The Psychology of Individual Adult Abusers

Written Responses for the Scottish Child Abuse Inquiry

Judi Bolton

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Preface

The Scottish Child Abuse Inquiry ("SCAI") held roundtable sessions on 22nd and 23rd March 2022, at its premises in Edinburgh. The sessions were open to the public.

The purpose of the sessions was to explore, with relevant experts, aspects of the psychology of those who abuse children in a way that would help the Chair of SCAI to understand them and to apply that understanding when deciding, at a future date, what recommendations ought to be made for the protection of children in care from abuse.

In advance of the sessions, the experts were invited to consider a set of questions and they provided written responses which were used to assist in facilitating the discussions. The responses provided by Judi Bolton, Consultant Forensic Clinical Psychologist, are set out below.

Written Responses

1. Individual Abuser Psychology

1a. Drawing on your professional experience, what characteristics of child abusers impact upon the likelihood and/or nature of their abuse of children?

The term characteristic is defined as a "featural quality belonging typically to a person" (Oxford Language Dictionary). The nearest psychological concept to characteristic would be 'personality' considered relevant in assessment of offenders. In addition, the assessment of personality has measurable diagnostic thresholds, i.e. the diagnosis of personality disorder asa recognised mental disorder in both the research literature and diagnostic medicine.

The difficulty regarding personality disorder research evidence is that the findings are often inconclusive, but personality disorder remains an important factor to consider in individual risk assessment. There is strict governance of the training and experience of the person to administer the assessment of both personality disorder and risk. There is further difficulty in the use of the diagnosis of personality disorder to predict offending, i.e. would a group of offenders have the same diagnosis? For clarity, not all individuals within a category of offenders will have the same mental disorder diagnosis. For example, sexual offenders may have no diagnosis of personality or a diagnosis of antisocial personality or any other type of personality disorder. There are a number of personality disorder diagnoses (see DSM5). What additional factors would need to be present for offending to be committed? These additional factors can increase the likelihood of offending, an example of which would be disinhibition due to drugs or alcohol and/or lack of protective factors (prosocial intimate relationships, etc). There are a number of protective factors. These can be formally assessed via structured professional judgement tools, e.g. the SAPROF. Factors include, amongst others, pro-social intimate relationships, access to employment, access to professional supervision. Additionally, the nature of the abuse of children has a large variation, but would be defined in part with a need to define abuse in terms of the difference between sexual and physical abuse and contact/non-contact offences. The research regarding personality disorders and offending is extensive. At what clinically may be seen as the severe end, this may include information with regard to a diagnosis of psychopathy. In summary, within offender management, focus is often based on antisocial personality disorder, particularly associated with violent criminal behaviour and emotionally unstable personality disorder, or traits that particularly impact risk management.

There are thought to be a number of ways in which a history of insecure attachment leads to the risk of the development of a personality disorder. Insecure attachment makes reference to the psychological theory of attachment. Again this literature is extensive, but in summary there is evidence regarding

childhood adversity impacting upon an individual's ability to consider others' perspectives and feelings whether through disengagement or a lack of psychological awareness. Childhood adversity also makes socialisation practices less effective, putting a child at risk of being more susceptible to negative influences within society. In some cases child rearing practices, especially physical and emotional abuse, models antisocial behaviours for children who subsequently adopt the same behaviour. Offending behaviours have also been associated with a lack of resolution of trauma, particularly relevant to childhood trauma. Attachment difficulties related to early life trauma has also been highlighted within the research as contributing to the diagnosis of antisocial personality disorder, and highly prevalent in research samples of men convicted of intimate partner violence.

Certain personality disorder traits are associated with a lack of empathy for others and a tendency to objectify others, characteristics considered to make it less acceptable to hurt other people. Characteristics also include being distrustful, tending to make negative attributions of others' intentions and behaviours, thereby fuelling their own hostility. It is of note that people can be diagnosed with more than one personality disorder, which would be considered relevant to offending pathways. Overall, evidence would suggest there are multiple pathways to the development of personality disorders.

1b. What does your professional experience tell you about abusers' perceptions of children and how those perceptions may contribute to their perpetration of abuse?

Abusers' perception of children is likely not to be a permanent or consistent construct. For example, an offender may be able to psychologically vary their perception of their relationship with children—an example of which would be the difference between their own biological children and non-biological children. Other large variations in individuals' perceptions would include perception of gender differences, etc. Individuals' perceptions vary greatly in regard to the attributions they make about children. An example of which is gender differences, which also impacts upon attributions that may be made in regard to sexual development and emotional development. These perceptual variations are complex to account for, and based on individual multifactorial differences, including not exclusively education (understanding of developmental stages, own early-life experiences, external influences and determination of the motivation to offend).

1c. What does your professional experience tell you about the link, if any, between the viewing of pornography including indecent images of children and the abuse of children?

There is a body of research information available attempting to determine a link between pornography use and the abuse of children. In summary and in my clinical experience, the use of pornography is highly prevalent in society and

determination needs to focus on illegal images of children. This complex area would include a portion of the population who would be sexually gratified by images of children for sexual purposes, although the image would not be sexual in nature. The majority of the evidence would conclude that only a fraction of these offenders who view illegal images of children will progress to contact sexual offending, or be involved at the time of the pornography-use in contact offending. There is some evidence, and my clinical experience would validate this, that use of pornography can desensitise the individual to child sexual images. There are also aspects of difficulties within all pornography use in terms of the satiation effect, i.e. that abusers of child pornography become satiated with the material that they are viewing and need to increase both the volume and level of abusive imagery that they are consuming. My clinical experience would also point to firm evidence that pornography use could impart information for risk management, in terms of offending particularly in the absence of pro-social (pro-social is a reference in regard to behaviours or relationships that are motivated by adherence to the rules, regulations and cultural norms) or any intimate relationships. This causes much clinical controversy in terms of case management and other countries (for example Germany, see the Prevention Project Dunkelfeld (PPD)) have adopted some radical strategies including the provision of avatar child pornography images for the management of offenders.

2. Individual Abuse in Religious Institutions

2a. Some members of religious orders were obedient to most of the strict rules, requirements, and practices of their orders, yet they flouted rules of their orders devised for the protection of children (e.g. being kind to children and providing them with the best possible care,[1] refraining from corporal punishment,[2] never being alone with a child[3] and never fondling a child[4]) and abused children. What does your professional experience tell you about this?

The behavioural practices of all individuals is rarely consistent. In terms of the question posed, rules required for maintenance of employment or the reinforcement of values and beliefs, e.g. within religious orders, are not consistently applied. In summary, these inconsistences are best accounted for by an examination of the motivation to offend, and this is likely to impact upon behaviours where the care of children has been overlooked. As discussed in question 1a, the motivation for offending involves a complex assessment, but would be most likely to account for any observed inconsistency in behaviours.

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[1] See, for example, Case Study Findings for Sisters of Nazareth, p.3.
[2] See, for example, Case Study Findings for Christian Brothers, p.3.
[3] See, for example, Case Study Findings for Christian Brothers, p.3-4.
[4] See, for example, Case Study Findings for Christian Brothers, p.5.

2b. What role, if any, does the celibacy of an abuser play in the sexual abuse of children?

The evidence for celibacy is controversial both in terms of society and organisations' beliefs in the ability to achieve celibacy. Celibacy itself also varies by developmental age and stage in individuals, according to lifespan development. Developmental psychologists would, with good evidence, argue that the majority of the population will follow a developmental pathway that would include physical and sexual development. Facilitation of intimate relationships and sexual relationships would play a significant part in certain stages of the lifestyle development. It would be my opinion that the requirement to not engage in any sexual gratification or the management of sexual desire would in the majority of people therefore set them on a different developmental pathway that would require extensive management (and what would be in my clinical experience) prove difficult to manage within their lives. For example, I have clinically had patients who have stated their sexual preference towards children and have as a process in their rehabilitation found the concept of celibacy impossible and have required as part of their clinical rehabilitation the determination of how to achieve sexual gratification without sexual contact with another individual.

I have also had a clinical case where a patient found the knowledge that he was homosexual adversive, reinforced by his perception of likely family rejection. Therefore, as a coping strategy, he chose a religious career in the belief that adopting celibacy would deny him any form of sexual expression.

3. Denial & Minimisation

3a. What does your professional experience tell you about denial and minimisation of offending by abusers?

The consideration of the concepts of denial and minimisation of offending by abusers has changed over the course of my clinical career. Previously, denial was considered a factor that would increase an individual's risk of recidivism. More recently, there has been consideration given to the concept of denial, evidencing that offenders have prosocial values and value relationships with others—hence their need for their denial when faced with evidence of their offending. Clinically it is necessary to determine by complex assessment the role that denial and minimisation plays in the abusers life; not exclusively, this often involves looking at individuals' values, core beliefs, and relationships with others that have contributed to their denial and minimisation.

3b. What does your professional experience tell you about the shift in attitudes of abusers from denial and minimisation to acceptance?

My clinical experience has shown me that attitudes and beliefs in offenders can alter particularly with engagement in rehabilitative treatment. The concept of

acceptance requires further clarification in terms of what acceptance may mean to an individual who may only concede that their wish is to not have to manage some of the consequences of their offending behaviours, e.g. prison, etc. Consequences for offenders in regard to their offending behaviours are many and include not exclusively custodial time in prison, breakdown of relationships, loss of employment, and consequences of time spent in custodial care. On the other hand, some individuals certainly determine that they wish to lead a different life, and in fact most offender treatments are based broadly upon the concept of The Good Lives model (see Ward). In reference to The Good Lives model (Professor Tony Ward, variety of publications) adopting different behaviours to reduce risk of recidivism include not exclusively meaningful activity, establishing healthy relationships, and access and adherence to mental health care and treatment. When clinically implemented, this translates as facilitating individual insight into their behaviours, but additionally focuses on risk management, including them adopting different behaviours, particularly the adoption of behaviours such as meaningful activity, pro-social relationships, and maintainence of good mental health.

Similarly, the change in offender rehabilitation, previously focussing on victim empathy as a treatment aim, has altered, with the focus not being on people, spending treatment aimed at understanding the emotions of others, but with a focus more on their own adoption of a different lifestyle.

4. Individual & Group Abuse

4a. Drawing on your professional experience, why do some people abuse in groups, some in isolation, and some both in groups and in isolation?

My clinical experience has in very large part focussed upon individuals who have committed offences in isolation. A more frequent example of what may be considered group abuse has been internet offenders; however, the majority of my direct clinical work has been with individual contact offenders. A small number of these have abused in groups, particularly historical offences involving only one or two cases where children have been procured by men with other men (particularly relatives) for sexual purposes. I would not consider myself someone who has extensive experience in group abuse.

5. Victims & Attachment

5a. Drawing on your professional experience, please explain (if you can) why different children within care settings may be treated differently by caregivers—some favoured and well-cared for, whilst others are abused?

I have limited experience of clinical work with the victims of abuse directly, however, many of the offenders I have worked with have themselves been victims of abuse as part of their own early lived experience. I have known these individuals to comment on vulnerability of certain individuals within particular

institutions. This vulnerability has been difficult to determine, but seems to include features of age, the presence of other protective relationships (e.g. siblings, etc.) and personality differences (particularly determination to acquiesce to behaviours, particularly in the absence of any other protective relationships). It is highly likely that complicated personality structures form part of the explanation including their attachment framework, e.g. a young child without a stable early life attachment feature is highly likely to form inappropriate, and ultimately often damaging, attachment relationships even with abusers.

5b. A strong attachment may be formed between a child and her/his abuser. How can you, drawing on your professional experience, explain this?

I have covered this question in part in 5a. The behavioural practices (e.g. evident in clinical cases I have had) that may even arise from survival behaviours, such as the procurement of 'additional or special treatment', which may provide (in addition to gratification, e.g. by additional food, treats, etc. emotional gratification in the absence of any alternative).

6. Grooming

6a. Drawing on your professional expertise, how would you define the term "grooming"?

I would define the term grooming as an attempt to facilitate a relationship or aspects of a relationship that would make it more likely to escalate into an achievement of a particular aim.

6b. In your experience, how do abusers groom children and/or children and their families? How do they create opportunities for abuse?

Analysis of the vulnerabilities of the individual children and their families and the motivational structure of the offender is needed to determine this. The risk in these processes is often what may be perceived as the blaming of victims by the exposure of their vulnerability. In people with weak attachment relationships, or vulnerable to social structures with a lack of protective factors, offenders are most likely to utilise these adult relationships for the procurement of children or engage in activities with a high likelihood of access to children (for example, women who have had adversive life experiences and have difficulty with relationships are increasingly vulnerable).

7. Victim to Perpetrator Journey

7a. Some victims of abuse go on to abuse. What is the current understanding of this victim to perpetrator journey? What does your professional experience tell you about it?

The current understanding of the victim to perpetrator journey is often a complex one, but it is my clinical experience that I have had a large number of offenders with histories of abuse in childhood, the majority of which has been physical abuse by prevalence rate, but also a significant prevalence of sexual abuse. This journey is very likely to have involved many factors including lack of their own acknowledgment of the abuse they have suffered. According to the age and stage in their development, there is some evidence in the early formation of sexual preference—although this may also be due to trauma factors, e.g. children who have become physically aroused have high levels of cognitive dissonance and difficulties with their explanation of this and their acceptance of these factors. Similarly, there can be cultural factors in the upbringing of children, particularly in terms of the high prevalence of domestic violence that contributes to a normalisation and the acceptance of abuse as 'normal'. I will continue to discuss this in my answer to 7b.

7b. What protective factors, if any, may minimise the risk of victims becoming perpetrators?

Engagement in education and psychoeducation on the effect of abuse particularly according to the age and stage of a child is highly relevant. Protective factors as in those used in offender management are also highly relevant in minimising victims becoming perpetrators, e.g. engagement in meaningful activity and prosocial relationships. Similar disinhibitive risk factors can be drug and alcohol misuse and I would note the frequent absence of protective relationships and healthy intimate sexual relationships. A long-term risk in victims is psychological damage; abusers cause this damage, leading to an understandable lack of psychological resilience and psychological vulnerability that sadly is often life-long. Protective factors also include education on the provision of sexual education, and the learning of the importance of and skills to promote healthy relationships. It is highly likely in children that they are unable to engage in this process, particularly if their home circumstances do not resonate with an environment modelling protective relationships.

8. Risk, Recruitment, & Training

8a. In your professional experience, what risk assessments do you use, and what are the barriers to the implementation of the risk management strategies?

I am involved in a variety of risk assessments through my work with different organisations. In my own clinical practice I use structured professional judgement risk assessments, not exclusively including Risk of Sexual Violence Protocol, the HCR-20, CARE, SARA, Stalking Risk Profile. The practice of risk assessment varies predominantly by the use of actuarial or structured professional judgement risk assessment tools. Structured professional judgement risk assessment tools require the availability of a professional trained in the utilisation of these tools. These tools include the diagnosing of mental

disorders and they all vary in terms of the number of items within the tool that measure a great variety of items including individual, behavioural, and offending factors for an individual. The use of structured professional risk assessments are important in the assessment of offenders and subsequent development of treatment plans and interventions. Uses of these risk assessments are impacted upon by lack of available trained staff to administer them and once they are completed the subsequent adoption of the risk management recommendations. Barriers to the adoption of risk management strategies can be extensive, including lack of provision of treatment services, lack of engagement in services, poor governance of services. I would particularly highlight the lack of preventative services, although some of this has been enhanced by anonymous disclosure and third-sector organisations including Stop It Now, etc.

8b. Drawing on your professional knowledge and understanding, if you were asked to design a process to ensure recruitment meets with child protection requirements, what would you advise?

Prevention is, in the main, reliant on police disclosure of former offending that forms part of a recruitment process. Personality assessments have some research evidence and can in part—if administered correctly—help form an understanding of an individual that may have the potential to determine features that may increase risk, including absence of relationships and engagement in meaningful activity. I feel this is a complex area of which I have little clinical experience. However, from my clinical experience, I have, when working with people particularly from religious organisations (although this work has not been extensive), these cases have consistently shown a lack of early sexual education, a lack of consideration of the role of sexual development, and a lack of strategies to ensure the best possible engagement in healthy sexual functioning.

8c. In your opinion, how could existing child protection requirements and recruitment practices be strengthened?

Extending the points that I have raised in section 8b, it has been my clinical experience that offenders have felt that consideration has not been given to the above factors and this would be particularly challenging in cases of religious demands for celibacy. It would be my opinion that recruitment practices need to as a priority address this issue and offenders have reported brief/no assessments of sexual functioning during recruitment.

Addendum

The roundtable event provided further detail and clarity in regard to many of my written answers and therefore I have not repeated that information here. In my opinion, which I have made in light of clinical assessments I have completed with offenders from within church organisations, is that the only information not presented at the roundtable event was specifically in regard to procedural assessments conducted by the Catholic Church. These procedures are highly relevant in terms of preventing offending and safeguarding practices. No clinical evidence was submitted to the Inquiry in regard to the content of mental health workshops that I have had reported to me are facilitated by the Catholic Church, and these workshops may well address concerns I have in regard to the assessement and support available in regard to individual sexual functioning and child safeguarding procedures. I have been made aware of a programme referred to as "In God's Image", but have no information to give to the Inquiry on content, utility, or outcomes.

In addition to workshops I believe are undertaken by the Catholic Church, information was also not submitted in regard to the assessment of candidates upon applying to the Church. From evidence I have heard from offenders, these assessments would particularly need to address healthy sexual functioning and use of pornography. I have also heard offenders report resentment at their beliefs in family coercion into joining the Church and again these factors would be relevant for recruitment assessments. Not inclusively, other relevant factors will be their level of motivation to work with young people, alcohol use and gambling, and their previous sexual history. Lastly, following recruitment and on-going procedures undertaken by the Church, if someone was to leave the Church there would need to be assistance to deal with their identity and community interactions with non-Church peers and their potential to deal with these adjustments and isolation. To the best of my knowledge none of this information has been made available to the Inquiry.

All these issues form what I would consider to be an essential part of the organisation's mental health care and assessment of their personnel.