The Nova Scotia Sexual Behaviour Clinic: Evaluation, 1 September 1990-31 March 1991

Developed with a $105,000, seven-month contract between the Correctional Service of Canada and Saint Mary's University, the Nova Scotia Sexual Behaviour Clinic offered group and individual cognitive-behavioural treatment for sex offenders. Program participants underwent extensive psychological testing before and after treatment in this community-based program. Test results showed significant improvements in those behaviours, attitudes and cognitive distortions targetted for change, and no significant differences in untargetted behaviour.

Close contacts with enforcement agencies, the courts and the Correctional Service of Canada indicated no new offences at the end of the seven-month contract period among 16 treated offenders. An additional follow-up period of five months showed no offences. Three offenders who had been assessed as high risk but who were not treated in the program did reoffend.

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The primary purpose of the Nova Scotia Sexual Behaviour Clinic was to reduce the likelihood of recidivism among known sex offenders.

Additional objectives of the clinic were:

- to provide intensive training and education to parole officers and Correctional Service of Canada administrators who worked with sexual offenders;
- to collect relevant research and secure appropriate methodologies for the assessment and treatment of sexual offenders; and
- to support the development of education and training for undergraduate and graduate students in forensic and clinical psychology at universities in Nova Scotia.

The clinic had secondary objectives. It was hoped that the development of this community program and a close liaison between the clinic and the psychology departments at other federal institutions in the Nova Scotia district would spark the development of similar programs at those institutions. In addition, there are few community services for sexual offenders offered by the Nova Scotia departments of the Attorney General and the Solicitor General. It was hoped that the development of a community program by the Correctional Service of Canada and the liaison of this clinic with various provincial facilities would encourage the development of provincial services.

To garner support for the program and inform relevant parties of the clinic's role and objectives, numerous presentations were made to Correctional Service of Canada psychologists, case management officers, parole officers, county court judges, health professionals in local hospitals, lawyers, police officers and representatives of the National Parole Board.

The contract provided the clinic with funding for the assessment of 39 offenders and for the provision of

three cycles of 16-week group therapy.

Assessment

Sex offenders are not homogeneous.[1] No single factor has been identified as the causal agent inherent in, or even common among, all types of sexual offences. Indeed, even in a single subtype of sexual offences, a variety of psychological factors may be found.

The clinic did not choose to use those measures that were only useful for discriminating offenders from non-offenders. Rather, assessment in the clinic was intended to provide a comprehensive description of both the offender and the events contributing to the offence. This information was important for helping offenders to understand themselves, estimating the risk of recidivism, guiding the choice of treatment options and estimating the effect of treatment.

An 18-hour assessment procedure was standard for most participants.

Initial Interview

The offender was provided with a brief description of the clinic and the assessment procedures. Offenders were asked to sign release forms allowing the clinic to communicate with such bodies as the Correctional Service of Canada and the courts.

Test Battery

A comprehensive test battery, consisting of some 22 scales and questionnaires, was administered. This included the following: Clarke Sex History Questionnaire, Michigan Alcohol Screening Test, Drug Use and Suicide Risk Test, Abel and Becker Cognitive Distortion Scale, Wilson Sexual Fantasy Questionnaire, Attitudes Towards Women Scale, Hostility Towards Women Scale, Clarke Violence Scale, Clarke Gender Identity Scale, Clarke Parent/Child Questionnaire, Minnesota Multiphasic Personality Inventory-2, Millon Clinical Multiaxial Inventory-Il, Wechsler Adult Intelligence Scale-Revised, Social Response Inventory, Social Avoidance and Distress Scale, Social Self-Esteem Inventory, Marlowe-Crowne Social Desirability Questionnaire, Short Marital Adjustment Scale, Waring Intimacy Questionnaire, Neuropsychological Screening Questionnaire, Halstead Reitan Neuropsychological Test Battery (as required) and the Wechsler Memory Scale (as required).

Phallometric Testing[2]

Level of sexual arousal was measured in response to various sexual stimuli by recording changes in air pressure in a glass tube covering the offender's penis.[3]
A sophisticated hardware and software package was used to analyse changes in penis size (including the offender's minimum and maximum response and the time it took for the offender to "recover" from the state of arousal) in response to the sexual stimuli (e.g., video material, audio material, slides) which

varied the nature of the sexual activity portrayed, and the age and gender of subjects featured, etc. The program also recorded personal information about the offender (e.g., employment status, previous offences, I.Q.).

Review of Collateral Information

Information was gathered from victim statements, police reports, court transcripts and interviews with such relevant parties as the wife of the offender.

Clinical Interview

The interviewer's questions were intended to draw out information so that the various questions of the referring agent could be answered. One such question is "What conditions of parole will reduce this individual's risk of reoffending?" Interviews usually lasted approximately four hours.

Report and Recommendations

Information gathered during the assessment is organized according to admitter status, sexual preference, substance abuse, cognitive distortions, violence/sexual history, mental status, physical health, neuropsychological status, social competence, marital dysfunction, family dynamics, risk of reoffence, appropriate treatment options and probability of success in treatment.[(4)]

Full feedback was provided to offenders before the results of the assessment were shared. Detailed reports were provided to the Correctional Service of Canada and other relevant bodies.

Treatment

As assessment and treatment were considered inextricably linked, no offenders were treated before assessment. As the assessment of the offender was being completed, some aspects of treatment, such as dealing with denial, were initiated. Furthermore, while the offender was in treatment, assessment was updated regularly.

The contract funded three 16-week, group-therapy cycles. Group sessions, lasting approximately three hours, were offered once a week. There were two therapists and six to ten participants per group. The clinic preferred to have a female and a male facilitating the groups: the first group was led by two males, a social worker and a parole officer, and the second and third were led by a male psychologist and a female parole officer.

The conditions, expectations and guidelines for the group were clearly explained to offenders. Each client signed a treatment contract outlining responsibilities of the participant and therapists as well as guidelines for confidentiality.

Participants were told that their parole officers would be contacted if they reported having engaged in

assault or other criminal activity; reported plans to commit an assault; missed a meeting without having a documented and appropriate excuse; were not participating in the group; showed a clinically significant change in mental status; reported plans to commit suicide; were intoxicated when attending the group; or reported a breach of a condition of abstinence.

Treatment included individual and group therapy, broad-based cognitive and behavioural therapy(5) and relapse prevention(6) which clearly focused on sexual behaviour. The program was not designed to address all of the concerns identified through the assessment. For example, if the individual had an addiction problem, he was referred to an appropriate agency such as Metro Drug Dependency or Alcoholics Anonymous.

The focus of treatment in this program was specifically to:

- reduce the offender's denial and minimization of the offence,
- change the cognitive distortions relevant to the aberrant behaviour,
- increase victim empathy,
- modify deviant sexual preferences,
- improve problem-solving and coping skills,
- improve social and communication skills, and
- construct a relapse-prevention plan.

The purpose of the relapse-prevention plan is to make offenders aware of any pattern of behaviour they exhibited before committing an assault. Such behaviour may include, for example, feeling lonely and unappreciated, viewing pornographic material, watching children play in the community, or purposely seeking out places that offer the opportunity to talk with children.

Offenders learn about their own offence patterns and develop clear action plans for changing their behaviour. An action plan for some offenders may involve calling a friend when they feel lonely and meeting that person for a cup of coffee.

Part of the task of preparing an acceptable relapse-prevention plan involved writing relapse cards, which list multiple fall-back strategies. Offenders were asked to keep the relapse cards on hand at all times, to practise the interventions on a regular basis and to report problems encountered in using the cards. Offenders' parole officers and significant others were made aware of the cards and were asked to review them regularly with the offenders.

In addition to the treatment described above, three offenders were on medication. Two received a drug to reduce sex drive, and one was taking an anti-psychotic drug.

The clinic also offered a long-term maintenance group for individuals who had been treated in the program. This group met once a month for about three hours.

Evaluation

Program success was measured by tracking offenders and counting the number of sexual offences, non-sexual offences, technical violations of parole leading to incarceration and technical violations of parole not leading to incarceration that were committed. This information was obtained from the Correctional Service of Canada and other enforcement agencies.

No one treated by the clinic has committed a sexual or non-sexual offence since treatment. Only one offender, who had several convictions for rape, was suspended for a violation of halfway-house rules. No other offenders showed violations of parole.

Three offenders, who were assessed and identified as high risk but who were not treated, committed further offences: two committed sexual offences, and one committed theft.

Commonly, the battery of tests administered during assessment showed the presence of problematic behaviours, cognitive distortions and attitudes relevant to the offence(s). The treatment plan for each offender targetted specific cognitive, behavioural or psychological deficits.

If offenders did not improve through group therapy, they were given further assessment, individual therapy, additional group therapy or referral to other agencies. Twelve of 16 offenders were required to attend an average of 13.3 individual therapy sessions, four were required to attend a second cycle of group therapy and six were referred to psychiatrists.

All offenders were tested after treatment for psychopathology, self-esteem, anxiety in social situations and capacity to form healthy and intimate adult relationships. The only subgroup of offenders with more than five subjects was child molesters. Accordingly, test scores before and after treatment are reported only for this group of 10 child molesters.

Various post-treatment tests were administered after the completion of group therapy (see table).

Table 1

Pre and Post Test Mean Scores on the Test Battery

Number of Subjects	Test	Before Treatment	After Treatment	Probability
10	ABC*	127.90	-134.30	0.028
9	ATW**	23.20	14.89	0.029
9	SRI**	-4.11	-3.25	0.034
9	SSEI*	122.20	123.29	0.260
9	SADS**	15.90	10.43	0.104
9	WIQ**	21.89	20.33	0.207
9	HTW**	6.56	5.33	0.575

Scale abbreviations
ABC - Abel and Becker Cognitive Distortion Scale
ATW - Attitudes Towards Women Scale
SRI - Social Response Inventory
SSEI* - Secial Self Esteem Inventory
SADS** - Social Avoidance and Distress Scale
WIQ** - Waring Intimacy Questionnaire
HTW** - Hostility Towards Women Scale
* Movement to higher scaores indicates improvement
** Movement to lower scores indicates improvement

Offenders sometimes have a tendency to show positive change on tests given after treatment even when no change has actually taken place. To judge offenders' tendency to do this, a particular test - the Hostility Towards Women Scale (HTW) - measuring attitudes that were not targetted for treatment was also given. Because this scale measures attitudes not targetted for treatment, no change in before-and after-treatment scores was expected. The reasoning was that if offenders showed an improvement on this scale, there would be reason to question the validity of changes shown on other scales.

Generally, the results indicate that treated offenders improved in regard to targetted attitudes (ABC, ATW, SRI [underassertion], SSEI, SADS and WIQ), and there was no change in the non-targetted attitudes (HTW). While the results were as expected, statistically significant differences in test scores before and after treatment were found only for the Abel and Becker Cognitive Distortion Scale (ABC), the Attitudes Towards Women Scale (ATW) and the Social Response Inventory (SRI).

In addition to assessing and treating offenders, the clinic has achieved other objectives. Close links have been made with provincial and federal correctional institutions. Two parole officers have received intensive practicum training. The provision of services to sexual offenders has generally been expanded. And one student, after working on the project, entered the forensic psychology program at the University of British Columbia.

Summary

The key elements that appear to characterize the clinic are the careful assessment of offenders; the linking of assessment and treatment; the interaction of professional staff and Correctional Service of Canada staff in the delivery of service; the ongoing evaluation of change; the speed with which concerns are communicated to the Correctional Service of Canada and appropriate responses given; and the variety of intervention strategies employed, including referrals for treatment to other health professionals.

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[1]*Solicitor General of Canada, "The Management and Treatment of Sex Offenders."* Report of the Working Group: Sex Offender Treatment Review. *(Ottawa: Minister of Supply and Services, 1990). See also R. Langevin, P. Wright and L. Handy, "Characteristics of Sex Offenders Who Were Sexually Victimized as Children,"* Annals of Sex Research, *2 (1989): 227-253.*

[2]*For this article, our description of phallometric testing is brief and relatively non-technical. A more detailed description of our comprehensive process and method of phallometric testing, which was developed from scratch, is available. Please contact us at the Nova Scotia Sexual Behaviour Clinic at tel.(902) 492-2489.*

[3]*R. Langevin,* Sexual Preference Testing. *(Toronto: Juniper Press, 1988). See also K. Freund and R. Blanchard, "Phallometric Diagnosis of Pedophilia,"* Journal of Consulting and Clinical Psychology, *57 1 (1989): 100-102. And see K. Freund, R. Watson and D. Rienzo, "Signs of Feigning in the Phallometric Test,"* Behavior Research and Therapy, *26, 2 (1988): 105-112.*

[4]*R. Langevin, "Proposal for a New Treatment Program of Sex Offenders on Release in the Toronto Area." Unpublished report, 1990.*

[5]*W.L. Marshall and H.E. Barbaree, "A Manual for the Treatment of Child Molesters." Unpublished manuscript, Department of Psychology, Queen's University, Kingston, Ontario, 1988. See also W.L. Marshall, P. Johnston, T. Ward and R. Jones, "A Cognitive/Behavioral Approach to Treatment of Incarcerated Child Molesters: The Kia Marama Program." Unpublished manuscript, 1990. And see W.L. Marshall and H.E. Barbaree, "An Integrated Theory of the Etiology of Sexual Offending," in W.L. Marshall, D.R. Laws and H.E. Barbaree (Eds.),* Handbook of Sexual Assault: Issues, Theories and Treatment of the Offender. *(New York: Guilford Press, 1990) 257-271.*

[6]*G.A. Marlatt, "Relapse Prevention: Theoretical Rationale and Overview of the Model," in R.B. Stuart (Ed.),* Adherence, Compliance and Generalization in Behavioral Medicine. *(New York: Brunner/Mazel, 1982) 3-70 and 329-378. See also G.A. Marlatt and J.R. Gordon,* Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors. *(New York: Guilford Press, 1985). See also G.A. Marlatt and J.R. Gordon, "Determinants of Relapse: Implications for the Maintenance of Behavior Change," in P.O. Davidson and £M. Davidson (Eds.),* Behavioral Medicine: Changing Health Lifestyles. *(New York: Brunner/Mazel, 1980). See also W.D. Pithers, "Relapse Prevention with Sexual Aggressors: A Method for Maintaining Therapeutic Gain and Enhancing External Supervision," in W.L. Marshall, D.R. Laws and H.E. Barbaree (Eds.),* Handbook of Sexual Assault: Issues, Theories and Treatment of the Offender*, 343-360. And see W.D. Pithers, J.K. Marques, C. C. Gibat and G.A. Marlatt, "Relapse Prevention with Sexual Aggressives: A Self Control Model of Treatment and Maintenance of Change," in J.G. Greer and L.R. Stuart (Eds.),* The Sexual Aggressor: Current Perspectives on Treatment *(New York: Van Nostrand Reinhold Company, 1983) 214-239.*