Personality Patterns and Clinical Syndromes among Incarcerated Sex Offenders

Shraddha Kulkarni*, G.S. Venumadhava**
*Research Scholar, Dept. of Studies in Criminology & Forensic Science, Karnatak University, Dharwad, Karnataka, India
**Asst.Professor, Dept. of Studies in Criminology & Forensic Science, Karnatak University, Dharwad, Karnataka, India

---

Abstract

The current paper studies the personality and psychopathology of imprisoned offenders in Karnataka state. The percentage of prevalence and prominence of the personality patterns and clinical syndromes among the sex offenders was derived by using MCMI-III. High percentage of prevalence among sex offenders was noticed on the scales of Schizoid(24%), Avoidant(20%), Depressive(19%), Compulsive(17%) and Paranoid(23%) Personality Patterns, whereas, high percentage of prominence was found on scales of Avoidant(10%), Dependent(27%) and Schizotypal(5%). Whereas, High percentage ratios of prevalence was seen on scales on Anxiety(12%), Somatoform(12%) and Dysthymia(18%), whereas, high prominence was noticed on Anxiety(33%), Major Depression(37%) and Delusional Disorder(19%).

KEYWORDS: Personality, Psychopathology, Personality Patterns, Clinical syndromes

---

Introduction

A sex offense is defined in the American Psychological Association Dictionary of Psychology as a sex act that is prohibited by law. Some crimes are acts of violence involving sex and others are violations of social taboos (VandenBos, 2007). Sexual abuse defined by the APA Dictionary of Psychology as a violation or exploitation by sexual means, including all sexual contact between adults and children and between people in other relationship of trust.

Sexual perversion is defined as any sexual practice that is considered by a community or culture as an abnormal means of achieving orgasm or sexual arousal and is defined as a paraphilia by the DSM-IV (VandenBos, 2007).

Rape is generally considered forced sexual intercourse without consent against adult victims. Rapists are primarily interested in self-gratification, dominance and control (Jeglic, 2008). Groth (1979) defines rape as a pseudosexual act that addresses issues of anger and power more than sexuality. He asserts that rape is never simply the result of sexual arousal that cannot be gratified. While sexuality is not only the primary motive underlying rape, it is the means through which conflicts surrounding issues of anger and power become released (Groth, 1979). Unlike child molesters and incest offenders, rapist usually offend against the same victim only once (Jeglic, 2008).

Sex offenders are not compelled to offend because of one single need but rather for many reasons, most of which are non-sexual (Williams, 2009). Groth originally defined four categories of power and control needs that rapist exhibits:

- Power-reassurance is a non-aggressive behaviour, which serves to

normalize the attack for offenders and to fulfil the need of restoring their doubts about their own desirability.

- ❖ Power-assertive behaviour is defined as an aggressive behaviour, which is rarely lethal and shows no outward doubt of masculinity but serves to restore inner doubts and fears.
- ❖ Anger-retaliatory behaviour is defined as high levels of physical and sexual aggression that serve as an outlet for feelings of persuasive and cumulative rage.
- ❖ Anger-excitation is classified as pain and suffering inflicted upon the victim in order to heighten the offender's pleasure (Groth, 1979).

Personality describes an individual's characteristic ways of relating to others, experiencing and expressing emotion, thinking about self and others behaviour. Personality is best viewed dimensionally. Various types of personality disorders (e.g. antisocial, borderline, narcissistic, paranoid, schizoid) are currently described in mental disorders classification systems ICD-10 (WHO, 1992) and DSM- IV (APA, 1994).

Following are the personality patterns

i. **Schizoid :** Individuals are socially detached, prefer solitary activities, seem aloof, apathetic and distant with difficulties in forming and maintaining relationships.

ii. **Avoidant :** Individual are socially anxious due to perceived expectations of rejection.

iii. **Depressive:** Individuals are down cast and glory even in the absence of a clinical depression.

iv. **Dependent:** Individuals are passive, submissive and feel inadequate. They generally lack autonomy and initiative.

v. **Histrionic:** Individuals are gregarious with a strong need to be at the center of attention. They can be highly manipulative.

vi. **Narcissistic:** Individuals are self-centered, exploitative, arrogant and egoistical.

vii. **Antisocial:** Individuals are irresponsible, vengeful, engage in criminal behaviour and are strongly independent.

viii. **Aggressive (Sadistic):** Individuals are controlling and abusive; they enjoy humiliating other.

ix. **Compulsive:** Individuals are orderly organized efficient and perfectionist. They engage in these behaviours to avoid chastisement from authority.

x. **Negativistic (Passive-Aggressive):** Individuals are disgruntled, argumentative, petulant, oppositional, negativistic; they keep others on edge.

xi. **Masochistic (Self-Defeating):** Individuals seem to engage in behaviours that result in people taking advantage of and abusing them. They act like a martyr and are self-sacrificing.

xii. **Schizotypal:** Individuals seem "spacey", self-absorbed, idiosyncratic,

eccentric and cognitively confused.

xiii. **Borderline:** Individuals display a liable affect and erratic behaviour. They are emotionally intense, often dissatisfied and depressed and may become self-destructive.

xiv. **Paranoid:** Individuals are persuasive distrust and suspicion on others and their motives. Unjustified suspicion of the loyalty or trustworthiness of others.

- Psychopathy encompasses a particular set of personality traits characterised by emotional detachment, coldness and superficiality; an exploitative domineering and controlling interpersonal style an antisocial and impulsive behaviour (Patrick, 2006). Many people with psychopathy will also meet criteria for Antisocial Personality Disorder which essentially describes antisocial attitudes and behaviour. Many people with Antisocial Personality Disorder lack grandiosity, callousness and emotional detachment of Psychopathy. The personality characteristics of sexual offenders are heterogeneous and there is no 'sex offender personality profile' (Craissati, et al. 2008). In Hanson & Morton – Bourgon's (2004) meta-analysis psychopathology and personality disorder were associated with sexual and violent offenders. Psychopathy is one of the strongest predictors of future offending and violence in offenders, including sex offenders (Hare, 2006). Psychopathy in combination with sexual deviance has been found to be a particularly malignant combination (Olver & Wrong, 2006). Clinical syndromes under Axis I of DSM – IV:

  i. **Anxiety Disorder:** Individuals are anxious, tense, apprehensive and physiologically aroused.

  ii. **Somatoform:** Individuals are preoccupied with vague physical problems with known organic cause. They tend to be hyponcondriacal and somaticizing.

  iii. **Bipolar-Mania Disorder:** Individuals have excessive energy and are over-active, impulsive, unable to sleep and are maniac.

  iv. **Dysthymia Disorder:** Individuals are able to maintain day to day functions but are depressed, pessimistic and dysphoric. They have low self-esteem and feel inadequate.

  v. **Alcohol Dependence:** Individuals admit to serious problems with alcohol and /or associated with abusing alcohol.

  vi. **Drug Dependence:** Individuals admit to serious problems with drugs and /or endorse personality trait often associated with abusing alcohol.

  vii. **Post Traumatic Stress Disorder (PTSD):** Individuals report unwanted and intrusive memories and/or nightmares of a disturbing, traumatic event, they may have flashbacks.

  viii. **Thought Disorder:** Individuals experience thought disorder of psychotic proportions; they often report hallucinations and delusions.

  ix. **Major Depression:** Individuals are severely depressed to the extent that they are unable to function in day to day activities. They have vegetative

signs of clinical depression (poor appetite & sleep, low energy, loss of interest) and feel hopeless and helpless.

x. **Delusional Disorder:** Individuals are acutely paranoid with delusions and irrational thinking. They may become belligerent and act out their delusions.

Sex Offending Theories

I. Integrated Theory

Marshall & Barbaree propose that sexual crimes such as rape and child molestation are the result of multiple interacting factors that cover at a particular point in time to result in offending. In Integrated theory, the salient causal factors are developmental experiences, biological processes, cultural norms and attitudes about sex and gender roles and the psychological vulnerabilities resulting from these causes.

According to Marshall & Barbaree, the negative emotions caused by experiencing social and romantic rejection can trigger the onset of deviant sexual fantasies. These sexual fantasises would be characterised by sadistic and aggressive themes or relatively being content.

The integrated theory proposes that for individuals already to behave in antisocal manner, the biological changes occurring in puberty and fuse sex and aggression and result in sexually aggressive actions in certain contexts.

Marshall & Barbaree draw similarities between the psychological characteristics of psychopaths and sexual offenders. They suggest that because both groups are likely to have experience physical and sexual abuse as children, they may share certain features such as deficits in intimacy skills, lack of empathy, social ineptness and a tendency to egocentricity and negative attitude towards women.

Marshall & Barbaree suggest that positive and negative reinforcing effects of sexual abuse effectively maintain it, consolidate the individuals array of psychological and behavioural problems. A person who lacks the capacity to manage effectively his feelings of unhappiness and anxiety. He discovers that masturbation to deviant fantasies reduces the intensity of these negative emotion making him feel better, more powerful and important. The tendency to utilise sex as coping strategy not only contributes to his intial offending, it also helps to maintain it. The difference now is that the person regulates his mood by offending rather than through masturbatory practices. The maintaining of sexual offending is concerned the acquisition of rationalisation to legitimate and excuse the offender's sexually abusive actions. The cognitions used in the service of this goal are called Cognitive Distortions.

II. Quadripartite Model

Hall & Hirschman (1992) reformulation of Quadripartite Model was modified to account for the sexual abuse of children as well as rape. They hypothesized that inappropriate physiological sexual arousal, distorted cognition, affective dyscontrol and problematic personality trait. The first three were viewed as state factors and personality problem as a trait factor.

Hall & Hirschman proposed that these factors could function either independently or in combination to generate sexual abuse.

Hall & Hirschman acknowledged that negative affective state such as depression and anxiety can trigger an offence process and ultimately result in sexually abusive behaviour (Knight & Prentky, 1990; Pither, 1990).

According to Hall & Hirschman personality problems emerge from adverse developmental experiences such as physical/sexual abuse or parental divorce. Events like these function to shape offenders antisocial attitudes and problematic interpersonal strategies. These attitudes and the reluctant skills deficit tend to restrict individual's opportunities for social and personal success and increase the likelihood they will me embrace an antisocial lifestyle (Bard et al. 1987; Hall & Proctor, 1987; Lipton, Mc Donel & McFall, 1987).

III. Pathway Model

Pathway model recognises that sexual offenders are likely to vary in terms of particular profile of clinical phenomena that they display. Some individual may struggle to establish and maintain close personal relationships while others report no problems in this aspect of their lives and instead experience difficulties monitoring their emotional states. Thus, sex offenders constitute a diverse group who reveal considerable variation in the type, severity and range of problems they present. The causes for these differences reside in distinct psychological disposition or traits, essentially vulnerability factors.

IV. Malamuth Model

Malamuth, from evolutionary psychology adopted important distinction of ultimate and proximate causes enriching confluence model with both. Ultimate causes are concerned with whether a particular characteristics or pattern of behaviour arises from natural selection. Proximate causes focus on how a particular genetic inheritance comes to be expressed in a specific individual's life course. Ultimate causes can explain why humans may have developed particular behavioural tendencies, proximate causes explain how these patterns develop (Symons, 1979)

Malamuth, Heavey & Linz (1993) proposed interactive model and its four central elements:

i. That sexual offending results from convergence of risk factors.
ii. That the causes of aggression against women are somewhat specialised and do not predict as effectively as men's behaviour towards other men.
iii. Yet the causes of sexual aggression also predict other controlling and coercive behaviour towards women
iv. Non-evolutionary factors referred to here as environmental factors are important in explaining variations in actual behaviour.

V. Personality Theory

Theories of personality development are perhaps the earliest means

through which clinicians and researchers have attempted to explain deviant or abnormal behaviour in human beings. Early theorists such as Freud (1905/1962) and Kraft Ebing suggested that something in the development of the self or person significantly contributed to the development of sexually deviant interests and behaviours.

Sigmund Freud's original psychoanalytic hypotheses development, which he believed would significantly impact later adult functioning. Freud's initial ideas regarding sexually deviant behaviours were that the individual had become fixated in an earlier stage of sexual development and was acting out the behaviour of that particular stage. The deviant sexual act became a ritual through which sexual pleasure could be achieved (Gabbard, 1994).

The psychodynamic hypotheses ultimately suggested that personality and human behaviour are largely shaped by mental mechanisms operating outside conscious awareness. The conscious mechanism develop similarly during early childhood and define adult interaction styles and motivation (Larsen & Buss, 2002).

Freud states that just as sexual expression is a natural human tendency, so is aggression or violence. He posited that because cruelty and sexuality are both fundamental human traits, it is not unusual that these basic human instincts might come to be associated (Freud, 1905/1962). Believing the association between these two instincts are deviant and unthinkable, society has evolved moral standards that forbid the co-occurrence of violence and sexual activity. One who does not learn them, is at increased risk of abandoning himself to these two competing drives (i.e. sexuality & aggression), which may result in sexually aggressive or sadistic acts.

Palermo (2002) added that the differences between individual's in ego strength and fundamental ego formulation creates differences in their fantasies and expression of their sexual and aggressive drives from the id. Because of the idiosyncratic features of the ego, the individual will manifest various forms of sexual deviance.

Bowlby (1958) introduced attachment theory as a means to explain a child's primary object relation (e.g. relationship with the mother) as the foundation of personality. One of the early goals of attachment theorists was to explain the development of pathological personality features in adulthood, including psychopathy. Bowlby & Ainsworth developed a typology of attachment styles, noting features of secure, insecure and avoidant attachment. The different attachment styles were attributed to different experiences with attachment in the childhood, with a maladpatively attached child forming persistent patterns of detachment towards others hostility and anxiety (Bowlby,1969/1979).

Robert Stoller (1991) noted that the original psychodynamic term for sexually deviant fantasies and behaviours perversions because it connotes a sense of sinfulness and humiliation that is the core of deviance bact. HE views the motivation behind perverse sexual activity as one of hostility and revenge. The trauma that threatened the gender identity resulted in the separation of an individual male from his mother, seeks for hostile nature and revenge in adulthood. This adult male will seek to harm his sexual partner, reverse the role of pain and humiliation and instead emerge victorious from the perverse sexual situation. While orgasm would be

equated with this feeling of victory, the individual would need to relive the perverse and humiliating sexual act repeatedly overtime because he will not be able to permanently banish the danger to his gender and sexual identity that was created in childhood (Stoller, 1975).

Relevant Studies

Many studies have attempted to understand sex offenders by examining personality traits. These studies have attempted to minimize the heterogeneity of this group by organizing sex offenders into offense categories (Baxter et al.,1984; Fisher, 1969; Fisher & Howell, 1970; Fisher & Rivlin, 1971; Scott, 1982; Wilson & Cox, 1983).

Baxter et al. (1984) examined 144 incarcerated sex offenders who were assessed for either treatment or parole purposes. They reported that all sex offender groups were anxious in social situations, had low self-esteem, expressed negative attitudes concerning women and were unassertive. The only significant differences between the groups (rapists and child molesters) were in levels of arousal to erotic stimuli. They found that homosexual paedophiles responded more to males than females and paedophiles responded more to children than to adults (Baxter et al. 1994).

Valliant & Blasutti (1992) examined 64 jailed sex offenders to explore personality differences between child molesters and rapists. The only significant result between the groups was related trait Anxiety level. They found that extra familial child molesters were significantly more than incestuous molesters. They reported decrease in trait anxiety with treatment for extra familial but not incestuous offenders (Valliant & Blasutti, 1992).Wilson & Cox (1983) utilised Eysenck Personality Questionnaire (EPQ) to study paedophiles in a community based self-help club in England. The most significant finding was that paedophiles are introverted and lack social skills.

Fagan et al. (1991) utilized NEO-PI to examine personality characteristics of 51 men diagnosed with paraphilia's at the Sexual Behaviours Consultation Unit of John Hospital. Fagan et al. reported that paraphilic men were high on all facets of Neuroticism and low on the agreeableness and Conscientiousness factors. These men also scored high on excitement seeking facet of Extraversion and on the Openness to Fantasy facet of the Openness to New Experience factor.

Lehne (1994) utilized the NEO-PI to measure personality traits of sex offenders in treatment at the Sexual Disorder Clinic of John Hopkins Hospital. Lehne (1994) examined the correlation between NEW-PI and MCMI-I. Lehne (1994) found that sex offenders were high on all facets of Neuroticism but cored in the average range on Extraversion and Openness to New Experience. Similar to Fagan et al. (1991) and Wise et al. (1991) the sex offenders high on the Excitement –seeking facet of Extraversion. These findings suggest that sex offenders are anxious, depressed, hostile individual who crave constant stimulation.

Researchers have found that same sex offenders can be significantly distinguished by their personality profiles on the MMPI when compared to other offending groups (Curnoe & Langevin, 2002; Herkov et al., 1996; Losada – Paisey, 1998). The latter findings demonstrating differences between sex offenders and other offenders, identify the sex offenders as

being more socially withdrawn, higher in psychopathic deviances and more likely to endorse items suggestive of paranoia and thought disorders (Carnoe & Langevin, 2002).

Studies using cluster analysis found that the personality profiles of diverse groups of adults and adolescent sex offender cluster into three to four types, characterized by varying levels of psychopathic traits, neurotic symptoms and social maladjustment (Anderson, P.; Proulx, J. & Mckibben, A, 200; Smith Monastersky & Deisher, 1987; Worling, 2001). Other of these studies have demonstrated that rapists tend to show higher rates of hostility, resentfulness and social alienation than child molesters who endorse symptoms more consistent with passivity, emotional disturbance and avoidance (Armentrout & Hauer, 1987; Carpenter, Peed & Eastman, 1995; Chantry & Craig, 1994b, Duthie & Mclvor, 1990; SHealy & Kalichman, Henderson, Szymanowski & McKee,1991)

Methodology

Objectives

- To study the percentage of prevalence and prominence of clinical personality patterns and clinical syndromes among offenders.
- To know the difference in the personality patterns of incarcerated sex offenders and violent offenders.

Hypothesis

- There is no significant difference in the clinical personality patterns and clinical syndromes of sex offenders and violent offenders.

Universe

The samples were drawn from Central Prisons of Karnataka from incarcerated sex offenders and violent offenders. Sex offenders comprised of (Rapists) whereas, violent offenders comprised of offenders imprisoned for crime such as Murder, Kidnapping and Dowry Deaths. In total 100 samples were subjected to self-reporting psychological inventory Millon Clinical Multiaxial Inventory – III.

Psychological Inventory

The MCMI-III which provides characterological assessment through items measuring various psychological symptomology. This instrument require respondents to provide a consistent and coherent description of their psychological traits (e.g. Narcissism, Psychopathy) and report these results as personality profile (i.e. combination of psychological traits like psychopathy, specific psychological symptoms such Post-traumatic stress). The end result is an evaluation of an individual's level of psychological distress and some interpretation of how that distress and some interpretation would impact his over all ability to function.

Result

The present study intends to figure out the prevalence and prominence of personality patterns and various clinical syndromes that the incarcerated sex

offenders and violent offenders might dwell. It is said that violent offenders prevails with traditional personality patterns with more of antisocial and sadistic personality patterns, whereas sex offenders have different array of personality patterns. The prevalence and prominence of the personality patterns and clinical syndromes were based on the cut off on the Base Rates derived while scoring the test. As per MCMI-III, individuals with base rate scores between 73-84 have said to have prevalence of personality patterns or clinical syndromes, whereas, the individuals having scores 85 & above reflects the prominence of personality patterns and clinical syndromes needing immediate attention and treatment.

Table1 Shows the Percentage of Prevalence and Prominence of Personality Patterns among Sex Offenders and Violent Offenders

ClinicalPersonality Patterns	**Prevalence**	**Prominence**
Schizoid		
Sex Offenders	24%	1%
Violent Offenders	12%	5%
Avoidant		
Sex Offenders	20%	10%
Violent Offenders	22%	1%
Depressive		
Sex Offenders	19%	4%
Violent Offenders	18%	3%
Dependent1%		
Sex Offenders	14%	27%
Violent Offenders	23%	7%
Histrionic		
Sex Offenders	1%	00
Violent Offenders	1%	1%
Narcissistic		
Sex Offenders	1%	00
Violent Offenders	3%	00
Antisocial		
Sex Offenders	00	2%
Violent Offenders	4%	00
Sadistic (Aggressive)		
Sex Offenders	1%	2%
Violent Offenders	00	00
Compulsive		
Sex Offenders	17%	00
Violent Offenders	7%	5%
Negativistic(Passive-Aggressive)		
Sex Offenders	14%	1%
Violent Offenders	00	1%
Masochistic(Self-Defeating)		
Sex Offenders	9%	1%
Violent Offenders	7%	00
Severe Clinical Personality Pathology		

Schizotypal		
Sex Offenders	6%	5%
Violent Offenders	00	3%
Borderline		
Sex Offenders	10%	3%
Violent Offenders	13%	00
Paranoid		
Sex Offenders	23%	4%
Violent Offenders	16%	7%

High percentage of prevalence among sex offenders was noticed on the scales of Schizoid(24%), Avoidant(20%), Depressive(19%), Compulsive(17%) and Paranoid(23%) Personality Patterns, whereas, high percentage of prominence was found on scales of Avoidant(10%), Dependent(27%) and Schizotypal(5%). Among violent offenders, high percentage of prevalence was relatively found on scales of Avoidant(12%) and Dependent(23%), whereas, high percentage of prominence was relatively seen on scales of Schizoid(5%), Dependent(7%) and Paranoid(7%) personality patterns.

Table2 Shows the Percentage of Prevalence and Prominence of Clinical Syndromes among Sex offenders and Violent Offenders.

Clinical Syndromes	Prevalence	Prominence
Anxiety		
Sex Offenders	12%	33%
Violent Offenders	12%	29%
Somatoform		
Sex Offenders	12%	3%
Violent Offenders	00	00
Bipolar Mania		
Sex Offenders	10%	4%
Violent Offenders	14%	00
Dysthymia		
Sex Offenders	18%	3%
Violent Offenders	7%	00
Alcohol Dependence		
Sex Offenders	9%	3%
Violent Offenders	10%	5%
Drug Dependence		
Sex Offenders	7%	2%
Violent Offenders	5%	00
PTSD		
Sex Offenders	6%	5%
Violent Offenders	15%	5%
Severe Clinical Syndromes		
Thought Disorder		
Sex Offenders	7%	2%
Violent Offenders	3%	1%

Major Depression		
Sex Offenders	6%	37%
Violent Offenders	15%	16%
Delusional Disorder		
Sex Offenders	2%	19%
Violent Offenders	12%	9%

Clinical Syndromes were found to have more of Prevalence and Prominence among Sex Offenders and Violent Offenders. High percentage ratios of prevalence was seen on scales on Anxiety(12%), Somatoform(12%) and Dysthymia(18%), whereas, high prominence was noticed on Anxiety(33%), Major Depression(37%) and Delusional Disorder(19%). Among violent offenders, high prevalence rate were found on the scales of Anxiety(12%), Bipolar-Mania(14%), and Major Depression(15%) were as high percentage on prominence on clinical syndromes were observed on Anxiety(29%) and Major Depression(16%).

The study also aims to understand if any difference exist between sex offenders and violent offenders on the clinical personality patterns and clinical syndromes. The difference might reflect the clinical profile of sex offenders and with the help of in-depth interview, a channelized treatment therapy could be drafted to condense the chances of recidivism. To understand the difference between the groups, independent t-test was conducted along with Cohen's *d* to comprehend effect size of the difference.

Table3 *M*, *SD*, *t*-values, and effect sizes for clinical personality patterns scores of sex offenders and violent offenders

Clinical personality patterns	**Sex offenders**		**Violent offenders**		***t*(98)**	**Cohen's *d***
	M	***SD***	***M***	***SD***		
1. Schizoid	73.18	9.46	69.86	12.93	1.47	
2. Avoidant	72.36	16.91	70.86	12.20	.51	
3. Depressive	66.76	20.13	67.74	20.21	.50	
4. Dependent	80.90	15.26	71.00	17.28	3.04**	.61
5. Histrionic	43.54	12.47	42.28	15.37	.45	
6. Narcisstic	48.16	11.66	50.14	15.78	.81	
7. Anti- Social	49.96	24.00	55.60	15.49	2.14*	.28
8. Sadistic (Aggressive)	56.66	17.56	64.04	5.44	2.84**	.57
9. Compulsive	64.84	10.99	61.40	15.00	1.31	
10.Negativistic (Passive-Aggressive)	64.44	17.54	63.68	13.61	.24	
11. Masochistic (Self-Defeating)	64.86	13.84	57.60	15.92	2.43*	.52

Note. * < .05, ** < .01

An independent t-test was conducted to compare, out of which Dependent, Antisocial, Sadistic and Masochistic Personality Patterns were found to be significant between sex offenders and violent offenders. There is a significant difference in the scores of Dependent Personality patterns of sex offenders [M= 80.90, SD= 15.26] and violent offenders [M= 71.00, SD= 17.28], *t*(98)= 3.04,24.00 p < .01, C.I 95% [3.43-16.37] demonstrating large effect size Cohen's *d* = .61

There is a significant difference in the scores of Anti-social Personality pattern of sex offenders [M= 49.96, SD= 24.00] and violent offenders [M= 55.60, SD= 15.29], *t*(98)= 2.14, p< .05, C.I. 95% [-16.66 - -.62], demonstrating small effect size Cohen's *d* = .28.

There is a significant difference in the scores of Sadistic (Aggressive) Personality pattern of sex offenders [M= 56.66, SD= 17.56] and violent offenders [M= 64.04, SD= 5.44], *t*(98)= 2.84, p< .01, C.I. 95% [-12.54 - -2.22], demonstrating medium effect size Cohen's *d* =.57.

There is a significant difference in the scores of Masochistic (Self-Defeating) Personality pattern of sex offenders [M= 64.86, SD= 13.84] and violent offenders [M=57.60, SD= 15.92], *t*(98)= 2.43, p< .05, C.I. 95% [1.34 – 13.18], demonstrating medium effect size Cohen's *d* =.52.

Table4 *M*, *SD*, *t*-values, and effect sizes for severe clinical personality patterns scores of sex offenders and violent offenders

Personality Pathology Patterns	Sex offenders		Violent offenders		*t*(98)	Cohen's *d*
	M	*SD*	*M*	*SD*		
1. Schizotypal	66.48	16.47	68.10	13.12	.59	
2. Borderline	61.76	18.82	62.16	19.87	.92	
3. Paranoid	69.28	25.79	73.10	12.12	.26	

Note. * < .05, ** < .01

Although scales Schizotypal, Borderline and Paranoid forms the integral part of respective Personality clusters as described in DSM-IV, here they have been considered as severe personality pathology. In this group, its evident that there is no significant difference in the scores of sex offenders and violent offenders.

Table5 *M*, *SD*, *t*-values, and effect sizes for clinical syndrome scores of sex offenders and violent offenders

Clinical Syndromes	Sex offenders		Violent offenders		*t*(98)	Cohen's *d*
	M	*SD*	*M*	*SD*		
1. Anxiety	84.98	21.86	78.28	24.78	1.43	
2. Somatoform	67.92	17.20	51.26	17.98	4.73**	.95

3. Bipolar Mania	64.32	19.84	66.52	19.77	.56	
4. Dysthymia	69.26	17.80	58.56	18.20	2.97**	.59
5. Alcohol Dependence	64.64	13.99	65.04	15.98	.13	
6. Drug Dependence	47.18	26.86	57.10	18.84	2.14**	.42
7. PTSD	62.08	16.84	63.26	23.07	.29	

Note. * < .05, ** < .01

The independent-test was carried out to understand the differences on Clinical Syndromes between sex offenders and violent offenders. Significance was found on scales of Clinical Syndromes of Somatoform, Dysthymia and Drug Dependence. There is a significant difference in the scores of Somatoform of sex offenders [M= 67.92, SD= 17.20] and violent offenders [M= 51.26, SD= 17.98], t(98)= 4.73, p < .01, C.I. 95% [-2.57 – 15.97], demonstrating large effect size Cohen's *d* = .95.

There is a significant difference in the scores of Dysthymia- clinical syndrome of sex offenders [M= 69.26, SD= 17.80] and violent offenders [M= 58.56, SD= 18.20], t(98)= 2.97, p< .01., demonstrating medium effect size Cohen's *d* = .59.

There is a significant difference in the scores of Drug Dependence of sex offenders [M= 47.18, SD= 26.86] and violent offenders [M= 57.10, SD= 18.84], t(98)= 2.14, p< .05, C.I. 95% [-19.13 – -.71], demonstrating medium effect size Cohen's *d* = .42.

Table6 M, SD, t-values, and effect sizes for severe clinical syndrome scores of sex offenders and violent offenders

Clinical personality patterns	**Sex offenders**		**Violent offenders**		***t*(98)**	**Cohen's *d***
	M	***SD***	***M***	***SD***		
1. Thought Disorder	67.36	8.16	62.68	14.19	2.02*	.40
2. Major Depression	85.76	15.82	72.74	25.55	3.06**	.61
3. Delusional Disorder	77.70	13.12	71.88	13.09	2.22*	.44

Note. * < .05, ** < .01

Significant differences were found on the scales of Severe Clinical Syndromes like Thought Disorder, Major Depression and Delusional Disorder. There is a significant difference in the scores of Thought Disorder of sex offenders [M= 67.36, SD= 8.16] and violent offenders [M= 62.68, SD= 14.19], t(98) = 2.02, p < .05 demonstrating medium effect size Cohen's *d* = .40

Significant difference was found in the scores of Major Depression of sex offenders [M= 85.76, SD= 15.85] and violent offenders [M= 72.74, SD= 25.55], t(98)= 3.06, p< .01, demonstrating large effect size Cohen's *d*= .61.

There was also significant difference in the scores of Delusional Disorder of sex offenders [M= 77.70, SD= 13.12] and violent offenders [M= 71.88, SD= 13.09],

t(98)= p< .05 demonstrating medium effect size.

Discussion

Review of related literature have suggested there are differences in the personality patterns of sex offenders that from other non-sexual offender or no offense population. Francis et al. examined personality of 251 rapists, 311 child molesters and compared it with non-sexual offender group using Coolidge Correctional Inventory, a self reporting inventory aligned with DSM-IV Personality clusters and neuropsychological inventory. They found that rapists had significantly higher levels of antisocial personality traits than child molesters but no difference in narcissistic traits. Non-sexual offenders also scored higher on antisocial scale than the child molesters but not higher than rapists. The cut off for personality disorder diagnoses for non-sexual offenders and greatest prevalence was for obsessive compulsive disorder, antisocial, avoidant and narcissistic personality disorder.

In the present study, the prevalence percentage reflects more numbers personality patterns dwelled by the sex offenders affecting their daily life than compared to violent offenders. The personality patterns such as Schizoid (24%), Avoidant(20%), Depressive(19%), Compulsive(17%) and Paranoid(23%), whereas among violent offenders only two personalities had higher percentage towards prevalence Avoidant(12%) and Dependent(23%). The prominence group which emits the seriousness of disorder or clinical syndrome reflects that sex offenders had higher prominence on Avoidant(10%), Dependent(27%) and Schizotypal (5%) whereas violent offenders were high on Schizoid(5%), Dependent(7%) and Paranoid(7%).

Similarly, with respect to clinical syndromes comprised of various Axis I mental disorders describe in DSM-IV, Anxiety and Major Depression were found to be higher on prevalence as well as prominence on the sex offenders (12%) and (33%) as well as in violent offenders(12%) and 29%) respectively. Major Depression was the only prominent clinical syndrome between sex offenders (37%) and violent offenders (16%)

Eher et al. studied 807 incarcerated sex offenders. They found that sexual offenders displayed high rates of mental illness, sexual disorder, personality disorders and substance abuse. However, there were differences between rapists and child molesters. Rapists had higher rates of personality disorders overall (76% v/s 60%). Rapists had personality disorders such as Antisocial and Borderline disorder among them.

Conclusion

A critical component in the evaluation and treatment of sex offenders is an understanding of personality styles and their effects on the types of sex offense committed. Numerous studies (Hall, Graham & Shephered, 1991; Kalichman, 1990; Kalichman, 1991; Kalichman, Dwyer, Henderson & Hoffman, 1992) have examined the possibility of categorizing sex offenders into homogeneous sub-groups based upon personality and psychopathological characteristics.

It can be concluded from the data collected and analysed that there exist a few differences in the personality patterns and clinical syndromes between sex offenders and violent offenders. Although due to homogeneous character imbibed in their nature of offense, it's difficult to draw a clinical profile or personality profile. But along with

quantitative data collected on the basis of psychological or neuropsychological aspects and qualitative data drawn through in-depth interviews related to allied aspects of behaviour that nurtured criminal would yield in organizing prolific treatment approach to curb the recidivism. If the knowledge imparted in best interest of common man would be more helpful in evaluating the nature of crime and criminal.

References

1. Eher, R., Neuwirth, W., Fruehwald, S., & Frottier P. (2003). Sexualization and lifestyle impulsivity:clinically valid discriminators in sexual offenders. International Journal of Offender Therapy and Comparative Criminology 47(3):452-467.

2. Bickley, J.A, & Beech, A.R. (2001). Classifying child abusers:Its relevance to theory and clinical practice. International Journal of Offender Therapy and Comparative Criminology 45(1):51-66.

3. Sewell, K.W, & Salekin, R.T. (1997). Understanding and detecting dissimulation in sex offenders, in Clinical Assessment of Malingering and Decpetion. Edited by Rogers R. New York:Guilford Press, PP 328-350.

4. Raymond, N.C., Coleman, E., Ohlerking, F., Christenson, G.A., & Miner, M. (1999). Psychiatric comorbidity in paedophilic sex offenders. The American Journal of Psychiatry156(5):786-788.

5. Ahlmeyer, S., Kleinsasser, D., Stoner, J., & Retzlaff, P. (2003). Psychopathology of incarcerated sex offenders. Journal of Personality Disorders 17(4):306-318.

6. Ryder, A.G., & Wetzeler, S. (2005). Validity of the MCMI-III in the description and diagnosis of psychopathology, in New Directions in Interpreting the Millon Clinical Multiaxial Inventory-III. Edited by Craig RJ. Hoboken, New Jersey:John Wiley & Sons, PP 248-271.

7. Retzlaff, P., Stoner, J., & Kleinsasser, D., (2002). The use of the MCMI-III in the screening and triage of offenders, International Journal of Offender Therapy and Comparative Criminology 46(3):319-332.

8. Timmerman, I.G., & Emmelkamp, P.M. (2001). The prevalence comorbidity of axis I and axis II pathology in a group of forensic patients, International Journal of Offender Therapy and Comparative Criminology 45(2):198-213.

9. Fazel, S., Sjöstedt, G., Långström, N., & Grann, M. (2007). Sexual offending and the risk of severe mental illness. Journal of Clinical Psychiatry, 68(4):588-94