Assessment and treatment of sexual offenders

by ***W.L. Marshall***[1]
Department of Psychology, Queen's University
and ***Sharon Williams***[2]
Regional Treatment Centre (Ontario), Correctional Service of Canada

The true prevalence of sexual offending can only be estimated. It is clear, for example, that many victims of sexual offending do not report the crime to the police or, all too often, to anyone at all.[3] The Committee on Sexual Offences Against Children and Youth reporting the results of Canadian national surveys[4] found that one-half of females and one-third of males reported being subjected to some form of sexual abuse during their lives, with 70% of the males and 62% of the females indicating that it occurred prior to pubescence. There is, therefore, a pressing need to develop a comprehensive social response to this very serious social problem.

One aspect to this response should include not only the treatment of identified offenders, but also the development of an understanding of these offenders; what features need to be addressed in treatment; how these features should be assessed; and the generation of an actuarial basis for estimating risk to reoffend and response to treatment. Of course, if treatment is implemented, its effectiveness must be evaluated.

For the past 26 years, Correctional Service of Canada (CSC) has been at the forefront of the development of assessment and treatment for incarcerated sexual offenders. Over the last 10 years, CSC has expanded and refined its programs for sexual offenders so that it now funds numerous institutional programs and community-based follow-up treatment for released sexual offenders. For the most part, programs that have proliferated in all Western societies over the past 10 years have adopted the "cognitive-behavioural/relapse prevention" approach developed in North America.[5] This is also the approach adopted by CSC from the first systematic application of sexual offender treatment in 1973.

In considering treatment, cognitive-behaviourists who adhere to the early form of relapse prevention take the view that sexual offending cannot be "cured" and claims the offender can be taught to "control" their propensity to abuse.

Measurement

Measurement is a critical feature of any program. Assessments are done for various reasons, and the types of measures chosen should be guided both by what is known about the problem in question (in the present case, sexual offending), and why testing is being done. In prison settings, assessments of sexual offenders may be used to determine: (1) the treatment needs of sexual offenders; (2) their security needs; (3) the effects of treatment; and (4) the offenders' risk to reoffend upon release. Such comprehensive evaluations can provide a basis for all the above decisions except, of course, that it would be necessary to repeat the assessment package after treatment was complete to determine the degree to which treatment targets have been met. In community settings, the same issues might be relevant, although hopefully the within-prison evaluations, if they are recent enough, should provide most of this information. In addition, community programs may be asked to provide an evaluation to assist in determining whether or not an offender is ready to return to their family or to some other setting where access to victims may occur.

The first concern clinicians should have when planning assessment is to determine the domains that need to be assessed. Once the targets of assessment have been identified, a search can be made for the best measures of each target.

Treatment

Conceptual model

The first thing to note about treatment for sexual offenders is that group therapy is usually the chosen approach due to the superior efficiency of group therapy, allowing, as it does, the possibility of treating far more clients in the same amount of time.

Responsivity

Setting

Although some writers suggest that treating an offender in the community is superior to treating them in prison, there seems no reason to force a choice between settings. The National Strategy described by Williams, Marcoux-Galarneau, Malcolm, Motiuk, Deurloo, Holden and Smiley[6] involves a continuum of services that are initiated during the incarceration phase at an intensity level commensurate with risk and needs, and continues

into the community as less intensive, but equally important, maintenance. This strategy also provides more structured maintenance treatment for sexual offenders at higher risk on release, and may involve placement in a supervised halfway house.

Contraindications

Most programs exclude offenders who are suffering from an acute psychiatric disorder because they are unlikely to gain from treatment and are a disruptive influence. However, as soon as the illness can be managed effectively (i.e., via medication), such sexual offenders should be permitted to join a suitable treatment program. Their offence chain should incorporate those idiosyncratic internal or external stimuli that may be part of the relapse process.

For all sexual offenders, management difficulties may arise in the course of treatment. These may include refusal to participate, breaking confidentiality, or disruptiveness during group sessions. All efforts should be made to engage the offender in the treatment process, but if individual counselling, peer confrontation, or, as a last resort, behavioural contracting, is ineffective, the group needs should take precedence over the individual. There is no evidence that individual therapy is conducive to changes in sexual offenders, and providing the option of one-on-one treatment may discourage the offender from discussing critical issues in group sessions.

Program timing

There is some debate regarding the best time to provide sexual offender treatment programs. Often the timing of treatment is related to availability of treatment services. By matching risk and need to treatment intensity, resources can be directed to the programs serving the largest populations.

Program sequencing

Programs which target thinking styles, impulsivity, educational upgrading, employment skills, alcohol and drug abuse, as well as family violence, could be provided while the higher risk sexual offender is awaiting specialized treatment. These programs could prepare the offender by addressing general therapeutic issues such as group processes, confidentiality, trust, openness, and by exposing offenders to specific strategies such as videotaping.

Special applications

Females make up a very small percentage of the total population of sexual offenders under federal jurisdiction in Canada (0.3%). A recent study by Kleinknecht, Williams and Nicholaichuk[7] identified only 70 convicted female sexual offenders who had served federal sentences between 1972 and 1998. However, there has been an increase in this population over these three decades.

Kleinknecht et al. surveying all female sexual offenders incarcerated since 1972, found that their primary characteristics were consistent with those of female offenders in general. They had little education, minimal or no employment history, and patterns of alcohol or drug abuse. The majority described childhood and adult histories of being emotionally, physically, and sexually abused. Many had diminished self-esteem, assertiveness deficits, relationship problems, and mental health concerns, such as depression, post-traumatic stress disorder, and eating disorders. Of those who had a criminal history, most involved acquisitive, drug-related, or prostitution offences.

Treatment features

Therapist requirements

The only evidence currently available on the influence of therapist features in the treatment of sexual offenders comes from two studies by Beech and his colleagues in England.[8] The study found, in both community and prison programs, that therapists who treated clients with respect, challenged supportively, and displayed empathy toward clients, generated far greater behavioural change than did more authoritarian, confrontative, and unempathic therapists. The importance of therapist characteristics or style has been neglected, yet it is a seemingly important feature of sexual offender treatment that needs to be addressed. A joint project between the English Prison Service and Canadian researchers is underway to examine the influence of both therapists' behaviours and offenders' responsivity in the effectiveness of treatment with sexual offenders.[9] To date, this study has demonstrated that a number of therapist features can be reliably identified,[10] and that these are related to beneficial changes in the clients' targeted behaviours, thoughts, and feelings.[11]

Mode of delivery

Most treatment programs for sexual offenders in North America, Britain, Australia, and New Zealand are based on a cognitive-behavioural model incorporating relapse prevention strategies. These models lend themselves to the specification of treatment procedures.

There are three dimensions on which group therapy for sexual offenders may vary: it may be psycho-educational or more psychotherapeutic in approach; it may involve discrete components that are procedurally specified in detail, or it may simply set targets and be more process-oriented; and groups

may be open or closed. Presently we have no evidence that would allow us to decide between these alternatives, so it seems therapist preference should be the deciding factor.

Level of treatment

It would be both pointless and a waste of resources to provide the same level of treatment to all sexual offenders. CSC is among the few systems that actually adjusts the intensity and extensiveness of treatment to the level of need among its clients. CSC quite sensibly attempts matching treatment needs with differing intensities of treatment. In order to meet the needs of a heterogeneous population of sexual offenders, Williams et al. developed a National Strategy for Canadian sexual offenders under the jurisdiction of Correctional Service of Canada.[12] This strategy uses a specialized sexual offender assessment in conjunction with the Offender Intake Assessment (OIA) (PROCESS) to determine the risk, need, and responsivity factors for each sexual offender. Thorough evaluations permit the identification of three levels of need: high, moderate, and low.

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High needs offenders need more time to reach acceptable levels of functioning for each of the targets of treatment, and they will almost certainly need programming additional to sexual offender specific treatment (e.g., cognitive skills, living without violence, substance abuse).

It is important to note that increasing self-esteem facilitates changes in all other targets of treatment,[13] including the reduction of deviant sexual preferences.[14]

Treatment effectiveness

There are several aspects to determining the value of treatment, although the typical approach with sexual offenders has been to look at reductions in post-discharge recidivism. While this latter index is critical, even if recidivism is significantly reduced, a treatment program would be of little value if either few candidates entered treatment, or most withdrew or remained but were non-compliant. Thus, treatment refusals, dropouts, or failure to effectively comply are relevant indices of the utility of a treatment program. These variables can all be considered to be features of treatment participation.

Treatment outcome

There are two aspects to outcome evaluations. The first concerns an evaluation of whether or not participants meet the goals of treatment. This is assessed by evaluating changes from pre- to post-treatment on measures that assess functioning on each of the targets (or components) of treatment. If a treatment program aims at increasing self-esteem, correcting cognitive distortions, enhancing empathy, improving social and relationship skills, eliminating deviant sexual preferences, and generating clear offence chains and relapse prevention plans, then measures of these targets must demonstrate change. Treatment providers must first demonstrate that the procedures and processes they use typically generate the anticipated changes, otherwise it is unfair to hold any individual offender responsible for not having reached the expected goals. A series of studies have demonstrated that the procedures outlined above produce the desired changes in self-esteem, empathy, denial, minimization, loneliness and intimacy.

Recidivism studies

One of the problems that beset those who attempt to evaluate treatment effectiveness is the low base rate of reoffending among untreated sexual offenders. As Barbaree points out, this low base rate increases the probability that we may falsely reject the hypothesis that treatment has beneficial effects, simply because we do not have the statistical power to discern real effects.[15] Quinsey and his colleagues, on the other hand, have expressed concern that we may too hastily conclude that treatment is effective when in fact properly designed studies may subsequently reveal no effects for treatment.[16] To date, no resolution has been reached on the best way to deal with these problems.

It is somewhat incomplete to determine the benefits of treatment solely in terms of reducing future victimization. This, of course, ought to be our concern, but we also have to be fiscally responsible; that is, it may be possible to provide effective treatment, but the cost may be beyond society's willingness to pay for such benefits. This may be particularly so if reductions in recidivism are statistically significant but not remarkable.

While overall the presently available data may not convincingly demonstrate to all readers the benefits of treating sexual offenders, we are inclined to believe that, at the very least, they encourage optimism about the value of treatment. ■

[1] Department of Psychology, Queen's University, Kingston, Ontario K7L 3N6.

[2] 555 King Street West, Kingston, Ontario K7L 4V7.

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[5] For examples of such programs, see Marshall, W.L., Fernandez, Y.M., Hudson, S.M. and Ward, T. (Eds.) (1998). ***Sourcebook of treatment programs for sexual offenders***. New York, NY: Plenum Press.

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