (Ward & Hudson, 1998, p.702) and hence are seen as important components of personality through which individuals either achieve or avoid desired states (Austin & Vancouver, 1996; Emmons, 1996). Researchers report different functions of goals and delineate between acquisitional and inhibitory goals (Cochran & Tesser, 1996). Ward and Hudson (1998) suggest that acquisitional goals involve approach behaviours in which the offender aims to satiate a desire for sexual gratification and therefore involves positive affective states. Offenders with strong negative emotions, on the other hand, may desire to avoid sexually offending and these inhibitory goals take the form of avoidance behaviours. Due to the negative nature of this goal, individuals are more
fearful and anxious and are reported to experience higher levels of psychological distress (Emmons, 1996). Through a series of empirical studies with child molesters (Bickley & Beech, 2002, 2003; Ward et al., 1998; Ward et al., 1995) and rapists (Polaschek & Hudson, 2004; Polaschek, 1997; Polaschek et al., 2001), researchers have demonstrated the existence of diverse offence pathways containing a number of distinct phases, with varying goals, capacity to plan offences and the experience of emotions throughout the offence process. Thus, approach goals have been shown to involve the successful achievement of a particular state or situation characterised by positive affect, intact regulation, instrumental violence and endorsement of cognitive distortions about women and children. However, avoidance goals are concerned with the reduction of a particular state or situation and are seen in individuals with negative affect, under-regulation, and exhibiting gratuitous violence but with little or no cognitive distortions.

Item 1. Affect at the time of the offence: Theorists argue that motivation to offend is intrinsically linked to affective states (Ward, McCormack et al., 1997), and suggest that depression and anger in rapists arising from financial problems, interpersonal conflict and substance abuse were more frequent in the months and weeks prior to offending (Zamble & Quinsey, 1997). This sexual affective state can be characterised as an appetitive process during which time deviant sexual thoughts, beliefs and behaviours predominate. Some studies suggest that sexually aggressive individuals experiencing stress or other aversive emotional states relieve tension by committing sexual offences that could involve the use of force and humiliation, which act as a negative reinforcer (Hayes et al., 1996; Marx, Miranda, & Meyerson, 1999).
However, other researchers suggest that rape has been committed in the context of enhancing a pre-existing positive mood (Polaschek et al., 2001).

Table 2: Empirical evidence for construct-items included in Part I of the COP-RV

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Item</th>
<th>Supporting Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Affect at the time of the offence.</td>
<td>(Hayes et al., 1996; Hudson, Ward, &amp; McCormack, 1999; Polaschek et al., 2001; Zamble &amp; Quinsey, 1997).</td>
</tr>
<tr>
<td>2.</td>
<td>Degree of control to prevent offending.*</td>
<td>(Hirschi &amp; Gottfredson, 1994; Polaschek et al., 2001; Seto &amp; Barbarac, 1995; Testa, 2002; Ward, McCormack et al., 1997).</td>
</tr>
<tr>
<td>3.</td>
<td>Communication of intent to victim</td>
<td>(Canter, 1994; Canter et al., 2003; Kanin, 2003; Polaschek et al., 2001).</td>
</tr>
</tbody>
</table>

*Note: * = Items that have been derived and adapted from Bickley and Beech (2002)
**Item 2. Degree of control to prevent offending:** An inability to regulate behaviour is so common among offenders that low self-control is regarded as an essential element to all criminal behaviour (Hirschi & Gottfredson, 1994). Research indicates that the degree of control exerted to prevent offending may take the form of under-regulation (an inability to regulate) which may be the result of excessive engagement in disinhibiting substances like alcohol and illicit substances (Seto & Barbaree, 1995; Testa, 2002). At the other end of the spectrum, an offender may exhibit sufficient regulation but be reckless as to the consequences of the offending behaviour (Polaschek et al., 2001; Ward, McCormack et al., 1997).

**Item 3. Communication of intent to victim:** In rape offences, a victim can experience a range of violations from intrusive penetrative sexual assaults to personal humiliation and physical assault (Canter et al., 2003). Canter (1994) discusses these variations of violations in terms of the way in which the rapist perceives the victim. If the victim is perceived as a significant individual, the offender attempts to develop a “pseudo-intimate relationship with the victim” (Canter et al., 2003, p.161). More indirect methods are utilised to achieve their goal of sexual satiation such as attempts to groom the victim, asking questions, complimenting the victim and steering the conversation with escalated touching. These strategies are usually employed by date rapists who frequently report that the use of alcohol is an effective tactic to gain sex (Kanin, 2003) and that drinking women are ‘fair game’ for sexual aggression (Abbey et al., 2001). On the contrary, an offender who treats the victim as an object has no real concern for the feelings of the victim and consequently uses more overt strategies to convey their intention in committing the offence, such as verbal threats, physical force, gagging and/or blindfolding the victim and controlling the victim with a
weapon (Canter et al., 2003). Offenders have reported responses by the victim to this form of direct communication as both compliant and resistant, with compliance often being interpreted as implicit consent (Polaschek et al., 2001).

**Item 4. Infliction of violence and degrading sexual behaviour:** Early classificatory systems have typically resulted in the identification of components based on the amount of aggression used in the offence (Prentky & Knight, 1991). Distinctions have been made between instrumental violence, wherein only sufficient force has been used to commit the crime, and gratuitous violence which covers sexual activity and aggression carried out with a view to humiliate and degrade the victim (Hudson & Ward, 1997). In cases with high levels of gratuitous violence, researchers (Knight & Prentky, 1990; Rosenberg et al., 1988) have further delineated those rapes that are sadistic and are accompanied by harm (that is clearly part of the sexual gratification) from more indiscriminate violence. Some authors (Dietz, Hazelwood, & Warren, 1990) have defined the anal rape of women as being a sadistic act, although the Massachusetts Treatment Centre Typology for Rapists (MTC-R3: Knight & Prentky, 1990) does not take into account the type of penetration in its classification. Neuwirth and Eher (2003) while examining differences between anal and vaginal rapists found that in sixty seven per cent (67%) of the crimes committed by anal rapists, the victims were also beaten and degraded, whereas only twenty eight per cent (28%) of vaginal rapists beat their victims. Polaschek and colleagues (2001) report that in their sample of rapists the most common form of instrumental violence is conventional penile-vaginal intercourse. Gratuitous violence is less common and only occurs with degrading sexual behaviour such as anal penetration, object insertion into the victim’s vagina and coerced fellatio. Other studies examining more aggressive rapists have
found that these violent offenders get sexually aroused to nonsexual violence more than control subjects (Quinsey, Chaplin, & Upfold, 1984). Although it is still not clear if there is a small subset of offenders for whom the violence and victim distress are themselves sexually arousing (Prentky & Knight, 1991), those rapists who engage in gratuitous violence often have associated characteristics such as manipulative and impulsive behaviour, lack of empathy for the victim, unstable interpersonal relationships, a history of nonsexual offences and early signs of psychiatric disturbance (Knight, Rosenberg, & Schneider, 1985; Prentky, Cohen, & Seghorn, 1985; Prentky & Knight, 1991).

**Item 5. Cognitive distortions about women and sex:** Rapists’ cognitive distortions or offence-supportive attitudes and beliefs have been consistently implicated in the research literature. Rapists have been found to have rape-supportive attitudes (Bumby, 1996; Burt, 1980, 1998; Dean & Malamuth, 1997; Malamuth & Check, 1983); hostility toward women (Marshall & Moulden, 2001); minimization, acceptance and justification of violence against women (Dewhurst, Moore, & Alfano, 1992; Marolla & Scully, 1986; Scully & Marolla, 1984); implicit theories about women’s behaviour and sexuality (Polaschek & Gannon, 2004; Polaschek & Ward, 2002); and conservative and traditional attitudes toward women (Scott & Tetreault, 1987). Recent meta-analytic studies (Hanson & Bussiere, 1998; Hanson & Morton-Bourgan, 2004) report a small positive correlation between deviant sexual attitudes and sexual offence recidivism, supporting its inclusion as a criminogenic risk factor in sexual offender treatment programmes.
Item 6. Guilt/Shame following the offence: Analysis of rapists’ reactions subsequent to the offence has been found to provide useful information about the pathway implicated in offending. Research suggests that there is considerable variation between offenders in the way they think, feel and behave after a sexual assault (Ward & Hudson, 1998; Ward, Hudson, & McCormack, 1997). For instance, in an analysis of the offence chain of sexual offenders, Ward et al. (1995) found that those offenders who evaluate their offence negatively feel disgusted and guilty and engage in considerable self-blame. These negative conclusions are accompanied by a change in perception, viewing the act as an abuse of the victim as opposed to a willing contribution by the victim. Positive evaluations on the other hand are a consequence of restructuring the situation in a way such as to blame the victim or minimise what the offender has done (Ward et al., 1995). Post-offence evaluations by rapists’ have been found to range from anger (victim blaming), neutral/positive (lack of guilt or shame) to negative (considerable self-blame) (Polaschek et al., 2001). These negative or positive evaluations often determine the offender’s future resolutions to either avoid further sexual aggression against women or to continue offending (Hudson, Ward, & McCormack, 1999). Affective and cognitive states subsequent to the offence are typically closely linked to the rapists affective condition prior to offending such that offenders who experience negative affective states early in the offence chain engage in covert planning, gratuitously degrading and violent sexual behaviour and evaluate themselves negatively after the offence. Those rapists who begin their offending in a positive mood are more likely to consciously plan their offences, engage in only instrumental violence sufficient to restrain the victim, perceive the act as pleasurable and beneficial to the victim and make resolutions for further offending (Polaschek et al., 2001; Ward, McCormack et al., 1997).
Item 7. Engagement in pro-offending behaviours: The commission of rape crimes is often associated with an antisocial personality and a history of lifestyle instability, which manifest in a number of pro-offending behaviours such as frequent fights, association with antisocial peer groups, instability in living arrangements, impulsive and reckless behaviour, excessive drinking and unsafe work practices (Hanson & Morton-Bourgan, 2004). Antisocial orientation has been found to be a particularly important predictor of both general and sexual recidivism amongst rapists (Hanson & Bussiere, 1998) indicating a general utility of assessing for such pro-offending behaviours during the course of a clinical assessment. Additional risk behaviours include the use of pornography, high rates of masturbation and engagement in impersonal sex with evidence of a progression in the type and frequency of deviant sexual activity (Hanson & Morton-Bourgan, 2004). These sexual preoccupations are considered to be important predictors of sexual, violent and general recidivism and the prevalence and use of pornography among rapists has been noted in a number of studies (for a detailed review see Russell, 1998).

B. PART II: SELF-REGULATION STRATEGIES

Baumeister and Heatherton (1996) suggest that self-regulation is a process whereby dispositional and situational factors propel an individual to engage in goal-directed actions over time, and in different contexts. Self-regulation is not solely concerned with inhibiting or suppressing behaviour (Karoly, 1993), but can include the enhancement and elicitation of behaviour as one evaluates and modifies one’s behaviour to accomplish one’s goal (Ward, Hudson, & Keenan, 1998). The implementation of self-regulatory strategies is often in response to the activation of a particular goal. When a goal becomes salient it functions as a reference value for an
individual’s behaviour and when relevant dispositional cues such as emotions or situational factors such as people’s responses are compared to the reference value, an individual will attempt to change his behaviour to match the desired outcome (Carver & Scheier, 1990). This process of monitoring the relationship between a goal and one’s behaviour is referred to as a “feedback loop” (Ward, Hudson, & Keenan, 1998, p.146) and, typically, where there is a loss of goal salience there is an associated impairment in self-regulation.

Ward and colleagues have tested this theory of self-regulation in sex offenders using a grounded theory approach (Ward et al., 1998; Ward & Hudson, 1998; Ward, Hudson, & Keenan, 1998) and posit a series of phases through which an offence is completed, known as the offence chain. The authors suggest that sex offenders exhibit under-regulation through disinhibition in which there is a failure to control sexually deviant behaviour. This may be the result of powerful affective states that lead to loss of control, or an inability to control deviant thoughts and fantasies, which paradoxically result in loss of control. The other pathway involves intact self-regulation but harmful goals such as demeaning attitudes towards women, and represents maladaptive ways of meeting such needs, such as the use of power and control to be intimate with someone. Research also suggests that such complex offence chain models comprising of a number of phases, goals and strategies exist with rapists and indicate the need for closer attention to these strategies in the service of more proximal and distal goals (Polaschek & Hudson, 2004; Polaschek, 1997, 2003; Polaschek et al., 2001; Ward, McCormack et al., 1997). The literature therefore suggests that individuals who follow a passive or under-regulation pathway are impulsive, unassertive, exhibit poor problem solving skills, have an external locus of control and are unable to delay
gratification. In contrast the individual following the active pathway ironically has an effective self-regulation style and is therefore more assertive, capable of delaying gratification, engages in explicit planning, has good problem-solving skills and can act in a goal directed manner (Ward, Hudson, & Keenan, 1998).

Table 3: Empirical evidence for construct-items included in Part II of the COP-RV

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Item</th>
<th>Supporting Evidence</th>
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</table>

Note: * = Items that have been derived and adapted from Bickley and Beech (2002)
Item 11. Degree of planning prior to the offence: The desire for deviant sexual activity is usually accompanied by a process that involves either covert planning, chance contact or explicit planning (Hudson, Ward, & McCormack, 1999). These different types of planning usually lead to different offence patterns and are therefore considered critical to assess during a clinical interview (Ward, McCormack et al., 1997). In instances of covert planning, it appears that some offenders do not engage in any planning and move from deciding on their goal to enacting it (Polaschek et al., 2001). However, this type of planning usually comprises of a series of unrelated mini decisions in which the offender adjusts circumstances to facilitate contact with the potential victim, collectively setting-up the high-risk situation and creating an opportunity to offend (Hudson, Ward, & McCormack, 1999; Pithers, 1990). Alternatively, overt or explicit planning involves careful evaluation and preparation before the crime takes place and has three foci: sexual access, sexual assault or redress of harm non-sexually (Polaschek et al., 2001). In these instances offenders deliberately initiate contact for sexual purposes and those offenders who report having positive background affective states are more likely to engage in conscious or explicit planning (Hudson, Ward, & McCormack, 1999). Finally, there is the possibility that an offender can come in contact with a potential victim and commit a sexual assault purely by chance, usually while committing some other type of crime (Knight & Prentky, 1990).

Item 12. Level of impulsivity: Lack of impulse control has been linked to a wide range of criminal behaviours (Hirschi & Gottfredson, 1994) and is considered to be a risk factor for general and sexual recidivism in rapists (Hanson & Morton-Bourgan, 2004). Scales such as the Hare Psychopathy Checklist - Revised (PCL-R: Hare, 1991)
and the Level of Service Inventory – Revised (LSI-R: Andrews & Bonta, 1995) that are routinely used to predict criminal recidivism contain numerous items related to impulsivity and lifestyle instability. The Massachusetts Treatment Centre Typology of Rapists (MTC-R1) that used as one of its classifications the impulsive type of rapist (Prentky & Knight, 1986), has in recent studies expanded the role of impulse control as a more generic discriminator among multiple classifications of rapists (Prentky & Knight, 1991). Thus the creation of low and high impulsiveness essentially assesses the presence of an enduring pattern of poor impulse control and irresponsible behaviour. Poor behavioural controls directly contribute to sexual offending (Hanson & Harris, 2000a) as some rapists impulsively commit sexual assaults given the mix of contextual factors and opportunity. The presence or absence of impulsivity, therefore determines the self-regulation pathway an offender utilises and becomes an important consideration for treatment and sustainability of long-term life changes.

**Item 13. Complexity of strategies used to offend or prevent offending:** Sexual offenders typically have poor problem-solving abilities in comparison to non-offenders (Marshall, Anderson, & Fernandez, 1999). Barbaree, Marshall and Connor (1988) conducted a study of the problem-solving abilities of sexual offenders and report that although the offenders identify as many potential solutions to the problems as do other participants, they typically choose inadequate solutions. In spite of these deficiencies in coping styles, rapists are likely to exhibit either task-focused problem-solving strategies or avoidance/emotion-focused problem-solving abilities (Cortoni & Marshall, 2001). This suggests that in times of stress, depression, anxiety or anger, rapists focus on their inadequacies, which either accelerates their desire to offend by establishing a sense of power and importance, or promotes the onset of avoidance-
focused solutions. While utilising these strategies, offenders generally direct their attention to the consequences of experiencing such emotions rather than attempting to generate problem-based solutions (Marshall, Anderson, & Fernandez, 1999). As a consequence, problem-solving training and the development of a problem-focused coping style is often the focus of intervention in treatment programmes.

**Item 14. Use of inappropriate coping mechanisms prior to offence:** Theories on sexual offending have often implicated the role of disinhibition in the commission of a sexual offence, which can take the form of alcohol or drugs, pornography or particular emotional states (Ward, McCormack et al., 1997). Alcohol is particularly common preceding a rape and is found more often in spontaneous rather than planned assaults with a likelihood of increased use of force (Testa, 2002). Research studies indicate that a majority of rapists are intoxicated at the time of the offence (Seto & Barbaree, 1995) and alcohol constitutes a major risk factor in acquaintance rape (Cameron & Stritzke, 2003). Pornography and masturbation have also been associated with increased disinhibition proximal to the sexual offence since it provides material for sexual fantasy and deviant sexual arousal (Russell, 1998). Interestingly, Cortoni and Mashall (2001) found that rapists are more likely to turn to sex as a way of coping with difficulties than other men, and although a small number of offenders seek out consenting sex to begin with, a majority engage in rape and deviant sexual activity. Some theorists (Hudson, Ward, & Marshall, 1992; Pithers, 1990) explain this behaviour and the use of these coping mechanisms by positing that during stressful times, a failure to cope can result in a lapse and increase the use of inappropriate coping strategies such as alcohol, pornography and masturbation. Although the intention of such an effort is to avoid offending, there is a rebound effect (Johnston,
Ward, & Hudson, 1998) and a weakening of both cognitive and behavioural regulatory control, which can lead to the commission of a sexual offence.

**Item 15. Harm redressal:** The literature indicates that a rapist implements a harm redressal strategy depending on their affective state and the selection of dominant goals (Hudson, Ward, & McCormack, 1999). In a study conducted by Polaschek and colleagues (2001) two strategies become apparent that are closely related to the rapist’s proximal mood state. The first is to seek sexual gratification either to enhance a pre-existing positive mood or to escape a negative mood. Thus the motivation is to have consensual sex with the targeted victim and not to use force. The second is to redress harm to self and is motivated by physical violence against the victim usually because of a perceived affront, with sex as a secondary consideration. In pathways employing a predominantly sexual gratification strategy, it is reported that offenders either under-regulate or mis-regulate their coping strategy with more offenders consuming alcohol prior to the offence. Offenders following this pathway also engage in non-gratuitous sexual behaviour and articulate traditional date rape cognitive distortions with a majority of victims being acquaintances or ex-partners (Polaschek & Hudson, 2004). On the other hand, those offenders who redress harm through physical force, generally have a negative distal background, and invariably have emotion-based coping styles. Proximal moods are either depression or anger and the offence is characterised by high levels of gratuitous sexual behaviour and physical violence (Polaschek & Hudson, 2004; Polaschek & King, 2002). The evidence of rapists’ harm redressal strategies closely resemble the passive and active pathways postulated under the self-regulation model by Ward and Hudson (Hudson, Ward, & McCormack, 1999; Ward & Hudson, 1998; Ward, Hudson, & Keenan, 1998).
Item 16. **Locus of control:** Some researchers have proposed a link between inadequacies in socio-affective functioning (i.e. low self-esteem, external locus of control and under-assertiveness) and sexual offending (Beech, Fisher, & Thornton, 2003; Thornton, 2002). Indeed, Baumeister, Smart and Boden (1996) suggest that low self-esteem and a perception that events may be out of one’s control may play a role in sexual violence, as it can lead men to channel their aggression into attacks on external targets they perceive to be weak and helpless such as women and children. Those who suffer from low-self esteem experience unpleasant emotions and often attempt to deflect any deprecations to their self-concept (Marshall, Anderson, & Fernandez, 1999). Thus, Ward and colleagues (1997) argue that cognitive distortions whereby rapists justify and minimise their offences by blaming the victim or other situational variables (external locus of control) may be related to their sense of self-esteem. Marshall and colleagues (1999) suggest that self-serving biases function to protect low self-esteem individuals by maintaining control over an existing yet tolerable negative self-evaluation. These biases are sexual offenders’ attempts to deny and minimise the nature and severity of their crimes. Rapists often use cognitive processes that allow them to interpret events, their own behaviour and behaviour of others in ways that protect negative appraisals by others and preserves their self-image (Scully & Marolla, 1984). Of course not all rapists suffer from low self-esteem or are under-assertive in social situations and often can be found to have sound internal locus of control. For instance, Segal and Marshall (1985) found rapists to have adequate social functioning and Overholser and Beck (1986) were unable to find significant differences in the assertiveness of rapists compared to non-sexual offenders and non-offenders. It therefore appears that locus of control can vary along a continuum and manifest differently in different sub-populations of rapists.
**Item 17. Offender evaluation of victim resistance:** Proponents of the pathways model of sexual offending have demonstrated the significance of an offender’s evaluation in delineating the different kinds of self-regulatory failure (Hudson, Ward, & McCormack, 1999; Polaschek et al., 2001; Ward & Hudson, 1998). For instance, in a study involving both child molesters and rapists, Hudson, Ward and McCormack (1999) report the influence of three foci on the nature of the sexual assaults. Those offenders who have a self-focus during the commission of the offence – focusing on their needs – have clear and detailed plans about the offence, were egocentric, had high levels of sexual arousal, high intrusiveness and typically evaluated the victims’ behaviour as being resistant and thwarting of his attempts to achieve his goal (Polaschek & Hudson, 2004; Polaschek et al., 2001). On the other hand, offenders who have a passive self-regulatory style, often report having a victim or mutual focus with distortions of victim compliance, willingness and enjoyment. Offenders who follow this pathway report having lower levels of sexual arousal, are more impulsive and have lower levels of offence intrusiveness than offenders with evaluations of victim resistance (Hudson, Ward, & McCormack, 1999; Polaschek et al., 2001).

**Item 18. Ability to delay gratification:** The Problem of Immediate Gratification (PIG) is a term that has been coined by Pithers (1990) and refers to an offender’s position in which he focuses on the immediate rewards and gratification of offending. Researchers argue that at this stage in the offence cycle it is unlikely that the offender will be able to implement adaptive coping strategies and will relapse into the commission of an offence (Marshall, Anderson, & Fernandez, 1999). This problem of sexual self-regulation is considered to be a distinctive risk factor and Hanson and Bussiere (1998) demonstrate that sexual offenders perceive themselves to have strong
sexual urges and feel entitled to act out their impulses, usually to reduce a negative mood (Hanson & Harris, 1998). Ward and Hudson (1998) have indicated that PIG is more likely to be observed in rapists who follow an approach and passive pathway, as they will be concerned about their chances of achieving sexual pleasure and related goals. For those rapists who follow an avoidant and passive pathway, the inability to actively control deviant sexual desires is viewed as a failure and as a consequence they adopt an approach or acquisitional goal. The dominance of appetitive processes is facilitated by a focus on immediate gratification and is typically observed in the lead up to a sexual offence (Ward, Hudson, & Marshall, 1995).

2.3 Participants

Participants for this study were comprised from a panel of experts in the area of sexual offending and test construction. Two of the experts are the primary researcher’s supervisors. Four other sex offender clinicians employed at Corrections Victoria – Sex Offender Programmes were invited to be part of a panel, and participated in a half-day workshop in which they provided expert advice on the development of the COP-RV in such areas as test cohesion, suitability of items, ease of comprehension and selection of a scale. The average age of the expert panel was 34 years with 35 years of cumulative experience in the field of sexual offending.

2.4 Setting

The Sex Offender Programme located in Melbourne is a community-based, government-funded agency providing specialist sex offender assessment and
treatment in prisons and the community throughout Victoria. The programme is
designed for offenders who are deemed to be at medium to high risk of sexual re-
offending, and offers intensive cognitive-behavioural treatment subsequent to a
thorough risk and needs assessment. Clinicians at the Sex Offender Programme are
trained in the clinical assessment of sexual offenders and utilise a range of techniques
that are considered pertinent to assess for factors associated with sexually deviant
behaviour, and develop comprehensive treatment plans based on case formulations
(Ward, Vertue, & Haig, 1999). Clinicians are also routinely required to administer,
score and interpret a battery of psychometric tests that assess a range of deviant
attitudes, beliefs and behaviours. They are, therefore, acutely aware of the pitfalls
associated with transparent self-report measures and have keen insights into
appropriate assessment and treatment targets for sexual offenders.

2.5 Procedure

Once a draft version of the test was compiled from the theoretical and empirical
literature it was presented at a half-day workshop to a panel of specialist sex-offender
clinicians. The purpose of this workshop was to receive feedback from these experts
regarding the comprehensiveness of the test items, issues related to reliability and
validity of the test, relevance of items measuring a particular construct, cohesion of
the test items, use of a Likert-type scale and the ease of comprehension.

To begin with the words “GOALS” and “STRATEGIES” were written in block letters
on the top left and right-hand corners, respectively of a large white board.
Subsequently, each of the items (15 in all) were placed in the middle of the white
board. The panel was then asked to go through these items, and using their clinical experience, select and sort the items according to the overarching constructs of goals and self-regulation strategies. Each item was picked in a random order and a brief discussion was generated about its operationalisation and conceptual fit within the broader construct. When there was absolute agreement about the item, the next one was discussed and so on.

Once the items were approved and sorted into the two parts of the test, the clinicians were asked to consider the type of scale that should be selected for use. While various suggestions were made for a scale type, clinicians were instructed that a unanimous decision had to be reached for a particular scale to be incorporated within the measure.

Upon completion of the workshop all the information was collated and a final version of the test was developed incorporating the suggestions by the expert panel.

2.6 Results

2.6.1 Content validity

The COP-RV was designed to follow the principles of the domain-sampling model of measurement (Nunnally & Bernstein, 1994). According to this model there are an infinite number of items that could be pooled to create each subscale (i.e. Part I: Goals and Part II: Strategies). If one were to randomly sample this infinite population of items, the law of probability would suggest that the breadth and depth of each
domain-subscale could be covered. Since it is impossible to randomly sample this population of items, Nunnally and Bernstein (1994) suggest assessing content validity through the consensus of competent judges on whether each item is a member of the population of items that comprise each intended domain. The clinicians were asked to review the current items and write additional items that could aid in covering the breadth and depth of the defined domain-constructs. All clinicians were in agreement about the comprehensiveness of the test and were satisfied that each of the items adequately contributed to the overall pathways model as proposed by Ward and Hudson (1999). Factors that were considered by the clinicians during this process were the item’s theoretical link to sexual offending, potential amenability to change, and scope for intervention in sex offender programmes. No additional items were suggested or added to the list and none were removed, resulting in an overall pool of 15 items. However, during this process most of the items were refined and reworded, and further conceptual and operational clarity was provided. Finally, the order in which the test items were to appear was discussed and agreed upon based on the ease of comprehension of each item, and the order in which the typical offence process of a rapist unfolded.

Although the clinicians were unanimous in their endorsement of the relevance and cohesion of the test items, there were suggestions to simplify the language and reword items 3, 14 and 16 (see Appendix A) so that they would complement the structure of the scale and enhance the comprehensibility of the test. For example in item 3, the word ‘indirect’ was added to ‘degree of communication of intent to victim’ so that indirect communication would represent an extreme value for that item. A similar methodology was applied for item 16 by including ‘internal’ in the item so that a
internal locus of control would represent an extreme value. For item 14, clinicians suggested adding the word ‘inappropriate’ to the item so that any example of inappropriate coping mechanisms would be endorsed for that item.

The next step consisted of the clinicians assessing the degree to which each of the 15 items reflected the definitions of their respective domains. The breadth and depth of item coverage of each domain was also considered. Clinicians were asked to score each item in terms of item-domain fit on a scale from \(1 = \text{does not fit}\) to \(5 = \text{perfect fit}\). No items were kept in the instrument that did not have a mean score of at least 4, which was defined as ‘an excellent fit’. All items were scored at 4 or 5, resulting in them being retained in the measure.

Finally, the panel selected the type of scale that would be suitable for such a measure. One suggestion was to use a forced-choice response of yes or no, but this was vigorously debated and rejected as it was felt that none of the items represented a construct that could be categorically accepted or rejected. Rather, the unanimous opinion appeared to be that each item represented a continuum of an attitude, belief or behaviour and as such should be represented by a Likert-type scale that would capture the magnitude of its presence. Thus, the test has been structured such that avoidant and approach goals represent extreme ends of a continuum, as do passive and active strategies. A 7-point scale adapted from the one used in the Level of Service Inventory – Revised (Andrews & Bonta, 1995) was agreed upon (\(0 = \text{Not at all}, 1 = \text{Low}, 2 = \text{Slightly}, 3 = \text{Moderately}, 4 = \text{High}, 5 = \text{Very High} \) and \(6 = \text{Extremely}\)), deliberately keeping a mid-point for those instances in which a clinician believed only a moderate degree of the construct was present. Since each item was to be represented
as a continuum, the clinicians also suggested that each extreme end of each scale item be anchored, to provide the clinician with a reference point. As a result, the information obtained during the course of the discussions about the items were refined and provided the basis for the item-scale anchors. Furthermore, since the test has been formatted such that lower scores are indicative of avoidant goals and passive strategies, and higher scores are indicative of approach goals and active strategies, items 4 and 6 caused some confusion as higher scores for these items are indicative of avoidant goals. The panel suggested that these items be reversed to maintain a uniform appearance on the test and provide an unhindered flow from ‘absence’ to ‘extreme presence’ for each item. As a result both these items are reverse scored.

A copy of the final measure with a scoring template is available in Appendix A.

2.6.2 Scoring instructions

Each subscale in the final version of the COP-RV consisted of 7 and 8 items for Parts I and II respectively. Each item is scored on a 7-point Likert-type scale. This makes summing and interpreting scores quick and easy. There are three steps in the scoring process: (a) finding each subscale score, (b) determining the pathway for that subscale, (c) combining the pathways for each subscale to determine final pathway membership.

To find subscale score

In Part I, items 1 to 7 are added, reverse scoring items 4 and 6. Once a total score is attained it is divided by 7 to generate a mean score. If the mean score is less than 3 the
pathway membership is *avoidant* and if it is more than 3 it is *approach*. If it is equal to 3 the pathway selection is *mixed*.

In Part II, items 11 to 18 are added. Once a total score is attained it is divided by 8 to generate a mean score. If the mean score is less than 3 the pathway membership is *passive* and if it is more than 3 it is *active*. If it is equal to 3 the pathway selection is *mixed*.

*To find global pathway membership*

Once each subscale membership is determined, pathway selection from Part I and Part II are combined to produce the global pathway membership.
CHAPTER THREE

Study 2

3.1 Design

As is the case with most psychometric instruments, the development and refinement of these measures takes place over a period of time. While Study 1 was designed to conceptualise, generate and develop a clinician-rated instrument to assess rapists for appropriate therapeutic interventions, this study was designed to test the interrater reliability, internal consistency, convergent and discriminant validity of the COP-RV (Appendix A). The methodology was designed so that two independent raters rated each casefile. It was considered necessary to have each casefile rated by two independent raters rather than subjecting a random sample of casefiles to a review by a second rater, because the former method is considered to be more robust in calculating interrater reliability than generalising interrater reliability estimates from a portion of the sample to the entire sample (Fan & Chen, 2000).

In all, the COP-RV consists of twenty-three items. Part I of the measure assesses the goals of the offender and comprises of seven items (item numbers 1 to 7) that are theoretically linked to the measurement of these goals. Part II comprises of eight items (item numbers 11 to 18) that have been demonstrated to measure divergent strategies in the service of these goals. Each of the items are scored on a 7-point Likert-type scale ranging from 0 = Not at all, 1 = Low, 2 = Slightly, 3 = Moderately, 4 = High, 5 = Very High and 6 = Extremely, deliberately keeping a mid-point for those instances in which the clinicians believe that the construct is moderately indicated. The test has been designed so that lower scores are indicative of avoidant
goals and passive strategies, and higher scores suggest approach goals and active strategies. Each item is anchored on either side of the scale with a descriptive statement to provide the clinician with a reference point. Each part also contains questions asking the clinician to make a global judgment about the dominant goal and strategy employed by the offender, as well as endorsing the level of confidence in their decisions using the Likert-type scale. Finally, the last segment of the test has two questions to assess for prior contact with the offender and whether such contact has influenced clinician responses.

### 3.2 Participants

A total of four clinicians employed at Corrections Victoria – Sex Offender Programme were recruited to participate in this study. Of the clinicians who took part in this study, two (50%) were more than 30 years of age. All the clinicians worked full-time and possessed undergraduate degree qualifications, with one (25%) holding a Masters degree and the remaining (75%) holding either a graduate diploma or honours in Psychology. Three of the clinicians (75%) were either provisionally or fully-registered psychologists. The clinicians had 11.5 years of cumulative experience in the area of sexual offending.

Each clinician was required to peruse through twenty-five de-identified casefiles and utilise the archival information to complete the Checklist of Offence Pathways – Rapist Version (Appendix A). The casefiles contained information belonging to adult males in Victoria convicted of offences related to non-consensual sexual penetration of a female victim over the age of 16 years.
Upon approval by the Department of Justice Ethics Committee in Victoria (Appendix G), the researcher was invited to provide a brief general overview of the study at a clinical staff meeting at Sex Offender Programme and invited four clinical staff to participate in the study. At this time clinical staff were provided an explanation of the reasons for the study, the responsibilities involved in participating and the way in which the results would be reported and disseminated. Information sheets (Appendix B) providing more detailed information were distributed and consent forms (Appendix C) were made available to them. Individuals were given the option of reviewing the material for a week or completing and returning the consent form at that time if they chose to participate. Four participants volunteered, and once the informed consent forms were signed an appointment was made to meet with the researcher to begin the next phase of the study.

3.3 Selection of Casefiles

Casefiles for fifty adult male rapists were selected for this study. This number was achieved based upon availability following the exclusion/inclusion criteria below. Offender casefiles were selected based on a rape conviction for their most recent offence as defined under section 38 of the Crimes Act (Vic) (1958). All testing information contained in the casefiles had been completed by offenders as part of the clinical assessment process at the Sex Offender Programme.
The casefiles were randomly selected based on the following inclusionary criteria provided by the researcher:

1. The offender should be an adult male; and,
2. be convicted for offences related to non-consensual sexual penetration of a female victim over the age of 16 years; and,
3. have been clinically assessed by a clinician working with the Sex Offender Programme between the period January 1997 to December 2004; and,
4. must have completed the psychometric test battery administered as part of the clinical assessment process at the Sex Offender Programme.

Casefiles were excluded if they failed to meet all of the above criteria. All data contained in the casefiles were provided to the researcher by the Sex Offender Programme and consisted of two phases:

**Phase 1:** The researcher was provided with an electronic database table containing information for the fifty adult male rapists. A table summarising the descriptive information from these casefiles can be found under the results section of this study (Table 3). All information pertaining to an offender was de-identified and each case was assigned a unique code (C1 to C50) in order to maintain absolute confidentiality before handing over to the researcher. The electronic information consisted of:

1. Demographic and offence information.
   a. Ethnicity and religion;
   b. Family status and living arrangement at the time of the offence;
   c. Level of education and employment information;
   d. Previous treatment for a sexual offence;
e. Age at first sexual offence/conviction;
f. Number of convictions for prior sexual offences;
g. Number of convictions for current sexual offences;
h. Number of victim(s);
i. Age of victim(s);
j. Relationship to victim(s);
k. Length of sexual offence history; and,
l. Alcohol and/or Drug abuse at the time of the offence.

2. Psychometric test scores.

Phase 2: After casefiles were selected, all relevant information for each casefile, including the clinical report, clinical interview notes, police summary sheet of the charges and description of the offence, the victim impact statement, pre-sentence report, parole report (if applicable) and judges sentencing comments were photocopied and placed in a manila folder. All identifying information of the offender, namely, first name, last name, CRN and date of birth were blacked out on all documents using a black marker to de-identify the files. Once this was complete, the unique code generated for the electronic data for each casefile was placed on top of the manila folder and acted as the unique identifier for the particular casefile.

3.4 Setting

The Corrections Victoria - Sex Offender Programme is a government-funded agency offering assessment and treatment services to convicted sex offenders both in prison and the community. The Sex Offender Programme runs an intensive cognitive-
behavioural treatment programme, designed for offenders who are designated as medium to high risk of sexual re-offending. The specific goals of the programme involve the following: challenging offenders’ denial/minimisation of their offences by encouraging them to take full and active responsibility for their sexual behaviour; identifying and challenging distorted perceptions and attitudes towards the appropriateness of their sexual contact (cognitive distortions); increasing awareness of the victim’s perspective of sexual abuse; addressing identified social skills deficits that may hinder the development or maintenance of more appropriate adult intimate relationships; and helping participants to recognise, avoid, or cope with situations which could lead to further sexual assaults (relapse prevention).

Prior to any determination being made about an offender’s suitability for the programme, a comprehensive clinical assessment is conducted for each individual. During the clinical interview process, clinicians focus on the role of developmental, cognitive, affective, social/contextual, and behavioural factors associated with sexually deviant behaviour, and their interrelationships (Ward, McCormack et al., 1997). Offenders are also required to complete a battery of psychometric tests that contain self-report instruments assessing a range of attitudes, beliefs and behaviours. These include social presentation biases and denial, cognitive distortions, victim empathy, emotional regulation and social and intimacy skills deficits. Once this and other collateral information is collated, clinicians develop a case formulation (Ward, Vertue, & Haig, 1999) and make recommendations for treatment and/or supervision and monitoring in the community.
The clinicians working in the sexual offender treatment programme are often confronted with detailed and sometimes gruesome accounts of sexual offences as part of the treatment modalities for convicted sex offenders. They are required as part of their job to assess and recommend interventions with these offenders which entail face to face interviews, as well as perusing through a number of documents including victim impact statements, police summary reports, court transcripts etc. All staff are supervised internally by coordinators of the community and prison team and also by highly skilled external supervisors.

The programme does not accept offenders with convictions for abduction, stalking, current substance abuse problems, or who are clinically diagnosed as suffering from a major mental health disorder. All of the men are screened for their level of intellectual functioning using the Wechsler Adult Intelligence Scale-III (Wechsler, 1999) to determine the ability to cope with both the written work and group discussions.

### 3.5 Procedure

Each of the casefiles involved in the study were classified as belonging to one of the four pathway groups identified by Ward and Hudson (1998) using the Checklist of Offence Pathways – Rapist Version (COP-RV: Appendix A) developed by the researcher.

Four clinicians volunteered to take part in this study. Two clinicians were from the community team, which assesses and treats convicted sex offenders who are on non-custodial orders and two clinicians were from the prison team, which assesses and
treats incarcerated sex offenders. All four of the clinicians (raters) involved in the study received instructions from the researcher in the implementation of the model and were provided a copy of the relevant article – Ward and Hudson (1998). Each clinician was randomly allocated a code (T1, T2, T3 and T4), which they were instructed to place on each COP-RV. Although each casefile was randomly allocated a unique code, the files were sequentially allocated to clinicians to ensure that each file was rated twice by different clinicians (see Figure 2) and that twenty five casefiles had heterogenous raters comprising of one community team clinician (CT) and one prison team clinician (PT), and the remaining twenty five casefiles had homogenous raters. These homogenously rated casefiles were further divided into twelve casefiles that were rated by two prison team clinicians and thirteen casefiles that were rated by two community team clinicians (Table 4).

Figure 2: Total number of casefiles allocated to the four participant clinicians

Note: T = Clinician code (T1 to T4)
Table 4: Distribution of casefiles among heterogenous and homogenous raters

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Based on the information contained in these casefiles, each clinician was asked to make global classifications of the type of goal (i.e. approach vs. avoidant) implemented by the offender and the self-regulatory strategy (i.e. active vs. passive) initiated to achieve the desired goal. To further assess the reliability of the classification, each clinician was asked to rate each casefile (using the scale between 0 to 6) on a number of factors that have been identified as being pertinent to the model (see Appendix A).

Upon allocation of a casefile, each clinician was instructed to rate each item on the COP-RV (Appendix A) using the above-mentioned scale and restricted to information from the particular casefile. At the end of Part I the clinician was instructed to provide an overall rating of their confidence in their item responses. Then the clinicians gave the client a global rating on one of the dominant goals (i.e. avoidant or approach), based on their impression of the client. Subsequently, they were instructed to provide a rating of their confidence in their global clinical decision. Similarly, at the end of Part II, the clinician was instructed to provide an overall rating of their confidence in their item responses and then provide the client a global rating on one of the dominant strategies (i.e. passive or active), based on their impression of the client. Subsequently, they were instructed to provide a rating of their confidence in their global clinical decision. Upon completion of Part I and II, the clinician was asked to indicate if they had incorporated knowledge about the offender other than that provided in the file, for example past experiences with the offender during clinical assessment and/or therapy. When the instrument was completed, clinicians were instructed to place it in the casefile folder and return it to the researcher. The completed instrument was then removed from the casefile, replaced
with a fresh one and allocated to the second rater. This process was repeated with all clinicians until they had completed their allocated number of casefiles.

After having entered the item scores onto a database, the interrater reliability of both the overall global classification as well as the aggregate numerical score for part I (Approach vs Avoidant Goals) and Part II (Active vs Passive Strategies) was assessed using Cohen’s kappa. The kappa was interpreted using a set of guidelines proposed by Fliess (1981). These guidelines suggest that kappa between 0.40 and 0.60 are fair, between 0.60 and 0.75 are good, and more than 0.75 are excellent.

3.6 Measures

The following tests clustered under the broad headings of Risk Classification, Sexual Attitudes, Beliefs and Behaviours, Emotional Functioning and Interpersonal Competence (Appendix H) were collected to test the convergent and discriminant validity of the Checklist of Offence Pathways – Rapist Version.

3.6.1 Risk Classification

3.6.1.1 STATIC-99 (Hanson & Thornton, 2000)

The STATIC-99 is a clinician-rated actuarial instrument designed to measure sexual recidivism risk among sexual offenders. It contains a total of 10 items using a forced choice format (Yes = 1) or (No = 0). The items from this scale have been taken from the Rapid Risk Assessment for Sexual Offender Recidivism (RRASOR: Hanson, 1997) and the Structured Anchored Clinical Judgment (SACJ: Grubin, 1998). These items can be grouped into four broad categories: sexual deviance (male victims,
single, committed non-contact sex offences), range of potential victims (unrelated victims, stranger victims), persistence (prior sex offences), and antisociality (nonsexual violence, prior sentencing occasions). A final item concerns the age of the perpetrator. Scores range from 0 to 12 and can be grouped into the following categories: low (0, 1 points), medium-low (2, 3), medium-high (4, 5), and high (6 or more points). The strengths of the STATIC-99 are that it uses risk factors that have been empirically shown to be associated with sexual recidivism and gives explicit rules for combining these factors into a total risk score. The instrument provides explicit probability estimates of sexual reconviction, and has been shown to be robustly predictive across several settings using a variety of samples. It has been found to have moderate predictive power for both sexual offence recidivism \((r = .71)\) and violent recidivism \((r = .32)\) (Hanson & Thornton, 2000).

3.6.2 Sexual Attitudes, Beliefs and Behaviours

3.6.2.1 Rape Myth Acceptance Scale (RMAS: Burt, 1980)

The RMAS is one of several scales developed by Burt to assess culturally derived beliefs supportive of sexual aggression (Burt, 1980). The scale is a self-report questionnaire consisting of 19 possible beliefs concerning rape, rated on a 7-point Likert-type scale \((1 = \text{strongly agree}, 7 = \text{strongly disagree})\). Of these beliefs, 11 are related to the justification of rape and victim blaming, whereas 8 are primarily concerned with false accusations and the respondent’s likelihood of believing various individual’s claims of rape (e.g. best friend, compared with a black woman or a young child). The RMAS has good internal consistency with an alpha coefficient of .88 (Burt, 1980) and has been found to discriminate between convicted rapists and
nonrapists (Schewe & O'Donohue, 1998). No test-retest correlations have been reported.

3.6.2.2 Abel and Becker Cognition Scale (ABCS: Abel et al., 1989)
The ABCS is used to measure a participant’s distorted attitudes and beliefs about sex offending. Twenty-nine ‘pro-pedophile’ statements are scored on a 5-point scale (1 = strongly agree, 5 = strongly disagree). The ABCS is reported to have acceptable reliability with Cronbach alphas ranging from .59 to .64 and test-retest reliabilities from .64 to .76 (Murphy, 1990). Abel and colleagues (1989) also report that the scale has been able to differentiate between child molesters, rapists and non-sex offenders.

3.6.2.3 Wilson Sexual Fantasy Questionnaire (WSFQ: Wilson, 1978)
The WSFQ has 40 items each on a 6-point scale (0 = never, 5 = regularly) designed to measure the frequency of a variety of sexual fantasies (Wilson, 1978). There are four subscales: (1) intimate themes, such as kissing and coitus with a loved one; (2) exploratory themes, such as engaging in simultaneous sex with multiple partners, or partner swapping; (3) impersonal themes, such as having sex with a stranger, voyeurism, and fetishism; and, (4) sado-masochistic, involving the use of force or humiliation. Subscale scores on the WSFQ range from 0 to 50, with a total range of scores from 0 to 200. Higher scores represent more frequent sexual fantasising. Gosselin and Wilson (1980) reported mean scores on the WSFQ for an adult male community sample: Intimate subscale (16.9), Exploratory subscale (8.1), Impersonal subscale (7.6), Sado-Masochistic subscale (2.3), and Total (34.9). In a more recent study (Baumgartner, Scalora, & Huss, 2002) examining differences between nonsexual offenders (n = 41) and child molesters (n = 64), the authors reported
different means and standard deviations for all four subscales of the non-sexual offender sample: Intimate subscale (M = 20.7, SD = 12.7), Exploratory subscale (M = 9.2, SD = 9.6), Impersonal subscale (M = 9.7, SD = 9.8), Sado-Masochistic subscale (M = 5.9, SD = 8.4).

3.6.2.4 Multiphasic Sex Inventory (MSI: Nichols & Molinder, 1984)

The MSI is a 300-item questionnaire specifically designed to be used with sex offenders. As this test provides a measure of dissimulation and deviant sexual behaviour, a more extensive review of its psychometric properties is presented here.

The test is divided into 20 scales, which measure the extent of a rapist’s Social and Sexual Desirability responding, Lying and Denial, Sexual Deviance Admittance, Sexual Obsessions, Treatment Attitudes, Cognitive Distortions and Immaturity, Justifications, Paraphilias, Sexual Dysfunction, Sex Knowledge and Beliefs and Sexual History.

Two of the MSI scales, Justifications and Cognitive Distortions and Immaturity, are designed to explicitly measure cognitive distortions in rapists. The Cognitive Distortions and Immaturity scale (21 items) assesses the extent to which the offender takes responsibility for his actions. Scores between 10 and 15 suggest a character disturbance in that the offender exhibits a victim stance, and scores greater than 15 demonstrate a severe lack of accountability for his actions. This scale has good internal consistency, with an $\alpha = .82$ (Nichols & Molinder, 1984). The Justifications scale has 24 items which assesses the various excuses the rapist uses to account for his offences, for example, stress, alcohol, the victim’s behaviour, and/or some other
external factor. This subscale has a reported internal consistency of $\alpha = .71$ (Nichols & Molinder, 1984). Kalichman and colleagues (1992) in a study of the psychometric properties of the MSI reported an internal consistency of $\alpha = .53$ for the Cognitive Distortions and Immaturity scale and a relatively high internal consistency of $\alpha = .82$ for the Justifications scale.

The three validity scales of the MSI (Social and Sexual Desirability scale, Sexual Obsessions scale, and the Lie scale) provide useful information about the response set of the rapist and his potential to dissimulate the MSI results. These scales are structured to identify rapists who defend their sexual deviance and try to present in a socially desirable manner by either denying the existence of sexual deviance or minimising or justifying their behaviour. The Social and Sexual Desirability scale (35 items) is designed to measure ‘normal’ sex drives and interests and helps to identify whether offenders are responding in a socially desirable manner. Some offenders may respond in a manner that is ‘sexually hypernormal’ which may suggest dissimulation in that the offender is trying to present as someone who is not interested in sex. The Sexual Obsessions scale which contains 20 items, measures an offender’s obsession with sex and any tendency to exaggerate his problem. It consists of a range of responses from no obsessions or fake good, where the client denies that he has any interest in sex, to a malingering or fake bad response set. Rapists who are honest about their high interest in sex are expected to score in the deviant range. The Lie scale, which contains thirteen standardised items, measures the extent to which an offender is honest in their admission of sexually deviant thoughts and behaviours. Higher scores suggest a dishonest response in deviant sex interests.
The core of the MSI is the Sexual Deviance Admittance Scale, which amongst others comprises of the Rape scale. This assesses the style, magnitude and duration of the sexually deviant behaviour and is premised on the identifiable cognitive and behavioural trajectory that leads up to a sexual offence. The scale has the following sub-tests for rapists measuring sexually deviant patterns: fantasy cruising, sexual assault, aggravated assault and sado-masochism. The total score on these scales can be converted into standardised $T$ scores to assess an acknowledgement of offending patterns, ranging from *expected minimum* to *frankly dishonest*.

Nichols and Molinder (1984) report that the MSI appears to be quite reliable over time with no scale under $r = .58$ and many scales and subtests in the $r = .8$ and .9 range. The total reliability for all items of the MSI is $r = .86$. The authors (Nichols & Molinder, 1984) have included a number of reliability studies in their manual and suggest that evidence indicates that the MSI subtests and scales are reliable, and for the most part the MSI appears to be consistently measuring each of the various traits being assessed.

3.6.3 Emotional Functioning

3.6.3.1 State-Trait Anger Expression Inventory-II (STAXI: Spielberger, 1999)

The STAXI measures several aspects of anger and anger expression (Spielberger, 1999). The STAXI is a three-part measure, consisting of 44 questions answered on a 4-point Likert scale ($1 = not at all/never, 4 = very much so/almost always$). The STAXI measures five aspects of anger: State Anger, the degree to which an individual feels angry at a particular point in time; Trait Anger, the degree to which an individual feels disposed to being angry; Anger In, the degree to which a person
internalises anger; Anger Out, the degree to which the person externalises anger by expressing it toward other people or objects; Anger Control, the frequency with which anger is controlled; and Anger Expression, the general tendency to express anger regardless of the direction of that expression.

Both the state and trait scales have been shown to have high internal consistency (\( \alpha = .93 \) and .86, respectively) (Spielberger, 1999). The anger expression scales (i.e. Anger In, Anger Out and Anger Expression) have also been shown to be valid with both American (Spielberger, 1999) and New Zealand samples (Knight et al., 1988). Spielberger (1999) reports good levels of convergent and divergent validity for the anger expression scales and initial evidence for the validity of the Anger Control subscale. Marshall and Barbaree (1989) have found that the STAXI is an ideal instrument for prison populations because of the distinction it draws between different aspects of anger, and this is especially relevant for sex offenders, as they tend to differ with respect to their expression of anger. In a study of the psychometric properties of the STAXI, Fuqua et al. (1991) found subscale correlations from .02 to .80 with general support for the structure of the scale. In another study using the STAXI with sex offenders, Dalton and colleagues (1998) found a modest correlation between subscales ranging from .27 to .62, suggesting that the STAXI represents related but separate constructs.

### 3.6.3.2 Symptom Checklist-90-R (SCL-90-R: Derogatis, 1992; Derogatis, Lippman, & Coni, 1973)

The SCL-90-R is a 90-item multi-dimensional questionnaire designed to screen for a broad range of psychological problems. Each of the 90 items is rated on a 5-point
discrete scale of distress \((0 = \text{Not at all}, \ 4 = \text{Extremely})\). The instrument is a self-report clinical rating scale that measures subjective symptoms on nine primary symptom dimensions: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. Three global indices provide measures of overall psychological distress: the Global Severity Index (measure of the depth of the disorder), the Positive Symptom Distress Index (measure of symptom intensity), and the Positive Symptom Total (measure of symptom breadth).

The raw scores for the nine symptom dimensions and the three global indices are converted to standardised (normalised) \(T\) scores using the norm group that is appropriate for the person being examined. Derogatis (1992) presents in-patient norms based on a psychiatric in-patient sample that consisted of 313 subjects. In a Norwegian sample of 973 subjects Vassend and co-workers (1992) found that means, standard deviations and reliability coefficients for the primary symptom dimensions on the SCL-90-R were comparable to the findings from the American studies. Other studies (Derogatis, 1992; Schmitz et al., 2000) have found that the internal consistencies of the subscales are high ranging from .77 to .97 and the overall one-week test-retest reliability of the measure ranges from \(r = .78\) to .90.

3.6.4 Interpersonal Competence

3.6.4.1 Assertion Inventory (AI: Gambrill & Richey, 1975)

The AI is a 40-item self-report questionnaire designed to record both the probability of emitting the assertive behaviour (AIRP) and associated levels of discomfort (AID). Both sections are scored on a 5-point scale \((1 = \text{None/Always do it}, \ 5 = \text{Very}\)
much/Never do it), with a possible range of total scores from 40 to 200. The questionnaire elicits responses in the following areas: refusing requests, expressing personal limitations, initiating social contacts, expressing positive feelings, handling criticism, differing with others, assertion in service settings, and giving negative feedback. Normative data have been provided which suggest that scores greater than 96 correspond to high levels of discomfort being assertive, and 105 correspond to low assertive response probability. The psychometrics of the questionnaire are good with a test-retest reliability coefficient of $r = .87$ for the AID scale and .81 for the AIRP scale (Gambrill & Richey, 1975).

### 3.6.4.2 Interpersonal Reactivity Index (IRI: Davis, 1980, 1983)

The IRI was developed to measure the four components that are believed to comprise the general empathic response: perspective taking, fantasy (identification with others), empathic concern and personal distress at the plight of others. The difference between perspective taking and empathic concern may be particularly important for sex offenders because they often show the ability to take a victim’s perspective but use this knowledge to control or manipulate them (Marshall et al., 1995). What seems to be lacking is concern for the victim’s experience of the abuse. The IRI consists of four 10-item subscales and is scored by calculating agreement and disagreement for each item on a 4-point Likert scale ($0 = \text{Does not describe me well}, 4 = \text{Describes me very well}$). Davis (1983) has demonstrated a stable factor structure of the IRI across samples. The IRI is also reported to have convergent validity with the test being strongly associated with other measures of empathy and related constructs such as sensitivity and social competence.
3.6.4.3 Social Avoidance and Distress Scale (SADS: Watson & Friend, 1969)

The SADS is a 28-item true/false self-report questionnaire designed to measure aspects of anxiety in social situations (Watson & Friend, 1969). The items are equally balanced for positive and negative items. The constructs measured include avoidance behaviour and the experience of negative emotion (e.g. being upset, distressed, or anxious). The scale, developed using 297 undergraduate students, is reportedly homogenous ($\alpha = .94$), not markedly affected by social desirability (correlation with the Crowne-Marlow $r = -.25$) and has a mean score of 9.1 (mode = 0).

3.6.4.4 Fear of Negative Evaluation (FONE: Watson & Friend, 1969)

The FONE is a 30-item true/false self-report questionnaire that measures sensitivity to negative evaluations by others and the degree of avoidance of criticism. The scale, developed using 297 subjects comprises of three score classifications: Low scores (0-8), which comprised 25% of the college-based sample, Average scores (9-18), which comprised 50% of the college-based sample and High scores (19-30), comprising 25% of the sample. Higher scorers tend to be sensitive to criticism, are more defensive, less autonomous, less dominant and more self-effacing than their low-scoring counterparts (Watson & Friend, 1969). The interitem reliability of the FONE was found to be quite high with $\alpha = .92$ (Watson & Friend, 1969) and a KR-20 coefficient of $r = .94$. The 4-week test-retest reliability coefficient is reported to be $r = .68$. 
3.7 Results

3.7.1 Descriptive statistics

The casefiles of the fifty adult rapists revealed some interesting demographic and offence characteristics (see Table 5). The majority of casefiles consisted of Anglo-saxon offenders (70%). Thirty-seven percent ($n = 18$) of the offenders ascribed to the Catholic faith and twenty-three percent ($n = 11$) to the more general Christian faith. At the time of the offence 36% of the offenders lived alone, 34% lived with their partner and 16% lived with their parents. The majority of the offenders had attempted but not completed secondary school (66%). Almost half of the offenders (47%) were not employed at the time of the commission of the offence, while the remaining thirty-seven percent ($n = 18$) were in their current jobs for more than a year. The average age of the offender at the time of commission of their first sexual offence was 29.4 years ($SD = 8.2$) with a range of 13 years to 50 years, and the average age at the time of conviction was 30.2 years ($SD = 8.7$; Range 14 to 52 years). The sentence length ranged from 12 months to 180 months ($M = 77.1$, $SD = 36.0$). Only fourteen percent ($n = 7$) of the offenders were identified as being a low risk of re-offending according to the STATIC-99, with the majority being medium-low (36%) followed by medium-high (28%) and high risk (22%). The offenders’ most recent convictions for sexual offences ranged from 1 to 13 ($M = 2.9$, $SD = 2.9$). The average age of the victim was 28.8 years ($SD = 11.9$; Range 16 to 72 years) and they were most likely to have an extra-familial relationship to the offender (84%). For a majority of the offenders, the current sexual offence comprised a single incident (84%) with no more than twelve percent (12%) offending for up to a month. The majority of the sample (74%) did not have a previous conviction for a sexual offence and the remaining (26%) ranged from 1 to 18 prior sexual offence convictions. The vast majority (68%)
of the offenders were under the influence of alcohol at the time of the offence while only twenty-six (26%) had committed the crime under the influence of an illicit substance. Ninety-six (96%) of the offenders had no prior treatment for a sexual offence.

Table 5: Rapists demographic and offence characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sentence length (in months)</td>
<td>77.06</td>
<td>35.96</td>
<td>12</td>
<td>180</td>
</tr>
<tr>
<td>Age at first commission of sexual offence</td>
<td>29.38</td>
<td>8.15</td>
<td>13</td>
<td>50</td>
</tr>
<tr>
<td>(in years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at first conviction for sexual offence</td>
<td>30.20</td>
<td>8.65</td>
<td>14</td>
<td>52</td>
</tr>
<tr>
<td>(in years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of prior sexual convictions</td>
<td>0.98</td>
<td>2.84</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Number of current sexual convictions</td>
<td>2.92</td>
<td>2.88</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Number of victims</td>
<td>1.28</td>
<td>1.21</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Age of victims</td>
<td>28.76</td>
<td>11.87</td>
<td>16</td>
<td>72</td>
</tr>
<tr>
<td>Frequency of offending</td>
<td>2.72</td>
<td>2.63</td>
<td>1</td>
<td>11</td>
</tr>
</tbody>
</table>

Ethnicity:

- Anglo-Saxon: 70% (n = 35)
- Indigenous: 6% (n = 3)
- Greek: 4% (n = 2)
- British: 4% (n = 2)
- Other: 16% (n = 8)

Religion:

- Catholic: 37% (n = 18)
- Christian: 23% (n = 11)
- Muslim: 2% (n = 1)
- None: 36% (n = 18)
- Atheist: 2% (n = 1)

Family Status at time of the offence:

- Single (Never married): 42% (n = 21)
- Married: 12% (n = 6)
- De Facto: 16% (n = 8)
- Separated: 12% (n = 6)
- Divorced: 18% (n = 9)
<table>
<thead>
<tr>
<th>Variable</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living arrangement at time of the offence</td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>36% (n = 18)</td>
</tr>
<tr>
<td>With Parents</td>
<td>16% (n = 8)</td>
</tr>
<tr>
<td>With Partner</td>
<td>34% (n = 17)</td>
</tr>
<tr>
<td>Shared House</td>
<td>10% (n = 5)</td>
</tr>
<tr>
<td>Other</td>
<td>4% (n = 2)</td>
</tr>
<tr>
<td>Level of Education</td>
<td></td>
</tr>
<tr>
<td>Attempted secondary school</td>
<td>66% (n = 33)</td>
</tr>
<tr>
<td>Completed secondary school</td>
<td>4% (n = 2)</td>
</tr>
<tr>
<td>Undergraduate education</td>
<td>8% (n = 4)</td>
</tr>
<tr>
<td>Vocational training</td>
<td>18% (n = 9)</td>
</tr>
<tr>
<td>Other</td>
<td>4% (n = 2)</td>
</tr>
<tr>
<td>Employment history prior to offence</td>
<td></td>
</tr>
<tr>
<td>Not employed</td>
<td>22% (n = 11)</td>
</tr>
<tr>
<td>Stable employment</td>
<td>43% (n = 21)</td>
</tr>
<tr>
<td>Unstable employment</td>
<td>35% (n = 17)</td>
</tr>
<tr>
<td>Employment status at time of the offence</td>
<td></td>
</tr>
<tr>
<td>Not employed</td>
<td>47% (n = 23)</td>
</tr>
<tr>
<td>Between 1 and 12 months</td>
<td>16% (n = 8)</td>
</tr>
<tr>
<td>More than a year</td>
<td>37% (n = 18)</td>
</tr>
<tr>
<td>STATIC-99 – Risk Level</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>22% (n = 11)</td>
</tr>
<tr>
<td>Medium-High</td>
<td>28% (n = 14)</td>
</tr>
<tr>
<td>Medium-Low</td>
<td>36% (n = 18)</td>
</tr>
<tr>
<td>Low</td>
<td>14% (n = 7)</td>
</tr>
<tr>
<td>Order Type</td>
<td></td>
</tr>
<tr>
<td>Prison Sentence</td>
<td>96% (n = 48)</td>
</tr>
<tr>
<td>Community Based Order</td>
<td>4% (n = 2)</td>
</tr>
<tr>
<td>Previous Treatment for a sexual offence</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>96% (n = 48)</td>
</tr>
<tr>
<td>Yes</td>
<td>4% (n = 2)</td>
</tr>
<tr>
<td>Nature of relationship to victim</td>
<td></td>
</tr>
<tr>
<td>Extra-familial</td>
<td>84% (n = 42)</td>
</tr>
<tr>
<td>Intra-familial</td>
<td>16% (n = 8)</td>
</tr>
<tr>
<td>Total duration of sexual offending</td>
<td></td>
</tr>
<tr>
<td>Single Incident</td>
<td>84% (n = 42)</td>
</tr>
<tr>
<td>Upto 1 week</td>
<td>6% (n = 3)</td>
</tr>
<tr>
<td>Upto 1 month</td>
<td>6% (n = 3)</td>
</tr>
<tr>
<td>More than 1 year</td>
<td>4% (n = 2)</td>
</tr>
<tr>
<td>Under the influence of alcohol at time of the offence</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>68% (n = 34)</td>
</tr>
<tr>
<td>No</td>
<td>32% (n = 16)</td>
</tr>
<tr>
<td>Under the influence of illicit substance at time of the offence</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>26% (n = 13)</td>
</tr>
<tr>
<td>No</td>
<td>74% (n = 37)</td>
</tr>
</tbody>
</table>
3.7.2 Data Screening

Prior to any analyses being performed on the data, all independent variables were examined for accuracy of data entry, missing values, presence of univariate and multivariate outliers and the distribution of data. All data screening and analysis were conducted using SPSS Version 12 for Windows (SPSS Inc., 2003).

3.7.2.1 Checklist of Offence Pathways – Rapist Version

There were no missing values for any of the items in the COP-RV. Item numbers 4 and 6 were reverse scored using the SPSS RECODE function for all cases and for both raters (i.e. Rater 1 and Rater 2) consistent with the scoring instructions for the test. Subsequently, the items within the COP-RV subscale (i.e. Goals and Strategies) were aggregated to provide an overall subscale score. Two additional variables were added to the dataset that contained the total global score for each subscale of the COP-RV for both raters.

The dataset was then subjected to a series of analyses to check the distribution of data. As this is the first time this data has been presented, the graphs have been put in the main text. Box plots and frequency histograms for each variable were examined revealing a normal distribution of subscale scores (Figure 3). The skewness and kurtosis values for each of the subscale variables were also examined. The resulting skewness values did not exceed 1.96 (Tabachnik & Fidell, 2001) suggesting that the data is not significantly skewed and comes from a symmetrical sample. The kurtosis values revealed that although the data was normally distributed, Rater 2’s goals subscale score had a relatively steeper curve when compared to the other subscale variables, which had flat curves.
Figure 3: Distribution of total subscale scores for Rater 1 and Rater 2.
Univariate outliers were examined for each subscale variable by examining a range of scores using SPSS EXPLORE. For all analyses requiring normal distributions, outliers beyond two standard deviations were eliminated when individual variables were screened for normality. Two cases were identified as potential outliers, but did not fall outside the two standard deviation criteria, and hence were retained within the dataset.

### 3.7.2.2 Psychometric Instruments

Distributions of all psychometric test variables were checked for non-normality and outliers. Table 6 below provides a summary of the means and standard deviations of all scales used for the validity analysis. A standard procedure was used throughout the analysis to deal with missing data and outliers. In cases where there was missing data, the mean sample value for that variable was added. This method ensured that substitution of missing values did not alter the overall sample mean.
Table 6: Summary of means and standard deviations for scales used in the validity analysis

<table>
<thead>
<tr>
<th>Scale</th>
<th>n</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>STATIC - 99</td>
<td>50</td>
<td>3.88</td>
<td>2.15</td>
</tr>
<tr>
<td>RMAS</td>
<td>42</td>
<td>42.05</td>
<td>16.61</td>
</tr>
<tr>
<td>ABCS</td>
<td>45</td>
<td>134.38</td>
<td>9.48</td>
</tr>
<tr>
<td>WSFQ Exploratory scale</td>
<td>27</td>
<td>7.93</td>
<td>8.49</td>
</tr>
<tr>
<td>WSFQ Intimacy scale</td>
<td>27</td>
<td>16.37</td>
<td>9.37</td>
</tr>
<tr>
<td>WSFQ Impersonal scale</td>
<td>27</td>
<td>4.63</td>
<td>4.68</td>
</tr>
<tr>
<td>WSFQ Sado-Masochistic scale</td>
<td>27</td>
<td>1.44</td>
<td>2.15</td>
</tr>
<tr>
<td>MSI Social and Sexual Desirability scale</td>
<td>48</td>
<td>24.44</td>
<td>7.62</td>
</tr>
<tr>
<td>MSI Lie scale</td>
<td>48</td>
<td>10.31</td>
<td>2.59</td>
</tr>
<tr>
<td>MSI Cognitive Distortion scale</td>
<td>48</td>
<td>4.94</td>
<td>3.10</td>
</tr>
<tr>
<td>MSI Justification scale</td>
<td>48</td>
<td>3.48</td>
<td>3.00</td>
</tr>
<tr>
<td>MSI Treatment Attitude scale</td>
<td>48</td>
<td>2.56</td>
<td>1.80</td>
</tr>
<tr>
<td>MSI Cruising scale</td>
<td>48</td>
<td>0.92</td>
<td>1.58</td>
</tr>
<tr>
<td>MSI Sexual Assault scale</td>
<td>48</td>
<td>2.27</td>
<td>1.55</td>
</tr>
<tr>
<td>MSI Aggravated Assault scale</td>
<td>48</td>
<td>1.02</td>
<td>1.21</td>
</tr>
<tr>
<td>MSI Sex Deviance - Rape scale</td>
<td>48</td>
<td>5.81</td>
<td>6.18</td>
</tr>
<tr>
<td>MSI Fetish scale</td>
<td>48</td>
<td>0.77</td>
<td>1.63</td>
</tr>
<tr>
<td>MSI Voyeurism scale</td>
<td>48</td>
<td>1.17</td>
<td>1.84</td>
</tr>
<tr>
<td>MSI Obscene Phone Call scale</td>
<td>48</td>
<td>0.35</td>
<td>0.76</td>
</tr>
<tr>
<td>STAXI-II Trait Anger scale</td>
<td>50</td>
<td>50.70</td>
<td>11.56</td>
</tr>
<tr>
<td>STAXI-II Anger Expressed Out scale</td>
<td>50</td>
<td>50.40</td>
<td>13.62</td>
</tr>
<tr>
<td>STAXI-II Anger Expression Index</td>
<td>50</td>
<td>51.32</td>
<td>13.71</td>
</tr>
<tr>
<td>SCL-90-R Obsessive Compulsive scale</td>
<td>49</td>
<td>55.90</td>
<td>11.38</td>
</tr>
<tr>
<td>SCL-90-R Interpersonal Sensitivity scale</td>
<td>49</td>
<td>58.00</td>
<td>13.08</td>
</tr>
<tr>
<td>SCL-90-R Depression scale</td>
<td>49</td>
<td>62.45</td>
<td>11.93</td>
</tr>
<tr>
<td>SCL-90-R Anxiety scale</td>
<td>49</td>
<td>56.41</td>
<td>13.33</td>
</tr>
<tr>
<td>SCL-90-R Hostility scale</td>
<td>49</td>
<td>52.92</td>
<td>17.26</td>
</tr>
<tr>
<td>AI Response Probability scale</td>
<td>27</td>
<td>93.00</td>
<td>31.45</td>
</tr>
<tr>
<td>IRI Personal Distress scale</td>
<td>47</td>
<td>13.94</td>
<td>5.56</td>
</tr>
<tr>
<td>SADS</td>
<td>30</td>
<td>6.30</td>
<td>6.76</td>
</tr>
<tr>
<td>FONE</td>
<td>48</td>
<td>11.21</td>
<td>7.81</td>
</tr>
</tbody>
</table>

Note: RMAS = Rape Myth Acceptance Scale, ABCS = Abel and Becker Cognition Scale, WSFQ = Wilson Sex Fantasy Questionnaire, MSI = Multiphasic Sex Inventory, STAXI-II = State Trait Anger Expression Inventory, SCL-90-R = Symptom Checklist-90-R, AI = Assertion Inventory, IRI = Interpersonal Reactivity Index, SADS = Social Avoidance and Distress Scale, FONE = Fear of Negative Evaluation.

Each of the test scales were evaluated for skewness and kurtosis using SPSS distribution statistics and expected normal probability plots. Slight skewness and kurtosis was observed in some of the test variables but none of the statistics exceeded two standard errors of either skewness or kurtosis and these variables were therefore retained for analysis. Five subscales of the Multiphasic Sex Inventory (MSI) however,
reflected significant skeweness (Appendix D) and exceeded the skeweness value of 1.96 (Tabachnik & Fidell, 2001). Examination of the graphical representations of the test variables confirmed that no serious departures from normality were present except for the MSI subscales identified in Appendix D. This skeweness represents real world presentations. Therefore, rather than transform the variables, which would intrinsically change the results, a non-parametric correlation (Spearman’s Rho) was used for any tests conducted with the MSI.

To identify potential univariate outliers a range of scores were examined for normal distributions using SPSS EXPLORE. Outliers beyond two standard deviations were eliminated when individual variables were screened for normality. Eleven cases were identified as potential outliers across all the tests that were examined, but since they did not fall outside the two standard deviation criteria, they were retained within the dataset.

3.7.3 Reliability of the COP-RV

3.7.3.1 Item analysis and distribution of scores

COP-RV individual item and subscale score means and standard deviations are reported for Rater 1 and Rater 2 in Table 7. The total subscale score for Rater 1 (which comprised of four participant-raters, T1, T2, T3 and T4 during Time 1) in Part I ranged from 10 to 31, with a mean of 21.06 and in Part II ranged from 9 to 30, with a mean of 20.94. Rater 2 (comprised of four participant-raters, T1, T2, T3 and T4 during Time 2) had a similar spread of subscale scores with a total in Part I ranging from 8 to 33, with a mean of 22.04 and the total in Part II ranging from 10 to 37, with
a mean of 22.64. Figure 3 above presents a distribution of the total subscale scores for each rater.

*Table 7:* Item and subscale score means and interrater reliability.

<table>
<thead>
<tr>
<th>Item</th>
<th>Rater 1 Mean</th>
<th>Rater 1 SD</th>
<th>Rater 2 Mean</th>
<th>Rater 2 SD</th>
<th>Interrater Reliability (r)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Degree of positive affect at the time of the offence.</td>
<td>3.14</td>
<td>1.23</td>
<td>2.74</td>
<td>1.61</td>
<td>.43**</td>
</tr>
<tr>
<td>2. Degree of control to prevent offending.</td>
<td>3.36</td>
<td>1.23</td>
<td>3.50</td>
<td>1.50</td>
<td>.32*</td>
</tr>
<tr>
<td>3. Degree of indirect communication of intent to victim.</td>
<td>2.00</td>
<td>1.23</td>
<td>2.02</td>
<td>1.61</td>
<td>.24</td>
</tr>
<tr>
<td>4. Degree of violence and degrading sexual behaviour.</td>
<td>2.76</td>
<td>1.62</td>
<td>2.74</td>
<td>1.71</td>
<td>.51**</td>
</tr>
<tr>
<td>5. Degree of cognitive distortions about women and sex.</td>
<td>3.34</td>
<td>1.15</td>
<td>3.68</td>
<td>1.20</td>
<td>.54**</td>
</tr>
<tr>
<td>6. Degree of guilt/shame following the offence.</td>
<td>3.66</td>
<td>1.32</td>
<td>3.80</td>
<td>1.63</td>
<td>.41**</td>
</tr>
<tr>
<td>7. Degree of pro-offending behaviours.</td>
<td>2.80</td>
<td>1.34</td>
<td>3.56</td>
<td>1.78</td>
<td>.59**</td>
</tr>
<tr>
<td><strong>TOTAL SUBSCALE SCORE (PART I)</strong></td>
<td><strong>21.06</strong></td>
<td><strong>4.65</strong></td>
<td><strong>22.04</strong></td>
<td><strong>5.52</strong></td>
<td><strong>.53</strong></td>
</tr>
<tr>
<td>11. Degree of explicit planning.</td>
<td>2.66</td>
<td>1.26</td>
<td>2.80</td>
<td>1.51</td>
<td>.32*</td>
</tr>
<tr>
<td>12. Degree of thought before acting.</td>
<td>2.58</td>
<td>1.23</td>
<td>2.78</td>
<td>1.42</td>
<td>.29*</td>
</tr>
<tr>
<td>13. Complexity of strategies used (either to offend or prevent offending).</td>
<td>2.32</td>
<td>1.04</td>
<td>2.40</td>
<td>1.63</td>
<td>.36*</td>
</tr>
<tr>
<td>14. Use of inappropriate coping mechanisms prior to offence.</td>
<td>3.06</td>
<td>1.42</td>
<td>3.84</td>
<td>1.63</td>
<td>.57**</td>
</tr>
<tr>
<td>15. Harm redressal through physical force.</td>
<td>2.94</td>
<td>1.57</td>
<td>3.34</td>
<td>1.59</td>
<td>.62**</td>
</tr>
<tr>
<td>16. Internal locus of control.</td>
<td>2.72</td>
<td>0.99</td>
<td>2.48</td>
<td>1.34</td>
<td>.16</td>
</tr>
<tr>
<td>17. Offender evaluation of victim resistance.</td>
<td>2.42</td>
<td>1.34</td>
<td>2.64</td>
<td>1.48</td>
<td>.60**</td>
</tr>
<tr>
<td>18. Ability to delay gratification.</td>
<td>2.24</td>
<td>0.89</td>
<td>2.36</td>
<td>1.35</td>
<td>.06</td>
</tr>
<tr>
<td><strong>TOTAL SUBSCALE SCORE (PART II)</strong></td>
<td><strong>20.94</strong></td>
<td><strong>5.06</strong></td>
<td><strong>22.64</strong></td>
<td><strong>6.11</strong></td>
<td><strong>.46</strong></td>
</tr>
</tbody>
</table>

*Note: SD = Standard Deviation, r = Pearson correlation coefficient, *p < .05, **p < .01*
3.7.3.2 Interrater reliability

Analysis of item and total subscale scores for Rater 1 and Rater 2

Table 7 also summarises the interrater reliability statistics for each item and for the total subscale score in Part I and Part II of the COP-RV. The interrater reliability for the total subscale score measuring the goals (Part I) of the offender was good achieving significance at the .01 level (Pearson $r = .53$, $p < .01$) and was better than the interrater reliability for the total subscale score measuring self-regulation strategies (Part II) which also attained significance at the .01 level (Pearson $r = .46$, $p < .01$). Individual item interrater reliabilities ranged from .06 to .62 and all items achieved significance except for item numbers 3, 16 and 18 (see Table 7). Furthermore, 8 items (53%) had interrater reliabilities of at least .40.

Analysis of item and total subscale scores by homogenous and heterogenous raters

A more detailed analysis of the interrater reliability between pairs of raters on each item was performed (see Appendix E) but more meaningful results were identified when an analyses was conducted between teams of raters on each item (see Table 8). The interrater reliability between heterogenous raters was significantly better than their homogenous counterparts on item numbers 2, 4, 5, 12 14 and 15 and varied between $r = .41$ and $r = .77$, whereas homogenous raters had significantly better interrater reliability on item numbers 1, 3, 7, 13 and 16 with a correlation coefficient varying between $r = .47$ and $r = .62$. Interestingly, heterogenous raters displayed a negative interrater reliability on item numbers 16 (Spearman $r = -.07$) and 18 (Spearman $r = -.09$) which although not significant was the lowest correlation coefficient amongst all 18 items of the test between both teams of raters. However, on total subscale scores, heterogenous raters produced significantly better results than
homogenous raters displaying significantly greater interrater reliability for both Part I
(Spearman \( r = .71, p < .01 \)) and Part II of the scale (Spearman \( r = .53, p < .01 \)).

*Table 8:* Item and subscale score interrater reliability for homogenous and heterogenous raters.

<table>
<thead>
<tr>
<th>Item</th>
<th>Interrater Reliability (r)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Homogenous Raters</td>
</tr>
<tr>
<td>1. Degree of positive affect at the time of the offence.</td>
<td>.47*</td>
</tr>
<tr>
<td>2. Degree of control to prevent offending.</td>
<td>.13</td>
</tr>
<tr>
<td>3. Degree of indirect communication of intent to victim.</td>
<td>.47*</td>
</tr>
<tr>
<td>4. Degree of violence and degrading sexual behaviour.</td>
<td>.34</td>
</tr>
<tr>
<td>5. Degree of cognitive distortions about women and sex.</td>
<td>.26</td>
</tr>
<tr>
<td>6. Degree of guilt/ shame following the offence.</td>
<td>.50*</td>
</tr>
<tr>
<td>7. Degree of pro-offending behaviours.</td>
<td>.62**</td>
</tr>
<tr>
<td><strong>TOTAL SUBSCALE SCORE (PART I)</strong></td>
<td>.31</td>
</tr>
<tr>
<td>11. Degree of explicit planning.</td>
<td>.29</td>
</tr>
<tr>
<td>12. Degree of thought before acting.</td>
<td>.14</td>
</tr>
<tr>
<td>13. Complexity of strategies used (either to offend or prevent offending).</td>
<td>.50*</td>
</tr>
<tr>
<td>14. Use of inappropriate coping mechanisms prior to offence.</td>
<td>.51**</td>
</tr>
<tr>
<td>15. Harm redressal through physical force.</td>
<td>.43*</td>
</tr>
<tr>
<td>16. Internal locus of control.</td>
<td>.49*</td>
</tr>
<tr>
<td>17. Offender evaluation of victim resistance.</td>
<td>.62**</td>
</tr>
<tr>
<td>18. Ability to delay gratification.</td>
<td>.29</td>
</tr>
<tr>
<td><strong>TOTAL SUBSCALE SCORE (PART II)</strong></td>
<td>.28</td>
</tr>
</tbody>
</table>

*Note: \( r = \) Spearman’s Rho correlation coefficient, \(* p < .05, ** p < .01\)*
Global classification into pathways by raters

The global categorical classification of rapists into each of the discrete pathways (item numbers 9 and 20 of the COP-RV) was also analysed. Table 9 summarises the agreement in classification by two independent raters for each rapist in the sample. Of the four pathways, the passive and the approach group were the most reliable containing the highest number of agreements between raters (68%). Although Cohen’s Kappa for the Passive vs. Active pathways achieved clinical significance ($r = .28, p < .05$) it was poor by the Fliess (1981) criteria. Of all the pathways, the avoidant group had the poorest interrater agreement (37%) with the overall Cohen’s Kappa for the Approach vs. Avoidant pathway failing to reach significance ($r = .05, ns$). Nonetheless, based on global clinical decision-making, the numbers demonstrate (see Table 10) that on average, Rater 1 ($\chi^2 = 2.88, df = 1, p < .10$) and Rater 2 ($\chi^2 = 5.12, df = 1, p < .05$) were significantly more likely to classify rapists as following an approach (64%) rather than an avoidant (36%) pathway, while there is an approximately equal and nonsignificant distribution by the raters of rapists using active and passive strategies to achieve their goals (48% compared with 52%, respectively). When overall pathway assignment combining a dominant goal with a dominant strategy was analysed (Table 11), rapists were on average significantly more likely to be assigned to the approach-active pathway (39%) by both Rater 1 ($\chi^2 = 9.36, df = 3, p < .05$) and Rater 2 ($\chi^2 = 9.36, df = 3, p < .05$).
Table 9: Summary of agreement between raters’ global pathway classification of rapists.

<table>
<thead>
<tr>
<th>Rater 1</th>
<th>Approach</th>
<th>Avoidant</th>
<th>Active</th>
<th>Passive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approach</td>
<td>21</td>
<td>12</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Avoidant</td>
<td>10</td>
<td>7</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Rater 2</td>
<td>Active</td>
<td>-</td>
<td>-</td>
<td>15*</td>
</tr>
<tr>
<td>Passive</td>
<td>-</td>
<td>-</td>
<td>10</td>
<td>17*</td>
</tr>
<tr>
<td>Agreement (%)</td>
<td>68%</td>
<td>37%</td>
<td>60%</td>
<td>68%</td>
</tr>
</tbody>
</table>

Note: Agreement between raters is indicated in bold, *p < .05

Table 10: Average distribution of rapists to the four pathways

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Rater 1</th>
<th>Rater 2</th>
<th>Average</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOALS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approach</td>
<td>31*</td>
<td>33**</td>
<td>32</td>
<td>64%</td>
</tr>
<tr>
<td>Avoidant</td>
<td>19</td>
<td>17</td>
<td>18</td>
<td>36%</td>
</tr>
<tr>
<td><strong>SELF-REGULATION STRATEGIES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active</td>
<td>25</td>
<td>23</td>
<td>24</td>
<td>48%</td>
</tr>
<tr>
<td>Passive</td>
<td>25</td>
<td>27</td>
<td>26</td>
<td>52%</td>
</tr>
</tbody>
</table>

Note: n = 50, *p < .10, **p < .05

Table 11: Average distribution of rapists to a combined pathway

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Rater 1</th>
<th>Rater 2</th>
<th>Average</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approach-Active</td>
<td>20*</td>
<td>19*</td>
<td>19.5</td>
<td>39%</td>
</tr>
<tr>
<td>Approach-Passive</td>
<td>11</td>
<td>14</td>
<td>12.5</td>
<td>25%</td>
</tr>
<tr>
<td>Avoidant-Active</td>
<td>5</td>
<td>4</td>
<td>4.5</td>
<td>9%</td>
</tr>
<tr>
<td>Avoidant-Passive</td>
<td>14</td>
<td>13</td>
<td>13.5</td>
<td>27%</td>
</tr>
</tbody>
</table>

Note: n = 50, *p < .05
Interrater reliability of heterogenous and homogenous raters of subscale score and global categorical classification into pathways

Analyses were also conducted to determine if there were any differences in interrater reliability between the teams of clinicians as heterogenous and homogenous raters (see Table 12). When the total subscale scores for each part was analysed, the interrater reliability for heterogenous raters was significantly better than their homogenous counterparts in both assessing the approach vs. avoidant pathways (Spearman \( r = .71, p < .01 \)) as well as the active vs. passive pathways (Spearman \( r = .53, p < .01 \)). Interestingly, when the overall global categorical classification for both sub-parts of the test were analysed for differences between heterogenous raters and homogenous raters, an opposite effect was found, with significant interrater reliability between homogenous raters for the active vs. passive strategies (Cohen’s Kappa \( r = .60, p < .01 \)).

Table 12: Comparison of interrater reliability of heterogenous and homogenous raters by total subscale score and global categorical classification.

<table>
<thead>
<tr>
<th></th>
<th>Approach Vs. Avoidant Pathway</th>
<th>Active vs. Passive Pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Subscale Classification (Sr)</td>
<td>Categorical Classification (Cr)</td>
</tr>
<tr>
<td><strong>Heterogenous Raters</strong></td>
<td>.71**</td>
<td>.07</td>
</tr>
<tr>
<td><strong>Homogenous Raters</strong></td>
<td>.31</td>
<td>.02</td>
</tr>
</tbody>
</table>

*Note: Sr = Spearman’s Rho, Cr = Cohen’s Kappa, *\( p < .05 \), **\( p < .01 \)*
Degree of agreement within clinicians’ classification into pathways based on global categorisation and total subscale score

Since this analysis was investigating the level of agreement within each clinicians’ classification of the casefile into one of the pathways based on a global categorisation, and pathway membership as a result of total subscale score, there were 100 unique data points available. To determine pathway membership the average score for each subscale was calculated. For the goals and strategy subscale an average subscale score of 3 or more was classified as Approach and Active respectively, whereas an average subscale score of less than 3 was classified as Avoidant and Passive respectively. A chi-square analysis using the absolute value of the goals subscale (Approach vs. Avoidant) revealed a significant association between the global clinical decision and total subscale score categorisation for each clinician \((\chi^2 = 11.06, df = 1, p < .01)\). Although the overall level of agreement for the goals categories was sixty-eight percent (68%), a clinician was more likely to agree between a global clinical decision and subscale score category for approach (70%) rather than avoidant (64%) individuals (see Table 13). A similar analysis for the strategies subscale (Active vs. Passive) revealed a significant overall level of agreement between the global clinical decision and total subscale score categorisation (74%; \(\chi^2 = 23.52, df = 1, p < .01\)). However, for this subscale a clinician was more likely to agree between a global clinical decision and subscale score category for passive (85%) rather than active (63%) individuals (see Table 13).
Table 13: Summary of agreement within clinicians’ classification into pathways based on global decision and total subscale score.

<table>
<thead>
<tr>
<th>Subscale score categorisation</th>
<th>Approach</th>
<th>Avoidant</th>
<th>Active</th>
<th>Passive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Approach</td>
<td>45*</td>
<td>13</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Clinical Avoidant</td>
<td>19</td>
<td>23*</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Decision Active</td>
<td>-</td>
<td>-</td>
<td>30*</td>
<td>8</td>
</tr>
<tr>
<td>Passive</td>
<td>-</td>
<td>-</td>
<td>18</td>
<td>44*</td>
</tr>
<tr>
<td>Agreement (%)</td>
<td>70%</td>
<td>64%</td>
<td>63%</td>
<td>85%</td>
</tr>
</tbody>
</table>

*Note: Agreement between categorisation methods is indicated in bold, *p < .01*

Rater confidence in responses and effect of past experience on endorsement of items

An analysis was conducted to determine the confidence of the raters on the endorsement of the items in the COP-RV and their confidence in their overall classification of the rapists into the approach vs. avoidant and active vs. passive pathways. The average response of the raters was situated around ‘moderate’ for both their confidence in the endorsement of all the subscale items as well as their confidence in their overall global classification of the rapist. There appeared to be no differences in their level of confidence while endorsing items on the subscales or making global judgments about the pathway to which the rapist belonged. The mean for their confidence in responses to the subscale items ranged from 2.76 (SD = 1.02) to 3.08 (SD = .94) and the mean for their confidence in providing a global classification of the offender into approach vs. avoidant and active vs. passive ranged from 2.78 (SD = 1.01) to 3.00 (SD = 1.01).

The raters belief of exposure to either assessment or treatment of the rapist whose casefile they were reviewing was analysed to determine if belief of prior face to face contact influenced the reliability of the ratings. A summary of the percentage of raters
who had a belief of past experience or face to face contact with the rapist is provided in Table 14.

Table 14: Percentage of raters belief of prior exposure to the rapist and acknowledgement of influence on endorsement of COP-RV items

<table>
<thead>
<tr>
<th>Belief of past experience</th>
<th>Rater 1</th>
<th>Rater 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Could not guess whose file it was</td>
<td>84%</td>
<td>78%</td>
</tr>
<tr>
<td>Guessed but went strictly by the information in the file</td>
<td>12%</td>
<td>20%</td>
</tr>
<tr>
<td>Guessed and used personal experience to respond to COP-RV</td>
<td>4%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Belief of face to face contact

<table>
<thead>
<tr>
<th>Belief of face to face contact</th>
<th>Rater 1</th>
<th>Rater 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>No face to face contact</td>
<td>86%</td>
<td>80%</td>
</tr>
<tr>
<td>Assessment only</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Therapy only</td>
<td>10%</td>
<td>18%</td>
</tr>
<tr>
<td>Both assessment and therapy</td>
<td>2%</td>
<td>0%</td>
</tr>
</tbody>
</table>

As can be seen from the numbers above, both raters responded to a majority of casefiles in a way in which they believed that they were not influenced by past exposure to the rapists (96% for Rater 1 and 98% for Rater 2). In fact Rater 1 believed they were unable to identify eighty-four percent (84%) of the casefiles while Rater 2 could not identify seventy-eight percent (78%) of the cases. In a vast majority of cases, the raters did not believe they had had face-to-face contact with the rapist in the past (86% for Rater 1 and 80% for Rater 2). In order to analyse the effects of the ‘belief of prior contact’ on clinician responses the data was collapsed to provide two groups of raters in which both raters in the first group \( n = 47 \) went strictly by casefile information and either one of the raters in the second group \( n = 3 \) allowed the belief of personal contact with the rapist to influence the decision-making. The oneway analysis of variance did not provide significant results for any of the subscale comparisons, indicating that even if clinicians had a belief of prior contact with the
rapist it did not significantly account for differences between the raters in endorsing items on the COP-RV.

3.7.3.3 Internal consistency

Internal reliability for the COP-RV was assessed using Cronbach’s alpha coefficient ($\alpha$). Since each casefile ($n = 50$) was rated by two independent raters, one hundred unique data points were made available for this analysis. Alphas were initially assessed on both subscales of the measure for both raters ($n = 50$) but the correlations were found to be of the same magnitude as when using one hundred data points ($n = 100$). As a result, all analyses for internal consistency were conducted using one hundred data points ($n = 100$) and were evaluated by alpha-if-item-deleted as well as interitem correlations across all domains, as produced in the Statistical Packages for the Social Sciences Version 12 for Windows (SPSS Inc., 2003).

The corrected item-total correlation, subscale alphas and subscale alpha-if-item deleted is reported in Table 15. The alpha coefficient of the strategies subscale ($\alpha = .60$) is markedly better than the goals subscale ($\alpha = .50$). When the alpha-if-item-deleted measure was analysed, the results indicated that if a particular item was deleted from the scale, there was improvement in the alpha coefficient. For instance when item number 7 was dropped from the goals subscale the alpha coefficient increased to $\alpha = .52$. Similarly when item number 14 was dropped from the strategies subscale there was a corresponding increase in the alpha coefficient to $\alpha = .69$. Since deleting only one item from each scale does not substantially alter the length of the test and provides a corresponding increase in the subscale alpha coefficient, discarding these two items would enhance the ability of the scales to more reliably
capture the pathways of the rapists. However, as there is currently no predictive validity of these test items it may be unwise to delete them at this stage, and further analysis is conducted retaining all 15 of the original test items.

Table 15: Scale reliability descriptives

<table>
<thead>
<tr>
<th>Part I</th>
<th>Corrected Item-Total Correlation</th>
<th>Subscale Alpha if item deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item Numbers</td>
<td>Goals Item number 1</td>
<td>.23</td>
</tr>
<tr>
<td></td>
<td>Goals Item number 2</td>
<td>.25</td>
</tr>
<tr>
<td></td>
<td>Goals Item number 3</td>
<td>.27</td>
</tr>
<tr>
<td></td>
<td>Goals Item number 4</td>
<td>.23</td>
</tr>
<tr>
<td></td>
<td>Goals Item number 5</td>
<td>.44</td>
</tr>
<tr>
<td></td>
<td>Goals Item number 6</td>
<td>.20</td>
</tr>
<tr>
<td></td>
<td>Goals Item number 7</td>
<td>.12</td>
</tr>
</tbody>
</table>

Goals Subscale Alpha ($\alpha$) = .50

<table>
<thead>
<tr>
<th>Part II</th>
<th>Corrected Item-Total Correlation</th>
<th>Subscale Alpha if item deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item Numbers</td>
<td>Strategies Item number 11</td>
<td>.66</td>
</tr>
<tr>
<td></td>
<td>Strategies Item number 12</td>
<td>.63</td>
</tr>
<tr>
<td></td>
<td>Strategies Item number 13</td>
<td>.48</td>
</tr>
<tr>
<td></td>
<td>Strategies Item number 14</td>
<td>-.11</td>
</tr>
<tr>
<td></td>
<td>Strategies Item number 15</td>
<td>.30</td>
</tr>
<tr>
<td></td>
<td>Strategies Item number 16</td>
<td>.17</td>
</tr>
<tr>
<td></td>
<td>Strategies Item number 17</td>
<td>.10</td>
</tr>
<tr>
<td></td>
<td>Strategies Item number 18</td>
<td>.37</td>
</tr>
</tbody>
</table>

Strategies Subscale Alpha ($\alpha$) = .60

Note: $n = 100$

Examination of the scale’s interitem correlation matrix was similarly encouraging, displaying correlations between those items that were predicted to be related. Table 16 sets out the interitem correlations for all items endorsed by Rater 1 and Rater 2 ($n = 100$). All items that have both positive and negative correlations of .50 and above are marked in bold. The results indicate that there are strong positive correlations between items that purport to measure similar constructs. For instance correlation coefficients of $r = .50$ (between item 2 and item 11), $r = .54$ (between item 2 and item...
12), $r = .54$ (between item 2 and item 13) indicate a moderate relationship between affective states, level of planning, impulsivity and activation of problem solving strategies. The strongest correlations within scales were between item 11 and 12 ($r = .75$) and item 12 and 13 ($r = .71$) supporting previous findings on the cognitive processes implicated in sexual offending. Similarly a correlation of $r = .52$ supports previous findings on the link between the use of inappropriate coping mechanisms and engagement in pro-offending behaviours. As expected significant negative correlations were found in only two instances, between item 1 and item 15 ($r = -.51$) and item 4 and 15 ($r = .67$) which supports previous findings on the relationship between negative affect, harm redressal motivated by physical assault and the use of gratuitous sexual violence to humiliate and degrade the victim. Additional correlations between item 13 and item 18 ($r = .52$) support empirical findings that implicate the activation of advanced grooming strategies and the ability to delay gratification and a correlation of $r = .53$ between item 15 and item 17 supports previous literature that suggests offenders who are primarily motivated by physical assault evaluate victims as being resistant to their sexual advances. Unsurprisingly, eighty percent (80%) of the interitem correlations for Part I of the measure were weak or uncorrelated ($r$ ranged from .00 to .25), while seventy-one percent (71%) of the interitem correlations for Part II of the measure were weak or uncorrelated, indicating that the majority of the test items were assessing separate constructs.
Table 16: Interitem correlation (r) matrix for the COP-RV.

<table>
<thead>
<tr>
<th>Item</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>18</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>.06</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>.33</td>
<td>.13</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>.25</td>
<td>.11</td>
<td>.42</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>.24</td>
<td>.15</td>
<td>.09</td>
<td>.00</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>-.02</td>
<td>.22</td>
<td>.04</td>
<td>-.11</td>
<td>.44</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>-.10</td>
<td>.11</td>
<td>-.18</td>
<td>.07</td>
<td>.40</td>
<td>.15</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>-.28</td>
<td>.50</td>
<td>-.09</td>
<td>-.15</td>
<td>.04</td>
<td>.04</td>
<td>.20</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>-.16</td>
<td>.54</td>
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<td>-.19</td>
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<td>-.04</td>
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<td>.16</td>
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</table>

Note: n = 100

3.7.4 Validity of the COP-RV

The convergent and discriminant validity of the COP-RV was analysed by comparing the individual items in the COP-RV to scores on other psychometric scales purporting to measure either related or unrelated constructs. Table 17 provides a summary of the scales used to measure the validity of each item. A composite score for each item was utilised in the final analysis, which was obtained by averaging the scores between Rater 1 and Rater 2 (n = 50). Each item’s average score was obtained by adding the square of the item score for Rater 1 and Rater 2, dividing the sum by two and obtaining the square root of the final figure (equation 1).

Equation 1: Formula for calculating composite score.

$$\sqrt{\frac{(r_1)^2 + (r_2)^2}{2}}$$

A psychometric measure is said to have convergent validity to the extent that it correlates with other measures that are purported to measure the same or similar
constructs (Campbell & Fiske, 1959). Discriminant validity, on the other hand, refers to the nonexistent or weak correlation of subscale items or scores to variables with which they are theoretically unrelated (Nunnally & Bernstein, 1994). To assess the convergent and discriminant validity of the COP-RV, the composite score obtained for each item was compared with scores on other scales measuring either a related or unrelated construct using both Pearson’s product moment correlations for normal distributions and Spearman’s rank correlation coefficients for non-normal distributions.

Table 17: Summary of scales used to measure the convergent and discriminant validity of each item.

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Item Description</th>
<th>Scales</th>
<th>Correlation (r)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Affect at the time of the offence</td>
<td>STAXI-II Trait Anger scale</td>
<td>-.19^</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCL-90-R Depression scale</td>
<td>-.05^</td>
</tr>
<tr>
<td>2.</td>
<td>Degree of control to prevent offending</td>
<td>IRI Personal Distress scale</td>
<td>-.32^***</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FONE</td>
<td>-.31^**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SADS</td>
<td>-.42^**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AI Response Probability scale</td>
<td>-.04^†</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCL-90-R Obsessive Compulsive scale</td>
<td>-.28^**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCL-90-R Interpersonal Sensitivity scale</td>
<td>-.53^***</td>
</tr>
<tr>
<td>3.</td>
<td>Communication of intent to victim</td>
<td>MSI Sexual Assault scale</td>
<td>-.37^***</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MSI Aggravated Assault scale</td>
<td>-.20^</td>
</tr>
<tr>
<td></td>
<td></td>
<td>WSFQ Exploratory scale</td>
<td>-.36^*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>WSFQ Impersonal scale</td>
<td>-.34^*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCL-90-R Interpersonal Sensitivity scale</td>
<td>-.36^**</td>
</tr>
<tr>
<td>4.</td>
<td>Infliction of violence and degrading sexual behaviour</td>
<td>Fellatio°</td>
<td>.38^***</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Penile Anal Penetration°</td>
<td>.35^**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Penile Vaginal Penetration°</td>
<td>-.10^†</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of Sexual Convictions°</td>
<td>.31^**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Injury°</td>
<td>.33^**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assault°</td>
<td>.25^†</td>
</tr>
<tr>
<td>5.</td>
<td>Cognitive distortions about women and sex</td>
<td>MSI Cognitive Distortion and Immaturity scale</td>
<td>.36^**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RMAS</td>
<td>.13^</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ABCS</td>
<td>-.20^†</td>
</tr>
<tr>
<td>6.</td>
<td>Guilt/ Shame following the offence</td>
<td>MSI Treatment Attitude scale</td>
<td>.44^***</td>
</tr>
<tr>
<td>Item No.</td>
<td>Item</td>
<td>Scales</td>
<td>Correlation (r)</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>7.</td>
<td>Engagement in pro-offending behaviours</td>
<td>MSI Voyeurism scale</td>
<td>.40c, ***</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MSI Fetish scale</td>
<td>.21c</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MSI Obscene Phone Call scale</td>
<td>.28c, *</td>
</tr>
<tr>
<td></td>
<td></td>
<td>WSFQ Exploratory scale</td>
<td>.50c, ***</td>
</tr>
<tr>
<td></td>
<td></td>
<td>WSFQ Impersonal scale</td>
<td>.50c, ***</td>
</tr>
<tr>
<td></td>
<td></td>
<td>WSFQ Intimacy scale</td>
<td>-.03d, †</td>
</tr>
<tr>
<td>11.</td>
<td>Degree of planning prior to the offence</td>
<td>MSI Sex Deviance - Rape scale</td>
<td>.38c, ***</td>
</tr>
<tr>
<td>12.</td>
<td>Level of impulsivity</td>
<td>MSI Cruising scale</td>
<td>.34c, **</td>
</tr>
<tr>
<td>13.</td>
<td>Complexity of strategies used to offend or prevent offending</td>
<td>SADS</td>
<td>-.08d, †</td>
</tr>
<tr>
<td></td>
<td></td>
<td>STAXI-II Trait Anger scale</td>
<td>-.03d, †</td>
</tr>
<tr>
<td></td>
<td></td>
<td>STAXI-II Anger Expressed Out scale</td>
<td>-.01d, †</td>
</tr>
<tr>
<td></td>
<td></td>
<td>STAXI-II Anger Expression Index</td>
<td>.04c, †</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCL-90-R Depression scale</td>
<td>-.01d, †</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCL-90-R Anxiety scale</td>
<td>-.01d, †</td>
</tr>
<tr>
<td>14.</td>
<td>Use of inappropriate coping mechanisms prior to offence</td>
<td>Influence of Alcohol°</td>
<td>.64c, ***</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Influence of Illicit Substance°</td>
<td>.36c, **</td>
</tr>
<tr>
<td>15.</td>
<td>Harm redressal</td>
<td>Fellatio°</td>
<td>.31c, **</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Penile Anal Penetration°</td>
<td>.26c, *</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Penile Vaginal Penetration°</td>
<td>-.06d, †</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Injury°</td>
<td>.27c, *</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assault°</td>
<td>.29c, **</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SCL-90-R Hostility scale</td>
<td>.26c, *</td>
</tr>
<tr>
<td>16.</td>
<td>Locus of control</td>
<td>MSI Justification scale</td>
<td>-.15c</td>
</tr>
<tr>
<td>17.</td>
<td>Offender evaluation of victim resistance</td>
<td>MSI Sex Deviance - Rape scale</td>
<td>.22c</td>
</tr>
<tr>
<td>18.</td>
<td>Ability to delay gratification</td>
<td>MSI Cruising scale</td>
<td>.16d, †</td>
</tr>
</tbody>
</table>

Note: ° = Variables from the electronic database containing demographic and offence information, c = Tested for Convergent Validity, d = Tested for Discriminant Validity, † = Expected nonsignificant relationship, * p < .10, ** p < .05, *** p < .01

Note on Type I and Type II Error: Based on the number of correlations that were conducted (48), it is expected that at least 2 correlations will be significant when they should not be and 2 correlations will not be significant when they should be. Since this is the first time this concept has been tested psychometrically it should be considered exploratory.

Item 1: Affect

Pearson’s product-moment correlations were conducted between the score on item 1 and the STAXI-II Trait Anger scale and SCL-90-R Depression scale. Low scores on
item 1 reflect negative affect prior to the offence. High scores on the STAXI-II Trait Anger scale reflect the pervasive experience of frustration and angry feelings. High scores on the SCL-90-R Depression scale reflect a range of depressive symptoms such as dysphoric mood, feelings of hopelessness, lack of motivation and energy and thoughts of suicide. As expected, results indicate that item 1 is negatively correlated with the STAXI-II Trait Anger scale (Pearson $r = -.19, ns$) but this was nonsignificant. A nonsignificant relationship with the SCL-90-R Depression scale (Pearson $r = -.05, ns$) was also found, which was unexpected.

**Item 2: Degree of control**

Pearson’s correlations were conducted between the score on item 2 and the IRI Personal Distress scale, FONE, SADS, AI Response Probability scale and SCL-90-R Obsessive Compulsive and Interpersonal Sensitivity scales. High scores on item 2 reflect greater self-control. Low scores on IRI Personal Distress, FONE and SADS reflect the ability to cope with negative feelings, less defensiveness, more autonomy, more dominance and less likelihood of experiencing social avoidance and distress. Low scores on the AI Response Probability reflect a high assertiveness response probability and high scores on SCL-90-R Obsessive Compulsive and Interpersonal Sensitivity scales reflect thoughts, impulses and actions that are experienced as unremitting and irresistible with significant discomfort during interpersonal interactions. Results indicate significant convergent validity between item 2 and the IRI Personal Distress scale (Pearson $r = -.32, p < .05$), FONE (Pearson $r = -.31, p < .05$), SADS (Pearson $r = -.42, p < .05$), SCL-90-R Obsessive Compulsive scale (Pearson $r = -.28, p < .05$), SCL-90-R Interpersonal Sensitivity scale (Pearson $r = -$
Item 3: Communication of intent

Spearman’s rank correlations were conducted between the score on item 3 and the MSI Sexual Assault and Aggravated Assault score because of a non-normal distribution, while Pearson’s correlations were conducted between item 3 and the WSFQ Exploratory and Impersonal scale and the SCL-90-R Interpersonal Sensitivity score. Low scores on item 3 reflect direct communication of intent to the victim either verbally or through physical force. High scores on MSI Sexual Assault and Aggravated Assault scales reflect the use of violence during the commission of the offence. High scores on the WSFQ Exploratory and Impersonal scales reflect fantasies of engaging in orgies, exchanging mates and having sex with a stranger. A high score on the SCL-90-R Interpersonal Sensitivity scale reflects feelings of inadequacy and inferiority and discomfort during interpersonal interactions. Results indicate significant convergent validity between item 3 and the MSI Sexual Assault scale (Spearman $r = -.37, p < .05$), and a weak and nonsignificant correlation with the MSI Aggravated Assault scale ($r = -.20, ns$). Significant convergent validity was displayed between item 3 and the WSFQ Exploratory scale ($r = -.36, p < .10$), WSFQ Impersonal scale ($r = -.34, p < .10$) and SCL-90-R Interpersonal Sensitivity score ($r = -.36, p < .05$).

Item 4: Infliction of violence and degrading sexual behaviour

Pearson’s correlations were conducted between the score on item 4 and variables measuring conviction for Fellatio, Penile Anal Penetration, Penile Vaginal
Penetration, Number of Sexual Convictions, Injury and Assault. A high score on item 4 reflects the use of extreme violence with sexual activity being performed to humiliate and degrade the victim such as anal penetration and fellatio. Results indicate convergent validity through significant positive correlations between item 4 and Fellatio (Pearson $r = .38, p < .01$), Penile Anal Penetration (Pearson $r = .35, p < .05$), Number of Sexual Convictions (Pearson $r = .31, p < .05$), Injury (Pearson $r = .33, p < .05$) and Assault (Pearson $r = .25, p < .10$). Discriminant validity was indicated by a nonsignificant negative correlation between item 4 and Penile Vaginal Penetration (Pearson $r = -.10, ns$).

**Item 5: Cognitive distortions**

Spearman’s correlations were conducted between the score on item 5 and the MSI Cognitive Distortion and Immaturity scale (MSI CDI). Pearson’s correlations were conducted between the score on item 5 and the Rape Myth Acceptance Scale (RMAS) and Abel and Becker Cognitions Scale (ABCS). High scores on item 5 reflect many stereotypical views about women and adherence to rape myths. High scores on the MSI CDI scale reflect difficulty taking responsibility for one’s actions and childhood distortions that have stayed with the offender, while high scores on the RMAS reflect self-reported acceptance of rape myths. High scores on the ABCS on the other hand reflect cognitive distortions around child molestation. Results indicate that item 5 has significant convergent validity with the MSI CDI scale (Spearman $r = .36, p < .05$). However, a nonsignificant relationship with the RMAS (Pearson $r = .13, ns$) was found, which was unexpected. Discriminant validity between item 5 and the ABCS was demonstrated through a weak and nonsignificant relationship (Pearson $r = -.20, ns$).
Item 6: Guilt/Shame

A Spearman’s correlation was conducted between the score on item 6 and MSI Treatment Attitude scale score. High scores on item 6 reflect negative self-evaluation, including guilt/shame following the offence. High scores on the MSI Treatment Attitude scale reflect an offender’s motivation for treatment and openness about his post-offence emotional and cognitive responses. Results indicate that item 6 has significant convergent validity with the MSI Treatment Attitude scale (Spearman \( r = .44, p < .01 \)).

Item 7: Engagement in pro-offending behaviours

Spearman’s correlations were conducted between the score on item 7 and the MSI Fetish, MSI Voyeurism and MSI Obscene Phone Call scale scores. Pearson’s correlations were conducted between the score on item 7 and the WSFQ Exploratory, Impersonal and Intimacy scale scores. High scores on item 7 reflect engagement in pro-offending and at-risk behaviours such as use of pornography and deviant fantasies, acting on fetishes and voyeuristic activities. High scores on the MSI Fetish, Voyeurism and Obscene Phone Calls scale suggest admission of fetishes supportive of the offending behaviour, engagement in peeping and cruising behaviours and the use of intimidation through obscene phone calls. High scores on the WSFQ Exploratory and Impersonal scale scores reflect fantasies of engaging in orgies, exchanging mates and having sex with strangers while high scores on the WSFQ Intimacy scale score reflects intimate themes with a loved one. Results indicate that item 7 has significant convergent validity with the MSI Voyeurism scale (Spearman \( r = .40, p < .01 \)), and the MSI Obscene Call scale (Spearman \( r = .28, p < .10 \)) but a nonsignificant relationship with the MSI Fetish scale (Spearman \( r = .21, ns \)). These
low correlations may be the result of low power \( (n = 50) \) or a socially desirable response bias. Convergent validity was also demonstrated through a significant positive relationship between item 7 and the WSFQ Exploratory scale score (Pearson \( r = .50, p < .01 \)) and Impersonal scale score (Pearson \( r = .50, p < .01 \)). Discriminant validity was indicated with the WSFQ Intimacy scale score (Pearson \( r = -.03, ns \)).

**Item 11: Degree of planning**

A Spearman’s correlation was conducted between the score on item 11 and the MSI Sex Deviance - Rape scale score. High scores on item 11 reflect explicit and detailed planning. High scores on the Rape scale reflect a staged pattern of rape involving fantasy (antecedent thoughts and planning), stalking the victim (cruising), preparing for the opportunity for sexual abuse and executing the sexual assault. Results indicate that item 11 has significant convergent validity with the MSI Rape scale (Spearman \( r = .38, p < .01 \)).

**Item 12: Level of impulsivity**

While there are no tests in the Sex Offender Programme test battery to directly measure impulsivity, some of the MSI subscales provide indication of low impulse control through behavioural markers. A Spearman’s correlation was conducted between the score on item 12 and the MSI Cruising scale. High scores on item 12 reflect a high degree of thought before acting. A high score on the MSI Cruising scale reflects engagement in stalking and preparatory behaviours to select the victim. Results indicate that item 12 has significant convergent validity with the MSI Cruising scale (Spearman \( r = .34, p < .05 \)).
Item 13: Complexity of strategies used

Since there were no tests available in the Sex Offender test battery to measure convergent validity, the following tests were used to measure divergent validity. As this scale measures the strategy of emotion-focused problem-solving abilities rather than affective emotional states it was important to make sure it was not correlated with other measures of affect. Pearson’s correlations were conducted between the score on item 13 and the SADS, STAXI-II Trait Anger scale, STAXI-II Anger Expressed Out scale, STAXI-II Anger Expression Index, SCL-90-R Depression scale and SCL-90-R Anxiety scale. High scores on item 13 reflect advanced problem-solving strategies. High scores on the SADS reflect a greater likelihood of experiencing social-evaluative anxiety and increased defensiveness. High scores on the STAXI-II Trait Anger scale, Anger Expressed Out scale and the Anger Expression Index reflect the experience of angry feelings and unfair treatment, frustration, expression of aggressive behaviour toward other persons or objects and the overall experience of intense angry feelings. Finally, high scores on the SCL-90-R Depression and Anxiety scales reflect a representative range of manifestations of clinical depression and general signs of anxiety such as nervousness, tension and apprehension. Results indicate that item 13 exhibits discriminant validity with nonsignificant correlations with the SADS (Pearson $r = -0.08, ns$), STAXI-II Trait Anger scale (Pearson $r = -0.03, ns$), STAXI-II Anger Expressed Out scale (Pearson $r = -0.01, ns$), STAXI-II Anger Expression Index (Pearson $r = 0.04, ns$), SCL-90-R Depression scale (Pearson $r = -0.01, ns$) and SCL-90-R Anxiety scale (Pearson $r = -0.01, ns$).
Item 14: Use of inappropriate coping mechanisms

Pearson’s correlations were conducted between the score on item 14 and variables measuring whether the offender was under the influence of Alcohol and/or an Illicit Substance prior to the commission of the offence. High scores on item 14 reflect the use of inappropriate coping mechanisms prior to the offence. Results indicate that item 14 has significant convergent validity with Alcohol (Pearson $r = .64, p < .01$) and Illicit Substance (Pearson $r = .30, p < .05$).

Item 15: Harm redressal

This scale is a measure of the strategy utilised by a rapist to redress harm to self and includes not only the nature of the violence but also the affective state in selecting the strategy. It differs from item 4, which is a measure of the severity of violence and degrading sexual behaviour inflicted on the victim. It was therefore considered important to include a validity measure of the negative affective state of the offender. Pearson’s correlations were conducted between the score on item 15 and variables measuring conviction for Fellatio, Penile Anal Penetration, Penile Vaginal Penetration, Injury, Assault and the SCL-90-R Hostility Scale. A high score on item 15 reflects harm redressal through physical force characterised by gratuitous sexual behaviour and physical violence. High scores on the SCL-90-R Hostility scale reflect negative affective states of anger, aggression, resentment and rage. As expected discriminant validity was displayed by a nonsignificant correlation between item 15 and Penile Vaginal Penetration (Pearson $r = -.06, ns$). Results also indicated significant convergent validity between item 15 and Fellatio (Pearson $r = .31, p < .05$), Penile Anal Penetration (Pearson $r = .26, p < .10$), Injury (Pearson $r = .27, p < .05$), and Penile Vaginal Penetration (Pearson $r = .05, ns$).
.10), Assault (Pearson $r = .29, p < .05$) and the SCL-90-R Hostility scale (Pearson $r = .26, p < .10$).

**Item 16: Locus of control**

A Spearman’s correlation was conducted between the score on item 16 and the MSI Justification scale. Low scores on item 16 reflect an external locus of control. High scores on the MSI Justification scale reflect a rapist’s tendency to justify his sexual behaviour by blaming his offending on external causes such as marital problems, alcohol or life stresses. As expected there was a negative correlation between item 16 and the MSI Justification scale (Spearman $r = -.15, ns$), but this was nonsignificant.

**Item 17: Offender evaluation of victim resistance**

A Spearman’s correlation was conducted between the score on item 17 and the MSI Sex Deviance - Rape Scale score. High scores on item 17 reflect the offender’s evaluation of the victim as being resistant. High scores on the MSI Rape scale reflect admittance to using manipulation and coercion to offend against the victim. As expected results indicate that item 17 is positively correlated with the MSI Rape scale (Spearman $r = .22, ns$), but this was nonsignificant.

**Item 18: Ability to delay gratification**

This scale is a measure of a rapist’s difficulty in sexual self-regulation proximal to the offending behaviour. Although there is some overlap, it is distinguished from item 12, which is a measure of general self-regulation. Since there is no test in the Sex Offender Test Battery to assess for sexual self-regulation analysis for discriminant validity was conducted. A Spearman’s correlation was conducted between the score
on item 18 and the MSI Cruising scale score. A high score on item 18 reflects the
ability to delay gratification. A high score on the MSI Cruising scale reflects
engagement in stalking and preparatory behaviours to select the victim. Discriminant
validity was indicated with a nonsignificant and weak correlation between item 18
and the MSI Cruising scale (Spearman $r = .16, ns$).

3.7.5 Socially Desirable Responding on Self-Report Measures

3.7.5.1 **Analysis of rapists response set on the validity scales of the Multiphasic Sex
Inventory (MSI)**

This analysis was conducted to determine the extent of socially desirable responding
on self-report measures within the current sample of rapists. Of the entire sample,
only two rapists did not complete the MSI leaving a sample size of forty-eight rapists
($n = 48$) for this analysis. The MSI is the only self-report measure in the Sex Offender
Programme test battery that contains scales to determine the openness of responses
and social desirability response bias. To investigate the extent of admitting behaviours
in this sample of rapists, results were compared to mean scores used to norm the
validity scales of the MSI (Table 18). The Social and Sexual Desirability scale of the
MSI has been standardised on 40 adult males in the general community, while the Lie
scale has been standardised on non-treated rapists.

*Table 18:* Comparison of rapists mean scores to the normative sample on the validity
scale of the MSI.

<table>
<thead>
<tr>
<th></th>
<th>Rapists $n = 48$</th>
<th>MSI $n = 40$</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSD</td>
<td>24.4*</td>
<td>30.9</td>
</tr>
<tr>
<td>LS</td>
<td>10.3*</td>
<td>5.1</td>
</tr>
</tbody>
</table>

*Note: SSD = Social and Sexual Desirability Scale, LS = Lie Scale,*$p < .001$
Independent sample $t$-tests were performed on the validity scale data presented in Table 18. It was found that significant differences are likely to exist between the mean scores of rapists in this sample and the normative sample of the MSI on the Social and Sexual desirability scale, $t(47) = -5.88, p < .001$ and the Lie scale, $t(47) = 13.92, p < .001$. Results indicate that the current sample of rapists were significantly more likely to present themselves in a favourable light in comparison to the normative sample of the MSI and attempted to present themselves as ‘sexually hyper-normal’ through denial and dishonesty.

Additional investigation of rapists under each category of the validity scales revealed interesting information about responding styles within this sample (Table 19). Using statistical techniques to assess for differences between categories on each scale was not considered prudent due to the likelihood of an inflated Type I error, and as a result descriptive data reported as percentages has been presented in Table 19.

**Table 19: Percentage of rapists under each category of the validity scales of the MSI**

<table>
<thead>
<tr>
<th>MSI VALIDITY SCALES</th>
<th>Normal</th>
<th>Questionable</th>
<th>Denies</th>
<th>Dissimulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSD</td>
<td>48%</td>
<td>19%</td>
<td>8%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>$(n = 23)$</td>
<td>$(n = 9)$</td>
<td>$(n = 4)$</td>
<td>$(n = 12)$</td>
</tr>
<tr>
<td>LS</td>
<td>0%</td>
<td>6%</td>
<td>13%</td>
<td>81%</td>
</tr>
<tr>
<td></td>
<td>$(n = 0)$</td>
<td>$(n = 3)$</td>
<td>$(n = 6)$</td>
<td>$(n = 39)$</td>
</tr>
</tbody>
</table>

*Note: SSD = Social and Sexual Desirability scale, LS = Lie scale.*

Of the 48 rapists in this sample, all of them were classified as likely to have dissembled their sexual deviance. More than three-quarters (81%) were dishonest, while the remaining minimised their offences (13%) and were in the questionable
range (6%). Significantly, not a single rapist acknowledged any sexual deviance on the Lie Scale. Similarly, more than half (52%) had engaged in some form of socially desirable responding with eight percent (8%) outright denying their offending behaviour and a quarter (25%) ‘faking-good’ their responses. Overall, the results indicate a severe response bias by this sample favouring positive self-presentation.
CHAPTER FOUR

Discussion

4.1 Aims of this Research

The overall aim of the current thesis was to develop a clinician-rated psychometric measure that could reliably and validly assign rapists into offending pathways based on their treatment needs. Previous research has generated two methods of assessing sex offender treatment needs. The first comprising of self-report psychological measures assessing specific, single construct presentations, and the second consisting of multi-component clinician-rated actuarial and dynamic assessments of risk. Despite limitations in these methods, there has been no study to date that has developed a clinician-rated measure specifically for the purpose of delineating rapists into offending pathways.

The present study aimed to extend this area of research by providing a comprehensive analysis of a psychometric measure developed to assign rapists to pathways based on their treatment needs. In order to achieve these aims, a measure was developed using items supported by the theoretical and empirical literature. The items were designed to delineate four treatment pathways for rapists: Approach-Active, Approach-Passive, Avoidant-Active and Avoidant-Passive by identifying approach vs. avoidant goals and active vs. passive self-regulation strategies. Once expert agreement was reached on the nature and structure of the measure it was subsequently subjected to a series of analyses designed to test its interrater reliability, internal consistency, convergent and discriminant validity.
The goal of developing a clinician-rated psychometric measure was accomplished in that preliminary support was found for the reliability and validity of the measure. The first stage of the reliability process was the assessment of interrater reliability of the items and subscales of the COP-RV. The interrater reliability of the measure was uneven, but with significant agreement between raters on the measures two subscales: Goals (Pearson $r = .53$) and Self-regulation strategies (Pearson $r = .46$). The interrater reliability for each of the 15 items of the scale ranged from .06 to .62, with 12 items (80%) exhibiting statistically significant interrater reliability. Fifty three percent of the items had interrater reliability coefficients of at least .40. Three items (item numbers 3, 16 and 18) did not achieve statistical significance and these will be dealt with in more detail in Section 4.2.1. The internal consistency of the measure displayed an alpha coefficient of .50 for the goals subscale while the strategies subscale displayed an alpha coefficient of .60. A widely accepted social science cut-off for alpha coefficients of internal reliability is .80 (Miller, 1995). Neither of the subscales met this criterion. However, both these subscale coefficients improved if a single item was dropped from each of the sub-scales. For instance if item 7 was dropped from the Goals subscale the alpha coefficient increased to .52, while dropping item 14 from the Strategies subscale enhanced its internal consistency to .69. However, since this measure for rapists is the first of its kind developed from the pathways model (Hudson, Ward, & McCormack, 1999; Ward, Hudson, & Keenan, 1998), there is currently no predictive validity for these test items and it was therefore considered prudent to retain all items within this test for future research. Significantly, the majority of the items in the COP-RV assessed separate constructs indicating a low rate of overlap of items assessing particular constructs, with eighty percent (80%) of
the interitem correlations for the Goals subscale and seventy percent (71%) of the interitem correlations for the Strategies subscale being weak or uncorrelated.

Evidence for the validity of the measure was also found by assessing the relationships between the items on the measure and other measures purporting to assess similar constructs. Furthermore, a majority of items in the measure were found to have significant relationships with measures of theoretically relevant constructs, such as, planning and control, ability to self-regulate, guilt/shame, level of violence, engagement in offending-supportive behaviours and use of maladaptive coping mechanisms. Finally, items also showed discriminant validity as measured by non-correlational relationships with measures of unrelated constructs such as problem-solving strategies, cognitive distortions and redressal of harm to self.

It should be noted that the process of validating a construct is never complete and no measure can be said to be validated in a final sense. In order to support or discredit the validity of a particular measure numerous studies must be conducted (Nunnally & Bernstein, 1994). The results of this study are a first step, suggesting initial evidence of the reliability and validity of a measure developed to delineate rapists into offending pathways. However, future research is necessary to assess the utility of such an approach.
4.2 Summary of Main Findings

4.2.1 Interrater reliability of the COP-RV

The interrater reliability of the COP-RV as a whole was unremarkable. Closer examination of agreements between raters reveals some interesting differences. Inasmuch as the total mean scores for each subscale of the COP-RV were generally similar across independent ratings, and interrater agreement achieved significance in both the goals ($r = .53$) and strategies ($r = .46$) subscales, the level of agreement between raters varied for individual items within each scale. The most poorly agreed upon items in the entire measure were items 16 (Locus of Control; $r = .16$) and 18 (Ability to delay gratification; $r = .06$) from the Strategies subscale. It is not surprising that raters had difficulty agreeing on a measure of a rapist’s locus of control, as there are a number of ways to assess self-serving biases that function to preserve self-image, and which may manifest as externalisation of blame (Scully & Marolla, 1984; Segal & Marshall, 1985). It appears that clinicians view this item as being qualitatively different from cognitive distortions about women (item 5) for which there was significant agreement between raters ($r = .54$). This is interesting given that previous research has implicated the cognitive scripts of rapists that support an external locus of control (Ward, Hudson et al., 1997). One possible explanation for low agreement on item 16 may be that once clinicians came across item 5 and utilised the information to assess cognitive distortions they did not see that information as being relevant for item 16. Similarly item 18 also challenged clinicians’ agreement and this may suggest a difficulty in assessing sexual self-regulation from self-report. It is possible that clinicians find it hard to evaluate private sensations rather than operant behaviours. However, low levels of agreement on these items appear to be a function of agreement between raters from different groups such as heterogenous
raters and homogenous raters. Thus when clinicians from the same team i.e. prison or community team (homogenous raters) rated a file they were significantly more likely to agree on items 3, 16 and 18 than if they were from different teams. This may suggest that raters from the same team are cued to identifying information in the same way for certain constructs. While agreement between raters from different teams (heterogenous raters) was very poor on these items, they agreed significantly more than their homogenous counterparts on the total Goals subscale ($r = .71$) and total Strategies subscale ($r = .53$), suggesting that the reliability of the measure is considerably enhanced when it is assessed by raters who have differential training. This has pertinent practical implications in that the COP-RV could be completed by any clinician who has received sex offender training and does not necessarily need to have specialised skills that are considered unique for any particular prison or community team. However, specialist training may need to be provided on assessing locus of control, communication of intent and ability to delay gratification to further enhance the reliability of the measure. It is also possible that this differential effect could be caused by the measure itself and enhancing the clarity of the items may enhance the interrater reliability of the measure. Future research could investigate this by comparing the measured used in this study with a revised version containing more relevant and specifically worded items.

Another aspect of the measure that displayed significant differences was the ability of clinicians to reliably make a global judgment of one of the dominant goals (approach vs. avoidant) and the use of a dominant self-regulation strategy (active vs. passive). Using this measure clinicians were very poor at making global judgments and assigning rapists into goals and self-regulation strategies. Although clinicians were
able to agree sixty-eight percent (68%) of the time on rapists offending pathways as approach and passive, a finer-grained analysis revealed that this was nonsignificant. The poorest interrater agreement was for the avoidant group with clinicians agreeing only thirty-five percent (35%) of the time on assignment to this pathway. This is not surprising as the goal of avoiding sexual offending provides a person with a number of ways to fail at preventing something from happening thereby making it more difficult to implement (Hudson, Ward, & McCormack, 1999; Ward & Hudson, 1998). This makes the assessment of the offending behaviour all the more difficult as behavioural antecedents, cognitive scripts, proximal and distal factors all have to be taken into account when making judgments of the goals employed (Ward, Hudson, & McCormack, 1997). On the other hand, since approach goals are characterised by positive affective states and acquisitory behaviour, they are usually associated with just one pathway. Interestingly, when clinicians were asked to make assessments of goals and strategies using the *items* listed in the COP-RV they were more likely to have significant agreement about the goals ($r = .53, p < .01$) and strategies ($r = .46, p < .01$) implicated in the sexual offence and performed better than making global judgments. This suggests that clinicians’ global decisions about pathway membership is no more reliable than chance, but when these pathways are delineated on the basis of more robust individual constructs, clinicians are more likely to agree on pathway membership. Furthermore, clinicians from heterogenous groups are more likely than their homogenous counterparts to agree on both approach vs. avoidant goals and active vs. passive strategies when these pathways have been selected based on the overall subscale score rather than a global decision about pathway membership. A global judgment about pathway membership was found to be only reliable between homogenous raters and only for active vs. passive pathways. This provides further
support for the view that clinicians are more likely to agree about pathway membership when using the COP-RV rather than simply making global decisions about their offending pathway, even if clinicians have prior experience working with sex offenders. Additionally, the analysis illustrates that while there was high intra-rater agreement between a clinician’s global judgment as to which pathway a rapist belonged and their objective decision based on the subscale scores of the COP-RV, there was more agreement for approach (85%) and passive (85%) categories. This is consistent with the earlier findings in this study that inter-rater reliability was highest for approach and passive pathways and confirms that clinicians are best at identifying agreed markers of overt offending goals and self-regulation deficits. This is puzzling as it suggests that clinicians are not as well trained at agreeing with each other on how to identify rapists with intact self-regulation and exemplifies the importance of focusing assessment training not only on skills deficits of offenders but also on areas of strength as well.

It also appears that raters’ confidence in responses does not account for the differences in the reliability between raters on the subscales and allocation into pathways. Raters reported being just as confident in their endorsement of subscale scores as their allocation of rapists into different pathways. Although all casefiles were de-identified, raters indicated that with a majority of the casefiles (86%) they did not believe they had prior exposure to the rapists in an assessment or treatment capacity and as a result it did not appear that prior knowledge influenced the clinicians in completing the COP-RV. These results support the notion that prior knowledge and perceived competence do not contribute to differences in the reliability of the measure. However, as suggested earlier there may be other ways to
improve the reliability of the measure. One option could be that clinician’s knowledge and skill in assessing certain constructs in the COP-RV could be enhanced by providing specialist training in the pathways model, or an alternative approach may be to revise the measure using more relevant and specifically worded items. It is suggested that an optimal approach would be to contain both of them.

4.2.2 Internal consistency of the COP-RV

An examination of the internal consistency of the measure illustrates that while both the subscales are comparable in their level of consistency, the strategies subscale appears to be more consistently measured than the goals subscale. As expected, the majority of the items in the measure assess separate constructs supporting the inclusion of these items in the COP-RV. Even so the results suggest that the internal consistency of the measure could be further enhanced if item 7 and 14 were dropped from Part I and Part II, respectively. It should be noted that both these constructs have been established as risk factors in the literature (Hanson & Morton-Bourgan, 2004; Ward, McCormack et al., 1997) and were found to have significant interrater reliability in this study. Although removing them from the measure would enhance the ability of the scales to capture the pathways of the rapists with more internal consistency, there is currently no predictive validity on the pathways model for these test items. As such it was considered prudent to retain these items for future research so that the predictive validity of all 15 items could be established for the four pathways. Interestingly, a closer examination of the internal consistency of Parts I and II revealed that if items 3, 16 and 18 were dropped from the measure, the scales consistency would deteriorate. As discussed in the earlier section these items had the lowest interrater agreement. It would therefore appear that while these items are
critical to the robustness of the scales and should be retained in the measure, clinicians may have to be provided more training to reliably assess these constructs and enhance interrater agreement.

The COP-RV also exhibited sufficient internal reliability for those items in which there was expected to be an association. For instance strong correlations between items 11, 12 and 13 support findings implicating a wide range of cognitive processes in sexual violence (Ward, McCormack et al., 1997). Indeed the risk factor of poor impulse control has been identified as a generic marker amongst different classes of rapists (Prentky & Knight, 1991) and in combination with other problem-solving skills is a strong determinant of the hypothesised self-regulation pathway of a rapist. Consistent with previous research, which has demonstrated links between affective states and the motivation to inflict violence and degrading sexual behaviour (Hayes et al., 1996; Marx, Miranda, & Meyerson, 1999), this study indicates a high correlation between constructs that measure affect and harm redressal strategies. Not surprisingly, this demonstrates clear goal-seeking behaviours by rapists with associated self-regulation deficits when redressing harm to self. In addition, strong correlations between motivation to offend and the nature and degree of violence inflicted also support previous pathways research (Hudson, Ward, & McCormack, 1999) in which it has been suggested that a rapist’s implementation of a harm redressal strategy is not only related to their affective state but also on the selection of dominant goals.

4.2.3 Validity of the COP-RV  
Comparisons between the COP-RV items and other measures of similar or unrelated constructs provide some understanding of what constructs the COP-RV is measuring.
Preliminary support was found for the validity of the COP-RV with measures of convergent validity ranging from small ($r = -0.25$) to large correlations to ($r = 0.64$). Negative correlations in this case were the result of the direction of scoring for individual measures and were all in expected directions. The construct with the strongest support was item 14 and was compared to file information on the influence of substance abuse immediately prior to the commission of the offence. Findings in this study, which indicate that the majority (68%) of the rapists were under the influence of alcohol at the time of the offence are consistent with extant literature (Seto & Barbaree, 1995). This adds weight to the suggestion that alcohol constitutes a major risk factor in rape, and that the use of inappropriate coping mechanisms seen in active pathways can have a rebound effect leading to a weakening in behavioural control and the commission of a sexual offence (Johnston, Ward, & Hudson, 1998). Often these inappropriate coping mechanisms are seen in the context of more global affective states which can be negative or positive and are proximal to the offending behaviour (Ward, McCormack et al., 1997). Although previous studies have suggested that motivation to offend is linked to affective states (Ward, McCormack et al., 1997), the results in this study indicate that the construct of affect in the COP-RV (item 1) did not validly measure the emotional state proximal to the offence. One possible explanation for this could be that the psychometric measures used for the validity analysis were administered to the offenders at the time of seeking treatment, and involves a significant time delay from the commission of the offence. Since the SCL-90-R is designed to assess for depressive symptoms at the time of administration (Derogatis, 1992) it may have been assessing offenders based on current presentations rather than affective states at the time of the offence. The use of such a retrospective methodology is a limitation, and has been identified in previous research as being a
threat to the validity of such studies (Henry et al., 1994). Another possible explanation may be that the rapists completed the psychometric measures with a socially desirable response bias, thereby minimising the true extent of their negative affect. This may be especially true for their responses on the STAXI-II (Spielberger, 1999) which is used to assess state and trait anger. Previous research has indicated that when sex offenders are placed in challenging contexts (e.g. assessments for treatment needs and risk) they are capable of manipulating their responses on self-report measures to achieve specific outcomes (Kroner & Weekes, 1996b; Nugent & Kroner, 1996).

Item 4, which is a measure of the degree of violence and degrading sexual behaviour inflicted on the victim displayed significant convergent validity with file information detailing the nature of the rape. Findings suggest that rapists with avoidant goals are more likely to have been rated as humiliating and degrading the victim using anal sex and fellatio (Quinsey, Chaplin, & Upfold, 1984) while approach rapists engaged in instrumental violence through the use of conventional penile-vaginal intercourse (Polaschek et al., 2001). Preliminary investigation indicates that not only is this item validly constructed in that it is significantly correlated with rape convictions for anal penetration, vaginal penetration and fellatio, but clinicians were likely to significantly agree on its role in determining the activation of avoidant or approach related goals.

Cognitive distortions appear to play an important role in distinguishing rapists who develop sexually motivated avoidant goals and cognitive processing characterised by appetitive-harm-related goals. Evidence was found for the validity of the construct (item 5) through convergent validity with the Multiphasic Sex Inventory – Cognitive Distortions and Immaturity scale (Nichols & Molinder, 1984) and divergent validity
with the Abel and Becker Cognition Scale, which measures distorted attitudes and beliefs about sexual activity with children (Abel et al., 1989). There was an unexpected nonsignificant relationship with the Rape Myth Acceptance Scale (Burt, 1980). A closer examination revealed that the mean score for rapists in this sample was three-quarters of a standard deviation less than the mean score reported in the Rape Myth Acceptance Scale, suggesting that rapists in this sample did not openly express rape myths about women. It is likely that many men do not overtly endorse positive attitudes to rape in a non-anonymous context. This is consistent with previous research that has found a tendency for rapists to deny or minimise their sexual deviance in an attempt to present in a socially favourable way (Scully & Marolla, 1984).

Finally, consistent with the harm redressal strategy detailed by Polaschek and colleagues (2001), item 15 contained a measure of hostility as measured by a correlation with the SCL-90-R Hostility scale (1992) and file information containing the nature of the rape. Aggressive, hostile motivations were dominant with the intent of rape being formed because of its physical impact on the victim and not for its sexual gratification value, supporting its inclusion as a discriminator between passive and active strategies. Unfortunately, such a distinction could not be achieved for the construct of impulsivity (item 12) and ability to delay gratification (item 18). While the literature distinguishes between a more generic lack of impulse control that exists among multiple classifications of rapists (Prentky & Knight, 1991) and the problem of immediate gratification as a distinct deficit in sexual self-regulation proximal to the offence (Hanson & Harris, 1998; Marshall, Anderson, & Fernandez, 1999), this distinction was not detected in this study. One possible explanation for this may be
that the validity measures used for this comparison were inadequate and future research may have to carefully select more direct measures of the constructs being investigated. Another possibility is that the constructs themselves may lack clarity and the way in which these items are worded in the COP-RV may need to be revised. However, preliminary investigation of self-regulation skills does suggest that those offenders who engage in stalking and preparatory behaviour are characterised by more active self-regulation strategies and are therefore more likely to carefully deliberate on the consequences of their actions.

4.2.4 Socially desirable responding on self-report measures

The analysis of the validity scales of the Multiphasic Sex Inventory (Nichols & Molinder, 1984) in a broad sense highlights the problem of socially desirable responding and denial as a method of dissimulation in the self-report assessments of sexual deviance. Studies have shown that offenders are skilled at altering scores when motivated to do so and when placed in contexts requiring the completion of self-report inventories are likely to respond in a socially desirable way (Kroner & Weekes, 1996b). This suggests that those self-report measures, which have been developed to assess sexual deviance, cognitive distortions, deviant attitudes and beliefs, aggressive temperaments and hostile behaviours, and which do not have inbuilt validity measures run the risk of non-detection of socially favourable presentation biases. It is therefore possible that low correlations between items on the COP-RV and comparative self-report measures are the result of biased responses on these self-report inventories. As a result, at this stage it is considered unwise to drop items, which do not display construct validity until further research has been conducted using more robust self-report inventories and measures of social desirability.
A closer examination of the validity scales of the MSI clearly indicates that dishonesty and suppression of deviant sexual interests are an issue with this sample of rapists. An investigation of the mean scores on the lie scale indicated that the average intensity of dishonest reporting of rapists in this sample is twice as much as the normative sample of the MSI. Although most of the items in the test are fairly transparent and direct, the breadth of validity measures permit different facets of the desirable responses to be measured. Thus, while the results indicate that the rapists have been dishonest about their interest in sexual deviance on the lie scale, they have presented an asexual image on the social and sexual desirability scale by ‘faking good’ their responses. In addition to indicating that these rapists were ‘faking good’, the repetition of these scales indicated how reliable and consistent the offenders were across the test, precluding the possibility of random responding. The overwhelming influence of social and sexual desirability as measured by the scale supports the view that rapists will present in a favourable light to achieve desirable outcomes in relation to the perceived repercussions for their offending behaviour (Kroner & Weekes, 1996b).

Finally, rapists in this sample appear to be more sexually deviant with half (50%) of them being classified as medium-high to high risk of reoffending on the STATIC-99. This is consistent with clinician classifications of rapists as predominantly following an approach (64%) pathway and almost half of them (48%) assessed as having active self-regulation strategies. Not surprisingly when these pathways were combined the predominant pathway was approach-active (39%). This is consistent with other studies in which rapists shown to predominantly follow an approach-explicit pathway have a higher risk of reoffending (Yates, Kingston, & Hall, 2003). Previous research
has demonstrated that rapists following an approach-active pathway have often
developed harmful goals with entrenched notions about the role of women and offend
to heighten positive emotions (Polaschek & Hudson, 2004; Ward & Hudson, 1998;
Ward, Hudson, & McCormack, 1997). This may help to explain why these rapists
displayed more cognitive distortions, and justifications, and were more likely to
blame their offending upon external causes like marital problems, alcohol or life
stresses thereby portraying themselves as a 'nice guy' who was essentially a victim of
circumstance (Scully & Marolla, 1984).

4.2.5 Practical implications of the study
The results of this investigation have some important implications for the assessment
and treatment of rapists.

Findings from this research highlight the extent of the problem of socially desirable
responding and dissimulation with self-report measures of sexual deviance, and
question the continued administration of such measures to rapists as a necessary and
even valid adjunct to the assessment process. The problem of socially desirable
responding is less than optimal from an assessment and treatment intervention
perspective and could be potentially misleading in the absence of other collateral
information. Given that the majority of sex offender programmes world-wide
(Marshall, Anderson, & Fernandez, 1999; Ward, McCormack et al., 1997) use self-
report measures in the assessment process and for treatment planning, this
investigation questions the utility and validity of such measures.
A more appropriate method in these circumstances would be to use a clinician-rated instrument consisting of treatment specific variables that are grounded in empirical literature and which could form the basis for a conceptual formulation of an appropriate treatment plan. The results from the pathways classification of rapists using the *Checklist of Offence Pathways: Rapist Version* suggest that clinicians reliably make such classifications when they are appropriately trained in the application of the model. It appears that there is greater agreement between clinicians in the classification of approach goals and self-regulation strategies employed by rapists than in the assessment of their avoidant goals. One possible explanation for this could be that the goal of avoiding sexual offending is accompanied by varying affective states and is more difficult to implement, thereby providing a person with a number of ways at which to fail at preventing something from happening. This makes the assessment of the offending behaviour all the more difficult as behavioural antecedents, cognitive scripts, proximal and distal factors all have to be considered when making judgments of the goals employed. On the other hand, since approach goals are characterized by positive affective states and acquisitory behaviour, they are usually associated with just one pathway. Interestingly, the clinicians classified more rapists as approach-oriented than avoidant, suggesting that the sample of rapists were more inclined to have overlearned behavioural scripts (Hudson, Ward, & McCormack, 1999) designed to lead to the commission of a sexual offence. Thus some of the rapists were impulsive, with the offence involving rudimentary planning, characterised by fluctuating emotional states, and an inability to regulate behaviour. However, others engaged in conscious and explicit planning, had appropriate self-regulation skills and displayed distorted beliefs and attitudes about women. Previous research suggests that these rapists offend to heighten positive emotional states (Ward
& Hudson, 1998). It is therefore, not surprising that a majority of those rapists who were dishonest, justified their offending behaviour and suppressed their sexual deviance on the validity scales were classified as approach and active. These sorts of denial and minimisations are characteristic of this sub-group of sexual offenders (Ward, McCormack et al., 1997) and, were it for a reliance on the self-report measures, would have provided little or no useful information on the nature of therapeutic interventions required.

Findings from this research indicate the importance of incorporating assessment measures for sex offenders, which do not rely solely on self-report. The present investigation supports the utility of a clinician-rated assessment measure as an intuitively useful way to structure the assessment process in sex offender specific treatment programmes, and develop a formulation-based treatment approach (Ward, Vertue, & Haig, 1999). Reliance on more robust clinician-rated measures could reduce the time spent by clinicians on administering, scoring and interpreting self-report test batteries, thereby increasing the human resource for intervention related activities.

4.2.6 Limitations of the study

In hindsight, the current study contains several shortcomings that require discussion. First, the sample used for the development of the COP-RV is by necessity a small one and may not have provided enough power for reliable use of some of the statistical techniques. As a result it is difficult to say if the lack of significant results in some analyses is a result of low power or because of an inherent lack of relationship between the variables.
Also, all the typical concerns inherent in retrospective methodologies apply to this study, particularly where the offences have occurred several years before and interview and psychometric data collected as part of the casefile information have been acquired later. There is substantial literature supporting the view that there are a variety of threats to reliability and validity in utilising retrospective data (Henry et al., 1994). Clinicians could potentially collect more reliable and valid data if they were not to rely on casefiles supplied to them. The fact that the clinicians had not met the rapists for a face-to-face clinical interview is a drawback, as effective and accurate assessment requires direct contact with the rapist. However, the justification for choice of methodology was the removal of demand characteristics through the use of casefile information. That being said, the reliance on archival data and data collected at different periods of time is still a limitation.

Continuing the discussion on the theme of retrospective vs. prospective studies a further limitation of this study is that the methodology employed for the validity study was limited by reliance on measures collected as part of the Sex Offender Test Battery. As a consequence, COP-RV items could not be compared to other robust psychometric measures that have been empirically established to measure particular constructs of interest. Furthermore, the lack of administration of measures more proximal to the construct being measured is another limitation. For example measures assessing state dependent symptoms need to be administered during or immediately after the event. A more optimal methodology would have been to collect prospective data whereby appropriate psychometric test data and COP-RV scores could have been collected at the same time. This would have ensured that the psychometric measures
selected would have been theoretically related or unrelated to the constructs in the COP-RV and would have validly assessed the construct being measured.

Another limitation was the use of raters who were not fully qualified psychologists with appropriate post-graduate education. Although clinicians who come into contact with sex offenders, are supervised by highly skilled supervisors, this does not substitute for specialised training and extensive experience working with sex offenders. Use of raters with varying experience may have contributed to differential results between raters. Future research methodologies should match raters on qualifications, experience and skill and provide them with rigorous training in the application of the model.

A final limitation of the developed measure is that it does not include all the possible types of deviant sexual behaviour. It was decided early on to follow a traditional path of scale development and to eliminate items that were not supported by the pathways model. However, it is believed that the right choice was made for the following reasons: First, the approach taken was suitable given the theoretical framework for the model. Second, only items supported by the theoretical model and other empirical data were included. Third, had certain deviant behaviours not been eliminated the measure would have become too cumbersome too have been used by others. And last, this research is seen as a building block for further enquiry.

4.2.7 Directions for future research

In light of some promising findings, this study opens up numerous possibilities for future research. First, further investigation of the psychometric properties of the COP-
RV with larger sample sizes would be desirable. Second, construct validity studies with prospective methodologies using current psychometric measures that are theoretically relevant to the constructs of the COP-RV should be designed. This would allow for the development of the measure and enhancement of its ability to validly capture constructs that delineate the different pathways. In addition this study could be extended by employing a methodology in which the COP-RV is completed during an interview with the offender. Differences between the COP-RV used during an interview and the COP-RV completed using casefile information could contribute to the reliability of the measure. Third, another line of enquiry could have studies designed to assess whether improved quality of the items or specialised training of the clinicians in the pathways model would improve the measure’s reliability. Thus a matched-groups design could be employed with specialised training as the independent variable. Fourth, predictive validity studies to assess the robustness of the measure to delineate sexual recidivists from sexual non-recidivists may be particularly relevant for clinical settings. Fifth, if the measure is to have true clinical utility by informing treatment interventions for different groups of rapists, future studies could employ a prospective methodology and compare sexual recidivists with those who do not reoffend after treatment using the developed measure. Comparing pre-treatment pathways may shed light on the treatability of different pathways and may have economic benefits by allocating treatment resources to those who will benefit most. This will also encourage treatment providers to enhance intervention programmes for those groups that do not benefit from current treatments. Sixth, research studies could be designed comparing offenders from different pathways to other psychometric measures and contribute to the growing literature on static and dynamic risk factors. Finally, cross-validation studies using the measure could be conducted to examine
cultural differences or patterns not captured in Australian rapists and focus on establishing categories that could discriminate between pathways which are not necessarily unique to that group but may be part of interaction effects between victims and offenders. Ultimately, such findings should encourage treatment providers to develop the most effective programmes for rapists, thereby reducing recidivism and limiting the social and economic costs of victimisation.

4.3 Conclusion

In summary, the aim of this study was to provide a comprehensive analysis of a clinician-rated psychometric measure that was developed to classify rapists into offending pathways based on their treatment needs. This investigation was an attempt to extend the research literature on the pathways model (Ward & Hudson, 1998; Ward, Hudson, & Keenan, 1998) and is the first study to directly apply this theoretical model to the development of a clinician-rated measure for the assessment of rapists. The 15-item measure was constructed from the theoretical and empirical literature on sexual offending and subjected to a series of reliability and validity analyses. The measure was divided into two subscales measuring approach vs. avoidant goals and active vs. passive strategies. Preliminary support for the measure’s interrater reliability was demonstrated although not to the level of usual psychometric acceptance. There was significant agreement between raters on the dominant goals \( r = .53 \) and selection of self-regulation strategies \( r = .46 \), with a majority (53%) of the items exhibiting interrater reliability coefficients of at least .40. An examination of the internal consistency of the measure illustrates that while both the subscales are comparable in their level of consistency, the strategies subscale \( \alpha = .60 \) is more
consistently measured than the goals subscale \( (\alpha = .50) \). However, neither of these subscales met the generally accepted criteria of .80 (Miller, 1995). As expected, the majority (80%) of the interitem correlations were uncorrelated or weak, indicating that the test items were likely to be measuring separate constructs. Validity analysis indicated that a number of test items displayed convergent and discriminant validity with established psychometric scales, but these were limited, as discussed earlier, by limitations that are inherent to retrospective studies. As this study is seen as a building block for future empirical studies, it is expected that the process of validation will continue through additional studies.

In summary, findings from this research provide preliminary data and support for the psychometric properties of the Checklist of Offence Pathways – Rapist Version. This provides clinicians with a useful framework for structuring the assessment process and selecting offence specific treatment strategies for rapists. It is suggested that such a clinician-rated measure not only reduces some of the pitfalls associated with dissimulation in self-report measures, but also ensures that treatment is responsive to the needs of the rapists, thereby enhancing the appropriateness and possible effectiveness of interventions to reduce recidivism.
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