De delictscenarioprocedure bij seksueel agressieve delinquenten: Een onderzoek naar de bruikbaarheid van de delictscenarioprocedure in de behandeling van seksueel agressieve delinquenten in de Dr. Henri van der Hoeven Kliniek

van Beek, D.J.

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Treatment of sexual aggressive offenders is a complex matter. For that reason, during the 80's, we looked for new ways as to improve the quality of treatment of these patients. The cognitive behavioural approach used in North America to treat sexual aggressive offenders appeared to be a suitable option. In this approach the direct, maintaining factors of the criminal behaviour are emphasised. Interventions are aimed at gaining control of the sexual aggressive behaviour (no cure, but control). The focus is on themes such as cognitive distortions, the role of sexuality, social skills, empathy, aggression and self-esteem in the sexual aggressive behaviour.

Until that time, the focus within Dutch forensic institutes was on psychiatric or personality disorders and interventions were broadly aimed at improving functioning in society, by education, job training and fostering insight into the aetiology of the sexual aggressive behaviour.

The focus on the criminal behaviour itself filled a gap in the treatment and offered a new impetus to the treatment of sexual aggressive offenders. This led to the development of the offence script procedure which aims at increasing the willingness of the patient to reflect upon the dynamics of his offensive behaviour. The offence script procedure involves a series of semi-structured sessions to explore the cognitive, emotional, behavioural and situational factors preceding, during and after the offence, as the script of the events surrounding the offence. We particularly wanted to focus on the role of sexual motivation and cognitive distortions in the offence. It would give the patient and his therapist a picture of the risk factors operating immediately before, during and after the offence and the particular meaning of the offence for the patient: for example, does the offence primarily regulate negative feelings or is it his way to seek a pleasant state? In addition to the diagnostic function of the offence script procedure, we also want to use it as a means of treatment by stimulating the patient to recognise his cognitive distortions and change them.

In this summary we examine the implementation of the offence script procedure in the Dr. Henri van der Hoeven Kliniek, the research project and its results, the theoretical significance of the offence script profiles, and its relevance for treatment. We discuss a number of expectations with respect to future developments in theory and treatment of sexual aggressive offenders from a cognitive behavioural perspective. We also examine the prognostic value of the offence script procedure and its application to other types of crime and treatment settings.

The offence script procedure has acquired a prominent place in the integrated treatment offered by the Dr. Henri van der Hoeven Kliniek. It has become a part of the individual treatment plan: the offence script plays an important role in formulating the patient's core problems and it provides insight into the extent to which the patient is capable of self management and to which degree external control remains necessary to manage his sexual aggressive behaviour. It also contributes to the information for the judiciary about the patient's progress in treatment.
Generally the conditions for implementation of the procedure (since 1986) were favourable: there was a clinical problem for which a solution was urgently needed. As we have shown in Chapter 2, the treatment of sexual aggressive patients is on average the longest and relapse is relatively high. Moreover, contact with these patients is often problematic and threatening. Severe relapse by a number of (former) patients, with the associated public indignation, put the effectiveness of treatment high on the political agenda (Ministry of Justice, 1991). But ultimately it was the direct confrontation with a patient who was seriously disruptive and sexually aggressive that motivated us to look for other methods of treatment. Several staff members were offered the opportunity to study new forms of treatment in the Netherlands and various other countries, including England, the United States and Canada. In collaboration with colleagues from other institutes, we founded the Netherlands Association for Forensic Sexology (VFS) and initiated co-operation with similar organisations in the United States (ATSA) and England (NOTA).

The problem-oriented approach in the offence script procedure is in line with the ambivalent motivation of the patients, who initially committed themselves reluctantly to it. Even though they found it hard to be confronted with negative aspects of themselves, they had to admit that the procedure focuses on precisely those problems which are directly related to their offensive behaviour. When patients became more familiar with the procedure and evaluated it as a positive experience, they started to encourage other patients to participate in the procedure. Soon patients asked to be allowed to participate in the procedure. Report to the judiciary of their commitment or non-commitment to the procedure, and the importance judges attached to it, served to dissolve their initial hesitation. Group counsellors often felt relieved from the difficult task of discussing threatening themes such as deviant sexuality with these patients. Finally, the method fitted well into the hospital’s philosophy, which emphasises the patient’s own responsibility for his behaviour, the dynamics of the living-group and co-operation with the patient’s social network outside the hospital.

The relapse prevention plan based on the offence script offers a practical framework to deal with risk-factors. Initially during the clinical phase, later in the transmural phase and finally during probationary release, the relapse prevention plan offers a possibility of systematic monitoring of progress in self management and the need for external control. After all, not every patient has the capacity to develop sufficient self management skills; many patients remain dependent on supervision.

The implementation process was not, of course, entirely problem free. Differences of opinion between treatment teams and psychotherapists arose when patients put the group counsellors under pressure through their offence script. Based on their co-operation with the offence script procedure, they demanded more privileges in and outside the hospital, demands which were sometimes supported by the psychotherapists, but refused by the treatment team. The position of the problem-oriented psychotherapist differs from that of an insight-oriented psychotherapist, in that the latter are less involved in the daily life in the hospital. Problem-oriented psychotherapists incorporate this daily life in the therapy. They give instructions to the group counsellors and stimulate the patients to experiment with new behaviours in and outside the hospital. To handle this problem co-operation between the treatment teams, patients and psychotherapists had to be co-ordinated. This required adaptation and flexibility from all involved.
Unrealistic expectations with regard to the effectiveness of the new procedure exacerbated the differences of opinion between treatment teams and psychotherapists concerning the relevance of the offence script procedure in the treatment. After all, it frequently became clear, particularly during the treatment phase, that it was difficult for patients to link the necessary behavioural consequences to their 'insights' into what led up to their offence. Denials of actions previously admitted to and the serious relapse of a patient who had co-operated with the offence script procedure, put a damper on these expectations. This brought some staff members to believe that the offence script procedure had little value, leading to reflection on the status of the procedure in the total treatment programme of the hospital. In addition, treatment supervisors and psychotherapists made agreements about their respective responsibilities.

In conclusion, it can be noted that the specific programme for sexually aggressive patients is now firmly anchored to that of the Dr. Henri van der Hoeven Kliniek as a whole. After a favourable trial period, the programme has acquired a realistic position in the broad spectrum treatment programme of the hospital. However, it does not appear to be a panacea for all problems arising in the treatment of sexually aggressive patients.

After a number of re-adjustments we developed a standardised protocol for the procedure (Chapter 3). On the basis of our clinical impressions of the first offence scripts and a review of the literature, we recognised three prototypical rapist offence script profiles, each with its specific developmental route which caused the sexually aggressive behaviour and its specific direct risk-factors which maintain it (Chapter 5). These profiles are called the sexualising, the antisocial and the vindictive type.

**The sexualising type**
The offender with the sexualising offence script profile has been a victim of rejection and sexual abuse in his early youth. He developed a negative self-image and an anxious-ambivalent attachment style. He was bullied and excluded by his schoolmates. He is strongly inclined toward avoidant behaviour such as withdrawal and taking refuge in a compensatory sexual fantasy world. He has committed sexual offences since the onset of puberty: initially hands-off offences, and later hands-on offences. Generally the offences are planned and based on longstanding sexual fantasies, which are derived from excessive pornography consumption. In the offences he usually hopes to have his fantasies come true: getting close to the victim and being (sexually) liked by her.

**The antisocial type**
The offender with the antisocial offence script profile has been a victim of inconsistent physical violence at home. He developed a dismissive-avoidant attachment style. He maintains a predominantly positive (superior) self-image. At school he bullied his peers and was aggressive toward them. At a young age he also joined up with criminal youth and committed non-sexual offences. Alcohol and drug abuse are characteristic for these offenders. They impulsively commit sexual offences. They often encounter their victim during other criminal activities.
(burglary). Sexual desire, the disinhibiting influence of alcohol and drugs and a lifestyle in which another person's boundaries are of little significance, lead to sexual violence in which the offender is only interested in the satisfaction of his desires of that moment. The victim has no further emotional significance for him.

**The vindictive type**

The offender with a vindictive profile was also a victim of physical violence in his early youth. He had a strict upbringing in which absolute submission to the values and norms, set by the father in particular, was demanded. Like the sexualising offenders, this offender developed an anxious-ambivalent attachment style. He kept himself on his feet by adopting a submissive and conformistic attitude. He too was bullied at school. He sought to deny his aggression as much as possible or to control it. He has an fragile self-image. Without validation by his partner he is vulnerable. He is eventually cornered, particularly in a relationship. When abandonment is imminent and he is under the influence of alcohol he commits an aggressive (sexual) offence. Aggression is the primary motive. The victim is usually an unknown woman (displaced aggression) but may also be his partner. The victims of these offenders have the greatest risk of serious injury or even death.

In our study we made a first initiative toward empirical validation of the offence script profiles and the differential effects of the offence script procedure on each profile. The first research question concerned empirical validation of the hypothesised differences between the profiles. In the second research question we wanted to examine whether the offence script procedure brought about the expected differential effects on the offenders of the various offence script profiles. In particular we were interested in the question whether the procedure would lead to taking more responsibility for the offences. We summarise the most prominent results of the study.

With regard to the first research question we found the following differences between the profiles.

- Approximately half of the fathers of the antisocial and vindictive offenders were guilty of serious alcohol abuse as opposed to none of the fathers of the sexualising offenders.

- A small majority of the offenders were frequently exposed to physical abuse by their father. The fathers of the antisocial and vindictive offenders were violent towards every family member, especially when they were drunk. The fathers of the sexualising offenders also used physical violence, but in these cases the violence was specifically directed towards the offender. These fathers were not alcohol abusers.

The majority of the sexualising offenders and a minority of the vindictive offenders were bullied and excluded by their schoolmates. They developed a negative self-image. Virtually all antisocial offenders joined up with criminal youth as opposed to none of the sexualising and vindictive offenders. Antisocial and most vindictive offenders abused alcohol and drugs, which evidently resulted in financial problems. None of the sexualising offenders engaged these behaviours.
With respect to psychosexual development we found that more than half of the sexualising offenders had ever been sexually abused as opposed to one of the antisocial offenders and one vindictive. Only one sexualising offender appeared to have had consensual sexual relations as opposed to all but one vindictive and all antisocial offenders. On average, the antisocial offenders had consensual sexual relations from the time they were fifteen and the vindictive offenders from the time they were nineteen. The sexualising offenders were the most preoccupied with (deviant) sexuality and the vindictive offenders the least.

The sexualising and vindictive offenders differed the most from each other with respect to their sexual offence career, which for the sexualising offenders began at a significantly younger age and includes more sexual offences. The antisocial offenders appeared more often than the other offenders to have been convicted of rape before detention under the judicial order (TBS-measure). Both the antisocial and the vindictive offenders were under the influence of alcohol and/or drugs at the time of their offence. This was not the case for any of the sexualising offenders. Sexualising offenders tend to run away when the victim resists. They commit their offences earlier in the evening than the other offenders. Antisocial offenders are more guilty of non-sexual criminal behaviour than the vindictive offenders. In this respect they hardly differ from the sexualising offenders.

At the categorical level the sexualising offenders have the most personality disorders. In clusters B and C they have more disorders than the antisocial offenders. With respect to specific disorders we find virtually no differences between the types. At the dimensional level only the vindictive offenders appear to have more traits of dependent personality disorder than the antisocial offenders; the antisocial offenders exhibit more traits of antisocial (youth) disorder than the sexualising offenders.

Sexualising offenders have the most empathic skills and the antisocial offenders the least.

Sexualising offenders show the most dissociative symptoms and the antisocial offenders the least.

Despite the fact that the sexualising offenders are the most aware of what they have done to their victims, they deny most strongly that there is a chance of relapse or that it is difficult to change. In comparison with the other offenders, the sexualising offenders see themselves the most as victim. Most of the time the vindictive offenders take up a middle position.

Generally speaking, the results provide empirical support for the profile descriptions (Chapter 3). In the Dutch forensic literature we often find a distinction between pure sexual and antisocial sexually aggressive offenders (Burgers, 1985; Van Marle, Van Putten & De Ridder, 1995). The pure sexually aggressive type (most resembling our sexualising offender) is supposed to have committed only sexually aggressive offences and the antisocial sexual type (our antisocial offender) is supposed to have committed also non-sexual offences. We found that all antisocial offenders had indeed also committed non-sexual offences, but this also appeared to be true for a majority of the sexualising offenders. The nature of the non-sexual offence is more violent with the antisocial offenders than with the sexualising offenders. Our study reveals that the fathers were often guilty of alcohol abuse, were physically abusive
and in a number of cases strongly rejected his son. Van Marle et al. (1995) mention the dominant role of the mother in the upbringing of the offenders. In their study 41 offenders in a sample of 161 offenders appeared to have had a dominant mother; in contrast, in our sample of twenty offenders we found only one offender with a dominant mother. Whether this is caused by sampling bias or by a theoretical one is unclear. The sample of Van Marle et al. (1995) consisted of offenders in the Pieter Baan Centre of whom approximately half will have had a TBS-measure. Our very small sample consisted exclusively of offenders with a TBS-measure. Theoretically psychodynamically oriented researchers place more emphasis on the role of the mother in the upbringing than cognitive behavioural therapists. In contrast, for the cognitive behavioural therapists, the emphasis lies on the father as a (behavioural) model for the son. Based on file material, Van Marle et al. conclude that with respect to sexual preferences there were no differences between pure sexually aggressive offenders and antisocial sexually aggressive offenders. Based on the Frenken Interview and the MSI we however have established that sexualising offenders have developed much more deviant sexual preferences than antisocial offenders. In our opinion, the results of our study underscore that in the Pieter Baan Centre too little attention is paid to the psychosexual development of the offenders.

Another relevant fact is that the vindictive offenders appear to be absent in the Dutch forensic literature and also form the most heterogeneous group in our study. One explanation may be that the antisocial and sexualising offenders show the most striking differences, resulting in the vindictive type offenders being overlooked. Given the fact that they belong to the category of the most violent offenders this is a point that deserves attention and requires further research.

With respect to the second research question, we found the following changes in the various types of offenders after the procedure has been completed.

- The sexualising offenders see themselves less as victims, admit that there is a chance of relapse and that it is difficult to change. The vindictive offenders, in contrast, see themselves more as a victim.
- The sexualising offenders have become more empathic. They succeed better in judging from the perspective of others. The antisocial offenders, in contrast, appear to have become more detached with respect to others.
- Among the sexualising offenders, there is an important decrease in absorption, which means that there is a marked drop in narrowed attention.

The results consistently show that the sexualising offenders have profited the most from the offence script procedure as a treatment method. A worrisome finding is that during the offence script procedure the antisocial offenders became more impassive rather than empathic. In Chapter six we already speculated about the role of psychopathic traits in this result. In the assessment Hare's Psychopathy Checklist Revised (PCL-R) can be used to measure the patient's level of psychopathy. High PCL-R scores indicate an unfavourable treatment prognosis and a high risk of violent recidivism (Quinsey, Lalumière, Rice, & Harris, 1995; Rice, Harris & Quinsey, 1990). This powerful actuarial predictor, however, can also influence the therapist's attitude toward the patient in such a way that it leads to a 'self-fulfilling prophecy' (negative expectation of treatment result causes negative treatment result). Therefore,
therapists must be continually aware that expectations with respect to developmental possibilities of the patients should never be based on only one aspect of their functioning but on a balance of as many of their positive and negative qualities as possible and on the social context in which they (will) live. For example, it is conceivable that a patient with psychopathic traits decides to quit using alcohol, finds a job that suits him or meets a partner who influences him in a positive way. This combination of factors would be able to lessen the actualisation of his psychopathic traits and reduce the risk of an unfavourable treatment outcome.

In general, cognitive behavioural therapists (of sexual offenders) are only interested in theoretical issues as far as these can be translated into clinical interventions. In the treatment, thinking is pragmatic and change-oriented; therefore there is more interest in a promising intervention than a promising theory. Because the treatment of sexual aggressive offenders should have an empirical, theoretical foundation, it is desirable for therapists, however, to acquaint themselves with and remain aware of theoretical developments in their field. According to Ward and Hudson (1998) theories on sexually aggressive behaviour can be separated into three levels. In their view none of these levels is superior to the other. On the contrary, they complement each other at a meta-theoretical level. Each of the levels provides impulses for hypotheses regarding the processes that cause sexual aggression, contribute to its development and maintain it.

At the first level we find broad comprehensive theories in which factors are brought together in a kind of general framework which have links to sexual aggression. The descriptions of the processes which explain the relationship between these factors are broad in nature. These theories primarily focus on the why-question of sexual aggression and on early determinants of the behaviour. Examples are the biosocial learning theory (Marshall & Barbaree, 1990), the confluence model (Malamuth, Linz, Heavy, Barnes & Acker, 1995) and the quadripartite model (Hall & Hirschman, 1991) (see Chapters 4 and 5).

In the so-called middle level theories a detailed explanation is given of one specific determinant of sexual aggression. Examples are intimacy problems (Marshall, 1989), social factors (Herman, 1990) and problems in early youth (Leeuwestein, 1992). At this level both the structures and the processes of the determinants are clearly described.

The third level contains microtheories such as the relapse prevention model (Pithers, 1990), the sexual abuse chain (Ryan & Lane, 1991), and the description of the pedosexual offence chain (Ward, Louden, Hudson & Marshall, 1995) (Chapter 4). These theories are descriptive in nature, with a focus on direct factors of the offence behaviour and on the how-question of the sexual aggression. These theories describe in detail cognitive, emotional, behavioural, motivational and social factors.

For each of the sexual offender types, the offence script procedure leads to a microtheory (level 3) about the maintaining factors in the offence behaviour. The offence scripts provide an answer to the how-question. In the offence script profiles we try to link these theories to determinants which may answer the why-question (level 1). The precise role of these determinants in the various profiles belongs as a research question at level 2 and can be answered in further research so that the three levels become integrated.
Our study shows that at the why-level physical violence by the father (for all types of offenders), being bullied at school, isolation from peers, sexual abuse, the development of a negative self-image and strong sexualisation (particularly for the sexualising offenders), and joining up with criminal youth and a criminal lifestyle (among antisocial offenders) are factors which play an important role. At the descriptive level we see that alcohol/drugs (the antisocial and vindictive offenders), the inability to make (sexual) contacts (the sexualising offenders) and the problematic development of relationships (the vindictive offenders) appear as disinhibiting influences. Cognitive distortions play an important role in all types of offenders. Based on our profile descriptions and the study results we believe that the formulation of one integrative theory (level 1) or one descriptive model for all sexual offenders is an illusion, while the micro theories (level 3) such as the relapse prevention model and the sexual abuse chain are generally aimed too exclusively at offenders of the sexualising type. These theories do not explain the processes in the antisocial and vindictive offenders. Also at the middle level (level 2) we find that the nature of the intimacy issue of sexual offenders such as described by Marshall fits better with the sexualising offenders than with the antisocial offenders (Marshall, 1989).

In the forensic field, theories at the first and second level are in vogue and the third level is lacking in its entirety. Since developmental disorder is considered to be decisive in judging accountability, there is a preoccupation with the middle level of theory formulation. We believe that it is erroneous to assume that the criminal behaviour of the patient can be made comprehensible only on that theoretical level. In estimating the risk of re-offending, to leave out direct factors is a serious shortcoming. It can be argued that any developmental disorder may play a role in the development of criminal behaviour, but this influence has been shown to be non-specific (see also our data). We believe that determinants from other theoretical levels also play an important role in the further development and maintenance of the behaviour. Therefore, for a careful analysis of the risk of recidivism, attention to and integration of all three levels is necessary. Factors at levels 1 and 2 are risk factors, of which the actualisation can only be explained by risk factors from level 3 (see also Grubin, 1997a, 1997b). The various theoretical levels should validate or falsify one another in a continuous process.

In addition to the theoretical importance of establishing various routes to sexually aggressive offences (particularly at the micro and broad theoretical level) the implication of the various offence script profiles for the treatment of sexual offenders is of importance.

Until late into the ‘80s the treatment of pedosexual offenders served as a model for the treatment of rapists in North America. Emphasis lay on sexual deviance (Axis I paraphilia) (Pithers, 1993). Change took place in the ‘80s and ‘90s under the influence of the theoretical developments (see Chapter 2). The relapse model offers therapists a framework to classify (early and direct) risk factors, at the same time the number of interventions aimed at alcohol/drug abuse, criminal lifestyle, impulse control and the improvement of self-esteem has also grown (Marshall, 1996; Brown & Forth, 1997).

From our offence script profiles we can indicate specific focal points of
treatment. It is, however, necessary to emphasise that these profiles are prototypes and that patients can deviate from them to a greater or lesser degree. Thus, we prefer to talk about dimensional rather than categorical differences between the profiles.

In the treatment of antisocial offenders their criminal lifestyle and attitude should be discussed. Improving empathy and bringing their impulsivity under control have high priority. Discouraging contact with criminal peers and encouraging contact with socially adjusted persons are also high on the agenda. Education and job training can facilitate the social reintegration of these offenders. The motto is that the patient learns to control and limit himself in exchange for a socially acceptable place in society.

In contrast to the antisocial offenders, the sexualising offenders are over-controlled. Improving self-efficacy and developing a positive self-image should be the focus in their treatment. To reduce their inhibition with respect to women they need to improve their heterosocial skills, thereby reducing their social anxiety. For these offenders, sexualisation as coping mechanism (high frequency of sexual fantasies both deviant and non-deviant and extreme masturbation practices) and confrontation of cognitive distortions (I am pathetic) should play a central role in the treatment. In a few cases it may be worthwhile to involve a sex-therapist to overcome their fear of sexual contact. Sometimes medication can be considered for obsessive-compulsive offenders.

Vindictive offenders are predominantly socially adjusted, but make themselves too dependent in a relationship. When they are confronted with imminent or actual abandonment in combination with alcohol abuse they can exhibit sexually aggressive behaviour. This indicates that marital therapy should not be excluded from their treatment and that they should focus on handling their aggression and alcohol abuse. Opposing cognitive distortions that allow them to hold women responsible for their misery should play an important role in the treatment. Our study showed that within this group some had relatively few personality disorders while others had strikingly many. This may point to the existence of a subgroup, which may have implications for treatment.

The specific focal points of treatment for the various types of offenders can easily fit into the description of the (core) problems which is made for each patient in the Dr. Henri van der Hoeven Kliniek. Current treatment only has to be supplemented or more precisely expressed. In practice it appears that the description of the core issues (theory level 1) is tested against the offence script profile theory (level 3) and vice versa. This has now become clinical practice.

In the theoretical development of the cognitive behavioural approach, an important role has been put aside for theories which in one way or another focus on man as a goal-oriented information processor (Polaschek, Ward & Hudson, 1997; Ward, Hudson & Johnston, 1997; Ward, Hudson & Keenan, 1998). Based on social cognition theory, Ward et al. (1998) argue that deficits in observing and processing information (cognitive distortions) contribute to a state of unrestrained thinking which clears the way for committing offences, particularly in people who already have a set of cognitions that justify (sexual) violence (against women) (Ward et al., 1997). Ward et al. (1998) point out the importance of cognitive self-regulation processes. Based on these processes, they indicate that human behaviour is
determined by the goals which they set for themselves. If these are socially unacceptable goals, they will behave in a socially unacceptable way. The antisocial offender, therefore, will not condemn his antisocial behaviour or even think about stopping it. He believes that he may do whatever he wants to and that others are there only for the satisfaction of his desires. From a treatment perspective, cognitive theories which are aimed at cognitive processes in patients with personality disorders are receiving more attention (Beck & Freeman, 1990; Young, 1994). These theories focus on early factors in the development of dysfunctional cognitive processes and the behavioural strategies that are based on them. We expect that this trend will continue.

However, we also expect that biological theories will become more influential. Developments in biomedical technology in brain research have made it possible to study processes at the hormonal and neurotransmitter level. Successful pharmacological treatment of problem behaviour such as depression and psychosis focus attention on the role of biological factors in the development and maintenance of sexually aggressive behaviour and how these can be influenced with medication. There is also increasing interest in evolutionary aspects of sexual aggression. Findings of research are to what extent sexually aggressive offenders are pre-programmed to switch over to this behaviour at the genetic (DNA) level and the evolutionary significance that can be attributed to it (Ellis, 1989; Greenberg & Bradford, 1997; Quinsey & Lalumiere, 1995).

These developments fit into the general trend to interpret sexual aggression as a multi-factorial phenomenon in which biological, social and psychological factors play a role (Marshall & Barbaree, 1990; Malamuth, Heavey & Linz, 1993). Time will tell whether these theories will withstand empirical testing.

In the treatment of sexual offenders a converging trend has been observed in which the North American and European traditions come closer to each other (Marshall & Frenken, in press). North American therapists pay more and more attention to the severely disturbed offenders and offer a broader treatment programme, while the Dutch forensic institutes have developed a greater awareness that the criminal behaviour itself also deserves attention in the treatment and that interventions that aim at bringing under control the behaviour and its direct precursors can be usefully incorporated in the broad spectrum treatment that they offer.

The offence script procedure is primarily developed for sexually aggressive offenders but has been increasingly applied for patients who have committed other offences. Usually it concerns obsessive, planned offences such as arson, but sometimes also murder or manslaughter. In this type of criminal offenders we can most clearly analyse the (long) route to their offensive behaviour. It offers the possibility to support the patient in taking protective measures at an early risk stage. Some treatment teams request the intervention to be introduced to specific patients, but there are also patients who ask for it themselves. Sometimes the diagnostic function is paramount, at other times it is the treatment function, such as learning to admit their planning and their cognitive distortions which facilitate offending. For the time being, the offence script procedure is a standard element of the treatment
programme for all sexually aggressive offenders and it is optional for other offenders.

Over the years, the application of the offence script procedure has spread to other places in the Netherlands through training programmes that we arranged for probation officers, psychologists and psychiatrists in the field. Various centres of rehabilitation offer their clientele individual or group programmes in which the offence script procedure and the relapse prevention model are included. A couple of prison psychologists apply the offence script procedure to prisoners. In various forensic institutions, staff members carry out a form of offence analysis under the name offence script (procedure). Sometimes they aim at collecting material for psychodynamic interpretations and sometimes at making an inventory of risk factors. The patient himself are not always involved in these procedures. In the 'de Waag', the outpatient hospital of the Dr. Henri van der Hoeven Foundation, a simplified form of the offence script procedure is applied for group use, with the relapse prevention model playing a central role.

In the Netherlands the offence-oriented relapse prevention model is brought into practice in various populations of sexually aggressive offenders. The offence chain always plays an important role in this, whether or not it is in the form of the offence script procedure. Examples are juvenile sexually aggressive offenders (Bruinsma, 1996), mentally retarded sexually aggressive offenders (Legrand, 1994) and incest perpetrators (Frenken and Van Stolk, 1990).

Although our research primarily aimed at the validation of the various profiles, we were able to examine the progression of treatment for all patients included in the study. This made it possible to study whether the types differed from one another with respect to the way of departure, absence without permission, separation, alcohol and/or drug abuse, length of treatment and recidivism during or after clinical treatment. This gives us insight into the behaviour that we can expect from the various types of offenders during and after the treatment, including possible recidivism. The results are summarised in Table 7.2.

The vindictive offenders have had the least absence without permission, were never separated and completed their clinical treatment one year earlier on average than the other offenders. None of them has re-offended. They were, however, the largest alcohol abusers during the treatment. Sexualising offenders went on probationary release the most frequently and never used alcohol. The antisocial offenders went on probationary release the least, had the most absence without permission, were the most often separated and were the most often under the influence of alcohol or drugs. They relapsed most frequently. We can conclude from these data that the antisocial offenders were the least successful in adapting to the hospital regime and the least able to stay on the right track after departure. The majority of the vindictive offenders adapted relatively well. The sexualising offenders take an intermediary position. None of the offenders relapsed after the clinical treatment with a sexual offence (the follow-up period is on average a bit more than two years). Four patients are still in the hospital (one antisocial, one sexualising and two vindictive offenders). For three of these patients the prognosis is unfavourable, for the fourth, a vindictive offender, we expect a positive end to the clinical treatment in the short term.
Table 7.2

Differences between the profiles with respect to treatment development (May 1998)

<table>
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<th>Profile</th>
<th>Year of admission (range)</th>
<th>Year of departure (range)</th>
<th>Means of departure</th>
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*Rounded off up to whole years ≥ 6 months

One sexualising offender returned to the hospital after relapse during probationary release

During the past thirty years it has become clear that treatment of sexual aggressive offenders is no sinecure. The idea that these offenders can be cured has been abandoned. In North America this has led to the notion that increasing internal control over the problem behaviour is a realistic objective. But that too did not always lead to the desired result: recidivism often remained unacceptably high. A further step appeared to be made in the reduction of recidivism with the introduction of the external control dimension (Pithers, 1990). Drug treatment (Gijs & Gooren, 1996) and long-term supervision are necessary for some sexually aggressive offenders. But that too does not guarantee complete absence of recidivism. Laws (1996) supports the option of harm reduction, which is to say that reduced recidivism is a legitimate treatment goal. For some very dangerous and violent offenders, however, this is not an acceptable option. This creates an ethical dilemma. Where is the limit at which we have to say that we have nothing more to offer in terms of treatment and that life-long incarceration in a hospital is all that remains? Creativity and discussion about practical and ethical boundaries are needed. As therapists we should continue to strive to have even the most dangerous offenders who are extremely difficult to treat return to society in a socially acceptable way. Options such as electronic surveillance with for instance a wristband will raise quite a few ethical and practical questions; however, when compared to life-long confinement this may perhaps be an acceptable solution. But are we prepared to go as far as the United States do with their 'public notification law'? The consequences of this law, which prescribes that the community be informed about the presence of a sexually aggressive offender in their neighbourhood, is that sexually aggressive offenders are turned over to popular fury and are hunted like animals (Freeman-Longo, 1996). Is this a better option than life-long confinement? Does this law reduce the chance of recidivism in sexual offenders? The boundaries of the possibilities will be determined by the demands placed by society. Therapists should carefully weigh the interests of
society and the interests of the patient. The reality is that only a few sexually aggressive offenders do not want to or cannot change or are not willing to co-operate with supervision. For the time being they should remain within the forensic institutes. In the meantime, we already have greatly expanded our treatment options and that gives us hope for the future.
<table>
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<th>2000-04</th>
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During the past thirty years, there has been a clear trend towards the increased use of psychiatric medication. This trend has been influenced by several factors, including the increasing acceptance of the concept of mental illness as a medical condition. However, there is a growing concern that the overuse of medication can lead to adverse effects, including physical dependence and withdrawal symptoms. It is therefore important to carefully consider the use of medication in the treatment of mental disorders and to explore alternative approaches, such as psychotherapy, counseling, and lifestyle modifications. The use of medication should be guided by a thorough assessment of the individual's needs and should be part of a comprehensive treatment plan. This may involve the use of medication in conjunction with other interventions, such as cognitive-behavioral therapy, medication management, and support groups. The goal of treatment is to improve functioning and quality of life, while minimizing the risk of side effects and adverse outcomes.