Untangling sexual murder: A Forensic Schema Therapy Case Conceptualisation of a child murderer

Authors:

Lars Bang Madsen, the Forensic and Clinical Psychology Centre, Australia

David P. Bernstein, Maaastrict University, the Netherlands

Word count excluding references:

7,010 words (excluding references and tables, total word count including these – 9245 words)

Max 7500 words

Abstract (200 words max):

The present case study details a Schema Therapy (ST) case conceptualisation of a Child Sex Murderer with Antisocial Personality Disorder who took part in ST over a two-year period. In the forensic field, Schema Therapy (Young et al., 2003) is a promising form of treatment for offenders with personality disorders. Bernstein and colleagues (2007) developed Forensic Schema Therapy (FST) out of the need for more effective treatment alternatives for forensic patients with severe personality disorders who represent a high risk of violence or sexual reoffending. This case study showcases the use of FST concepts, namely 'Schema Modes', for conceptualising a sexual offence and proposes that these concepts assist with making sense of the motivations for sexual offending and have broader applicability in risk assessment as well as in the identification of 'offence-paralleling behaviour'.

Introduction

Few crimes capture headlines and garner public fascination in the way that sexual murder (or sexual homicide) does. Indeed, the highly intelligent and meticulous serial killer or madman in the gripes of delusion, are common tropes used in popular films and television shows, such as CSI or Mindhunter. Such offenders are typically portrayed as unrepentant and intractable, difficult if not impossible to either understand or treat. Severe physical and sexual victimisation in childhood is presented as the central explanation for the genesis of such a monster in adulthood. Whilst these portrayals may titillate public interest, the concomitant effect is that such offenders become vulnerable to simplistic stereotypes and judgment through the prism of a manufactured popular myth. Does this portrait though of the

prototypical sexual murderer reflect reality and the motivations for why someone may offend in this way?

The present case study details a Schema Therapy (ST) case conceptualisation of a Child Sex Murderer (CSM) who took part in ST over a two-year period. Schema Therapy is an evidence-based treatment for personality disorders (Young, et.al., 2003) that has been adapted by Bernstein and colleagues to forensic patients (Bernstein et al., 2007), such as those with antisocial, borderline, narcissistic, or paranoid personality disorders, who represent a high risk of violent or sexual re-offending. In a recent three-year randomized clinical trial in eight Dutch forensic hospitals (Bernstein et al., 2021), Schema Therapy was more effective than usual treatment in reducing personality disorder pathology, lowering risks and increasing strengths, and facilitating re-entry into the community.

In this case study, core Schema Therapy concepts are used, 'early maladaptive schemas,' enduring patterns of thinking and feeling; and 'schema modes,' extreme, fluctuating emotional states,' to explain this complex crime. Previous studies have shown that early maladaptive schemas are associated with sexual offenses, violent offending, and psychopathy, while schema modes are associated with recidivism risk, psychopathy, and institutional violence (Keulen-de, et. al., 2016). In the aforementioned randomized clinical trial, Schema Therapy produced greater reductions in early maladaptive schemas and schema modes over the three-year course of treatment, which may have contributed to the reductions in risk in these patients. In this case conceptualization, these concepts are applied to clarify the nature of the violent sexual offense, but also to explain the developmental origins of the risk factors that were activated during the offense. It is proposed that the use of early maladaptive schemas and schema modes is not only of theoretical interest but provides a

framework for treatment that makes the '*un-understandable to be understandable*' in an accessible way for both practitioner and patient.

Schema Therapy

Schema Therapy (ST; Rafaeli, Bernstein, & Young, 2011; Young, et. al., 2003) is an integrative therapy specifically developed for personality disorders. It is one of the few evidence-based treatments for borderline personality disorder (Farrell, Shaw, & Webber, 2009; Nadort, et al., 2009) as well as for the Cluster C personality disorders (Bamelis, Evers, Spinhoven, & Arntz, 2014). ST has also been applied to forensic patients who present with severe personality disorders and a risk of violent or sexual recidivism (Bernstein, Arntz, & Vos, 2007). Within forensic contexts there is a high prevalence of personality disorders (Fazel & Danesh, 2002), with antisocial, narcissistic, and borderline being the most commonly diagnosed. These individuals typically present with high levels of anger, impulsivity, and interpersonal hostility as well as early onset of criminal behaviour, prolific offending, repeated imprisonment, substance abuse, and impaired social functioning (e.g., homelessness, unemployment). Psychopathic individuals, who represent between 7.9 to 30 percent of offender populations, are at especially high-risk for re-offending (e.g., Coid, et. al., 2009; Hemphill, Hare, & Wong, 2011). Such patients, in addition to showing many of the characteristic Cluster B symptoms, also display marked affective and interpersonal features, including a lack of remorse, deceitfulness, and a predisposition to exploit others (Hare, 1991). It is precisely because of these traits and tendencies that the process of therapy is a challenging one, and why personality disorder is a relevant responsivity factor to consider during any psychological intervention with forensic patients.

ST conceptualizes personality disorders as long-term, self-defeating patterns that originate in childhood (*early maladaptive schemas)* and manifest in maladaptive coping styles and behaviours, and dysfunctional moment-to-moment fluctuations in emotional states when schemas are activated (*schema modes*). Schemas develop when core emotional needs for *attachment/safety, autonomy, expression of needs, validation, limits, and spontaneity* are unmet or chronically frustrated during childhood. Eighteen early maladaptive schemas have been identified which can be separated into five domains, each linked to the unmet developmental need from which the schemas in this domain arise (see table 1; Young, et. al., 2003). *Maladaptive coping responses* reflect the three ways that a person copes with the activation of a schema. An individual may either a) "give in" to the schema as if it were true, typically in a passive, helpless, or submissive way (*surrender*); they can b) avoid situations that activate the schema (*avoidance*), or they can c) do the opposite of the schema (*overcompensation*). Irrespective of how a person responds (*surrender, avoidance, or overcompensation*) the effect usually is that the underlying schema is strengthened and thereby perpetuated in the person's life (Rafaeli et al., 2011; Young et al., 2003).

Insert Table 1

The concept of *schema modes* was more recently developed to account for the challenges of working with severely personality disordered patients, specifically those who present with the Cluster B personality disorders (Bernstein, et. al., 2007; Bernstein, et. al., 2019). These individuals characteristically display lability of mood and volatility in their interpersonal interactions, that often manifests within the therapeutic session. Patients, for instance, can fluctuate between intense emotional states of anxiety and anger or appear fixated and "stuck" in extreme states (e.g., states of emotional detachment and avoidance), making the process of therapy a challenging one, and progress slowed or stopped altogether. In ST, these moments are conceptualised as *'modes'* that represent a patient's *moment-to-moment* coping response

to an activated schema. When modes are triggered, they manifest as combinations of affect, cognitions, and behaviours. For example, an "Angry Child mode" consists of anger or hostile emotions and cognitions usually centring on themes of injustice or unfairness ("You're mistreating me!"), and open expressions of anger, such as yelling, screaming, clenching fists, or throwing things. Four mode categories have been identified each reflecting a core theme of the experience for the patient. These include: a) *child modes*, which refer to emotional responses that are nearly universal in children, such as sadness, fear, shame, anger and impulsivity; b) *dysfunctional parent modes*, which refer to internalised harsh parental demands or punitive criticism; c) *maladaptive coping modes*, which refer to extreme attempts to cope with the activation of schemas, either through surrender, avoidance, or overcompensation; and d) *healthy modes*, which reflect healthy self-reflection and feelings of joy and pleasure (see table 2).

Insert Table 2

Forensic Schema Therapy places relatively greater emphasis on schema modes, compared to early maladaptive schemas. Schema modes are readily observable in patients overt verbal and non-verbal behaviour. For example, in the restricted affect and behavioural avoidance of a Detached Protector mode, the dominance and superiority of a Self-Aggrandizer mode, or the threats and overt aggression of a Bully and Attack mode. In contrast, early maladaptive schemas are usually covert in nature, representing subjectively experienced patterns of feeling and thinking, often involving themes of vulnerability, such as abandonment, loneliness, failure, or defectiveness. Most forensic patients with personality disorders reveal little if any vulnerability, especially in the initial phase of treatment. Instead, their clinical presentation is dominated by maladaptive coping modes, whose function is to protect the patient behind a 'wall' of invulnerability. Behind this wall are the Child modes, which often reflect the histories of these patients, involving childhood abuse (Abused Child mode),

abandonment (Abandoned Child mode), emotional neglect (Lonely Child mode), and so forth. One of the most important goals in Forensic Schema Therapy is to eventually reach these vulnerable sides in order to reprocess early traumatic experiences, and provide for core emotional needs that were missed growing up. Thus, while Forensic Schema Therapy aims to reduce both the early maladaptive schemas and schema modes that are associated with (sexually) violent offending, an emphasis on schema modes has practical advantages for case conceptualization and treatment in this population.

A *Schema Mode Model* is an individualized depiction of a patient's schema modes in the form of a diagram (figure 1). The visual representation of the modes makes the model accessible for both practitioners and patients. One of the distinguishing features of schema modes in forensic populations is the prevalence of modes involving deceit, callousness, suspiciousness, and aggression. These modes reflect a reliance on *over-compensation* as a method of coping with whatever schema may be activated in the moment. Five over-compensatory modes have been recognised that are particularly salient in forensic populations, wherein the shared characteristic of each is a so-called pre-emptive response to psychological distress (i.e., when the vulnerable child modes are activated). The *Self Aggrandizer* mode, for instance, utilises arrogance and superiority to elevate themselves above others, whilst the *Conning Manipulator* mode uses deceiving, lying and manipulation to get their needs met. The *Paranoid Overcontroller* mode focusses on locating and uncovering threats before they themselves (they believe) get exploited, whereas the *Bully and Attack* and *Predator modes* use coercion and intimidation or cold instrumental aggression as a strategy for getting their needs met.

Specific personality disorders have been found to have characteristic mode configurations (Bamelis, Renner, Heidkamp, & Arntz, 2011; Chakhssi, Bernstein, & de Ruiter, 2012; Lobbestael, Arntz, Cima, & Chakhssi, 2009). Antisocial PDs, for instance, have a prominent *Bully and Attack mode*, reflecting the tendency to lead with aggression and hostility in challenging interactions. Interpersonally, they present with a macho exterior, aloof and impervious to pain, demonstrating a *Detached Protector mode,* whilst an *Angry Protector mode* communicates a clear message of 's*tay away and back off.'* They may also display other overcompensatory modes, such as a tendency to con and manipulate (*Conning Manipulator mode*), and a state of heightened alertness for threat (*Paranoid Overcontroller mode*).

Underneath these protective sides however can often be a surprising sensitivity and neediness. This vulnerable side can consist of *Abused, Abandoned, Humiliated,* and/or *Lonely Child* modes, depending on which of their emotional needs went unmet, and the specific early maladaptive schemas that resulted from them. Whereas, the "*hair trigger*" of their anger and aggression is an indication of an *Impulsive* and *Undisciplined Child* side that reacts quickly without thinking about consequences, having never learned to defer immediate gratification in the service of long-term goals. This impulsive side can also contribute to drug and/or alcohol abuse, and a '*devil may care*' sensation-seeking approach to life. A *Detached Self-Soother/Self-Stimulator* mode uses alcohol, opiates, or sedatives to numb painful feelings, or cocaine and other stimulants to induce feelings of euphoria and excitement.

In forensic ST, offending is understood as an unfolding sequence of schema modes that culminates in an offence (Bernstein et al., 2007). A sexual assault, for instance, can be motivated by anger (*Angry/Enraged Child mode*); feelings of abandonment, humiliation, or

betrayal (*Abandoned/Humiliated/Abused Child mode*); impulsivity and sensation seeking (*Impulsive Child mode*); or a sense of entitlement and the need for power and control (*Self-Aggrandizer mode*). Drug or alcohol abuse (*Detached Self-Soother mode*) may disinhibit sexual and aggressive impulses, overcoming the patient's internal barriers to acting out sexually. Conning and manipulation (*Conning and Manipulator mode*) may facilitate sexual crimes, by overcoming external barriers to offending, such as when child molesters "groom" victims, or sexual predators lure victims into vulnerable situations (e.g., getting a woman drunk to rape her). Sexual offenses can involve the use of threats and intimidation (*Bully and Attack mode*) or cold, predatory aggression (*Predator mode*). Sexual fantasies and behaviour can also serve an over compensatory function, enabling the patient to feel powerful and important (*Self-Aggrandizer mode)*, as opposed to weak and impotent, whilst in other cases, sexual fantasies or behaviour involve sadism, a state of cold, detached anger (*Predator mode*). In paedophilia, a patient may fantasise about having an idealized or special relationship with a child, a *Self-Aggrandizer mode* that compensates for feelings of mistrust and alienation.

Research has supported the link between offending and the activation of the vulnerable modes. Keulen-De Vos and colleagues (2016), for instance, found in sample of 95 offenders that: (a) criminal behaviour was usually preceded by the activation of modes involving emotional vulnerability (*vulnerable child mode*) and loneliness (*lonely child mode*), as well as states of intoxication (*detached Self-soother mode*); (b) followed by an escalating pattern of anger and impulsivity (*Angry and Impulsive child mode*), that is, these modes were present in the events leading up to the crime and increased over time during the crime itself; and (c) criminal behaviour was characterized by over compensatory modes, such as instrumental aggression (*Predator mode*) and intimidation (*Bully and Attack mode*). These findings

suggest that aggressive behaviour functioned as a form of coping in response to vulnerable emotional triggers.

The forensic ST model shows many similarities with a widely adopted theory of aggression, the General Aggression Model (GAM; Anderson, & Bushman, 2002). Like the forensic ST model, the GAM also emphasizes the importance of emotional activation (e.g., anger arousal) combined with maladaptive cognitions (e.g., early maladaptive schemas, hostile attributional biases) and dysfunctional coping (e.g., poor self-control). In the GAM, aggression represents a person by situation interaction, involving the state activation of these enduring affective, cognitive, and behavioural propensities (e.g., in situations perceived as hostile or threatening). In the forensic ST model, schema modes also represent a person by situation interaction, occurring when early maladaptive schemas, combined with dysfunctional coping responses are activated, increasing the risk for aggressive and other antisocial behaviour.

The focus in forensic ST is on reducing the severity of dysfunctional modes that represent internal risk factors for reoffending, and strengthening healthy modes, that are protective factors (Bernstein et al., 2007, 2019). In patients with severe personality disorders, therapy often takes three years or longer, and proceeds in three phases. In the initial part, the attachment phase, the therapist slowly builds a bond with the patient and provides, within appropriate limits, for some of the basic emotional, developmental needs the patient missed growing up, a process known as 'limited reparenting.' In forensic populations, these needs typically involve attachment needs such as warmth, attention, and stability, and the need for firm but fair and consequential limits (Bernstein et al., 2019). Given the pervasive mistrust evident in forensic patients, most of whom never experienced a healthy attachment, this process takes time and patience. This phase of therapy also involves developing the patient's

awareness of their modes through the development of a mode map that includes the patient's characteristics modes. This map is then utilised to elucidate ‘crime scenarios,’ that is, the events leading up to and culminating in criminal behaviours, are reconstructed in terms of a sequence of activated schema modes (Bernstein et al., 2007). This process assists with identifying the underlying psychological processes, needs, and drives that underpin a specific offence, which can subsequently be targeted in treatment. Indeed, examining the pattern of mode activation in a patient’s regular day to day interactions, and comparing this to the patient’s prior ‘offending pattern’, affords the practitioner the opportunity to assess risk of reoffending and identify ‘offence-paralleling’ behaviours that may be occurring within the current environment (Daffern, Howells & Ogloff, 2007).

In the schema mode reprocessing phase, the therapist uses experiential techniques to deepen the therapy process. The therapist uses chair-work and imagery rescripting to explore the patient’s reactions to current situations, and to retrieve and reprocess memories of early, traumatic experiences that played a role in the genesis of the patient’s problems. Cognitive techniques may be used to explore pros and cons of dysfunctional coping modes, and to identify and change cognitive distortions. Flashcards (written or audio), for example, may help remind patients of the cons of their dysfunctional behaviours and support their Healthy Adult mode to choose healthier, alternative (coping) behaviours. In the reintegration phase, the therapist focuses on behavioural changes and relapse prevention. Chain analyses and other techniques are used to identify the triggers and escalating mode sequences that comprise the patient’s typical crime scenarios, with the aim of breaking the chain (Chakhssi et al., 2014).

In short, therefore, the forensic ST model presents a coherent framework for understanding and conceptualising offending behaviours. By focusing on emotional states, known as schema modes, it allows the construction of an offence-pathway that explicates risk factors which can be targeted with treatment. In this way schema modes can be understood as the internal, or psychological, risk factors that increase likelihood of offending, and can be used to evaluate current risk and imminence of offending.

Schemas and Sexual Offending

Within the sexual offending literature various conceptualisations of the term 'schema' exist, and while the term reflects distinct theoretical models (Mann & Shingler, 2006; Polaschek & Ward, 2002), there are notable similarities, such as the shared notion that schemas bias information processing and are to a greater or lesser extent maladaptive. Studies have consistently found that rapists and child sex abusers endorse marked dysfunctional / maladaptive schemas. Rapists, for instance, tend to endorse schemas of control, sexualisation of and hostility towards women (e.g., Beech et al., 2005; Beech, Ward, & Fisher, 2006; Polaschek & Gannon, 2004; Mann & Shingler, 2006; Mann & Hollin, 2010; Szlachic, et. Al., 2014). They are also prone to be self-pitying and have a negativity bias (i.e., "*The world is a dangerous place*"). Child sexual abusers, in contrast, tend to endorse schemas of personal worthlessness and passivity, and a belief that children are motivated by a desire for sexual pleasure and that such contact is not harmful (e.g., Hanson, Gizzarelli, & Scott, 1994; Marziano et al., 2006; Ward & Keenan, 1999). Both child and adult offenders also see themselves as victims, worthless and powerless in their lives (e.g., Mann & Hollin, 2010; Milner & Webster, 2005; Stinson, Robbins & Crow, 2011; Ward & Beech, 2006; Ward, Polaschek, & Beech, 2006).

Few studies have specifically explored the relationship between early maladaptive schemas and sexual offending. The research that has been conducted though has tended to show sex offenders and sexual aggressors tend to endorse schemas within the *Disconnection and Rejection, Over-Vigilance* and *Inhibition, and Impaired Limits domains* when compared to non-offenders (i.e., Leirós, Carvalho & Nobre, 2013; Richardson, 2005; Szlachcic, Fox, Conway, Lord & Christie, 2014; Manesh, Baf, Abadi and Mahram, 2010). Two studies have specifically compared early maladaptive schemas between sexual offender types. Carvalho and Nobre (2014) found that the early maladaptive schemas were significantly more prevalent in individuals convicted for child sexual abuse compared to rapists and non-offenders. Differences between non-offenders and rapists were less evident, except for the *Impaired Autonomy/Performanc*e domain. Child sexual abusers presented significantly more schemas within the *Disconnection/Rejection* domain (i.e., *Abandonment, Mistrust/Abuse, and Defectiveness).* In a similar study Chakhssi, de Ruiter, and Bernstein (2013) found that child sexual offenders had a significantly higher prevalence of schemas within the *Disconnection / Rejection* and *Other-Directedness* domains (i.e., *Abandonment, Social Isolation, Defectiveness / Shame, Subjugation and Self-sacrifice)* compared to non-sexual offenders. Child sexual offenders also showed a trend for higher scores in *Social Isolation*, compared to adult sexual offenders.

In sum, investigation of the schemas of sexual offenders has been hampered by murky definitions. Some authors have proposed that attitudes about children's sexuality in fact are categorised as a schema. In other cases, beliefs studied under the umbrella of attitude research (e.g., entitlement) are conceived of as schemas. Regardless, the findings suggest that sexual offenders when compared to non-offenders report larger numbers of schemas,

including early maladaptive schemas. Child molesters tend to report schemas relating to passivity, and worthlessness, and isolation, whilst adult offenders endorse ones relating to entitlement and hostile-sexualised views of women. Both groups identify with sexual entitlement, insufficient self-control, and a broader sense of powerlessness. These findings resonate with the small amount of research that has specifically investigated early maladaptive schemas. Here, the research appears to show that the most commonly relevant domains relate to schemas within the *Disconnection and Rejection and Impaired Autonomy and Limits domains.*

Schemas and Sexual Murder

Sexual murder is fortunately a low frequency crime with studies from around the world estimating rates ranging between one to five percent of all homicides (Chan & Heide, 2016). Children represent about eight percent of victims of sexual murders (Spehr, Hill, Larose & Curry, 2010). Little is known about the characteristics of child sexual murderers (CSM) with only a small number of studies published (e.g., Proulx, James, Siwic & Beauregard, 2018). In one of the first, Firestone, et. al. (1998) compared sexual murders of children with child molesters and found that the CSM tended to be more antisocial, psychopathic, and sadistic. Studies comparing CSM with sexual murderers of woman (SMW) have described similar findings; CSM's were more likely to be sexually deviant, have a history of prior offending and to have suffered childhood sexual abuse (Beauregard, Stone, Proulex & Michaud, 2008; Langevin, 2006). Spehr, Hill, Habermann, Briken and Berner (2010) found fewer differences between adult and child sexual murderers; both groups were equally likely to have personality disorder, a history of emotional abuse and neglect, and had suffered social isolation. CSM's, in contrast, were more likely to be sexually deviant, to have planned their

offence, and immediately prior to their offence to have used pornography and been preoccupied with deviant fantasies (Proulx, et.al., 2018).

Whilst no studies have specifically investigated schemas in CSM, the findings do suggest that as a cohort, CSMs have a similar profile to that of child molesters. CSMs tend to have more psychopathic traits though, and like child molesters are interpersonally inadequate, socially isolated, and sexually preoccupied, suggesting prominent schemas within the *Disconnection and Rejection and Impaired Limits* domains. As regard to schema modes, CSMs are most likely to have planned the murder and to have been sexually preoccupied prior to offending, which suggests the presence of a *Predator-type* mode (i.e., a side that is focussed on eliminating a threat, rival, obstacle, or enemy in a cold, ruthless and calculating manner) and a *Detached-Self*-soother coping mode (i.e., a side that uses repetitive, 'addictive', compulsive, or self-stimulating behaviors to calm and soothe himself; uses pleasurable or exciting sensations to distance himself from painful feelings).

Finally, it is fair to say that CSMs represent a significant challenge for authorities and professionals alike. The cost of containment, treatment, and supervision are significant, whilst the implications of getting it wrong in terms of community reintegration is potentially catastrophic. Formal risk assessment can only say so much with such low frequency crimes, consequently the relevance of formulation in terms of understanding the 'true risk' of an offender is both prescient and necessary for decision making. The following, as far as we are aware, is the first attempt to present a case conceptualisation of a CSM using forensic ST concepts. Specifically, the case details the development of a patient's schemas and the emergence and then intensification of schema modes, that eventually leads to a double murder.

Patient

Viktor (a pseudonym) was serving life sentences for murder and rape of two female children. He was referred for additional treatment due to his parole eligibility date having passed, and the recommendations from a risk assessment. Viktor had completed three group-based sexual offender programs and various brief interventions for substance misuse. Viktor had been diagnosed with an *Unspecified Paraphilic Disorder* and *Antisocial Personality Disorder* and had been scored 25 on the Psychopathy Checklist Revised (PCL-R). During the time of his treatment, he lived in the least restrictive part of the prison and worked full-time in one of the prison-based industries.

Upon initial presentation Viktor reported that he was accepting of the recommendations for additional treatment and claimed that he had found his prior psychological treatments to have been beneficial. He believed that he had changed over the years, in terms of the person that he was when he had first entered custody and described feeling that he understood himself and coped better with emotional problems. Interpersonally, Viktor presented as an emotionally detached but not overcontrolling or angry individual. He maintained relationships with his family and stated that nowadays he was better at talking about his vulnerable feelings and emotional needs, though he was not sure what these were.

The starting point of treatment was a schema case conceptualisation which included evaluation of the following areas: (a) temperament of the patient, (b) the extent to which his basic emotional needs were met in childhood, (c) parent's modeling behaviours and family beliefs, (d) his early maladaptive schemas, (e) life events or traumatic experiences in

adulthood, (f) his mode model, and (g) his psychological symptoms and strengths. Linking psychological problems to Viktor's schema modes and early maladaptive schemas, and their origins in childhood, provided him and the therapist guidance in determining therapy objectives. In addition, the case conceptualization was supplemented with outcomes of risk assessment that were also linked to his schema modes and their origins in childhood.

Childhood and development of schemas

Viktor was adopted and grew up in a foster home with six other children. He described a chaotic and highly stressful early home environment. His adoptive mother was physically and emotionally abusive, whilst his adoptive father was either absent or ineffectual in providing nurturance, protection or care to him. Viktor recalled many memories of being scared and anxious in the home, and for much of his early life felt like he did not belong anywhere. From an early age he struggled with behaviour problems and described exhibiting many of the characteristic behaviours indicative of Oppositional Defiance Disorder (ODD) as a young child and then Conduct Disorder (CD) as an early teenager.

In school he struggled academically, described himself as a loner and was frequently in trouble for one thing or another. In grade 9 he was expelled for setting fire to the school and never returned. During his teenage years he became increasingly involved with criminality, drugs, and an older antisocial peer group. He also developed various sexual proclivities, including stalking behaviour, voyeurism, and a panty fetish. Throughout all this time Viktor felt deeply inadequate and undesirable in relation to his peers, especially women.

Examination of Viktor's childhood revealed that he suffered many unmet childhood needs. He felt unloved, misunderstood by his caregivers, and experienced the home environment as unsafe and unstable. Discipline was harsh, inconsistent, and unpredictable, and he was provided with minimal guidance and structure. He, himself, recalled feeling defective and different 'in a bad way' from others, failing at school and struggling to make friends. Correspondingly, Viktor's core schemas were within the *Disconnection and Rejection* (e*motional deprivation, abandonment, defectiveness and social isolation*), *Impaired Autonomy and Performance* (failure), *Impaired Limits* (Entitlement/Grandiosity) and *Other-directiveness* (Subjugation) Domains. These were identified through the use of Young's Schema Questionnaire (YSQ; Young & Brown, 1994), in addition to the detailed assessment approached described earlier.

Emergence of Coping Modes

Viktor recalled the beginning of deviant fantasies during his childhood and mid teen years. He described engaging in peeping-tom/voyeuristic-type behaviours from about age eight and then stealing panties from clothes lines in the neighbourhood from about age 12 or 13. He liked the thrill and power/control of these behaviours and would not specifically masturbate whilst he was doing it or keep the underwear that he stole. For him it was more about the actual 'doing' of the behaviour that was gratifying, rather than it being specifically sexual although he would occasionally masturbate with the panties. Notably, the behaviours made him feel special and powerful, suggesting the emergence of the *Self-Aggrandizer* overcompensating coping mode. Throughout this time, he struggled also to feel that he fitted in with others and whilst he had tried to date girls this had always gone badly leaving him feeling defective and ashamed, indicating the presence of Vulnerable Child modes

(*defectiveness, loneliness and humiliation*). He desperately wanted to be accepted and liked, however, felt a failure, unloved and 'broken' (*defectiveness, social isolation, and failure schemas*). Viktor struggled to tolerate these feelings and used drugs (cannabis initially), alcohol, pornography and 'risk taking' behaviour (including the above-described paraphilic behaviours and general criminal behaviour) both as a way of coping and as a strategy for gaining the acceptance and approval of others, thereby also showing the emergence of the *Detached Self-Soother* and *Self-Stimulator* modes. These behaviours, however, amplified just how 'different' he felt from peers (i.e., *I was always the one that got in trouble, did the most dangerous things, drank the most* etc), leading to further rejection and social exclusion, and intensification of his psychological distress, sense of defectiveness and personal failure. These circumstances however concomitantly fuelled his preoccupation with sex, abuse of substances, resentment of women, and a general sense of defectiveness and failure.

Sexual offending and Schema Modes

Viktor's first 'sexual' offence (although he was not charged with a sexual offence) was when he was 17 years old and had been drinking with peers at a local pub. It was at the end of the night and Viktor was making his way home. He recalled that he had been seeking sexual contact with a woman, however, had failed (*defectiveness and failure schemas*) and felt dejected and angry (v*ulnerable and angry child modes*). Incidentally when he was leaving the pub a woman cycled past him, he reacted impulsively by running after her and then pushing her to the ground (*impulsive child mode*). He recalled feeling energised and euphoric in the moment (*bully and attack / self-aggrandizer modes*). However, another man intervened (the victim's husband) before he could do anything else, and Viktor ran away. He was subsequently convicted and went to jail, though not for a sexual offence.

During his initial custodial episode, he started to experience and then cultivate rape and abduction fantasies. In this context he was exposed to other offenders who talked to him about these types of things. At the time he had still been a virgin, but these fantasies took hold in him and became increasingly elaborate and detailed. Viktor described the general narrative of these as having been about control of a passive female victim, and never about torturing or inflicting suffering, but rather about being powerful (*self-aggrandizer*), and giving the victim sexual gratification (i.e., "*the buzz was about being in control and being able to do anything to them sexually in the fantasies they (the victim) would end up enjoying the experience and orgasming"*).

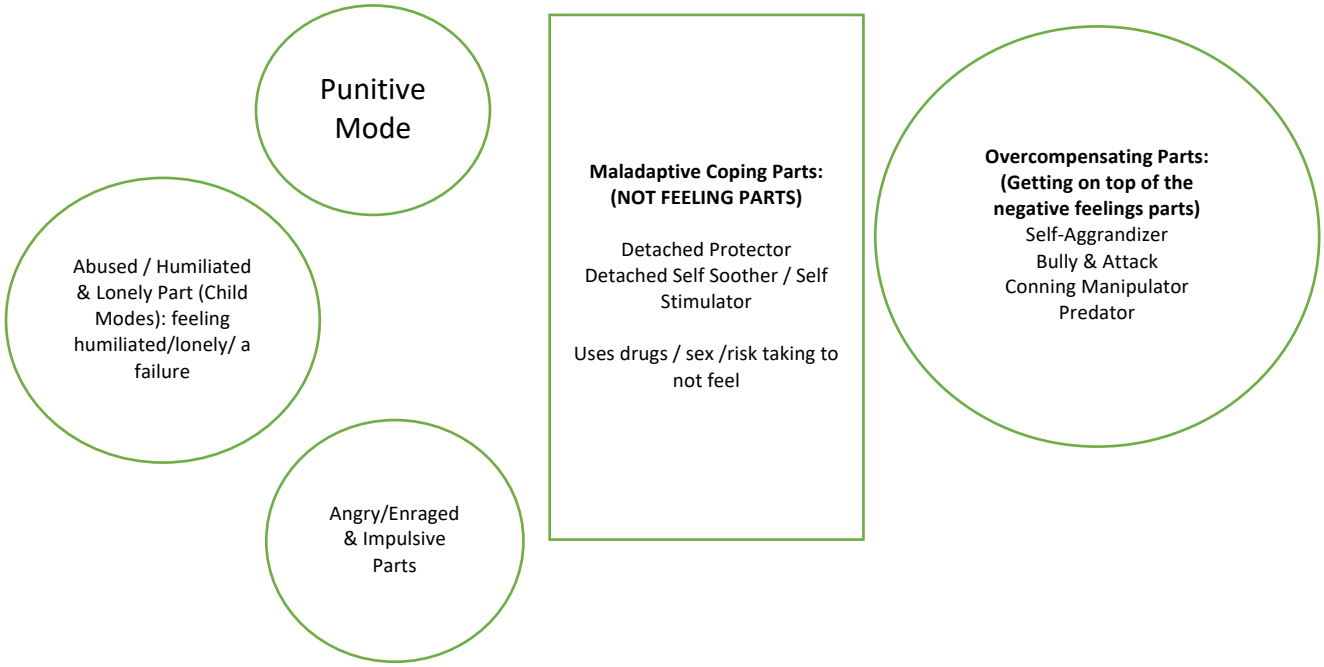
When Viktor was released from his first custodial term, age 21, he was still a virgin, a fact that caused him a great deal of shame. As a way of compensating for his sense of inadequacy he actively cultivated a 'tough guy' persona (fighting, drinking, risk taking etc) and led a chaotic and violent lifestyle. He eventually got into relationship with a woman, and they moved in together at a coastal town away from the city. Viktor's move to the coast was his attempt to get away from the problems that he was having due to his then behaviour and lifestyle. This move, however, did not go well. The relationship from the onset was fraught with conflict, substance misuse and general unhappiness. His partner was remarkably like his foster mother, with being emotionally abusive, depriving and manipulative. Viktor described high levels of volatility, frequent arguments, and physical abuse. Yet despite his unhappiness he remained in the relationship. He felt powerless in the situation and believed that he could not leave partly because he worried that his partner would completely decompensate (something that he felt responsible for) and partly due to a belief that no-one else would want him in the future.

Over time his resentment about his circumstances grew, and he started reverting to old ways of coping with emotional problems. Throughout the day he was using cannabis and amphetamines and spending large periods of time alone viewing pornography and masturbating (*detached self-soother / self-stimulator*). In the evenings or late afternoon, he would go for walks by himself where he would sometimes stalk women in isolated locations at the nearby beach while revelling in an abduction/rape fantasy (*self-aggrandizer / predator modes*). On other occasions he would engage in voyeurism or steal underwear off clotheslines. These experiences made him 'powerful,' 'alive' and 'in control,' feelings that were in marked contrast to his general day-to-day life where he felt a total failure and impotent. His need to utilise these maladaptive 'coping strategies' and fantasies seemed proportionately linked to the degree of unhappiness and resentment that he was experiencing at the time.

On the day of the murders Viktor reported that he had again been using a variety of drugs and had found himself walking alone at the beach after a fight with his partner. He could not recall what he had been feeling, however, speculated that he was angry and brooding (v*ulnerable and angry child modes*). These emotional states typically triggered his 'stalking' mindset (rape/abduction fantasies) and behaviour (cruising for women in isolated locations; *self-aggrandizer / predator modes*). Coincidently he then saw the two girls by themselves. Almost immediately he noted that he experienced an urge to have sexual contact with them and started to play through in his mind a rape/abduction fantasy in much the same way as he usually would. On this occasion, however, he decided to approach them by going for a swim, typically he would only watch a potential victim from afar and revel in the idea that he could 'take them' and that they 'didn't know' he was stalking them. When he left the water, the

girls followed him to the beach – he may have lured them with a story, but he did not remember (*conning manipulator mode*). Once in the secluded location he hit them with a branch until they were dead and proceeded to rape them (*bully and attack; self-aggrandizer; predator*). In retrospect he thought that he may have been in 'a rage' when he did this, however, he was also very focussed on getting his sexual needs met and recalled feeling powerful. Afterwards, he described a sense of *coming to* and realising what he had done.

Figure 1: Viktor's mode map



Case conceptualisation: Schema Mode Map

Viktor's sexual offenses can be understood in terms of an unfolding sequence of schema modes (see figure 1). Viktor's motivation for the sexual offending was the need for power and control (*Self-Aggrandizer mode*), to compensate for feeling of defectiveness/shame, failure, and personal inadequacy. The emergence of these coping modes occurred during his early childhood in response to an inadequate early home environment and were strengthened over time through elaboration and repetition. Viktor's MO (Modus Operandi) for the murders had been practiced in behaviour and fantasy for some time prior to the actual murders and followed a specific sequence. A trigger would be the activation of schema-generating distress (feelings of humiliation, shame, failure – vulnerable child modes) which would lead to drug or pornography use (*detached self-soother/self-stimulator*), and then to stalking/sadistic

fantasises and behaviour (*self-aggrandizer/predator*). As noted previously his stalking behaviours and rape/abduction fantasies made him feel powerful and potent, and typically this appears to have been 'enough' for him. On the day of the murders, drug and alcohol abuse disinhibited his sexual and aggressive impulses, thereby overcoming his internal barriers to acting out sexually. Conning and manipulative behaviour (*conning and manipulator mode*) facilitated the sexual offending, by overcoming external barriers to offending, as he lured the victims into a vulnerable situation. The use of threats and intimidation (*bully and attack mode*) and cold, predatory aggression (*predator mode*) allowed him to have control of the victims. The rapes and murders were performed in the self-aggrandizer mode , as he revelled in his sense of power and control.

Conclusions

This case study presented a forensic ST case conceptualisation of a child sexual murder (CSM). The value of this is that no prior studies that we are aware of have specifically attempted to investigate the application of forensic ST to sexual murder, or indeed to CSM. Notably, Viktor presented with many of the characteristic features and behaviour patterns identified in CSMs (Proulx, et.al., 2018). He had personality disorder, a history of emotional abuse and neglect, was socially isolated and sexually deviant. He also had planned the murders for some time prior through a process of rehearsing fantasies and actual stalking vulnerable women in isolated locations. Viktor's schema profile with elevations in the *disconnection and rejection; impaired autonomy and impaired limits* domains is consistent with findings investigating schemas in sexual offenders more generally, further supporting the relevance of schemas in this population (e.g., Chakhssi, de Ruiter, & Bernstein, 2013; Ward & Keenan, 1999; Polaschek & Ward, 2000).

Utilising the forensic ST approach showed that Viktor's early childhood experiences had contributed to the formation of schemas that had then led to the development of a range of over-compensatory coping modes. These modes throughout his childhood and early adulthood led to further problems causing him to feel progressively disconnected and rejected, and increasingly reliant on dysfunctional coping modes and rigid behavioural scripts for getting his needs met. In this regard the use of sexual fantasy early on, appears to have served partly as self-soothing function, however, also a psychological function for feeling powerful and competent. These fantasies over time became increasingly elaborate and dominant, with the degree of violence and overt sadism appearing to be concomitantly linked to his experience of distress in response to the activation of his schemas. In this regard the eventual murders could be understood in terms of an unfolding sequence of schema modes that culminated in the offending, an observation that again is consistent with the little research that has examined the link between modes and offending (Keulen-De Vos, et.al., 2016).

Notably, as highlighted previously, the forensic ST model as a method for conceptualising aggression share similarities with the General Aggression Model (Allen & Anderson, 2017) which posits that human aggression is heavily influence by knowledge structures that affect a wide variety of social-cognitive phenomena including perception, interpretation, decision-making, and behaviour. Some of the most important structures include attitudes and beliefs. These develop through an individual's experiences, and act as a type of 'road-map' for making sense of and responding to conflictual interpersonal situations. Behavioural scripts describe the sequences of actions or events that an individual enacts to achieve a specific goal, for example, using violence in response to an insult or a perceived threat. Such

reactions can, through a process of rehearsal and repetition, be the automatic reaction to a specific trigger. In Viktor's case he describes a rigid sequence of automatic behaviours, perceptions and thinking processes in response to specific psychological (e.g., feeling of powerlessness, failure, defectiveness) and contextual (e.g., conflict and unhappiness with partner) experiences. In this way he can be seen as having a chronically accessible aggressive script about powerlessness, personal inadequacy, and failure.

After two years of therapy Viktor had made significant progress. The antisocial modes, such as the predator, bully and attack, and self-aggrandizer modes, were clearly less prevalent than at the beginning. Moreover, there was more room for healthy adult considerations and vulnerable emotions. His main vulnerability remained the failure, and mistrust and abuse schema, however, he was better able to recognise and tolerate his reactions to this and address it more constructively. There were no identifiable pro-offending attitudes, and his level of psycho-social competency was good as could be measured within a secure prison environment, furthermore, there was no evidence of impulsivity, recklessness, or poor self-regulation. Sadistic sexual interests, which were so prominent in his life leading up to the index offence, appeared to either lie dormant or had been resolved. Determining a diagnosis was difficult; at the time of the index offending, he likely met the criteria for Antisocial Personality Disorder, Psychopathy and paraphilias. It was no longer clear whether these diagnoses applied at the conclusion of the treatment.

This forensic ST case conceptualization serves to make sense of inexplicable forms of offending, such as child sexual murders. This is an important contribution from a theoretical point of view, but also serves a practical function. The FST case conceptualization, including the schema mode model, provides a roadmap for treatment. It brings the case into sharper

focus by identifying the core concepts – schemas and schema modes – that explain the patient's offense patterns and may also play a role in the therapy process, for example, in the challenges of forming a therapeutic relationship and in offense paralleling behaviors. An adequate case conceptualization based on ST concepts can therefore lay the groundwork for treating patients who are often considered untreatable.

Table 1.

Early Maladaptive Schemas

Early Maladaptive Schemas
Disconnection and Rejection
1. Abandonment/Instability
The expectation that significant others will inevitably abandon one. Others are unreliable and unpredictable in their support and connection. One switches between feelings of anxiety, grief, and anger.
2. Mistrust/Abuse
The conviction that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage of one. One is mistrustful and continuously on edge.
3. Emotional Deprivation
The expectation that others won't meet one's emotional needs (for support, emotional nurturance, empathy and protection). One feels isolated and lonely.
4. Defectiveness/Shame
The belief that one is internally flawed, defective, bad, unwanted, inferior, or invalid in important respects. One feels ashamed and worthless.
5. Social Isolation/Alienation
The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.
Impaired Autonomy and Performance
6. Dependence/Incompetence
The belief that one can't handle everyday responsibilities without considerable help from others. One feels anxious, extremely helpless and incapable of functioning independently.
7. Vulnerability to Harm or Illness
The exaggerated fear that imminent catastrophe will strike one at any time and that one is unable to prevent it.
8. Enmeshment/Undeveloped Self
The excessive emotional involvement and closeness with others at the expense of full individuation or normal social development.
9. Failure
The belief that one has failed, or will inevitably fail, or is fundamentally inadequate in areas of achievement. One feels stupid or untalented.

Impaired Limits
10. Entitlement/Grandiosity
The belief that one is superior to others, entitled to special rights and privileges, or not bound by normal rules of social reciprocity. The core theme is power and being in control of situations or people.
11. Insufficient Self-Control/Self-Discipline
The pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression of one's emotions and impulses. One can't stand discomfort.
Other-Directedness
12. Subjugation
The excessive surrendering of control to others because one feels coerced, usually to avoid anger, retaliation, or abandonment. The two major forms are: subjugation of needs and subjugation of emotions.
13. Self-Sacrifice
The excessive focus on voluntarily meeting the needs of others in daily situations, at the expense of one's own gratification. Reasons: to prevent causing pain, to avoid guilt from feeling selfish and to connect with needy people.
14. Approval-Seeking/Recognition-Seeking
The excessive emphasis on gaining approval, recognition, or attention from other people, at the expense of one's own development and needs.
Over-Vigilance and Inhibition
15. Negativity/Pessimism
The pervasive, lifelong focus on the negative aspects of life (e.g., pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal) while minimizing the positive or optimistic aspects.
16. Emotional Inhibition
The excessive inhibition of spontaneous action, feeling, or communication to avoid disapproval by others, feelings of shame, or losing control of one's impulses.
17. Unrelenting Standards/Hypercriticalness
The belief that one must strive to meet very high internalized standards of behavior and performance, usually to avoid criticism. Presents as: (a) perfectionism, (b) rigid rules, or (c) preoccupation with time and efficiency.
18. Punitiveness
The belief that people should be harshly punished for making mistakes. Involves the tendency to be angry, intolerant, and impatient with those people (including oneself) who don't meet one's expectations or standards.

Table 2.

Schema Modes

Schema modes
Child Modes
1. Vulnerable Child (abandoned, abused, humiliated)
Feels vulnerable, overwhelmed with painful feelings, such as anxiety, depression, grief, or shame/humiliation.
2. Angry Child
Feels and expresses anger in an excessive way in response to perceived or real mistreatment, abandonment, humiliation or frustration; often feels being treated unjustly; acts like a child throwing a temper tantrum.
3. Enraged Child
Feels and acts for similar reasons as Angry Child, but loses control over aggression and attacks and destroys objects and humans; patients often report as if they went into a dissociative state ('everything went black'*)*
4. Impulsive Child
Acts impulsively to get needs met; can be motivated by rebelliousness against maltreatment or against internalized parental modes.
5. Undisciplined Child
Acts like a spoiled child who 'wants what he wants when he wants it', and doesn't want to do anything he dislikes; can't tolerate the frustration of limits and discipline.
6. Lonely Child
Feels lonely and empty, as if no one can understand him, sooth or comfort him, or make contact with him.
Maladaptive Parent Modes
7. Punitive, Critical Parent
Internalized, critical, blaming or punishing parent voice; directs harsh criticism or punishment towards the self; induces feelings of shame or guilt.
8. Demanding Parent
Directs impossibly high demands toward the self; pushes the self to do more, achieve more, to keep everything in order, to strive for high status, to put others needs before one's own; never be satisfied with oneself.
Avoidant and Surrendering Coping Modes
9. Detached Protector
Uses emotional detachment to protect himself from painful feelings; is unaware of his feelings, feels 'nothing', appears emotionally distant, flat, or robotic; avoids getting close to other people.

10. Detached Self-Soother/Self-Stimulator
Uses repetitive, 'addictive', compulsive, or self-stimulating behaviors to calm and soothe himself; uses pleasurable or exciting sensations to distance himself from painful feelings.
11. Angry Protector
Uses a 'wall of anger' to protect himself from others who are perceived as threatening; keeps others at a safe distance through displays of anger; this anger is more controlled than in Angry Child Mode.
12. Complaining Protector
Complains, whines, and demands in a victimized, dissatisfied manner; expresses his dissatisfaction in an off-putting manner that masks his real feelings and needs.
13. Compliant Surrenderer
Gives in to the real or perceived demands or expectations of other people in an anxious attempt to avoid pain or to get his needs met; anxiously surrenders to the demands of others who are perceived as more powerful than himself.
Over-Compensatory Modes
14. Self-Aggrandizer
Feels superior, special, or powerful, and entitled to special rights; looks down on others; sees the world in terms of 'top dog' and 'bottom dog'; shows off or acts in a self-important or self-aggrandizing manner; concerned about appearances rather than feelings or real contacts with others.
15. Bully and Attack mode
Uses threats, intimidation, aggression, or coercion, to get what he wants, including retaliation against others, or inserting one's dominant position; feels a sense of sadistic pleasure in attacking others.
16. Conning and Manipulative Mode
Cons, lies or manipulates in a manner designed to achieve a specific goal, which either involves victimizing others or escaping punishment
17. Predator Mode
Focuses on eliminating a threat, rival, obstacle, or enemy in a cold, ruthless and calculating manner.
18. Over-Controller Mode (paranoid or obsessive-compulsive)
Attempts to protect himself from a perceived or real threat by focusing attention, ruminating, and exercising extreme control. The Obsessive type uses order, repetition, or rituals. The Paranoid type attempts to locate and uncover a hidden (perceived) threat.

660

References

Anderson, A., & Bushman, B.J. (2002). Human aggression, *Annual Review of Psychology,* 53, 27–51.

Bamelis, L. L., Evers, S. M., Spinhoven, P., & Arntz, A. (2014). Results of a multicenter randomized controlled trial of the clinical effectiveness of schema therapy for personality disorders. *American Journal of Psychiatr*y, 171(3), 305–322.

Bamelis, L. L., Renner, F., Heidkamp, D., & Arntz, A. (2011). Extended schema mode conceptualizations for specific personality disorders: An empirical study. Journal of Personality Disorders, 25(1), 41–58.

Beauregard E, Stone MR, Proulx J, &., Michaud P. (2008) Sexual Murderers of Children: Developmental, Precrime, Crime, and Postcrime Factors. *International Journal of Offender Therapy and Comparative Criminology* 52(3):253-269.

Beech, A., Fisher, D., & Ward, T. (2005). Implicit theories in sexual murderers. *Journal of Interpersonal Violence*, 20, 1366-1389.

Bernstein, D. P., Arntz, A., & de Vos, M. E. (2007). Schema-Focused Therapy in forensic settings: theoretical model and recommendations for best clinical practice. I*nternational Journal of Forensic Mental Health*, 6(2): 169–83.

Bernstein, D. P., Clercx, M., & Keulen-De Vos, M. (2019). Schema therapy in forensic settings. In *The Wiley International Handbook of Correctional Psychology* (pp. 654-668). Wiley Blackwell.

Carvalho, J., & Nobre, P.J., (2014). Early maladaptive schemas in convicted sexual offenders: Preliminary findings. *International Journal of Law and Psychiatry*. 37 (2), 210-216.

Chakhssi, F., de Ruiter, C., & Bernstein, D. P. (2013). Early maladaptive schemas in child sexual offenders compared with sexual offenders against adults and nonsexual violent offenders: An exploratory study. *Journal of Sexual Medicine,* 10, 2201–2210.

Chakhssi, F., Kersten, T., de Ruiter, C., & Bernstein, D. P. (2014). Treating the untreatable: A single cas e study of a psychopathic inpatient treated with schema therapy. Psychotherapy (Chicago, Ill.), 51(3), 44 7–461.

Chan, H. & Heide, K. (2016). Sexual homocide offenders distinguished from non-homicidal sexual offenders: A review of the literature. *Aggression and Violent Behavior,* 31, 147-156.

Coid, J., Yang, M., Ullrich, S., Roberts, A., Moran., P., Bebbington, P., Brugha, T., Jenkins, R,. Farrell, M., Lewis, G., Singleton., N., & Hare., R. (2009). Psychopathy among prisoners in England and Wales. *International Journal of Law and Psychiatry*, 32, 134-141.

Daffern, M., Howells, K. & Ogloff, J. (2007). What's the point? Towards a methodology for assessing the function of psychiatric inpatient aggression. *Behavior Research and Therapy*, 45 (1): 101-111.

Farrell, J. M., Shaw, I. A., & Webber, M. A. (2009). A schema-focused approach to group psychotherapy for outpatients with borderline personality disorder: A randomized controlled trial. *Journal of Behavior Therapy and Experimental Psychiatry*, 40, 317–328.

Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23 000 prisoners: A systematic review of 62 surveys. *The Lancet*, 359(9306), 545–550.

Firestone, P., Bradford, J. M., Greenberg, D. M., Larose, M. R., & Curry, S. (1998). Homicidal and non-homicidal child molesters: Psychological, phallometric, and criminal features. Sexual Abuse: A Journal of Research and Treatment, 10, 305-323.

Hanson, R. K., Gizzarelli, R., & Scott, H. (1994). The attitudes of incest offenders: Sexual entitlement and acceptance of sex with children. *Criminal Justice and Behavior, 21*(2), 187–202.

Hemphill, J., Hare, R., & Wong, S. (2011). Psychopathy and Recidivism: A Review. *Legal and Criminological Psychology*, 3(1):139.

Keulen-de Vos, M. E., Bernstein, D. P., Vanstipelen, S., de Vogel, V., Lucker, T. P., Slaats, M., & Arntz, A. (2016). Schema modes in criminal and violent behaviour of forensic cluster B PD patients: A retrospective and prospective study. *Legal and Criminological Psychology*, 21(1), 56-76.

Langevin, R. (2006). An actuarial study of recidivism risk among sex killers of adults and children: Could we have identified them before it was too late? *Journal of Forensic Psychology Practice*, 6, 29-49.

Leirós, V., Carvalho, J., & Nobre, P. (2013). Early maladaptive schemas and aggressive sexual behaviour: A preliminary study with male college students. *Journal of Sexual Medicine,* 10, 1764-1772.

Lobbestael, J., Arntz, A., Cima., M. & Chakhassi., F. (2009). Effects of induced anger in patients with antisocial personality disorder. *Psychological Medicine, 39*, 557-568.

Manesh, E. H., Baf, H., Abadi, B., & Mahram, B. (2010). Early maladaptive schemas and schema domains in rapists. *Iranian Journal of Psychiatry and Clinical Psychology,* 16(2), 145–153.

Mann, R. E., & Hollin, C. (2010). Self-reported schemas in sexual offenders. *Journal of Psychiatry and Psychology*, 21, 834-851.

Mann, R. E., & Shingler, J. (2006). Schema-driven cognition in sexual offenders: Theory, assessment and treatment. In W. L. Marshall, Y. M. Fernandez, L. E. Marshall, & G. A. Serran (Eds.), *Sexual offender treatment: Controversial issues* (pp. 173-185). Chichester, UK: Wiley.

Marziano, V., Ward, T., Beech, A. & Pattison, P. (2006). Identification of five fundamental implicit theories underlying cognitive distortions in child abusers: A preliminary study. Psychology, Crime & Law, 12, 97-105.

Milner, R., & Webster, S. (2005). Identifying schemas in child moles- ters, rapists, and violent offenders. Sexual Abuse: *A Journal of Research and Treatment*, 17, 425-438.

Nadort, M., Arntz, A., Smit, J. H., Giesen-Bloo, J., Eikelenboom, M., Spinhoven, P., van Dyck, R. (2009). Implementation of outpatient schema therapy for borderline personality disorder with versus without crisis support of the therapist outside office hours: A randomized trial. *Behaviour Research and Therapy*, 47, 961–973.

Polaschek, D.L., & Gannon, T. (2004). The implicit theories of rapists: What convicted offenders tell us. *Sexual Abuse: A journal of Research and Treatment, 16*, 299-314.

Polaschek, T., & Ward, R. J. (2002). The implicit theories of potential rapists: What our questionnaires tell us. *Aggression and Violent Behavior,* 7, 385-406.

Proulx, J., James, J., Siwic, M. & Beauregard, E. (2018). Sexual murderers of children: psychopathological and modus operandi factors. In Proulx, J., Beauregard, E., Carter, A., Mokros, A., Darjee, & James, J. *Routledge International Handbook of Sexual Homicide Studies.* Routledge: London.

Rafaeli, E., Bernstein, D. P., & Young, J. E. (2011). *Schematherapy: Distinctive features.* New York: Routledge.

Richardson, G. (2005). Early maladaptive schemas in a sample of British adolescent sexual abusers: Implications for therapy. *Journal of Sexual Aggression, 11*, 259–276.

Spehr A, Hill A, Habermann N, Briken P, Berner W. (2010). Sexual Murderers With Adult or Child Victims: Are They Different? *Sexual Abuse.* 22(3):290-314.

Stinson, J. D., Robbins, S. B., & Crow, C. W. (2011). Self-regulatory deficits as predictors of sexual, aggressive, and self-harm behaviours in a psychiatric sex offender population. *Criminal Justice and Behavior,* 38, 885–895.

Szlachcic, R., Fox, S., Conway, C., Lord, A. & Christie, A. (2014). The relationship between schemas and offence supportive attitudes in mentally disordered sexual offenders, J*ournal of Sexual Aggression: An international, interdisciplinary forum for research, theory and practice,*21 (3), 318-336.

Ward, T., & Beech, A. (2006). An integrated theory of sexual offending. *Aggression and Violent Behaviour,* 11, 44–63.

Ward, T. & Keenan, T. (1999). Child Molesters' Implicit Theories. *Journal of Interpersonal Violence, 14*, 8, 821-838.

Ward, T., Polaschek, D. L. L., & Beech, A. R. (2006). Theories of sexual offending. Chichester, England, England: Wiley.

Young, J. E., & Brown, G. (1994). *Young Schema Questionnaire* (2nd ed.). New York:
775 Cognitive Therapy Center of New York.

Young, Y.E., Klosko, J., & Weishaar, M. (2003). *Schema Therapy: A practitioner's Guide.* New York: Guilford.