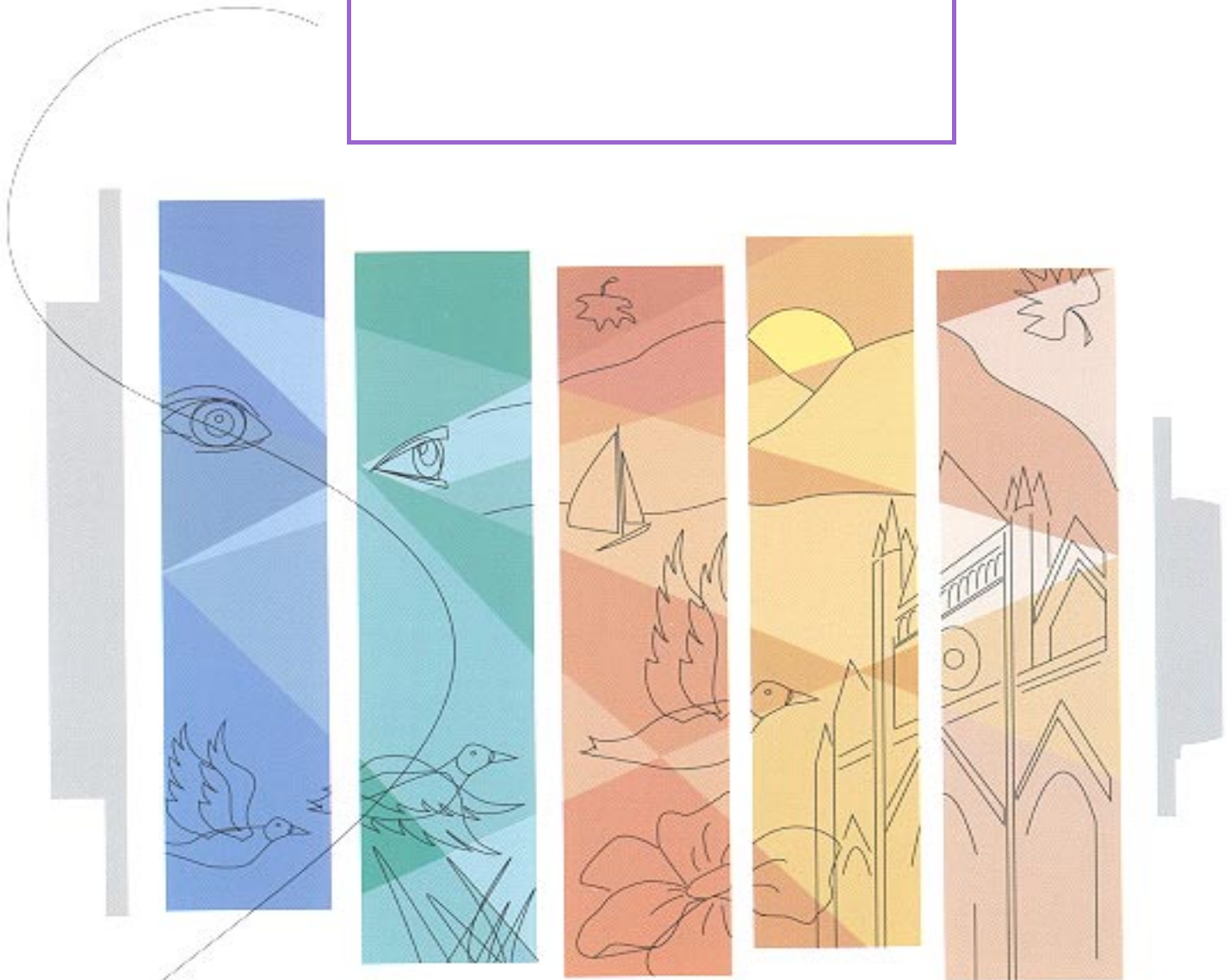




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**Sex Offender Assessment, Treatment
and Recidivism: A Literature Review**



**SEX OFFENDER ASSESSMENT, TREATMENT AND RECIDIVISM:
A LITERATURE REVIEW**

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INTRODUCTION

Awareness of the enormous personal, societal, and financial costs of sexual assault is not new, but is raised with new intensity in current times. The women's movement has propounded an increased recognition that sexual offending presents a serious social problem, and sensitivity has been heightened to those who have been victimized. As a result, we have witnessed a tremendous increase in the reporting of sexual offences over the last decade (Cooper, 1994). Concomitantly, more sex offenders have been identified and channeled into the criminal justice system. Moreover, the proportion of sex offenders, relative to the total offender population, has increased steadily over the past 10 years (Gordon & Porporino, 1990; Motiuk & Belcourt, 1996).

Motiuk and Belcourt (1996) used the Correctional Service of Canada (CSC) Offender Management System (OMS; an automated database) to create a profile of the Canadian federal sex offender population as of December 31, 1995. OMS yielded a total of 3,875 sex offenders under federal jurisdiction, comprising 17% of the total federal offender population. The authors advise, however, that these figures understate the actual number and proportion of sex offenders because current automated databases do not identify all previous convictions for sex offences (i.e., those with provincial sentences); sexually-related offences (e.g., accompanied by homicide); or, previous sex offences that did not result in convictions.

A 1991 National Sex Offender Census (Porporino & Motiuk) identified all sex offenders, accounting for the aforementioned limitations in automated data

extraction. The census revealed that 85% of the sex offender population could be accounted for by OMS. Considering this, Motiuk and Belcourt used a correction factor (1.173), and estimated that as of December 31, 1995, there were 4,542 sex offenders under Canadian Federal Jurisdiction. This adjusted figure accounts for approximately 20% of the total offender population.

As of December 31, 1995, CSC identified 2,766 sex offenders incarcerated in federal institutions, comprising about one-fifth (20%) of the federally-incarcerated population. Using the correction factor, Motiuk and Belcourt (1996) estimated that sex offenders comprise approximately 24.0% of the total federal incarcerated population. The majority (67.8%) of those were held in medium security institutions, 20% in maximum security institutions, and the remainder (11.9%) in minimum security institutions. At year-end 1995, CSC identified 1,109 sex offenders on conditional release, comprising about 12% of the federal conditional release population. Using the correction factor, the authors estimated that, as of December 31, 1995, there were actually 1,301 sex offenders under community supervision. This adjusted number accounts for about 14% of the total federal conditional release population.

Including all sex offenders admitted to federal custody in 1995, the average sentence length was 4 years and three months, which is about the same as the five preceding years (Motiuk & Belcourt, 1996). Most sex offenders admitted to federal custody were convicted of a sexual assault (50.2%), or 'mixed' sex offences (i.e., any combination of the sex offence types; 21.2%). Pedophilia was also common, accounting for 14.9% of recent sex offender

admissions to federal custody. A minority (8.4%) were admitted for incest offences, and the remainder (5.3%) had committed an 'other' sex offence, such as exhibitionism (Motiuk & Belcourt, 1996). The authors assert, however, that it is important to consider that these data reflect a breakdown of recent admissions to federal custody, and that the institutional population would likely be comprised of a larger proportion of more serious / violent sex offenders serving longer sentences, with lengthier criminal histories.

ASSESSMENT

The ultimate goal of Canadian correctional services is the management of risk and its subsidiary, recidivism reduction. Evaluation of sex offender risk is accomplished through the identification and assessment of variables that contribute to sexually deviant behaviour. Considering the large (and growing) proportion of sex offenders currently under correctional supervision, structured interim assessments have become increasingly important.

Sexual aggression is a complexly-determined phenomenon, with varied antecedents and sequelae. Perpetrators of sexual crimes differ in their personal and criminal histories, the circumstances preceding their offences, their victim age and gender preferences, the attitudes and beliefs that support their deviant behaviour, and the degree to which they have used force or brutality or caused physical harm to their victims (Gordon & Porporino, 1990). Thus, sexual offenders are a heterogeneous group of individuals, with diverse evaluative and treatment needs.

Sexual offenders also vary in their risk for reoffending (Gordon & Porporino, 1990), and in their response to treatment (Marques, Day, Nelson, & West, 1994). Consequently, it is requisite to provide assessments at various stages of the criminal justice process: admission, pre-treatment, during treatment, post-treatment, follow-up, pre-release, and post-release. As such, a systematic review of both static and dynamic risk / need factors occurs continually, thus contributing specific relevant information to the Correctional Plan. At each stage of the evaluative procedure, the assessment can be

employed to simultaneously predict risk and elucidate factors to be targeted for intervention. Specialized assessments for sex offenders characteristically cover cognitions, social difficulties, lifestyle problems, and sexual deviances (Marshall & Eccles, 1991a). Moreover, all assessments should converge on the principles of risk, need, and responsivity (Andrews & Bonta, 1994; Andrews, Bonta, & Hoge, 1990).

The risk principle stipulates that higher intensity services should be reserved for higher risk cases. This is predicated on observations that higher risk cases respond better to more intensive services than to less intensive services, while lower risk offenders fare as well or better with minimal intervention.

Relatedly, the need principle states that the targets of service should be matched to the criminogenic needs of the offender. Criminogenic needs are a subset of risk (Andrews, Bonta, & Hoge, 1990). They are characterized by their potential for change: they are case characteristics that, when altered, as associated with changes in the likelihood of recidivism. Finally, the responsivity principle asserts that the styles and modes of service should be matched to the learning styles and abilities of the offenders. This increases the potential for treatment gain, ultimately mitigating recidivism.

Pre-treatment assessments should determine the timing, focus, format and content of the treatment to be delivered. This is paramount because a large body of research has demonstrated that more serious / higher risk offenders succeed in longer-term and more intensive programs, and lower risk offenders fare better in less intensive programs (Fisher, 1995; Nicholaichuk, 1996).

Evidence also suggests that programs that reduce recidivism in child molesters have little impact on rapists and exhibitionists (Marshall & Barbaree, 1990). However, other treatment paradigms have been more successful with rapists than child molesters (Marques, Day, Nelson, & West, 1994).

Finally, within groups of convicted child molesters, there is some indication of differential treatment success, dependent upon the gender of the victim: while some programs are more effective with those who have molested boys, others are more effective with those who have molested girls (Marshall & Barbaree, 1990). Considering this heterogeneity, the admission and pre-treatment assessments can and should provide for both disposition planning and tailored, individualized treatment objectives.

Evaluative information gathered during treatment can help to determine the offender's progress / response to programming. This interim assessment addresses the responsivity principle by ascertaining whether the treatment is having any impact on changing or mitigating the dynamic factors (such as criminogenic needs) that contributed to previous sexual offending. Depending on the length and structure of the program, this assessment could either be performed as a formal evaluation report, or via progress notes. It is advised, however, that early treatment effects (or lack thereof) should be interpreted with caution. Research has demonstrated that highly deviant offenders have to make substantial positive changes in order to show a treatment effect, whereas less deviant offenders require relatively less change to show a treatment effect (Fisher, 1995).

Post-treatment, follow-up, and pre-release assessment information is especially important for the evaluation of treatment effectiveness and risk to re-offend. A comparison with the pre-treatment assessments provides valuable information in regards to change in criminogenic need areas. As such, these assessments assist in the determination of suitability for institutional transfers, private family visits, temporary absences, and conditional release or preventative detention. Evaluative information obtained post-treatment and pre-release is also essential in the pre-release and release-planning phases; it should outline the structure of subsequent interventions (e.g., institutional or community-based programs). Marshall (1996) has suggested that if the post-treatment evaluation reveals no change in particular criminogenic need areas, then the offender should be recycled through those aspects of the program where s/he appears not to have benefited. Alternatively, if risk is deemed appropriately reduced, and treatment appears to have addressed the criminogenic need areas, the pre-release assessment might serve to advocate for early release.

The vast majority of incarcerated sexual offenders will eventually be released. In Canada, offenders with finite federal prison sentences are eligible for day parole, at the discretion of the National Parole Board, after having served one-sixth of their sentence. Eligibility for full parole occurs after having served two-thirds of the sentence. Offenders who are not released on parole are generally liberated at statutory release, which transpires at two-thirds of the full sentence. Post-release assessments promote an alliance between Correctional

Services and the community by monitoring offenders' risk and need levels after discharge from secure custody.

As Marshall and Eccles (1991b) have aptly noted, all pre-release assessments occur within the physical confines of the institution, thereby eliminating the everyday enticements that sex offenders find provocative. For instance, while incarcerated, pedophiles rarely have the opportunity to see children, except perhaps under heavily supervised conditions (such as during visitation). Likewise, while rapists might be in contact with female prison staff or visitors, it is always under heavily supervised, therefore minimally tempting, conditions. Conversely, evaluations performed post-release proceed within an environment where the offender is faced with numerous temptations, and has more opportunity to reoffend. As such, post-release assessments might provide a more realistic view of the offender's proclivity to reoffend in the community. In addition, post-release evaluations serve to address the management and supervision strategies for offenders in the community, by assisting case managers with decision-making processes. Often, for instance, offenders are directed to community-based relapse-prevention programs which aim to maintain pro-social behaviour. Finally, post-release assessments serve to monitor the maintenance of treatment gain and to ensure a level of community supervision that is commensurate with risk.

Methods

Whenever possible, assessment information is garnered through a variety of modalities, including psychological and physiological testing, file reviews,

behavioural observations, clinical interviews, and collateral contacts (Motiuk, 1991; Leis, Motiuk, & Ogloff, 1995). The multi-modal assessment technique is necessary for two primary reasons: first, each source of information offers unique insight into past and present problems and potential avenues for intervention, and second, it helps to mitigate various forms bias in reporting. This is especially pertinent to sex offenders who often distort, deny, or minimize their offences (Barbaree, 1991; Happel & Auffrey, 1995).

Psychological. Psychological tests may provide information regarding mental ability and neuropsychological functioning, personality, values and attitudes, and risk evaluations. Admission and pre-treatment information in these areas is often used to screen out offenders who are deemed unlikely or unable to benefit from sex offender programming. For instance, many programs have exclusionary criteria prohibiting participation of offenders who are too low-functioning or who are actively psychotic. The majority of sex offender treatment programs also exclude offenders who fully deny their offences and those with attitude problems believed sufficient to impede group therapy or disrupt treatment progression (Correctional Service Canada, 1995a).

Personality tests, such as the Minnesota Multiphasic Personality Inventory (MMPI; Dahlstrom & Welsh, 1960) are useful in the identification of a large array of psychological assets and deficits. Inventories such as the MMPI provide important information regarding the test-taker's response set. With sexual offenders, this is particularly relevant to the determination of whether the respondent is attempting to portray himself in an overly positive fashion.

Moreover, subscale scores garner information pertaining to characterological disturbance(s), depression, anxiety, mania, antisocial personality, cognitive distortions, chronic impulsivity, sexual identity conflicts, depression, anxiety, and an array of other psychological characteristics (McGovern, 1991).

Physiological. Physiological assessment techniques such as phallometric evaluation render specific information regarding deviant sexual arousal / preferences. Phallometric evaluation is paramount because the modification of inappropriate sexual preferences is central to many treatment programs for sexual offenders (Correctional Service Canada, 1995a). Physiological assessment of sexual arousal uses various (audiotapes, videotapes, slides) standardized stimuli to determine age and gender preference, as well as interest in sexual violence relative to consensual sexual interactions. Application of this technique requires a sensor or transducer to measure penile tumescence (or vaginal swelling in female sex offenders), a recording system, and a variety of sexual stimuli. The most frequently-used transducers are circumferential plethysmographs and volumetric devices (Abel, Lawry, Karlstrom, Osborn & Gillespie, 1994).

It has been well-documented that the use of these instruments in physiological evaluation differentiates pedophiles from non-pedophiles (Abel et al., 1994) and rapists from non-rapists (Lalumière & Quinsey, 1994). Additionally, it has been demonstrated that a higher degree of violence and brutality in the stimulus set (i.e., the rape scenario) is better able to discriminate rapists from men with no known history of sexual assault (Lalumière & Quinsey 1994; Rice,

Chaplin, Harris, & Coutts, 1990). There is also some empirical evidence that, amongst rapists, sexual and violent recidivism are well predicted by phallometrically measured sexual interest in *nonsexual violence* (Rice, Harris, & Quinsey, 1990). Finally, phallometry has proven to be a useful tool in risk prediction, where sex offenders who demonstrate more deviant sexual arousal are more likely to commit new sex offences upon release (Quinsey, Rice, & Harris, 1995).

Treatment providers aim to reduce offenders' deviant sexual arousal. Comparison of pre- and post-treatment phallometric tests (within-subject) enables the assessor to determine whether programming has helped to achieve this goal. There are, however, some noteworthy problems with phallometric testing. The first issue involves the fact that over 20% of the respondents cannot be correctly assessed because sexual arousal levels are consistently too low (less than 10% of full erection) for accurate classification (Abel et al., 1994; Marshall, 1996). The second issue focuses on the reality that most respondents, especially convicted sex offenders, would likely want to inhibit their arousal to deviant stimuli. This limits the utility of phallometric testing. Quinsey and Chaplin (1988) demonstrated that respondents can both inhibit and enhance sexual responding in phallometric assessment procedures when motivated to do so. As Marshall (1996) pointed out, "there is no broadly accepted standardized approach to phallometric testing... [and] some men can successfully fake a response profile without any signs being evident" (p.167).

Despite this, research has also shown that it is possible to prevent faking in phallometric assessment procedures. Quinsey and Chaplin (1988) used phallometric evaluations to test non-deviant heterosexual males under three conditions: ordinary instructions, 'fake' instructions (i.e., to appear sexually interested in rape and nonsexual violence but not in consenting sex), and fake instructions while performing a secondary semantic tracking task. Audiotaped stimuli was used, and the tracking task required the participants to press a button whenever sexual activity was being described, and to press another button whenever violence occurred. This task ensured that the participants were attending to the stimuli and focused their attention on only the critical elements of the stories. Results showed that the respondents could fake inappropriate preferences (when instructed to do so) when not required to perform the secondary task. However, when required to attend to relevant stimuli through performing the semantic tracking task, group data indicated that arousal was inhibited and despite instructions to fake sexual interest. Further research is needed to determine whether these findings are consistent with sexually-deviant subjects.

File Reviews. Institutional files include, but are not limited to: police reports, court transcripts, victim impact statements, pre-sentence and pre-disposition reports, psychological and psychiatric reports, and case management documentation. Although institutional files contain much of the information that is available through other modalities, they are useful in the assessment procedure for a variety of reasons. First, the information that is contained in the institutional

files might serve to either confirm or negate that derived from other sources. Moreover, the file review enables the generation of hypotheses to be investigated during the clinical interview. Discrepant or missing information should be carefully documented during the assessment process. Interim review of the offender's file (i.e., during each assessment) also provides for an historical account of his/her criminal 'career' and behaviour while incarcerated. As such, retrogression or progress in criminal and institutional behaviour is easily monitored through the file review procedure. Finally, the use of institutional files in evaluation is valuable because they also contain unique information that is not available by other means. This is of notable relevance to risk assessment, where research has demonstrated that "a wide variety of pre-prison case-based variables, attributes of the broader prison community, and events while in prison have considerable predictive value" (Motiuk, 1991, ii).

Behavioural Observation. Behavioural assessments are based primarily on clinical observations, although they might also include the offender's self-monitoring reports and structured role-play scenarios. These observations can be used to provide information regarding the offender's social functioning and communication skills. Behavioural assessments are especially noteworthy when dealing with sex offenders, as early theories of sexual assault focused on social skills deficits in perpetrators of such crimes (e.g., Marshall, 1971). Moreover, recent research has demonstrated that rapists exhibit deficits in empathy (Rice et al., 1990), lending support to other investigations asserting a positive relationship

between empathy and prosocial behaviour (Miller & Eisenberg, 1988; cited in Rice et al., 1990).

Most current-day treatment programs include some form of social skills training (Correctional Service Canada, 1995a). Accordingly, behavioural self-monitoring and stress and anger management are essential components of contemporary Cognitive-Behavioural / Relapse Prevention (RP) therapies (Marques, Day, Nelson, & West, 1994; Marshall & Pithers, 1994; Miner, Marques, Day, & Nelson, 1990). Thus, a comparison of pre- and post-treatment behavioural evaluations might also help to determine whether treatment has had a positive impact and readiness for release.

Clinical Interviews. Clinical interviews involve face-to-face interaction with the offender, and are perhaps the most important component of the assessment procedure. The clinical interview is generally the sole source for ascertaining information such as: acceptance of responsibility for the offence, level of empathy for the victim, and sincere willingness to seek treatment for deviant sexual behaviour. This assessment method is usually combined with other evaluative procedures, such as psychological tests and behavioural observation. It is also a common practice for the evaluator to perform a review of the offender's file prior to the clinical interview.

Although it is common for sex offenders to deny or minimize their offences (Barbaree, 1991; Happel & Auffrey, 1995), it has also been demonstrated that, under controlled conditions, offenders will disclose a tremendous amount of information that cannot be obtained by other means (Weinrott & Saylor, 1991).

However, as suggested by O'Connell, Leberg, and Donaldson (1990), for optimal results in a clinical evaluation, the therapist / interviewer should be carefully selected. Suggested considerations when choosing a therapist are: academic history, clinical experience, specialized knowledge, and personal skills and qualifications. It has also been posited that the clinical interview serves the dual purpose of data collection and the establishment of rapport between the offender and the therapist (McGovern, 1991). Specialized expertise in dealing with sex offenders is advantageous because these clients often approach assessment and treatment in a defensive, manipulative, or deceptive manner (O'Connell et al., 1990). The therapist with experience and expertise in evaluating and treating sex offenders will be better able to seize and decipher behavioural nuances, be less susceptible to manipulation, and will elicit more accurate and relevant information from the interview.

The clinical interview is constitutive in the assessment of risk to reoffend. The comprehensive clinical interview includes, but is not limited to: the offender's social / criminal history, sexual development, psychological characteristics, and sexual arousal patterns (McGovern, 1991). Moreover, a thorough interview will delineate those factors most highly associated with the respondent's pattern of offending. Thus, together with other assessment modalities, the clinical interview helps to determine which dynamic factors should be targeted for intervention pre-treatment, and which dynamic attributes have been most amenable to intervention post-treatment.

Collateral contacts. Information gathered from collateral contacts might either confirm or negate that obtained from the offender during the clinical interview. Collateral contacts might include: a spouse / partner, other family members, criminal justice personnel, mental health professionals, and any other person who could provide a greater understanding of the offender's deviant behaviour. McGovern (1991) posits that interviews with collateral contacts (including victims) should be performed whenever possible, reasoning that "few individuals are skilled in observing their own behaviors" (p.39). It is especially noteworthy when information from a variety of collateral contacts corresponds with that provided by the offender in the clinical interview; this helps to establish confidence in his / her self-report. Conversely, extreme discordance between information provided by the offender and that provided by collateral contacts should signal added caution in accepting self-report data.

Comprehensive evaluation of sexual offenders is crucial to effective programming and correctional management. Although there is no standardized assessment procedure specific to sexual offenders (Canada Working Group, 1990), there is consensus among researchers, clinicians, and treatment providers that all assessments should converge on the principles of risk, need, and responsivity. Moreover, there is also general agreement that evaluative information should be obtained through a variety of modalities and at regular intervals throughout (and possibly beyond) the offender's sentence. Areas to be assessed include, but are not limited to: social, criminal, and sexual history, sexual preference, values and attitudes, cognitive abilities, social skills,

personality, behaviour, and potential for future violence. Pre-programming evaluation and treatment should be inextricably linked and no treatment plan should proceed without an initial risk / needs assessment to identify those dynamic areas most requisite for intervention. Post-treatment assessments are essential for the identification of factors that need to be monitored and addressed during follow-up, and also to establish a correctional plan for the management of the offender after leaving treatment and secure custody (Canada Working Group, 1990).

Typologies. Several investigators have used assessment methods to classify sex offenders into typologies, showing separate cognitive-behavioural precursors to offending (Barbaree, Seto, Serin, Amos, & Preston, 1994; Knight & Prentky, 1991) and different probabilities of recidivism (Hall & Hirschman, 1991). Knight and Prentky (1991) have attested to the well-established and indispensable role of classification in the study of deviant behaviour. They argue that “[u]nderstanding the taxonomic structure of a deviant population is the keystone of theory building and the cornerstone of intervention. It provides a pivotal underpinning for research on a population and is an essential prerequisite for determining the optimum response of society to deviance” (p.23). There are several proposed classification systems and models to explain sexual offending (see, for examples, Barbaree & Marshall, 1991), though a thorough description of each is beyond the scope of the present paper. Knight and Prentky (1991) have developed two separate taxonomic systems for male sexual offenders: one classifies child molesters, and the other classifies rapists. To provide a sampling of sex offender typologies, a brief overview of each of those classification paradigms is presented in the following section.

Child Molester: Predicated on the notion that offender classification is an invaluable tool for risk and need assessment, Knight and Prentky (1991) developed a taxonomic system for the understanding and management of pedophiles. Both deductive-rational and inductive-empirical research strategies were used to construct a valid and reliable biaxial taxonomy of child molesters. Child molesters are classified along the first axis according to degree of fixation

with children, reflecting the proportion of pedophilic interest and the extent to which children are a major focus of the individual's cognitions and fantasies. Offenders are either classified as high fixation or low fixation on this dimension. Then, the offender is further subtyped on the first axis according to social competence: either high social competence or low social competence. This factor reflects the offender's success in employment and adult relationships and responsibilities. Thus, the first axis of Knight and Prentky's child molester typology yields four possible categorizations: High fixation with either high or low social competence, and Low fixation with either high or low social competence.

The second axis consists of a hierarchical series of dichotomous categorizations, beginning with the amount of contact with children. The offender is either classified as 'high contact' or 'low contact', depending upon the quantity of time that he spends in close proximity to children. If there is clear evidence that the offender spends considerable time with children in multiple contexts (both sexual and non-sexual), then he should be classified as 'high contact'. Individuals classified as 'high contact' are then subtyped according to nature of contact: either interpersonal or narcissistic. If the offender has attempted to establish interpersonal (not necessarily sexual) relationships with children, and the sexual offences are rated as having a non-orgasmic aim, then the 'high contact' offender should be classified into the 'interpersonal' subtype. Conversely, if the 'high contact' offender is deemed to have had a phallic, orgasmic aim in the commission of his sex offence(s), then he should be subtyped as 'narcissistic'.

All offenders considered to be low in their contact with children are further subtyped on the basis of physical injury to their victim(s). In cases where the victim has demonstrated clear signs of assault, the offender would be classified as 'high physical injury'. The 'low physical injury' subtype would characterize offenders who have caused little (e.g., pushing, slapping, threats) or no injury to their victim(s). Next, both 'low' and 'high' physical injury classifications are further subdivided according to the presence or absence of sadistic fantasies and / or behaviours. Within the 'low' injury group, a distinction is made between: 1) the exploitative, nonsadistic offenders, and 2) muted sadistic offenders. A 'low' physical injury individual would be subtyped into the muted sadistic classification on the basis of a description of his sexual fantasies, suggesting that his offence was motivated, at least in part, by sadistic fantasies such as bondage, urination, spanking, and so on. A 'low' physical injury offender who presents with an absence of sadistic fantasies and / or behaviour would be further subtyped into the exploitative, nonsadistic category.

Within the 'high' injury group, the sadism distinction is made on the basis of whether victim pain and suffering are sexually arousing to the perpetrator. Evidence of sexual arousal resulting from victim fear / distress, violent sexual fantasies, ritualized behaviour, or bizarre sexual acts is suggestive that the 'high' injury offender should be subtyped in the sadistic classification. The absence of such evidence in a 'high' physical injury offender suggests a further subtype of nonsadistic, aggressive.

In Knight and Prentky's taxonomy of child molesters, each offender is assigned a separate Axis I and Axis II classification, each with further subtypes. Crossing the four types of Axis I and the six types of Axis II yields 24 possible biaxial combinations. While the authors acknowledge that this seems an excessive number of types, they offer good justification for having constructed the taxonomy as such (see Knight & Prentky, 1991). Moreover, it is arguable that a precise, specific classification system provides for more individualized, tailored treatment objectives.

Rapist: Knight and Prentky (1991) constructed a separate classification system for rapists. The typology categorizes these sexual offenders into one of nine different possible subtypes on the basis of their inferred motivation for raping and their social competence. Coincidentally, the subtypes also differ in their level of criminality and impulsivity. In this taxonomy, offenders are first categorized according to the primary motivation for the commission of the offence(s): opportunistic, pervasively angry, vindictive, or sexual.

(i) *Opportunistic Type:* Rapists classified as 'opportunistic' typically commit their sexual assaults on impulse. Their offences are unplanned, predatory acts "controlled more by contextual and immediately antecedent factors than by any obvious protracted or stylized sexual fantasy" (p.44). Opportunistic types demonstrate poor impulse control, as additionally evidenced in a history of unsocialized behaviour in multiple settings and contexts. Their sexual assaults are typically devoid of gratuitous force or aggression, and they exhibit little anger except in response to victim resistance. Their behaviour

suggests that the major motivating factor is immediate sexual gratification, and if violence is used, it is simply instrumental in gaining victim compliance.

Opportunistic offenders are further subtyped on the basis of social competence: either high social competence or low social competence.

(ii) Pervasively Angry Type: The primary motivation for the 'pervasively angry' rapist is undifferentiated anger. Contrasting to the opportunistic type, these offenders often use gratuitous violence, even in the absence of victim resistance. However, brutality might be exacerbated by such resistance, and often causing serious physical injury, and sometimes even causing death. There is no evidence that their assaults are inspired by pre-existing fantasies, and their rage is not typically sexualized / arousing. Accordingly, their anger is not only manifest with women. Pervasively angry rapists usually have long histories of difficulty controlling aggression and demonstrate poor impulse control in multiple domains.

(iii) Vindictive Type: According to Knight and Prentky, the 'vindictive' type manifests a pattern of behaviour that suggests that women are a central, exclusive focus of their anger. Their sexual assaults usually involve physical harm to their victims. Moreover, it can be inferred from their actions that a primary aim of their assaults is to degrade and humiliate their victims. The anger and aggression used by vindictive rapists ranges from verbal abuse to brutal murder. However, contrasting with the 'pervasively angry' rapist, the 'vindictive' type shows no diffuse anger-- their aggression is restricted to female victims, though there is no evidence that it is eroticized or preceded by sadistic fantasies.

Unlike the 'opportunistic' and 'pervasively angry' rapists, however, the 'vindictive' type exhibits a relatively lower level of lifestyle impulsivity. Like the 'opportunistic' rapists, 'vindictive' rapists are further differentiated on the basis of social competence, creating two subgroups: vindictive type with high social competence and vindictive type with low social competence.

(iv) *Sexual Type*: 'Sexual' rapists are motivated to offend by their protracted sexual or sadistic fantasies. A classic feature of the 'sexual' type is some form of enduring sexual preoccupation, often fused with aggression and feelings of inadequacy. Rapists within the 'sexual' classification are further subtyped according to two dimensions: sadism and social competence. First, 'sexual' rapists are classified into either 'sadistic' or 'nonsadistic' subgroups on the basis of a presence or absence of sadistic fantasies or behaviours.

The 'sadistic' subgroup is further reclassified as either 'overt' or 'muted' sadism, and the nonsadistic subgroup is comprised of 'high' and 'low' social competence types. Both 'overt' and 'muted' sadistic types show poor differentiation between aggressive and sexual drives with frequent erotic, destructive thoughts and fantasies. The 'overt' sadist uses violence and causes physical harm to his victim(s) during the sexual assault(s). Moreover, the 'overt' sadist is likely to plan his assault(s). The 'muted' sadist expresses his aggression either symbolically or through fantasy; it is not expressed behaviourally. Knight and Prentky (1991) have reported that, in preliminary analyses, the overt-muted distinction is highly correlated with social competence, with the 'overt' sadist scoring low in competence and the 'muted' sadist scoring high.

Knight and Prentky describe the 'nonsadistic' sexual type as having "sexual fantasies that are associated with their sexual assaults [that] are devoid of the synergistic relation of sex and aggression" (p.45). The authors hypothesize that both the high and low social competence nonsadistic sexual types exhibit *less* interpersonal aggression in all domains. Accordingly, if confronted with victim resistance, they are more likely to flee than to become violent or aggressive. It is also suggested that the sexual assaults and fantasies of both subgroups of the nonsadistic typology reflect an admixture of "sexual arousal, distorted 'male' cognitions about women and sex, and feelings of inadequacy about their sexuality and masculine self-image" (p. 45).

Validity

The above typologies of child molesters and rapists comprise two classification systems that might prove to be extremely lucrative, both clinically and heuristically, in the understanding of sexually assaultive behaviour. For instance, Knight and Prentky (1991) have already demonstrated a reliable and consistent relationship between child molester typologies and distinctive developmental antecedents to sexual offending. The authors also report that preliminary results of a 25-year recidivism study suggest that aspects of their child molester classification system have both explanatory and predictive power.

Barbaree et al. (1994) conducted a comparison between rapists based on Knight and Prentky's (1991) sexual (opportunistic and vindictive) and nonsexual (sadistic and nonsadistic) subtypes. Results supported the utility of the typology by indicating between-group differences in: violence and victim damage in index

offence(s), psychopathy and impulsivity, social isolation, and sexual arousal to rape cues. This points to a diversity in the characteristics of rapist populations, though is suggestive *some* congruity within smaller, subtyped groups.

In Barbaree et al's study, participants included 60 incarcerated adult rapists, each of whom was assigned a primary type of either opportunistic, vindictive, sexual sadist, or sexual nonsadist. Results of data analyses revealed that within the 'sexual' group, sadistic rapists scored significantly higher than nonsadistic types on a behavioural measure of psychopathy (Factor 2: Hare's psychopathy checklist), reflecting a longer history of criminal behaviour and entrenchment in the criminal lifestyle. Moreover, compared with their nonsadistic counterparts, sadistic rapists were also significantly more likely to have used a weapon in the commission of their offence(s).

There were also significant differences between the two nonsexual types (opportunistic and vindictive) and the sexual types (sadistic, nonsadistic) in the antecedents to offending. Rapists in the nonsexual groups were less impulsive, and showed less tendency to plan their offences. However, nonsexual rapists used more force in their assaults, and caused relatively more victim injury. Rapists in the sexual group scored significantly higher on measures of social isolation than those in the nonsexual group. Finally, not surprisingly, rapists in the nonsexual groups showed less sexual arousal to rape cues (in phallometric assessment) than sexual types.

It is also noteworthy that the investigators found no between-group differences in ratings of anger. This appears contrary to Knight and Prentky's

contentions, though Barbaree et al. (1994) did not include a 'pervasively angry' group in their study because only one participant was classified as such. It is assumed that inclusion of an adequate subsample of 'pervasively angry' rapists would have yielded different results. Notwithstanding that, the data presented by Barbaree and colleagues rendered significant information pertaining to many distinctive between-group differences on both static and dynamic risk factors. The majority of their findings were consistent with expectations outlined by Knight and Prentky (1991) in their taxonomy. Moreover, Barbaree et al. (1994) suggest that their results point to a number of distinctly different psychological processes leading to sexual assault.

Female Offender Typologies. Matthews (1993) has aptly noted some important differences between male and female sexual offenders. Female sexual aggressors are far more likely to commit their offences with a cohort, and rarely or never coerce others into being accomplices. Relative to men, women use force or violence far less often, and use fewer threats of violence in efforts to keep their victims silent. Moreover, when convicted, women are less likely to deny the abuse, and take responsibility more willingly. As a group, women offenders initiate sexual abuse at a later age. While it is common for male sexual abusers to begin offending in adolescence, it is extremely rare for female abusers to have sexually offended prior to adulthood (Matthews, 1993).

Research has also demonstrated that women sex offenders differ from their male counterparts in terms of their motivations for their sexual aggressions. Matthews, Mathews, & Speltz (1991) have developed a taxonomy of female sex

offenders to reflect this disparity. Based upon a review of the literature, Atkinson (1996) concedes that this typology is the most useful to date. It consists of three basic types, based on the motivational precursors to the offences: teacher/ lover, male coerced/ male accompanied, and predisposed.

(i) *Teacher / Lover*: As the designation implies, the teacher / lover offender type initiates and carries out the abuse of an adolescent; usually a male. This type of sex offender succeeds in offending through a position of power; usually through her age and role in the victim's life. She typically has no hostility towards her victim, and does not regard her behaviour as criminal. The teacher /lover appears to seek a loving sexual expression in her interactions with the victim, believing that her sexual encounters with him (or her) are an act of kindness (Matthews et al., 1991).

The teacher/ lover offender most typically grew up in an environment of verbal and emotional abuse. Most offenders classified as such have histories of extrafamilial sexual abuse, generally in the adolescent years. In fact, it is not unusual for the teacher/ lover offender to also have a history of sexually abusive relationships with lovers (Syed & Williams, 1996).

Initially, the teacher/ lover tends to be defensive and denies any criminal responsibility. This is reflective of her distorted cognitions that the victim enjoyed, and was not harmed by, the sexual relations. Accordingly, she also minimizes the negative impact that the offending has had upon the victim(s). Despite these distortions, Matthews (1993) maintains that the teacher/ lover is relatively easy to treat effectively. Essentially, the author argues that treatment entails

cognitive restructuring, whereby the offender is convinced that her offending behaviour is not appropriate and that the victim has suffered deleterious effects. Matthews et al. (1991) argue that, relative to the other types, teacher/ lover offenders tend to have more positive backgrounds and more social skills at their disposal. As such, therapy typically proceeds at a very fast pace.

(ii) Male Coerced /Male Accompanied: As the name implies, the male coerced offender is influenced by a male cohort to participate in the sexual abuse. Often, the victim of the abuse is the woman's own child- usually a daughter. Offenders who are male coerced offenders generally endorse traditional roles in relationships, taking the subordinate position of wife/ mother. They usually fear their husbands or partners and feel powerless in interpersonal relationships. They are commonly subject to threats or physical abuse by their partners. It is not uncommon for a male coerced offender to join their male partner in abuse that he had previously been committing alone (Matthews et al., 1991).

Common characteristics of these offenders include: dependence on males, nonassertive, low self esteem, low intelligence, feelings of being unloved or unworthy, loneliness, and feelings of powerlessness in relationships. Additionally, there is a tendency for male coerced offenders to have alcohol and / or drug problems (Syed & Williams, 1996).

Male accompanied offenders possess many of the same characteristics as the male coerced offenders, though usually participate more willingly and actively in abusing their victims. While the male coerced offenders are reluctant

and participate due to fear of repercussion, male accompanied offenders appear to be more self-motivated. Although Matthews included the male accompanied type in an earlier version of her taxonomy (Matthews, 1987; cited in Syed & Williams, 1996), it has since been abandoned. However, recent research has suggested that the male accompanied type warrants inclusion (Syed & Williams, 1996).

Atkinson (1996) suggests that, although male coerced offenders are a heterogeneous group, a focus of treatment for every offender of this type should be the development of independence from their male counterparts. Empathy training, discussed later in this report, is also viewed as paramount because it is common for this type of offender to perceive the victim as responsible for the abuse (Atkinson, 1996). Alternative support for the importance of empathy training for these offenders comes from the suggestion that a lack of empathy results from having to suppress one's own feelings after having witnessed and participated in tremendous abuse (Matthews, 1993).

Cognitive-behavioural treatment in a group setting is recommended for male coerced offenders, as it attempts to reduce denial and minimization through peer confrontation. Finally, Atkinson (1996) has aptly cautioned that post-release supervision is extremely important for male coerced sex offenders because any contact with abusive or manipulative males places them at risk to reoffend.

(iii) Predisposed: Female sex offenders who are classified as 'predisposed' usually victimize their own children, in absence of a male accomplice. These women usually report being sexually abused at very early

ages, and for a number of years, by numerous family members or entrusted caretakers. Although most extricate themselves from abusive family relationships in their teen years, the vast majority experience difficulty in establishing healthy sexual relationships (Matthews et al., 1991). Accordingly, many become involved with abusive male partners and believe that abuse is commensurate with acceptance and human contact.

It is not uncommon for predisposed offenders to reveal sadistic fantasies triggered by anger. Compared to the teacher/ lover and male coerced/ male accompanied types, the offences committed by the predisposed offender are more likely to be bizarre or violent, and involve children younger than six. Moreover, they are more likely to cause pain or physical harm to their young victims (Matthews et al., 1991). Alternatively or conjointly, they are self-injurious or chronically suicidal, manifesting a vast array of emotional health concerns (Matthews, 1993; Matthews et al., 1991).

Atkinson (1996) asserts that predisposed offenders are particularly difficult to treat because of the extent of their mental health problems. More specifically, the sequelae of their own childhood victimization is often manifest in extreme anxiety or dissociative disorders (Matthews et al., 1991). Atkinson (1996) recommends that a primary consideration for treatment should be the elimination of deviant sexual fantasies. Concurrently, “[i]t is important to ensure that these offenders have absolutely no contact with children or other potential victims... Apart from this, supervision largely depends on the offender’s willingness to self-report deviant fantasies” (p.41). Finally, if significant mental illness is diagnosed,

it is paramount to monitor symptoms and to provide specialized intervention whenever possible.

(iv) Angry /Impulsive: Syed and Williams (1996) posit that one woman in their study could not be classified in any of the above types. Accordingly, the authors point to the utility of an 'angry-impulsive' classification. Briefly, this type is described as a woman who acts alone in an angry and impulsive manner against an adult male victim. Admittedly, few offenders would fit this typology, though it did typify one woman in a small sample ($n = 19$; Syed & Williams, 1996). The authors suggest that treatment of this type would entail dealing with personal abuse issues, cognitive distortions, empathy training, and anger management. Moreover, deviant arousal and social skills deficits might not be pertinent to the angry/ impulsive offender type (Syed & Williams, 1996).

The scarcity of female sex offenders makes validation of classification systems such as that proposed by Matthews et al. (1991) a dubious task. Notwithstanding that, Syed and Williams (1996) have provided some support for the utility of this taxonomy. However, it was suggested that retention of the 'male accompanied' type, and addition of an 'angry-impulsive' type would augment the viability of this model. Further investigation into the area of female sex offender classification will elucidate this matter.

Within each typology, there appears to exist commonalties in the antecedents to sexual offending. As such, taxonomic systems such as those outlined above might serve to aid in the correctional management of sexual offenders. Moreover, Knight (in press) has presented substantial evidence

demonstrating the concurrent validity, cross-temporal stability, and predictive potency of many major components of the rapist taxonomy. This lends support to other investigations demonstrating the utility of classification instruments in the assessment of post-release risk to reoffend for both male (Harris, 1994) and female (Blanchette & Motiuk, 1995) samples. It is hoped that prospective research will replicate these findings with samples comprised exclusively of sex offenders.

One fundamental objective of correctional assessment and classification is to tailor treatment and supervision strategies to the characteristics of the offender. This approach reflects the principles of risk, need, and responsivity (Andrews & Bonta, 1994; Andrews, Bonta, & Hoge, 1990). Prospective research will demonstrate the usefulness of sex offender classification in post-release prognosis. It is hoped that customized classification, together with assessment results, will enhance offender rehabilitation thus providing protection to society through a greater ability to predict risk.

TREATMENT

There is some evidence that female sexual offenders differ from their male counterparts, in response to treatment, in some important ways. In response to therapy, there is a tendency for men to forgive themselves sooner; women ruminate on feelings of guilt and shame. Accordingly, women's anger towards themselves is more deeply entrenched, thus prolonging personal healing in relation to their offences (Matthews, 1993). Moreover, as previously noted, women's motivations for committing sexual offences are often different from those offered by their male counterparts. The typologies outlined above mirror this diversity. Reflecting the scarcity of occurrence, research and programming for female sex offenders is lacking (Syed & Williams, 1996). It is noteworthy, then, that the following section is based almost exclusively on research and practice with male sexual offenders.

Treatment for sexual offenders should begin while the offender is in the institution and continue following his or her release into the community (Canada Working Group, 1990). There are a variety of treatment approaches, each with its own theoretical rationale, though cognitive-behavioural therapy with relapse-prevention is currently the most prevalent (Correctional Service Canada, 1995a; Freeman-Longo & Knopp, 1992; Marshall & Barbaree, 1990). Regardless of the treatment paradigm, programming is aimed at reducing the criminogenic needs identified during assessment.

In response to the growing proportion of sex offenders in Canadian penitentiaries, capacity for treatment has moved from less than 200 per year in

1987 to over 1700 in 1995 (Correctional Service Canada, 1995a). There are a variety of sex offender treatment programs in existence. While all programs target criminogenic needs and seek to maintain pro-social behaviour, they differ in terms of the locale in which they are delivered, and the duration and intensity of service offered. Treatment modalities include high, moderate, and low intensity institutional programs, community-based relapse-prevention, individual counseling, and community-based self-help groups.

At the federal level (offenders serving sentences of two years or more), high intensity treatment programs are located in the Regional Treatment Centres and Regional Psychiatric Centres, and Institut Pinel in Québec. In the fiscal year 1994/95, high intensity programs had a capacity of two hundred per year. Most of these programs target high risk, high need offenders, and some offer specialized services to low functioning individuals. They are highly structured and residential, and typically last approximately eight months, though may extend to up to two years. Treatment providers and ancillary professionals include nurses, sexologists, psychologists, and psychiatrists (Correctional Service Canada, 1995a).

Programs of moderate intensity are usually institutionally-based, and may last up to five months. Treatment providers are typically psychologists and / or sexologists, employed either through contract or a combination of institutional staff and contract workers. In 1994/95, there were approximately 350 intermediate intensity treatment spaces available per annum. Programs of this nature may be offered at either minimum, medium, or high security institutions,

though are more typically located in the latter. Conversely, low intensity programs are usually offered in minimum security institutions, and for a shorter duration than either medium or high intensity services. Low intensity programs proceed for 2 to 4 months, and generally do not target offenders with special needs unless they have been at least partially addressed in previous programming. In 1994/95, there were 522 low-intensity sex offender treatment spaces available per annum (Correctional Service Canada, 1995a).

Community-based relapse prevention programs are designed to maintain therapeutic gain and pro-social behaviour after release from secure custody. They are generally provided by either contract or staff psychologists, serving offenders in a group setting on a weekly basis (Correctional Service Canada, 1995a). Community-based treatment services may be offered in collaboration with provincial or municipal government programs, community agencies, hospitals, or universities (Williams, 1996a). Including all regions of Canada, there are over 600 community-based treatment locales for sex offenders (Correctional Service Canada, 1995a).

Individual counseling often serves to supplement institutional programs or community-based group intervention. It is directed by either staff or contract psychologists on a periodic or regular basis, dependent on need. Although this type of treatment is offered within the Correctional Service, it is often also sought externally. Individual counseling might also address the offender's personal issues that are peripheral to sexual offending (e.g. childhood trauma, substance abuse). Moreover, individual counseling is offered in abundance and deals with a

variety of issues. Similarly, community self-help groups [e.g., Sexaholics Anonymous (S.A.) and Sex and Love Addicts Anonymous (S.L.A.A.)] are designed for individuals with aberrant sexual interests, though not exclusively for offenders. Self-help groups are provided and sustained by their members, and the duration of membership is self-determined and thus potentially indeterminate. Individual counseling and self-help treatments are not included in the above-cited sex offender treatment capacity of 1700 per year.

Services provided to offenders are an integral part of the correctional plan. Programming that is specific to sex offenders proceeds with the major goal of reducing sexual recidivism. Regardless of the treatment modality, participation in services provided to all offenders is necessarily *voluntary* and based on *informed consent* (Williams, 1996a). Individual priority for treatment is determined by a number of factors, including: voluntariness and motivation to change, proximity to probable release, likelihood of treatment gain, and risk to reoffend (Williams, 1996a). Ultimately, treatment should offer a continuum of intervention that is commensurate with risk and need. Moreover, services should be available both in the institution and post-release and interventions at different locations should complement each other thereby providing an integrated approach to rehabilitation (Williams, 1996a).

Some investigators question the utility of current treatment paradigms in their ability to reduce sexual offending over extended time periods. This assertion is generally predicated on the notion that virtually all treatment outcome studies are plagued by serious methodological flaws (Quinsey et al.,

1993). However, other researchers posit that some comprehensive sex offender treatments have been empirically validated and do, in fact, reduce reoffending (Marshall, 1993; Marshall & Pithers, 1994). Additionally, a recent, methodologically sound longitudinal study offers promising results in terms of treatment effectiveness (Marques et al., 1994).

Despite skepticism regarding the ability of treatment to reduce sexual offending, Williams (1996b) has noted that even minute reductions in recidivism are cost efficient. The average federal sex offender spends four years in federal custody, at a cost of about \$50,000 per year. Other expenditures, including court and legal costs, and victim compensation and hospitalization add a minimum of \$25,000. Conversely, the cost of treating a sex offender is about \$7,400 per year (Williams, 1996b). As such, even if treatment is only effective for a small minority of offenders or for a short period of time, the economic burden to society abated. Finally, it would be unconscionable not to note the extreme deleterious effects that sexual offenders inflict upon their victims. Although personal distress cannot be objectively quantified, the negative long-term effects to those subject to sexual aggression is incontestable (West, 1991). Marshall and Pithers (1994) have aptly noted that:

“we have a moral obligation to offer treatment to as many clients as possible, given the disastrous consequences to innocent women and children of reoffending. Because sex offenders who reoffend typically do so against more than one victim, effectively treating just one avoids considerable human suffering” (p.23).

Although the benefits of sex offender treatment are the subject of debate amongst contemporary researchers, correctional services are mandated to offer programming to their clients. Moreover, it is requisite that interventions be theoretically and empirically based, and provided in priority to those offenders who require them most (Correctional Service Canada, 1994). Despite these directives, the treatment of sex offenders still presents somewhat of a quandary in terms of what model works best, and for whom it is most effective.

Accordingly, most programs are multi-modal in their approach. The following section will review some of the most acclaimed, prevalent and / or prolific sex offender treatment approaches.

Approaches

Biological / Medical. Treatment paradigms that are biological / medical are predicated on theory asserting that sexual offenders have a physiological anomaly underlying their deviances. Indeed, some investigators claim that “[t]here can be *no doubt* [italics added] that some unknown proportion of sex offenders commit sexual offences due to an organic or psychiatric deficit or condition” (Cooper, 1994, paper #3, p.1). Accordingly, these physiological problems are seen to warrant medical intervention; either through surgery or pharmaceutical medication. There are three main types of medical interventions for sexual offenders: surgical castration, antiandrogens or other hormonal treatments, and psychosurgery (Bradford, 1988).

Castration - Surgical: Surgical castration involves the removal of the testicles, where 95% of the male body’s testosterone is produced. Due to the

fact that testosterone has been implicated in aggressive behaviour (e.g., Owens, Matteson, Schalling, & Low, 1980; cited in Hucker & Bain, 1990), and castration causes a drastic reduction in the amount of circulating testosterone, it is assumed that castration reduces aggression, thereby reducing sexual offending. Moreover, Bradford (1988) reviewed a series of pertinent studies and concluded that there is sufficient evidence to support the contention that castration reduces sexual recidivism.

Although in the past, testicle removal was the principle treatment for sexual deviates in Europe, it has never been commonly used in North America (Cooper, 1994). In current times, most European countries have abandoned the use of castration as a viable treatment option for sexual offenders (Marshall et al., 1991). Thus, mainly due to ethical considerations, treatment of sex offenders by surgical castration has become rather obsolete and is unlikely to be used in Canada in the foreseeable future (Cooper, 1994).

Castration - Chemical: The administration of antiandrogen medication is sometimes also called “chemical” or “temporary” castration, as it achieves similar effects to surgical castration. Similar to other biological treatments, the effect of antiandrogen medication is the alteration of sexual drive. With pharmaceuticals, this is accomplished through the reduction of serum testosterone levels. In North America, the two most commonly-used hormone medications for sexual offenders are Medroxyprogesterone Acetate (MPA) and Cyproterone Acetate (CPA).

The reported effects of MPA on sexual drive were documented about three decades ago (Heller, Laidlaw, Harvey, & Nelson, 1958; cited in Bradford, 1990). Although MPA has a long history in the treatment of sexually deviant men, some of the potential side effects of this medication make it a less desirable option. In Bradford's (1990) review of the pertinent literature, he cited a number of possible physiological side effects to MPA, such as: weight gain, headaches, fatigue, hot and cold flashes, phlebitis, nausea and vomiting, hyperglycemia, disrupted gall bladder and gastrointestinal function, and sleep disturbances.

It is noteworthy, however, that the author also cited numerous studies with data indicating that the desired effects were achieved: decrease in erotic fantasy, decreased frequency in erections and orgasms, reduction in sexual drive and activity, and less irritability and aggression. One study reported continued beneficial effects over an eight-year follow-up (Money, Wiedeking, Walder & Gain, 1976; cited in Bradford, 1990). Despite the positive attributes associated with the administration of MPA to sexual offenders, the aforementioned side effects are numerous and vexatious. As a result, there is a tendency for noncompliance and a return to old patterns of behaviour after discontinuing the drug (Bradford, 1990; Marshall et al., 1991).

CPA, like its predecessor (MPA), has the effect of reducing the body's serum testosterone levels. The metabolic and behavioural effects of CPA are largely dose-dependent, though generally the beneficial results are similar to those yielded by MPA: sexual fantasies are dramatically reduced or eliminated, and erections, ejaculate, and spermatogenesis are all significantly decreased.

Moreover, there is also some evidence of decreased anxiety and irritability, and “a general reduction in psychopathological symptoms found during treatment with CPA” (Bradford, 1990, p.304).

Although there are some potential side-effects associated with the use of CPA, Bradford (1990) refers to these as “theoretical risks”, asserting that they are highly unlikely to be manifest with the dosage that is used to treat the paraphilias. Based on a review of the research, the author posits that remote side-effects include liver dysfunction, adrenal suppression, and feminization manifesting with either temporary or protracted gynecomastia.

Notwithstanding inappreciable occurrences of deleterious physical effects, Bradford (1990) argues that “[i]t is clear that CPA can play an important role in the treatment of sexual offenders. It is well documented that it can substantially reduce recidivism rates of sexual offenders, and these beneficial effects continue even when treatment is terminated” (p.306). Additionally, the author argues that based on a review of the relevant research and his own clinical experience, the need for indefinite continuation of CPA is inessential. It is recommended that after a period of 6 to 12 months of treatment, CPA dosages can be gradually tapered without increased risk of relapse (Bradford, 1990).

There is little doubt that the administration of antiandrogen medication reduces sexual drive. Accordingly, sexual fantasies and erectile and ejaculatory responding are inhibited. Moreover, there is good evidence that antiandrogens reduce sexual recidivism, at least for the duration of the treatments. However, it should be noted that there are also numerous potential physical effects

associated with the consumption of these pharmaceuticals. Treatment by this method should be reserved for individuals where it has been unequivocally established that there are no medical contraindications.

For treatment with MPA or CPA, unrestrained and informed consent are absolutely required. This issue is especially pertinent to incarcerated offenders, where antiandrogen medications might otherwise be offered through subtle coercion as a means increasing the chances of obtaining early release. This might occur because parole eligibility is contingent, in part, upon the offender's participation in institutional treatment programs. Also, the value of antiandrogen medication in a strictly controlled environment such as a correctional institution is questionable. As mentioned earlier in the present report, sex offenders have little or no opportunity to commit undetected offences within the confines of a prison. As such, pharmaceutical treatments for sexual offenders are somewhat superfluous within institutional settings. For these reasons, Bradford (1990) has suggested that treatment by antiandrogens should be reserved for offenders who have been released into the community and are subjected to various temptations.

In a meta-analysis of the effect of treatment on sex offender recidivism, Hall (1995) concluded that hormonal treatments were amongst the most effective for reducing sexual reoffending. Moreover, Hall's (1995) findings support those reported in an earlier review by Marshall et al. (1991). Thus, evidence suggests that antiandrogens such as MPA or CPA are a viable option for the treatment of sex offenders. However, there are some important considerations in the decision

to administer pharmaceuticals for these reasons. First, it is suggested that antiandrogens be reserved for those offenders with no medical contraindications, and through free and informed consent. It is also suggested that antiandrogens be administered only to offenders who have already been released into the community. Finally, it must be remembered that antiandrogens do nothing to change other problems such as criminal values or cognitive distortions. For instance, antiandrogens appear to reduce the intensity of sexual drive, but not the direction of sexual expression. Thus, a pedophile who receives hormone treatment without adjunctive therapy might experience less frequent or less intense sexual urges, but his sexual preference remains deviant. To maximize the beneficial effects of MPA and CPA, it is suggested that they are best used to supplement, rather than replace other treatment approaches (Marshall et al., 1991).

Psychosurgery: : Some research has suggested that structural brain abnormalities play a substantial role in sexual offending (Barnard, Fuller, Robbins, & Shaw, 1989; cited in Cooper, 1994). Most commonly, structures and functions associated with the brain's temporal lobes are linked with sexual behaviour (Langevin, 1990). For instance, Langevin (1990) has reported an increased frequency of temporal lobe damage, most commonly dilation of the right temporal horn, in sexual sadists compared to non-sadists. Other investigators have demonstrated structural anomalies in the left hemisphere of pedophiles (Hucker et al., 1986; cited in Langevin, 1990), and functional deficits

in the left hemisphere of exhibitionists (Flor-Henry & Lang, 1988; cited in Langevin, 1990).

Psychosurgery permanently alters the cerebral structure by producing lesions between the frontal cortex and the limbic system of the brain (Bradford, 1985). Although psychosurgery is reputed to alter sexual deviance through structural metastasis, the exact mechanisms through which this is accomplished remain unknown. This, in addition to the extremely precarious and invasive nature of the procedure, makes it dubious at best. Psychosurgery has rarely been employed since it cannot be sanctioned on ethical grounds, and its value in the treatment of sex offenders remains questionable.

Cognitive Behavioural. Early behavioural approaches to the treatment of sex offenders were predicated on the notion that the motivation for their offences were entirely sexual in nature. Consequently, treatment procedures were aimed almost exclusively at changing deviant sexual preferences (Marshall & Barbaree, 1990; Marshall et al., 1991). More recent research, however, has demonstrated that sexual offending is a multi-determined phenomena and that treatment paradigms should include other components such as cognitive restructuring, social skills training, and anger management. Thus, behavioural treatment has evolved to include these dimensions in a more comprehensive model that is both cognitive and behavioural. Currently, cognitive behavioural programs are the most prolific in Canada (Correctional Service Canada, 1995). Moreover, literature reviews and meta-analyses have both asserted that cognitive behavioural therapy, relative to other treatment models, is preferable for reducing

recidivism (Marshall et al., 1991; Hall, 1995). Indeed, when accompanied by Relapse Prevention (RP) therapy, some authors have dubbed the cognitive behavioural approach as “state-of-the-art” in contemporary sex offender treatment (Freeman-Longo & Knopp, 1992).

Cognitive behavioural treatments are offered both within correctional institutions, and in the community after release. Many are supplemented with RP therapy, which will be described in the next section of the present paper.

Although cognitive behavioural intervention varies between programs, the major treatment targets typically include: deviant sexual behaviours and interests, a broad range of social skills deficits, and attitudes and cognitive distortions regarding the offensive behaviour (Marshall & Barbaree, 1990). Accordingly, the goals of cognitive behavioural treatment include the modification of deviant sexual behaviour and preferences, cognitive restructuring, and the cultivation of improved social adjustment. As with other programs, all treatment goals converge on the fundamental objective of reducing recidivism.

Deviant Sexual Preferences / Behaviours: Perusal of the relevant literature clearly indicates that some sexual offenders show arousal to behaviours (e.g., rape) or partners (e.g., children) that are not appropriate (Abel et al., 1994; Lalumière & Quinsey, 1994; Rice et al., 1990). Consequently, cognitive behavioural programs typically include a module that is aimed at reducing deviant sexual preferences while maintaining or increasing arousal to appropriate stimuli. There are several through which this is generally accomplished: covert sensitization, aversion therapy, shame therapy, and

mastubatory reconditioning. Most contemporary programs employ some combination of these methods.

With covert sensitization, the offender is first asked to identify the sequence of events or behaviours that leads to his or her sexual offending. Next, these events or behaviours are systematically paired with highly negative consequences such as being apprehended and going to prison. It is hoped that through this repetitive imagery, the offender will associate the precursors to his / her offending with these negative consequences. There is some variation to treatment by covert sensitization. For instance, some therapists produce scripts (with the offender's help) describing the chain of events leading to offending, as well as the aversive consequences. Subsequently, the scripts are written on pocket-sized cards which the offender carries with him, and reads at least three times daily (Marshall & Barbaree, 1990). Again, the objective of this practice is to develop an association between behaviour that precedes offending and negative consequences that derive from such behaviour.

Aversion therapy, like covert sensitization, uses the tenets of classical conditioning to reduce inappropriate arousal patterns. Generally, aversion therapy pairs the deviant object/ event of arousal with an unpleasant stimulus, such as a mild electric shock or a foul odor. Many aversion techniques follow by presenting a more appropriate object / event of arousal (e.g., a slide of a naked adult woman for pedophiles) with no aversive rejoinder. It is posited that repeated pairings of the deviant object or event of arousal with noxious stimuli

will create an association whereby the offender is no longer sexually stimulated by inappropriate partners or acts.

Similarly, masturbatory reconditioning seeks to reduce or eliminate sexual arousal to deviant cues, while simultaneously maintaining or augmenting arousal to more appropriate stimuli. With this method, the offender is directed to create an appropriate (nondeviant) sexual fantasy, and to masturbate to ejaculation. Immediately after orgasm, in an unaroused refractory state, he is directed to employ his deviant fantasies and masturbate for a preset period of time. Due to the fact that masturbation during the refractory period will generally not result in orgasm, the offender will learn to associate his deviant fantasies to unsatisfying sexual activity. Moreover, with repeated masturbatory reconditioning, deviant arousal is mitigated while arousal to appropriate stimuli is augmented.

Shame therapy, also called modified deviant behaviour rehearsal, is a more rarely employed method for treating deviant sexual preferences. Treatment with this technique proceeds by having the offender role-play his or her offending behaviour, using mannequins. The role-play scenario is videotaped and subsequently played for the offender to view. Some versions of shame therapy present the videotape to the treatment group or the spouse or family of the offender. The rationale behind this mode of behaviour modification is that the experience of viewing, and having others view the videotape may dramatically strip away any pleasurable illusions associated with the deviant fantasies (O'Connell et al., 1990).

Maletzky (1991) has provided good evidence for the value of these various methods in treating deviant preferences and behaviour. However, following a review of the pertinent literature, Laws and Marshall (1990) concluded that, while there is some evidence that these behaviour-specific treatments are superior to traditional psychotherapeutic interventions, definitive conclusions cannot be drawn. Moreover, the procedures described above are usually supplemented with other interventions such as social skills training and / or antiandrogen medications (Laws & Marshall, 1990). It is also worth emphasizing that certainly not *all* sex offenders manifest deviant sexual arousal patterns. In fact, it has been estimated that only a very small proportion (less than 10%) of sex offenders experience a high frequency of intrusive deviant thoughts associated with masturbation and strong urges to offend (Marshall, 1996). These data lend support to competing theories of sexual assault, which assert that sexual offences are motivated by power and control rather than libido (Darke, 1990). It should therefore be concluded that the treatment of deviant sexual preferences should be reserved for those offenders who manifest arousal to deviant cues. Additionally, it is suggested that the value of these methods would grow incrementally when employed in conjunction with other treatment approaches.

Social Skills Deficits: Many offenders present with a myriad of social skills deficits and attitudes and modes of thinking that, if not reversed, will propel them to further offending. Thus, cognitive behavioural treatment programs also seek to improve the offenders' ability to communicate in an appropriate manner, to

demonstrate empathy, and to initiate and maintain relationships with appropriate partners. Accordingly, these modules often provide intervention in the areas of attitudes towards women, anger management and impulse control with adjunctive assertiveness training (Correctional Service Canada, 1995a).

As previously noted, a large proportion of sex offenders deny or minimize their offences (Happel & Auffrey, 1995). Although some offenders categorically deny all participation in sexual offending, it is probably more common for them to minimize the extent of their involvement or the traumatic impact that their behaviour has had upon their victim(s) (Marshall, 1996). Before other aspects of treatment can be fully effective, the offender must recognize and accept full responsibility for his/her criminal behaviour and its damaging consequences. Denial, minimization, and rationalization are frequently targeted in group therapy. Some group therapy techniques include the use of a 'hot seat', whereby an individual offender is provided (often confrontational) feedback from other group members. Moreover, it often entails deliberate baiting or challenging, and the use of psychodynamic techniques like mirroring, doubling, or role-playing (Maletzky, 1991). There is some evidence that the use of these techniques in group therapy is helpful in mitigating denial and minimization in sexual offenders (Maletzky, 1991; Marshall, 1994a, cited in Marshall, 1996).

A common deficit in sexual offenders is the ability to empathize with the victim (Maletzky, 1991; Rice et al., 1994). Also, Rice and colleagues (1994) demonstrated that deviant sexual arousal (i.e., arousal to rape scenarios) is inversely related to empathy. This suggests that a lack of empathy, in addition to

cues of victim distress, contribute to sexual arousal among rapists. Accordingly, research on empathy and moral conduct has demonstrated that empathy is positively related to prosocial behaviour (Miller & Eisenberg, 1988; cited in Rice et al., 1994). Thus, many cognitive behavioural programs include some form of empathy training for sexual offenders (Correctional Service Canada, 1995a).

Some methods for establishing empathy include: group therapy with role play (role reversal) and feedback, writing hypothetical letters of clarification and apology to the victim(s), having the offender review victims' reports and police files, reading victim impact statements, and viewing videotapes of victims being interviewed about their experiences (Maletzky, 1991; Marshall, 1996). It is assumed that an increase in empathy would be accompanied by a decrease in deviant arousal. Although there are reports that offenders experience a "strong effect [of empathy training] on subsequent actions" (Maletzky, 1991, p.166), and data suggesting that empathy inhibits sexual aggression (Canada Working Group, 1990), it is difficult to determine whether such treatment alone reduces recidivism. Empathy training is invariably adjunctive to other treatment methods, thus making it both unfeasible and impractical to test its efficacy independently.

There is adequate research showing that sexually aggressive behaviour is associated with psychological characteristics such as acceptance of interpersonal violence, sexual conservatism, and hostility towards women (Koss & Dinero, 1988). Most cognitive behavioural treatment approaches address these attitudes through varied approaches. Educational modules attempt to increase knowledge and develop responsible, healthy attitudes towards sexuality

and intimacy. Anger management and assertiveness training can help to develop the skills needed to express needs and desires in an appropriate, nonaggressive, nonmanipulative manner. There are various ways in which these skills can be taught. Some of the most common include modeling, behaviour rehearsal, and desensitization (Maletzky, 1991). As the offender's repertoire of appropriate social and coping behaviour is increased, attitudes and behaviour supportive of interpersonal violence are mitigated.

Cognitive distortions: Cognitive distortions are manifest in distorted beliefs and attitudes that serve to justify behaviour. They might include, for example, the belief that children initiate sexual activity, that fondling does not constitute sexual abuse, or that women who dress seductively are inviting sexual activity. The majority of sex offenders enter treatment with a sundry of cognitive distortions (Murphy, 1990). In particular, endorsement of rape myths and hostility towards women are common characteristics of sexual offenders, especially rapists (Koss & Dinero, 1988). The modification of cognitive distortions, also called cognitive restructuring, is subsumed in social skills training modules. Virtually all contemporary sex offender treatment paradigms include some form of cognitive restructuring (Correctional Service Canada, 1995a).

Treatment of cognitive distortions proceeds by training offenders to develop an awareness of the cognitive and affective processes that sustain criminal sexual behaviour. Subsequently, these cognitions and affects are replaced with more appropriate and adaptive ones. Again, this is often accomplished through modeling, behaviour rehearsal, and direct confrontation.

Often, treatment facilitators include a male and a female to demonstrate gender equity. Additionally, examples of effective interactions with women can also be demonstrated through the use of videotapes or role playing with group feedback (Maletzky, 1991). This genre of treatment proceeds similarly with pedophiles, though the focus, of course, is the mitigation of distorted cognitions pertaining to children. It is suggested that group therapy might be particularly useful here, as other program participants challenge the offender's distortions and problematic thinking. Cognitive restructuring, like empathy and social skills training, is always adjunctive to other treatment methods. It comprises one component of cognitive behavioural intervention. Marshall and his colleagues are currently appraising its effectiveness (Marshall, 1996) in sex offender treatment.

Together, the various intervention techniques described above comprise cognitive behavioural intervention for sex offenders. Cognitive behavioural programs have become somewhat of an orthodoxy in contemporary treatment of sex offenders: They are unequivocally the most prolific (Correctional Service Canada, 199a), and are widely touted as the most effective amongst current treatment options (Canada Working Group, 1990; Hall, 1995; Marshall et al., 1991; Marshall & Pithers, 1994).

Relapse Prevention. Relapse prevention (RP) is the newest innovation in sex offender programming. Although it was originally designed for enhancing maintenance of therapeutic change in substance abusers (Pithers, 1990), research has demonstrated the value of its tenets with sex offenders (Marshall et al., 1991; Miner et al., 1990). It should be noted, however, that RP is invariably

adjunctive to cognitive behavioural intervention (Correctional Service Canada, 1995a), thus making it difficult to evaluate independently.

RP involves teaching offenders to recognize risky or problematic situations that could lead to reoffending, and providing the necessary coping, avoidance, and/ or escape strategies to deal with such situations appropriately (Fisher, 1995). As such, RP is a highly individualized intervention that provides a method for enhancing self-management skills. Considering that RP is unique for each offender, Pithers (1990) recommends a thorough assessment to determine the distinct foci of treatment. More specifically, the assessment should necessarily: 1) specify the client's high risk situations, 2) identify his or her existing coping skills, and 3) analyze the early antecedents of his or her sexually abusive behaviour (Pithers, 1990).

RP therapy proceeds by first assisting sexual offenders to identify and avoid situations that might lead to relapse. This process of recognizing offence precursors continues throughout treatment; as therapy progresses, the offender learns to discern behavioural and attitudinal subtleties that were previously not regarded as related to his or her offences. With continued analysis of case examples, group therapy sustains the offender's ability to recognize his or her own antecedents to offending (Pithers, 1990).

Subsequently, RP provides offenders with strategies to mitigate relapses and to effectively cope with regressions in self-management. If retrogression is detected by an offender, s/he and the therapist should analyze the circumstances that preceded it. By identifying the factors that preceded the

lapse, new strategies can be developed to decrease the likelihood of recurrence. As such, the offender learns which specific tactics s/he should use to prevent future lapses (Pithers, 1990).

RP uses several procedures for self-management and avoiding relapse. Once the offender learns to identify offence precursors, s/he is taught a variety of methods to effectively cope with them. They include: stimulus control procedures, avoidance and escape strategies, programmed coping responses, and mitigating urges, and skills-building interventions (Pithers, 1990).

Stimulus control: Stimulus control procedures involve the management of external stimuli that may elicit reoffending. For instance, if alcohol use normally precedes offending, then RP would suggest that the individual reside in an alcohol-free environment and refrain from possessing alcohol.

Avoidance / Escape: Similarly, avoidance strategies control the offender's external environment to some extent. A pedophile, for example, should not reside in direct proximity to a school yard or playground. Escape strategies should be used in cases where vulnerability to relapse was not precipitated, and the offender has entered upon a high risk situation. They should be enacted at the earliest possible moment once the offender realizes that s/he has entered a high risk situation that s/he is not prepared to handle. Expedient execution of escape strategies is paramount, as the offender in a high risk situation is akin to "being in a room with a ticking time bomb" (Pithers, 1990, p.354).

Programmed Coping Responses: Programmed coping responses are devised by the offender him/herself. They involve a standard problem-solving

process, whereby a routine sequence of stages are learned and practiced. The procedure begins by describing the problem situation in detail. Next, s/he devises potential coping responses, evaluates the projected outcome of each strategy, and rates his or her ability to enact the coping behaviour. Once a number of good strategies have been developed, the offender repeatedly practices and receives feedback. It is posited that by practicing these effective coping responses over time and in a variety of situations, generalization to critical circumstances will occur (Pithers, 1990).

Mitigating Urges: RP teaches offenders to mitigate their urges by informing them that acquiescing to an urge is a *decision* that they have *chosen* for themselves, and that the immediate gratification is not worth the long-term ramifications (such as feelings of guilt, imprisonment). Often, the probability of relapse is increased when an offender selectively remembers only the gratifying aspects of the offence, neglecting the negative consequences. RP therapy attempts to mitigate urges by replacing gratifying imagery with aversive images. Pithers (1990) has provided a good example of this strategy: “ an offender may be encouraged to visualize a favourite relative looking over his shoulder as he contemplates an urge to fellate a boy. Such images deter passive submission to urges, creating sufficient delay to consider the negative consequences of the act” (p.355).

Other RP methods: Finally, it should be noted that RP also employs some of the interventions more commonly associated with cognitive behavioural treatment. These include cognitive restructuring and skills-building procedures.

Additionally, contracting is common in RP therapy (Pithers, 1990). Contracting involves having the offender and the therapist together identify clear limits to precarious situations or behaviour. Unequivocal limits are set in the contract, which the offender signs upon entry to treatment. These specify the boundaries for which lapses may be tolerated. For an exemplary contract, see Pithers (1990, p.356).

A positive aspect of the internal self management dimension of RP is that it teaches offenders to become responsible for their own treatment.

Paradoxically, it has been suggested that sexual aggressors may neglect to employ the acquired skills at critical moments of vulnerability. To compound this problem, offenders often neglect to inform their therapists, treatment providers, or release supervisors of their lapses (Pithers, 1990). Some investigators, while acknowledging the benefits of enhancing self-control, maintain that the internal self management dimension of RP alone is inadequate (Pithers, 1990).

To respond to this shortcoming, Pithers and colleagues (Pithers, Buell, Kashima, Cumming, & Beal, 1987; cited in Pithers, 1990) added an 'external supervisory' dimension to RP therapy. The external supervisory dimension serves three functions to enhance the efficacy of supervision: 1) monitoring specific, offence precursors, 2) creating an informed network of collateral contacts to assist the parole or probation officer in monitoring the offender's behaviours, and 3) creating a collaborative relationship with mental health professionals (if any) who are involved in the offender's treatment plan.

Together, the internal self management and external supervisory dimensions of RP therapy offer great promise for the management of sexual offenders. When used in conjunction with cognitive behavioural therapy, or post-release, RP therapy is especially appealing. Preliminary longitudinal data supports the efficacy of this paradigm (Freeman-Longo & Knopp, 1992; Miner et al., 1990; Pithers & Cumming, 1989; cited in Pithers, 1990).

Other. Although the focus of the present paper is assessment and intervention for sexual offenders, it should be noted that sexual offenders possess many of the same deficits as nonsexual offenders, such as substance abuse problems, educational and employment deficits, and peer, emotional, and family background problems. Moreover, this is true for both male (Motiuk & Porporino, 1993) and female (Syed & Williams, 1996) sex offenders. The majority of deficits reflect criminogenic needs, which, if not treated, may lead to reoffending among samples of mixed (Gendreau, Little, & Goggin, 1995) and sexual (Motiuk & Brown, 1996) offenders. As such, it is also important to target these factors for intervention.

Special Groups. Concluding the preceding sections on the assessment and treatment of sexual offenders, it merits special mention that the paradigms and practices mentioned herein have invariably been designed and implemented for Caucasian male offenders. There are some important between-group differences that highlight the need for additional research on special groups of sex offenders.

For instance, the effectiveness of biological interventions, particularly the antiandrogens, has been discussed. These treatments are of no utility with female sex offenders. Some additional differences between male and female sex offenders have been noted elsewhere in the present report. Despite the ineffectual nature of some of the current treatments for female offenders, it is hoped that prospective knowledge may lead to some other paradigms that are specialized for this group.

Nahanee (1996) has highlighted some other issues that are of particular relevance to Aboriginal sex offenders. These issues are paramount because Aboriginal sex offenders are *highly* over-represented in federal correctional facilities in Canada. Approximately 40% of Aboriginal offenders serving sentences of two years or more (in federal institutions) have been convicted of a sex offence (Nahanee, 1996).

Additionally, among this group, there is an increased tendency to alcohol and drug abuse. The offences committed by Aboriginal offenders differ from those committed by non-Aboriginal offenders in other important ways, including the locations in which they offend, and who their victims are. Most notably, Aboriginal sex offenders typically restrict their offences to Aboriginal communities, with almost all offences being committed within the family unit (Nahanee, 1996). These differences should have important implications for treatment.

While the majority of approaches discussed are used for *all* sexual aggressors, it is hoped that future research will bring forth some new and

innovative approaches for special groups, such as Aboriginal and female offenders. The severe ramifications to victims of sexual aggression elucidates the urgency for such research, no matter how small the offending group.

RECIDIVISM

The determination of sex offender recidivism, its correlates, and the remedial power of treatment poses a formidable task for researchers.

Determining the causes and correlates of reoffending is confounded by such factors as time at risk in the community (longer post-release periods elicit higher recidivism rates), intensity of supervision, and a variety of moderating variables. Post-release outcome studies rarely concur on recidivism rates, partly due to the numerous definition of what constitutes 'recidivism'. Broad interpretations include parole suspensions and revocations, new charges, new convictions, and returns to custody for other reasons. Conversely, more conservative definitions consider only formal convictions (and sometimes only for specific offences) as official recidivism data. These issues make interpretation of offender recidivism studies an arduous duty.

Interpretation of treatment outcome research is plagued with a host of additional problems. In research with sex offenders, sample sizes need to be exceedingly large to account for low base rates of sexual reoffending (Marshall & Pithers, 1994). Moreover, exclusive use of official data spuriously lowers recidivism rates: a large amount of offending remains undetected by these sources (Weinrott & Saylor, 1991). The problem is further compounded by participant attrition (Marques et al., 1994), where individuals are lost from the study or treatment program for a variety of reasons.

All studies of treatment efficacy should match treated offenders with untreated offenders on a variety of relevant characteristics such as age, previous

criminal history, and admitting offence (Motiuk & Brown, 1996). Ideally the control group would also be matched with the treated group on variables such as psychopathy and deviant sexual arousal. These factors have been found to be related to re-offending among both rapists (Rice, Harris, & Quinsey, 1990), and child molesters (Rice et al., 1991). This presents an additional problem, as selection criteria for inclusion into treatment might mitigate the power of the matching procedure (Marshall & Pithers, 1994).

Random assignment of research participants to groups (treated vs. untreated) is also problematic. For instance, offenders who are not motivated to receive treatment cannot be forced to participate. Alternatively, many researchers and clinicians question the ethics of denying programming to offenders who wish to participate (Marshall, 1993).

Other problems include detailing the therapeutic intervention under investigation (most are multi-modal), measurement of the therapist's adherence to the treatment protocol, and factoring in the delay between treatment completion and discharge (Marshall, 1993; Marshall & Pithers, 1994). The list of potential confounds to firm conclusions is virtually inexhaustible. The aforementioned is but a sampling of the various methodological problems that potentiate confusion and disagreement between researchers today.

Having recognized the potential shortcomings, a foregone response to the question "Does sex offender treatment work?" is this: We are still uncertain. There is disagreement even amongst the most prolific and knowledgeable researchers in the area. While some contend that the effects of sex offender

programming are equivocal (Quinsey et al., 1993), others maintain that treatment has been *demonstrated* to reduce recidivism (Marshall, 1993; Marshall et al., 1991; Marshall & Pithers, 1994).

Preliminary results of a recent, methodologically stringent investigation are promising (Marques et al., 1994). Additionally, Hall's (1995) meta-analysis of recent treatment studies showed a small, but robust, effect size for treatment versus comparison conditions. More specifically, the author found that across studies, sexual recidivism for untreated offenders was 27 percent, compared with a 19 percent for treated offenders. As assessment and treatment approaches improve to meet more specialized needs of individual sex offenders, we may expect to see increases in program effectiveness and concurrent decreases in post-release offending.

A number of studies have concurred on variables that are associated with recidivism amongst sexual offenders. Not surprisingly, the predictors of nonsexual recidivism (violent and nonviolent) are similar to those recidivism predictors found among nonsexual criminals (Hanson & Bussière, 1996; Motiuk & Brown, 1996; Rice et al., 1990). These include factors such as age at release, prior criminal history, substance abuse, unemployment, and unstable living arrangements.

There is a significant body of research demonstrating that sexual recidivism is well predicted by number of prior sexual offences and deviant sexual arousal (Hanson & Bussière, 1996; Motiuk & Brown, 1996; Prentky, Knight, & Lee, in press; Quinsey, et al., 1995). Psychopathy is asserted to be

another salient risk factor for sexual recidivism (Harris, Rice, & Cormier, 1991; Quinsey et al., 1995).

In general, rapists reoffend more often than child molesters. This is true for both sexual (Canada Working Group, 1990) and nonsexual, violent recidivism (Hanson & Bussière, 1996). However, among child molesters, those with male victims have been found to have the highest recidivism rates, followed by those with unrelated female victims (Canada Working Group, 1990; Hanson & Bussière, 1996; Quinsey et al., 1995). Accordingly, incest offenders consistently show the lowest recidivism rates of all sexual offenders (Motiuk & Brown, 1996; Quinsey et al., 1995). When sexual aggressors do reoffend, they tend to repeat the offence for which they were originally convicted (Canada Working Group, 1990).

Finally, it is noteworthy that sexual recidivism is also predicted, to a lesser extent, by some of the same variables that predict reoffending in samples of nonsexual offenders. Examples include age at release (Hanson & Bussière, 1996; Motiuk & Brown, 1996), marital status (Hanson & Bussière, 1996; Quinsey et al., 1995), alcohol and drug abuse problems (Motiuk & Brown, 1996).

CONCLUSIONS

The present report has provided a literature review of contemporary assessment and treatment paradigms for sexual offenders. The importance of a thorough, comprehensive assessment and subsequent individualized treatment has been emphasized. It can be tentatively concluded that current treatment paradigms are encouraging in terms of recidivism reduction. This appears to be especially true for comprehensive approaches that follow a cognitive behavioural model with adjunctive relapse prevention components. For some offenders, treatment with antiandrogen / hormonal medications might prove to be additionally beneficial.

Some fundamental problems with recidivism and treatment outcome research have been elucidated. Notwithstanding those issues, some sound research has converged on several correlates and predictors of both sexual and nonsexual recidivism in samples of sex offenders. These variables have been briefly outlined above.

Sexual offending remains a serious problem in Canada today. With the numbers and proportions of sex offenders in federal custody on the rise, there is an urgent call for empirically robust longitudinal research. Although preliminary results regarding the effectiveness of current approaches appear favourable, assessment and treatment is invariably designed for the prototypical sex offender. More specifically, there has been little or no consideration of sex offenders who are female or Aboriginal, despite evidence that they do not fit the prototype.

It is hoped that prospective research will provide methods to improve upon current assessment and treatment models. In achieving these goals, recidivism is reduced and protection of the public is enhanced.

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