Vol. 3 No. 4 1991

On Corrections Research

FORUM

FEATURE ISSUE

Sex Offender Programming

Matching Risk and Needs with Programming

The Value of Community Treatment Programs

Relapse Prevention with Sex Offenders

Evaluations of Community-based Programs in the Pacific and Ontario Regions

Denial and Minimization among Sex Offenders

Correctional Service Canada
Service correctionnel Canada

FORUM ON CORRECTIONS RESEARCH is published quarterly in both English and French for the staff and management of the Correctional Service of Canada.

It reviews applied research related to corrections policy, programming and management issues. It also features original articles contributed by members of the Correctional Service of Canada and other correctional researchers and practitioners.

FORUM is prepared and published by the Research and Statistics Branch, with the assistance of the Communications Branch, Communications and Corporate Development Sector of the Correctional Service of Canada.

FORUM invites contributions to any section of the magazine from researchers in the field. Please send your contributions to Frank J. Porporino, Director General, Research and Statistics Branch, Correctional Service of Canada, 340 Laurier Avenue West, Ottawa, Ontario, Canada K1A 0P9. Accepted manuscripts are subject to editing for style and length.

Editors: Frank J. Porporino
Tanya M. Nouwens
Production Manager: Jean-Marc Plouffe
Text Editors: PMF Editorial Services Inc.
Design Concept: 246 Fifth Design Associates
Typesetting and Layout: Nancy Poirier Typesetting Ltd.
Creative Advice and Implementation:
Canada Communication Group
Professional Services Division
Supply and Services Canada

Sections of the magazine with no acknowledgement of authorship have been researched and written by the staff of the Research and Statistics Branch, Correctional Service of Canada. The following individuals have made significant contributions to this issue: Claire Stirling and Bart Millson.

For further information regarding the content of the magazine, please contact:
Research and Statistics Branch
Correctional Service of Canada
340 Laurier Avenue West
Ottawa, Ontario
K1A 0P9

To request copies of this publication, please contact:
Publishing and Editorial Services
Correctional Service of Canada
340 Laurier Avenue West
Ottawa, Ontario
K1A 0P9

Pour plus de renseignements sur le contenu de FORUM, prière de s'adresser à la :
Direction de la recherche et des statistiques
Service correctionnel du Canada
340, avenue Laurier ouest
Ottawa (Ontario)
K1A 0P9

Pour obtenir des exemplaires supplémentaires de FORUM, prière de s'adresser à l'adresse suivante :
Services de rédaction et de publication
Service correctionnel du Canada
340, avenue Laurier ouest
Ottawa (Ontario)
K1A 0P9

Printed on Recycled Paper

ISSN 0847-0464

Forum on Corrections Research

We have a certain humility in corrections, where we do not tend to acknowledge, and we sometimes even dismiss, areas in which we have made substantial progress. The assessment, treatment and management of sex offenders is one such area where Canada is leading the way.

Corrections is constantly reminded of its errors and its failures. When we err in how we deal with sex offenders, our error is usually catapulted into the public's eye. There is special sensitivity and understandable reaction, sometimes spilling over to the point of questioning whether there is value in any of our programs and practices. Under this type of scrutiny, it is often difficult to maintain momentum in our work.

This issue of FORUM is a tribute to the momentum we have sustained and to the value that can be found in a number of programming endeavours targetted for sex offenders. It is also a tribute to the rigour with which such programs are being developed, implemented, delivered and evaluated.

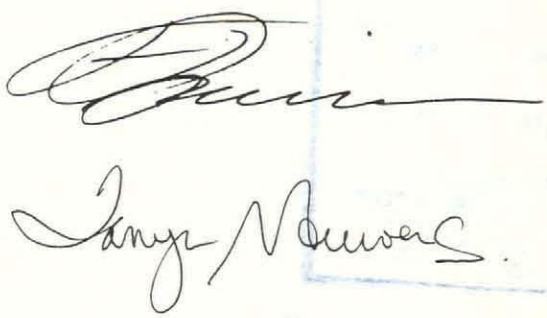
The first thing you will notice as you glance through the table of contents for this issue of FORUM is that it does not follow the traditional format of several sections of articles, all with a different focus. This issue has one format and one focus: articles written by practitioners and researchers, mostly Canadian, who have been working to develop and improve the state of the art in sex offender programming.

This work is recent, and has been pursued with rather feverish intensity, in part because of the pressure of numbers, but primarily because we have set our minds on the goal of better programming for sex offenders.

This is a classic example of organizational learning. Even as recently as a few years ago, when we talked about sex offenders, we spoke almost exclusively about protective custody and means of ensuring humane custody. Then, the talk of specialized programming came from a few experts found in small pockets across the country, for example, our regional psychiatric or treatment centres.

Now, we find programs for sex offenders at the institutional and community levels, developed and managed not only by professionals but also by case managers, other correctional staff and even offenders themselves. Of course, the mere existence of additional programs is not enough. But, as this issue of FORUM underscores, we are also seeing programs based on solid therapeutic principles specific to sex offenders' needs. Further, many of these programs now have the capacity to "self correct" and create new knowledge, incorporating comprehensive research and evaluation components.

But, despite these positive developments in the way corrections deals with sex offenders, it is not enough. Looked at in the broader social context, sexual victimization cannot be controlled by federal corrections alone. Crime statistics speak to this issue: of the more than 30,000 sexual crimes reported to the police in 1990, less than 30 were committed by federal offenders who were under supervision in the community. It is true that one sex offender recidivist is one too many. It is also true that not all sex offenders reach us in federal corrections, and it is therefore hoped that what we learn in dealing with the most serious sex offenders can be used and applied by other segments in our network of social and mental health services. This makes this issue of FORUM particularly important, as it represents one vehicle by which we may all become part of a learning society.



Frank J. Porporino and Tanya M. Nouwens
Editors

Everything You Wanted to Know about Canadian Federal Sex Offenders and More...

by the Research and Statistics Branch,* Correctional Service of Canada

Being convicted of a sex-related offence in Canada will not necessarily result in a federal sentence (i.e., two years or more). Individuals who are incarcerated for sex-related offences are more likely to be committed to provincial facilities for a period of less than two years.

Those who do end up under federal jurisdiction are most likely to have received a four-year sentence and to have committed a sexual assault on an adult female.

At any one time, there are apt to be twice as many federal sex offenders serving time in an institution, usually medium-security, than in the community under supervision. Those being supervised in the community are most likely to be on full parole.

Once released, federal sex offenders are less likely than other federal offenders to commit a new offence. In fact, there is less chance of a released federal sex offender committing a new offence than a non-sex offender. However, the probability of a sex offender committing a new sex-related offence once released is higher than that of a non-sex offender.

This information is part of a comprehensive statistical profile of federal sex offenders prepared by the Research and Statistics Branch of the Correctional Service of Canada.

Where information was already available, we reviewed the findings of past studies on Canadian sex offenders. For the most part, however, this article presents original data.

* This article is based on comprehensive statistical information and briefing material prepared by Larry Motiuk, Ray Belcourt, Roger Boe, David Robinson and Sue Séguin of the Research and Statistics Branch, Correctional Service of Canada and on an overview of this information and material which was prepared by Doug Borrowman of the Evaluation Branch.

Background

The Ministry of the Solicitor General struck a working group on the Management and Treatment of Sex Offenders as a result of a number of factors, including the rapid growth of the federal sex offender population and the recommendations of formal enquiries (e.g., Pepino, Daubney).

The working group reported its findings and recommendations in March 1990. Some of the key findings follow:

- Practitioners in the field of sex offender treatment do not claim to "cure" sex offenders. Rather, the treatment strategy is to manage the risk of reoffending (relapse prevention).
- Continuity of treatment from the institution to the community is critical.
- There are not enough experts to meet the demand for sex offender treatment.
- There is a need for more and diverse programming, and outcome research is lacking.
- The limitations of treatment are recognized. The risk of future dangerous behaviour must be addressed as an issue separate from progress in treatment.

A sound knowledge of the sex offender population is necessary for a follow-up on these recommendations and those of the Correctional Service of Canada's Task Force on Mental Health.

Recognizing this, the Research and Statistics Branch has developed a statistical information base on sex offenders, pooling information from a number of sources including the National Parole Board and the Canadian Centre for Justice Statistics. The following is an overview of some of the information available.

A Snapshot of the Current Situation

Total Population

- Categorizing offenders by their major admitting offence – the one for which they received the longest sentence – one finds that **11 of 100** federal offenders are sex offenders (11.3% of the total federal offender population, including incarcerated offenders and those on conditional release).
- On 31 July 1991, there were **2,469** offenders under the jurisdiction of the Correctional Service of Canada whose major admitting offence was sexual in nature.
- About **two thirds** of these sex offenders were in institutions (**incarcerated**) and about **one third** were in the community on some form of **conditional release**.

Incarcerated Population

- Categorizing offenders by their major admitting offence, one finds that **14 of 100** incarcerated offenders are sex offenders (13.9% of the population).
- On 31 July 1991, there were **1,679** offenders incarcerated under federal jurisdiction whose major admitting offence was a sexual offence.
- **One half** of these incarcerated sex offenders were in **medium**-security institutions, and about **one quarter** were in **maximum**-security institutions. More specifically:
  - minimum security: **18.5%** of all sex offenders;

- medium security: **51.3%** of all sex offenders;
- maximum security: **25.8%** of all sex offenders; and
- regional psychiatric or treatment centres: **4.3%** of all sex offenders.

Conditional Release Population

- Categorizing offenders by their major admitting offence, one finds that **eight of 100** offenders on conditional release are sex offenders (8.1% of the population).
- On 31 July 1991, there were **790** federal offenders on conditional release whose major admitting offence was a sexual offence.
- **One half** of these sex offenders on conditional release were on **full parole**, and a little more than **one third** were on **mandatory supervision**. More specifically, of the 790 sex offenders on conditional release:
  - **117** (14.8%) were on **day parole**;
  - **389** (49.2%) were on **full parole**; and
  - **284** (35.9%) were on **mandatory supervision**.

Where Are These Sex Offenders?

- Regionally, the **Ontario and Prairie regions** have the most sex offenders, with each being responsible for approximately **one quarter** of the sex offender population.
- In a comparison of the proportion of sex offenders in each region with the proportion of general offenders, **Quebec** has a **smaller proportion** of sex offenders than general offenders. The **Prairie and Pacific regions** have **larger proportions** of sex offenders than general offenders.
- More specifically:
  - Atlantic: **10.0%** of sex offenders, and **9.7%** of all offenders (about the same proportion of each);
  - Quebec: **20.3%** of sex offenders, and **29.6%** of all offenders (proportionately fewer sex offenders);
  - Ontario: **25.2%** of sex offenders, and **26.4%** of all offenders (about the same proportion of each);
  - Prairies: **26.2%** of sex offenders, and **20.9%** of all offenders (proportionately more sex offenders);
  - Pacific: **18.3%** of sex offenders, and **13.4%** of all offenders (proportionately more sex offenders).

Understatement of Sex Offender Population

The actual number of sex offenders incarcerated or under some form of conditional release is **understated** because current computer systems identify offenders by their major admitting offence.

The Correctional Service of Canada's National Sex Offender Census, conducted in March 1990, identified all offenders who had committed a sex offence, not just those whose most serious offence was sexual in nature.

The census included anyone currently serving a sentence for a sex offence (about 85% of those identified through the census fall into this group); anyone who was convicted in the past for a sex offence; anyone who has committed a sexually related offence; and anyone who has previously committed a sex offence but was never convicted.

- The census identified about **15% more** sex offenders than the computer systems.
- Accordingly, the census study showed that sex offenders make up **18.9%** of the incarcerated population (compared with 13.9% identified through computer systems) and **9.9%** of the conditional release population (compared with 8.1%).

Recent Trends

Sex Offender Population

- The incarcerated sex offender population under federal jurisdiction has **grown rapidly and disproportionately** to the total offender population over the last five years.
- The number of offenders whose major admitting offence was a sex offence has grown from **1,339** (**10.6%** of the offender population) in 1986/87 to **1,716** (**12.4%** of the population) at the end of March 1991.
- Only a small proportion of sex offenders in Canada fall under the jurisdiction of the Correctional Service of Canada. In 1987/88 and 1988/89, fewer than **one of four** sex offenders sentenced to a term of incarceration were given a federal sentence (of two years or more).

Admissions

- Over the past five years, there has been a **20.4% growth** in the rate of admission of offenders whose major admitting offence was a sex offence.
- In 1986/87, there were **545** admissions of sex offenders (**8.9%** of a total of 6,136 admissions). By 1990/91, this figure had risen to **692** (**10.7%** of a total of 6,475 admissions).

Releases

- Over the past five years, there has been a **17.6% growth** in the rate of release of offenders whose major admitting offence was a sex offence.
- In 1986/87, there were **501** releases of sex offenders (**8.1%** of a total of 6,165 releases). By 1990/91, this figure had risen to **599** (**9.6%** of a total of 6,266 releases).

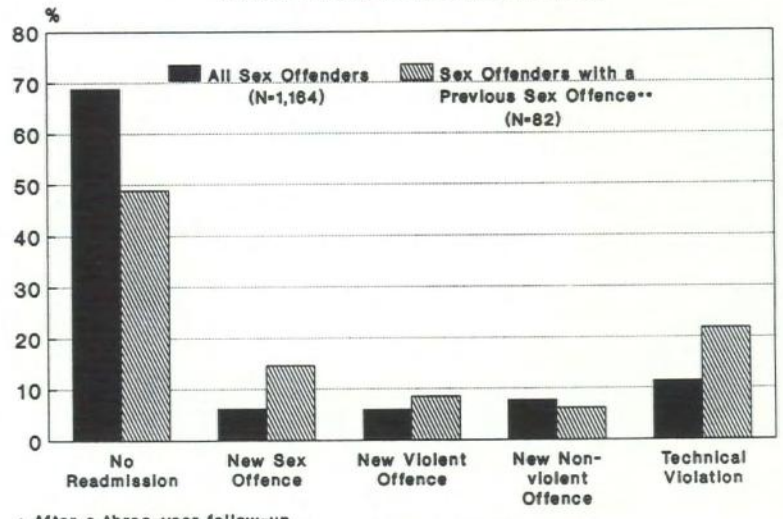
Sentence Length

- The average sentence length in 1990/91 for all offenders admitted with a sex offence as their major admitting offence was **four years and three months**.
- The average sentence length for sex offenders has **not changed** significantly over the last five years, although it has increased slightly (by **1.7%**).
- There is **no significant difference** between the average sentence length of sex offenders and that of all federal offenders.
- In 1990/91, the average sentence length for all federal offenders was **4.13 years**, or one month less than for sex offenders.

Recidivism and Return Rates

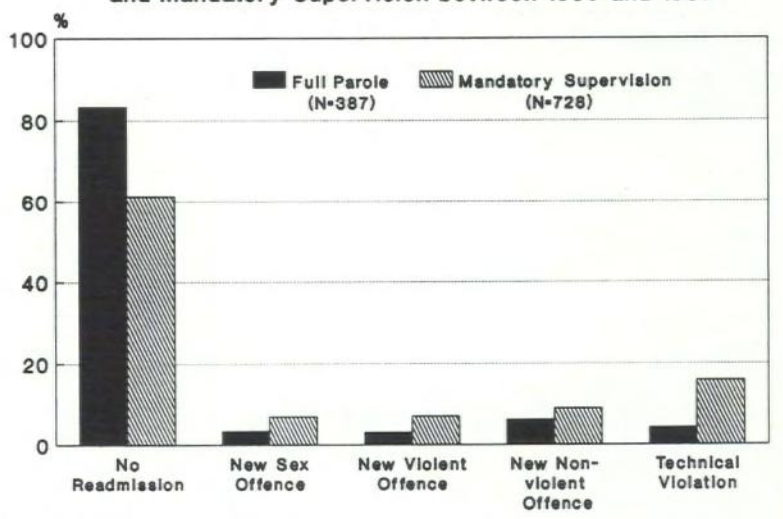
- The recidivism rate of sex offenders is **less** than that of offenders in general.
- Sex offenders are **more likely** than offenders in general to return to prison or to recidivate with a sex offence.
- Compared to all sex offenders, **repeat sex offenders** (those with a previous federal term for a sex offence) are more than **twice as likely** to commit further sex offences, **much more likely** to violate conditional release conditions, and **more likely** to reoffend with a non-sexual offence.[1] (See Figure 1.)
- More specifically, a three-year follow-up study of all sex offenders released from federal institutions between 1985 and 1987 (N=1,164) found the following (see also Figure 1):
  - no readmissions:
    repeat sex offenders – **48.8%**
    all sex offenders – **68.8%**
  - new sex offences:
    repeat sex offenders – **14.6%**
    all sex offenders – **6.2%**
  - new violent offences:
    repeat sex offenders – 8.5%
    all sex offenders – 5.9%
  - new non-violent offences:
    repeat sex offenders – 6.1%
    all sex offenders – 7.7%
  - technical violations:
    repeat sex offenders – 21.9%
    all sex offenders – 11.3%
- This study also found that sex offenders who were released on mandatory supervision were **twice** as likely to commit further sex offences than those released on full parole and **more than twice** as likely to commit violent offences. (See Figure 2.)
- More specifically, the study found the following:
  - no readmissions:
    mandatory supervision – **61.3%**
    full parole – **83.2%**
  - new sex offences:
    mandatory supervision – **6.9%**
    full parole – **3.4%**
  - new violent offences:
    mandatory supervision – **7%**
    full parole – **3.1%**
  - new non-violent offences:
    mandatory supervision – 8.9%
    full parole – 6.2%
  - technical violations:
    mandatory supervision – 15.9%
    full parole – 4.1%

Figure 1
Comparison of Release Outcome* of All Sex Offenders and Repeat Sex Offenders Released between 1985 and 1987



* After a three-year follow-up.
** Offenders with a previous federal term for a sex offence.

Figure 2
Comparison of Release Outcome* of Sex Offenders Released on Full Parole and Mandatory Supervision between 1985 and 1987



* After a three-year follow-up.

Detention Cases

Under normal circumstances, offenders are eligible to be released on

[1] *A. Gordon and F. Porporino, "Managing the Treatment of Incarcerated Sexual Offenders,"* Corrections Today, *53, 5 (1991): 162-168.*

day parole after serving one sixth of their sentence, and full parole may come after one third. If an offender poses too great a risk to the public, he or she will not be granted parole. After serving two thirds of their sentence, these offenders must be released on mandatory supervision unless exceptional circumstances warrant their being detained until the end of their sentence.

- Since detention legislation was effected, **half (52.6%)** of all offenders detained (309 of 587) have been sex offenders, a highly disproportionate number.
- Moreover, the number of sex offenders detained in federal penitentiaries has increased by **150%** over the last five years, from **32** in 1986 to **80** in 1990.

Types of Sex Offence

- According to the National Sex Offender Census,[2] **most** sex offenders had committed either a **sexual assault** or **"mixed" sex offences**. **Pedophilia** was also common. The **least** frequent offence was **incest**.
- More specifically:
  - mixed offences: **27.9%** of sex offenders;
  - sexual assault: **25.2%** of sex offenders;
  - pedophilia: **21.0%** of sex offenders;
  - incest: **6.2%** of sex offenders; and
  - other offences or not known: **4.6%** of sex offenders.

Information about Victims

The National Sex Offender Census also gathered information on the victims of federal sex offenders. While the census looked at offenders' past sex offences, for the purpose of this section on victims, only current sex offences are considered (N=2,561).

Age

- **Adults** are **more frequently** the victims of sex offenders. The sex offender census found that an adult was the victim in about **half** the cases, a **child** in about **one third** and an adolescent in about **one third**.[3]
- More specifically:
  - adult (18 or over) victims: 1,288 cases;
  - adolescent (12 to 17) victims: 847 cases; and
  - child (under 12) victims: 864 cases.

Degree of Physical Injury

- The census also showed that in more than **half** the cases, the victim had slight or no physical injuries.
- In more than **one of 20** cases, the victim had injuries severe enough to cause death.
- More specifically:
  - no physical injury: **26.2%** of cases;
  - slight physical injury: **31.2%** of cases;
  - treated and released: **11.5%** of cases;
  - hospitalized: **9.6%** of cases;
  - caused death: **6.4%** of cases; and
  - not known: **16.1%** of cases.

Psychological Harm to Victims

Although psychological harm is more difficult to assess than physical injury, a review of relevant literature, carried out on behalf of the Solicitor General Secretariat, had some important findings.

- The **majority** of victims suffer **severe trauma** shortly after a sexual attack.
- **One of four** adult victims and **one of two** child victims report **long-term negative effects.**
- Less than two days after the sexual attack, **three quarters** of adult victims are unable to do ordinary daily tasks, and **almost half** suffer severe psychological disturbances.
- More than a year after the incident, **one quarter** of adult victims report continuing negative effects.
- In the first year following disclosure of the sexual attack, **half to almost three quarters** of child victims display significant psychological symptoms.
- **Half** of adults who were sexually abused as children report lasting negative effects. ■

A Word on Recidivism...

"A reasonable conclusion from the available literature...is that treatment can be effective in reducing sexual recidivism from about 25% to 10-15%. No approach can guarantee complete success....The approaches currently considered especially promising are structured programs that address a range of sexual offenders' risk factors/needs and include relapse prevention components."

From: *Solicitor General of Canada, "The Management and Treatment of Sex Offenders."* Report of the Working Group: Sex Offender Treatment Review. *(Ottawa: Minister of Supply and Services Canada, 1990), p. 19.*

[2] *As mentioned previously, the sex offender census included offenders who had committed sex offences in the past as well as those who currently were serving a sentence for a sex offence.*

[3] *Figures may not total 100% as some offenders had multiple victims in more than one age group.*

Managing and Treating Sex Offenders: Matching Risk and Needs with Programming

by Arthur Gordon, Ph.D.,* Roger Holden, Ph.D.** and Timothy Leis, Ph.D.***

A recent census of federal sex offenders has confirmed what most prison staff already know: the number of sex offenders in federal institutions is increasing. In 1990, sex offenders accounted for 13.1% of new admissions to federal prisons, while a decade earlier the figure was 8.5%.[1] Indeed, the Correctional Service of Canada has more than 3,000 sex offenders currently within its jurisdiction.

Consistent with its Mission Document, the Correctional Service of Canada has attempted to respond to this increase by providing resources for more specialized treatment. In addition to treatment at the regional psychiatric centres, several institutions (e.g., Warkworth, Mission, Dorchester) have introduced formal programs. Despite these increased resources, only one quarter of sex offenders under the jurisdiction of the Correctional Service of Canada are receiving or have received treatment.[2]

* Chief Psychology/Research, Regional Psychiatric Centre (Prairies); Adjunct Professor, Department of Psychology, University of Saskatchewan

** Psychologist, Bowden Institution

*** Regional Psychologist, Prairie Region; Assistant Professor, Department of Psychiatry, University of Manitoba

The expansion of treatment resources is based on a major assumption that must be validated empirically. First, it is assumed that treatment will reduce an offender's risk of sexual recidivism, thus allowing for an earlier and safer return to the community. Despite some encouraging reports,[3] evidence that clearly demonstrates the impact of treatment on sex offenders is still ambiguous,[4] particularly for in-patient programs.[5] More important, few comprehensive evaluations of treatment programs funded by federal corrections have been reported.[6]

Even if treatment is shown to reduce recidivism, we must ask whether all sex offenders have an equal need for specialized and intensive treatment.[7] Can sufficient treatment for some sex offenders be found in programs already in place for the general offender population? Must all treatment be provided during incarceration, or could some offenders safely receive less costly services in the community? Is the delivery of programs in prison sufficient to affect offenders' behaviour in the community, or should treatment be continued following release? Answers to these questions are essential if we are to make the best use of available resources to minimize the risk sex offenders pose to the community.

This paper addresses some of these questions. A review of the data on treatment outcome from the sex offender program at the Regional Psychiatric Centre (Prairies) provides preliminary evidence that treatment may positively affect sexual recidivism. The data also suggest that the treatment uniquely affects different types of sex offenders.

This paper also proposes a program that integrates treatment services during and following incarceration. Known as the Parkland Wellness Program, this strategy is designed to provide timely, appropriate and cost-effective assessment and treatment services for sex offenders throughout their sentence.

The Clearwater Program

Since 1981, formalized treatment services for sex offenders have been provided at the Regional Psychiatric Centre (Prairies). The Clearwater Program, as it is known locally, has evolved into a six-month cognitive-behavioural package with a focus on relapse prevention.[8]

A comprehensive evaluation strategy, including a wide variety of

[1] *F. Porporino and L. Motiuk, "Preliminary Results from the National Sex Offender Census." Paper presented at the Third Annual CSC Research Forum. (Whistler, British Columbia, 1991).*

[2] Ibid.

[3] *For example, W. Marshall and H. Barbaree, "An Outpatient Treatment Program for Child Molesters," in R.A. Prentky and V.L. Quinsey (Eds.),* Human Sexual Aggression: Current Perspectives. *(New York: New York Academy of Sciences, 1988) 205-214.*

[4] *L. Furby, M.R. Weinrott and L. Blackshaw, "Sex Offender Recidivism: A Review,"* Psychological Bulletin, *105, 1 (1989): 3-30.*

[5] *W. Marshall and H. Barbaree, "Outcome of Comprehensive Cognitive Behavioral Treatment Programs," in W.L. Marshall, D.R. Laws and H.E. Barbaree (Eds.),* Handbook of Sexual Assault: Issues, Theories and Treatment of the Offender. *(New York: Plenum Press, 1990) 363-385.*

[6] *Solicitor General of Canada, "The Management and Treatment of Sex Offenders."* Report of the Working Group: Sex Offender Treatment Review. *(Ottawa: Minister of Supply and Services, 1990).*

[7] *A. Gordon and F. Porporino, "Managing the Treatment of Incarcerated Sexual Offenders,"* Corrections Today, *53, 5 (1991): 162-168.*

[8] *R. Laws,* Relapse Prevention with Sexual Offenders. *(New York: Guilford, 1989).*

theoretically relevant psychometric and behavioural measures,[9] has been part of the program since its inception. These evaluations consistently show that program graduates demonstrate highly significant and positive changes over the course of treatment.

Since 1981, 250 sex offenders have entered treatment. Fifteen percent of these did not complete the program (i.e., completed less than four months of treatment). Most of these (approximately 70%) left after only a few weeks, claiming that they had "changed their mind" or that they "weren't ready for treatment." Most of the others who did not complete the program were asked to leave because of their aggressive and disruptive behaviour.

As of June 1990 when the data were gathered, 169 treated men had been released into the community. The average length of time since release was four years, with a range of four months to nine years. We note that all analyses reported below were repeated using only those men who had been released for at least one year. Findings from this reanalysis did not change any conclusions.

Four types of outcome were defined, based on information from Finger Print Service (FPS) records: no readmission to a correctional institution, revocation of mandatory supervision or parole without any additional charges or convictions, one or more convictions for non-sexual offences, and one or more convictions for sexual offences with or without non-sexual offences.

Outcome was also measured at two different times. In some analyses, we considered only the first event that brought the offender back to prison. In other analyses, we considered all offences (events) recorded after the offender left treatment (post treatment).

Results

The outcome data are contrasted with several admittedly weak comparison groups. More appropriate comparison data are being gathered for a group of 90 men who were interviewed for the Clearwater Program but who did not receive treatment.

The treatment group was first compared to a group of 1,100 sex offenders released from federal institutions over a three-year period and followed up three years later.[10] Note that in gathering this data, Porporino and Robinson reported only the first event after release. No group differences in sexual recidivism rates are apparent between the treated men (7.1%) and the national sample (6.2%).

All sex offenders are not equally likely to recidivate.

However, if we consider only offenders who have a previous history of sex offences, the treatment sample shows 37% fewer sexual reconvictions than the non-treated sex offenders (with recidivism rates of 9.2% versus 14.6% respectively). This last finding is consistent with the conclusion of Andrews and colleagues[11] that correctional treatment has its greatest impact with higher-risk offenders.

We also looked at the outcome for the 25 released men who did not complete the Clearwater Program. The results suggest that these men represent a greater risk, and more effort should be made to keep them in treatment. Specifically, considering all events during the follow-up period, men who did not complete treatment were much less likely to avoid reincarceration (32% versus 53%). Furthermore, they were almost twice as likely as program completers to be convicted of at least one further sexual offence (24% versus 13.6%).

Our research indicates that all sex offenders are not equally likely to recidivate. As summarized in the following figure, pedophiles were most likely to be reconvicted of sex offences, while incest offenders were least likely to recidivate. Rapists were most likely to be reconvicted for non-sexual offences. Consistent with our earlier conclusions,[12] recidivism rates for men who had assaulted both adults and children (rapist/pedophile in the figure) resembled those of rapists rather than pedophiles.

Not all pedophiles were found to be equally likely to commit another sex offence. If we look at all events after treatment, we find that more than half (57%) of bisexual pedophiles, compared with less than one fifth (17%) of heterosexual pedophiles and no (0%) homosexual pedophiles, committed further sex offences. This is consistent with the work of Abel and colleagues[13] who found that, among child molesters, greater variety in the age and gender of victims was associated with higher rates of recidivism.

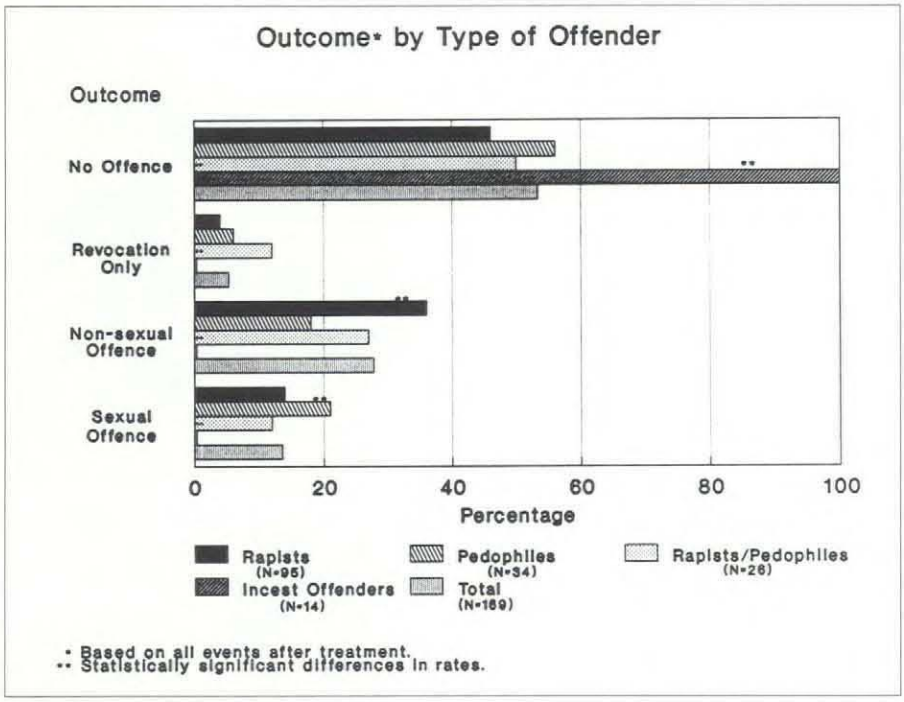
[9] *A. Gordon and H. Bergen, "Description and Evaluation of a Comprehensive Treatment Program for Sexual Offenders." Unpublished manuscript, Regional Psychiatric Centre, Saskatoon, Saskatchewan, 1988.*

[10] *F. Porporino and D. Robinson. Unpublished report, Research and Statistics Branch, Correctional Service of Canada, 1991.*

[11] *D. Andrews, I. Zinger, R. Hoge, J. Bonta, P. Gendreau and F. Cullen, "Does Correctional Treatment Work? A Clinically Relevant and Psychologically Informed Meta-analysis,"* Criminology, *28 (1990): 369-404.*

[12] *A. Gordon and J. Looman, "Characteristics of Men Who Sexually Assault Both Children and Adults." Presented at the IXth biennial meeting of the International Society for Research on Aggression. (Banff, Alberta, 1990).*

[13] *G. Abel, M. Mittleman, J. Becker, J. Rathner and J. Rouleau, "Predicting Child Molesters' Response to Treatment," in R.A. Prentky and V.L. Quinsey (Eds.),* Human Sexual Aggression: Current Perspectives. *(New York: New York Academy of Sciences, 1988) 223-234.*



Discussion

The present data provide preliminary evidence that treatment is affecting sexual recidivism among high-risk sex offenders. Firmer conclusions await analysis of our no-treatment group.

Our task should be to improve identification of higher-risk offenders and give them priority for treatment.

The Clearwater Program appears to be particularly effective with homosexual pedophiles but shows poorer results for men who have assaulted both boys and girls. Clearly, we have to review and improve our approach to the latter group.

It would also seem that the program is particularly successful with incest offenders. However, this apparent success must be viewed in context: incest offenders in general, even if left untreated, have very low rates of recidivism.[14]

The recidivism rates reported by Porporino and Robinson[15] for a largely untreated sample of sex offenders are lower than have been previously reported in the literature.[16] These relatively low recidivism rates suggest that not all sex offenders may "need" treatment. Our task should be to improve identification of higher-risk offenders and give them priority for treatment. We recognize that imposing treatment on low-risk and low-need offenders can be counter-productive.[17]

The data from the Clearwater Program indicate that pedophiles, even if treated, present a greater risk to the community than other sex offenders. These men should receive the most extensive treatment available while still incarcerated. Following release, continued treatment under close supervision is also warranted.

At the other extreme, incest offenders present the least risk to the community. It might, therefore, be more appropriate to offer these offenders community-based treatment following release, which costs less than institutional treatment. Currently, though, incest offenders are as likely as pedophiles to receive treatment during incarceration.[18]

The rapists in our sample present a moderate risk of committing new sex offences but are more likely to commit additional non-sexual crimes. This pattern is consistent with the conclusion that, as a group, rapists are most similar to the general offender population.[19] Sufficient treatment for most of these men may be provided through programs, such as anger management, already being offered in all federal institutions. Relapse-prevention training might well be useful for both rapists and non-sex offenders. The more violent and recidivistic rapist may require more intensive and specialized services, and his risk and needs should be carefully evaluated.

A final comment relates to postrelease follow-up. The relapse-prevention model of treatment does not attempt to "cure" sex offenders. Rather, offenders are helped to gain control over their urges and behaviours and to avoid future sexual deviance. It follows that offenders' ability to generalize and apply skills learned through treatment in the institution should be monitored and reinforced in the community by knowledgeable personnel.

In the Clearwater experience, the availability of treatment in the community has been very uneven. Some cities on the Canadian prairies are rich in resources to treat sex

[14] *Furby, Weinrott and Blackshaw, "Sex Offender Recidivism: A Review."*
[15] *Porporino and Robinson. Unpublished report.*
[16] *Furby, Weinrott and Blackshaw, "Sex Offender Recidivism: A Review."*
[17] *Andrews, Zinger, Hoge, Bonta, Gendreau and Cullen, "Does Correctional Treatment Work? A Clinically Relevant and Psychologically Informed Meta-analysis."*
[18] *Porporino and Motiuk, "Preliminary Results from the National Sex Offender Census."*
[19] *Gordon and Porporino, "Managing the Treatment of Incarcerated Sexual Offenders."*

offenders. Other communities have few service providers who will deal with these people. Moreover, community therapists may adopt a variety of treatment models that may be at odds with treatment already completed. Thus, rather than being helped to refine and implement self-management skills, many offenders find themselves starting treatment over again.

Ideally, we must integrate institutional and community services to provide continuity and consistency of care. We believe that the recidivism rates found with the Clearwater Program can be reduced through more systematic and consistent community follow-up.

The Parkland Wellness Program

We turn now to a recent programming initiative in the Prairie region of the Correctional Service of Canada. The Parkland Wellness Program was born out of the need to increase services for sex offenders at Bowden Institution, a medium-security penitentiary with approximately 450 inmates.

The need for such services was obvious. In March 1991, there were 208 men in Bowden Institution whose current conviction was a sex offence. (This did not include men who were in Bowden for other crimes but had previous sex offences on record.) Of these 208 sex offenders, 167 had never been involved in any sex-offender treatment program. Bowden inmates do have access to specialized programs at the Regional Psychiatric Centre, but the demand for admission was such that only about 20 inmates per year could be treated there.

In brief, the Parkland Wellness Program is designed to improve services for sex offenders by co-ordinating the efforts of Bowden Institution, the Regional Psychiatric Centre (Prairies), parole officials and the community.

Sex offenders will be screened and assessed upon their arrival at Bowden to determine their treatment needs and risk level. The highest-risk offenders will be referred to the Regional Psychiatric Centre. Low-risk offenders will be geared toward earlier release with treatment being provided in the community. Moderate-risk offenders will receive most of their treatment at Bowden with an option for transfer to the Regional Psychiatric Centre if necessary. In all cases, community follow-up will be provided to ensure that the positive effects of treatment are not lost.

Repeated assessment of psychological and risk status will provide important information for decisions on treatment and release throughout the offender's sentence. All involved centres are committed to adopting compatible treatment and assessment procedures to ensure continuity of care. Such continuity and consistency will also facilitate information sharing, while providing a data base to allow for clinical and evaluative research.

The triage approach to classifying risk and need (according to level of priority) will allow for more efficient use of resources.

Some of the issues and problems that the Parkland Wellness Program attempts to address include:

- **Effective Use of Resources**
  Providing all sex offenders with the type of intensive treatment available at the Regional Psychiatric Centre would be financially prohibitive as well as unnecessary. The triage approach to classifying risk and need (according to level of priority) will allow for more efficient use of resources. In general, we expect that pedophiles and more violent rapists will be prime candidates for the Regional Psychiatric Centre. Most rapists will be treated at Bowden, while most incest offenders will receive primary services in the community.

- **Reduction of Redundancy**
  Treatment settings that deal with the same offender type often develop their own assessment and treatment procedures. Typically, there is little or no integration of approach across these various settings. This lack of consistency can be particularly frustrating for the offender, who must complete yet another set of psychological tests at each setting or who must start treatment anew from a different perspective.

  The Parkland Wellness Program will address this problem in two ways. First, there will be consistent assessment and treatment provided to the inmate throughout incarceration and following release. Ideally, this treatment will start as soon as the inmate has been identified as a sex offender. From that point on, there will be a co-ordinated intervention throughout the offender's sentence. As 95% of those released Clearwater patients who reoffended did so before the end of their sentences, it was decided that follow-up should extend at least this long (until end of sentence). We recognize that even longer follow-ups would be beneficial for some offenders.[20]

  Second, assessment and treatment procedures must be complementary. All agencies involved in assessment and treatment of offenders in the Parkland Wellness Program will adopt the same core battery of psychometric, phallometric and related assessment instruments (e.g., risk assessments). Moreover, all centres will adopt a cognitive-behavioural relapse-prevention model of treatment.

[20] *Marshall and Barbaree, "Outcome of Comprehensive Cognitive Behavioral Treatment Programs."*

- **Accountability**
  To be successful, the Parkland Wellness Program must deal with at least three areas of accountability.
  1) **The inmate to the program**
  Participants must be accountable for their effort in the program. It is not sufficient merely to attend groups. Rather, participants must demonstrate that they have absorbed the information provided and that they have begun to alter their thinking and behaviour patterns.
  2) **Program providers to funding sources**
  It is not sufficient just to operate a program. Rather, we must be able to demonstrate that our efforts are both cost-efficient and effective. Because halfway-house placements are a fraction of the cost of institutional placements, treatment should be provided in the community whenever possible. Similarly, providing quality services in a main institution is considerably less expensive than transferring and treating an inmate in a regional psychiatric centre. As well, to increase timely releases to the community, we must work closely with parole authorities. In particular, to increase the National Parole Board's confidence in our recommendations, we must ensure that our assessments and treatment can be shown to be valid and effective.
  3) **The program to the inmate**
  The triage method of delivering services, where different levels of risk and need are matched with different levels of programming intensity, ensures that offenders will have access to the most appropriate resources. Providing complementary services in the community should ensure that offenders who complete the necessary program while incarcerated will not have to duplicate their efforts on release. Rather, once inmates have adequately demonstrated competence in institutionally based programs, they can expect to receive community support in maintaining and implementing these skills.

- **Efficacy**
  The Parkland Wellness Program must demonstrate that its components are actually achieving their goals. The assessment and triage processes will be closely monitored to ensure that valid decisions are made in a timely manner. Each component of the program (e.g., anger management) will be evaluated to ensure that the expected psychological and behavioural changes are being achieved. Finally, the impact of the program will be assessed to determine whether recidivism rates are dropping.

- **Research**
  Fundamental to the success of the Parkland Wellness Program is its commitment to both "pure" and treatment-outcome research. As just described, research on program effectiveness is an essential part of ensuring that the Parkland Wellness Program remains accountable. However, we also must conduct basic research on sex offenders to improve our treatment efforts. A comprehensive data base, now being implemented at Bowden Institution, will complement data bases at the Regional Psychiatric Centre and, ultimately, at community treatment sites. Although maintaining such a data base is resource intensive, it is indeed necessary for effective research in the future.

- **Phased Introduction**
  We believe that we can improve the delivery of services to offenders by ensuring that assessment and treatment strategies are consistent. Although this project is being piloted only on a limited scale at present, we will move toward more uniformity across the Prairie region.

The obvious advantages of this approach – for the sharing of information, non-duplication of services and research – are entirely consistent with the recommendations of the recent report of the Correctional Service of Canada's Task Force on Mental Health. ■

A Word on Responsibility...

"Sex offenders cannot remain solely a correctional problem. We would argue that, as part of its long-term planning for treating sex offenders, corrections must enter into discussions with the courts and with community mental health and social service agencies to ensure proper coordination, perhaps over the course of many years, until public safety is no longer threatened."

From: *A. Gordon and F.J. Porporino, "Managing the Treatment of Incarcerated Sexual Offenders,"* Corrections Today, *53, 5 (1991): 162-168, p. 168.*

The Value of Community Treatment Programs for Released Sex Offenders

by William L. Marshall, Ph.D.* and A. Eccles, Ph.D.*

Clinicians and researchers working with sex offenders now widely believe that these men require both reassessment and treatment once they are released from institutional settings.[1] Tentative long-term data from postrelease, community-based programs are now available. The data offer limited but encouraging support for the idea that adding these postrelease components – reassessment and treatment in the community – to the overall treatment approach for incarcerated sex offenders reduces their subsequent rates of recidivism.[2]

* Kingston Sexual Behaviour Clinic and Department of Psychology, Queen's University

During the past three years, the Correctional Service of Canada has been expanding its treatment programs for sex offenders in the Ontario region. This will give more sex offenders the opportunity to rehabilitate themselves, lessening the threat they pose to the security of women and children.

The number and capacity of treatment programs in maximum-security institutions (Kingston Penitentiary, Protective Custody and Ontario Regional Treatment Centre) and medium-security institutions (Warkworth Institution) have been increased and, more recently, a program has been established in a minimum-security setting (Bath Institution).

Programs at the maximum- and medium-security institutions are intended for those offenders who have extensive problems requiring comprehensive treatment. The more limited program at Bath Institution (minimum security) is intended for offenders with lesser problems (e.g., incest offenders) and for those who have already been through the more extensive programs.

These positive changes in the Correctional Service of Canada's approach to dealing with sex offenders match corresponding changes under way in the British Prison Service.[3] The changes also address much of the earlier criticism of the failure of Canadian society to treat many incarcerated sex offenders.[4]

In addition to these positive steps, the Correctional Service of Canada has recently begun funding post-release, community-based programs aimed at facilitating the move of sex offenders back into society.

Assessment

Community-based programs must reassess sex offenders once they are released. Assessments conducted within institutions are essential for determining the benefits an offender has derived from treatment programs and for judging postrelease risk and needs. However, these evaluations take place in an environment (i.e., a prison) where the everyday sights and sounds that sex offenders find provocative are mostly absent. A child molester may, while in prison, see images of children on television or in magazines, but only rarely will actually see a child (perhaps at visiting times). Even then, it is under conditions of maximum supervision and minimal temptation. Rapists certainly see female staff while in prison. Again though, supervision and the careful conduct of staff restrict opportunities for an offence to occur and reduce the likelihood of the rapist experiencing urges to offend.

Institutional assessment of a child molester's attraction to children or a rapist's proclivity to attack a woman sexually is done under the controlled and artificial conditions of a prison. It therefore cannot provide a sound basis for predicting sex offenders' responses in a postrelease world full of women and children.

One must keep in mind that treatment programs for sex offenders cannot "cure" their deviant tendencies. Treatment does not eliminate the urges or desires to offend sexually; it simply reduces them to a controllable level. This means, of course, that if a sex offender is placed in a highly

[1] *J.K. Marques, "The Sex Offender Treatment and Evaluation Project: California's New Outcome Study,"* Annals of the New York Academy of Sciences, *538 (1989): 235-243. See also W.L. Marshall, S.M. Hudson and T. Ward, "Sexual Deviance," in P.H. Wilson (Ed.),* Principles and Practice of Relapse Prevention. *(New York: Guilford Press, at press). And see W.D. Pithers, G.R. Martin and G.F. Cumming, "Vermont Treatment Program for Sexual Aggressors," in D.R. Laws (Ed.),* Relapse Prevention with Sex Offenders. *(New York: Guilford Press, 1989).*

[2] *J.K. Marques, D.M. Day, C. Nelson and M.H. Miner, "The Sex Offender Treatment and Evaluation Project." Third Report to the California Legislative, July 1989. See also W.D. Pithers and G.F. Cumming, "Can Relapses Be Prevented? Initial Outcome Data from the Vermont Treatment Program for Sexual Aggressors," in Laws,* Relapse Prevention with Sex Offenders.

[3] *W.L. Marshall, "The Design of Institutional Programs for Sex Offenders in Britain." Paper presented at the British Prison Psychologists Annual Conference. (Scarborough, England, October 1991).*

[4] *W.L. Marshall and S. Barrett,* Criminal Neglect: Why Sex Offenders Go Free. *(Toronto: Doubleday Publishing, 1990).*

provocative situation, this control will be threatened and the risk of offending will increase.

This rather obvious observation is the basis for the recent development of relapse-prevention components and their addition to treatment programs for sex offenders.[5] Relapse prevention helps the offender avoid risks and cope effectively when some degree of risk is unavoidable.

Once a sex offender is released from prison into an environment where temptations are prevalent, the possibility of encountering risky situations is at its maximum. This sudden change in the number and type of temptations is compounded by the fact that offenders are given much, if not complete, responsibility for their movement in the community. It would be negligent not to consider this radical change in potential risk.

Community-based programs must, therefore, re-evaluate sex offenders within the first month of their release back into society. While the sexual preferences of released offenders must be reassessed, their attitudes, emotional functioning, and current living style and conditions also need re-evaluation.

During the past year, we have evaluated, at our community clinic, a number of sex offenders who were released from penitentiaries in the Ontario region. These men had been assessed in their institutions before release, and most had been recommended for community treatment as part of their release plan. Prerelease assessments showed that most of these offenders were ready for a return to society: that is, their sexual preferences were normal, their anger and hostility were well under control, their attitudes were prosocial and their release plans were sensible.

In a small but important number of cases, however, release into the community led to new problems or significant reversals of treatment gains. In each of these cases, the return of deviant thoughts was prompted either by the stresses associated with readjustment to society or by the offender's perception of being surrounded by women or children and being allowed relative freedom to watch them in inappropriate ways.

Watching potential victims in this way is one of the behaviours that initiates a return to the whole cycle of deviance. It is typically followed by the reappearance of deviant fantasies, which usually trigger deviant urges. With the consequent distortion of thinking, when the offender convinces himself that offending is not all that bad, the stage is then set for a reoffence.

By retesting offenders, we can detect this negative drift early enough to prevent an offence. We must then decide whether the offender is sufficiently in control to continue treatment in the community, or whether he should be returned to a more secure setting, that is, either to a halfway house or back to a minimum-, medium- or maximum-security prison.

To illustrate what can happen when a previously incarcerated sex offender is exposed to the provocative situations of society, we present the particularly dramatic case of an offender who showed a remarkable loss of treatment gains after only a single month in the community. When this man was assessed at the Regional Treatment Centre (Ontario) after treatment and two months before release, he displayed clear sexual preferences for normal, consenting relations with adult women. He was also found to have significantly more self-confidence as a result of treatment and to have developed a more positive, less hostile attitude toward others, particularly women. It was determined that he had dealt with his propensity to abuse alcohol and that he now assumed responsibility for his behaviour. Finally, he had a release plan that involved placement in a halfway house while he searched for a job and accommodation.

We assessed this offender one month after release (i.e., three months after the institutional evaluation) and found that exposure to society had eroded all the gains of his institutional treatment. He showed strong sexual arousal to depictions of rape, and a level of arousal to young girls that put him at serious risk to reoffend. In our interviews, it was clear that he saw himself as a victim rather than as a responsible person able to direct his own life. He was angry at everyone, particularly the criminal justice system and all associated with it, and he was very hostile toward women. He had made little effort to find a job or a place to live. Perhaps not surprisingly, before we could initiate any treatment, he returned to the halfway house overdue, intoxicated and aggressive, and was immediately sent back to jail.

Although this case represents an unusual degree of reversal upon release, it does illustrate the risk we take if evaluations of sex offenders done in the institution are considered the final word in determining postrelease risk for reoffending.

Furthermore, it is not just the institutional evaluations of risk that may be altered by an offender's exposure to the community; the institutionally prepared relapse-prevention plans may also need to be changed. We saw one offender, for instance, who had been encouraged to follow his interest in fishing in order to fill idle release time with some constructive activity. Idle time is frequently associated with an increased risk of reoffending among sex offenders, so the recommendation to pursue an already-established interest was quite sensible. So that he could enter a treatment program, the man was released to an unfamiliar community, which also provided him with frequent opportunities to fish. The problem was that the available fishing sites were frequented by young boys, and his offence history involved the sexual molestation of boys. We advised him to seek out another, less risky pastime.

Our responsibility clearly does not end with evaluation; we must also

[5] *Laws,* Relapse Prevention with Sex Offenders.

involve these offenders in treatment and in informed supervision after release from prison.

Treatment

The community treatment of sex offenders who have been released from penitentiaries seems such a sensible part of rehabilitation that one wonders why it was not required long ago. Community treatment and supervision are the main components of the essential final stage in an overall plan to reduce recidivism among convicted sex offenders.

We have argued elsewhere[6] that incarceration is a sensible and appropriate part of society's response to a sex offender, and that treatment while the offender is in jail is essential.

Similarly, a graded and selective movement through the jail system is needed to optimize the offender's chance of rehabilitation. Extensive and comprehensive treatment in a medium- or maximum-security institution should be provided for those sex offenders who pose a moderate to high risk.

After completing this treatment, these offenders should be moved to a less intense program in a minimum-security setting. Here, they should be joined in treatment by those sex offenders who are designated as low risk.

From the minimum-security program, these sex offenders should be released into the community, either directly to a halfway house or as part of a gradual release program, depending on their risk to the community.

If unresolvable problems arise at any one of these stages, it should be possible to move the offender quickly back into a more secure setting. Clearly, several countries – most notably Canada, Britain, New Zealand and some states in the United States – are moving rapidly in this direction, although implementation of this comprehensive response has not yet been fully achieved.

There are two components to treating released sex offenders in the community: correction of those problems identified at community reassessment, and implementation and supervision of the offender's relapse-prevention program.

As we noted earlier, the responses some offenders display once back on the street are very different from those evident at the time of the institutional prerelease evaluation. In the case of the rapist illustrated in the section on community assessment, we would have had to implement a rather comprehensive program had the offender not been returned to jail. Returning him to the institution was a much more sensible response than leaving this dangerous man in the care of a community program.

Community programs are not meant to correct serious flaws in dangerous offenders. This is why it is so essential that movement backwards in the system be a ready option.

As we have described, we have seen sex offenders whose deviant urges, fantasies and distorted thinking patterns, successfully corrected in an institutional program, returned once they were on the street for a few weeks. For these men, many of the elements of their institutional treatment programs must be repeated.

For instance, if an offender shows a return to deviant sexual arousal patterns at assessment or reports strong deviant sexual urges or fantasies, then he should undergo some combination of masturbatory reconditioning[7] and covert sensitization or olfactory aversion[8] (where unpleasant images and odours are used to create an aversion to a particular sexual deviation). In those cases where urges are frequent and intense, then perhaps anti-androgen treatment[9] or a course of serotonergic medication (both drug treatments) will be required to reduce the strength of these urges.[10]

If the offender's distorted and self-serving thinking patterns have returned (e.g., negative views of women, acceptance of rape myths or beliefs that justify sex with children), then cognitive-restructuring techniques should be implemented.[11]

Anger management, victim empathy, substance abuse treatment, social skills training, relationship therapy and other components of comprehensive cognitive-behavioural programs[12] may be needed, depending upon the nature of the returning or emerging problem.

Emotional distress or cognitive disturbances brought on by the stress of return to society, and all the responsibilities and disappointments that go with it, may require referral to a psychiatric clinic if the community program does not have its own psychiatrist.

[6] *Marshall and Barrett,* Criminal Neglect: Why Sex Offenders Go Free.

[7] *D.R. Laws and W.L. Marshall, "Masturbatory Reconditioning with Sexual Deviates: An Evaluative Review,"* Advances in Behaviour Research and Therapy, *13 (1991): 13-25.*

[8] *W.L. Marshall and A. Eccles, "Issues in Clinical Practice with Sex Offenders,"* Journal of Interpersonal Violence, *6 (1991): 68-93.*

[9] *J.M.W. Bradford, "The Antiandrogen and Hormonal Treatment of Sex Offenders," in W.L. Marshall, D.R. Laws and H.E. Barbaree (Eds.),* Handbook of Sexual Assault: Issues, Theories and Treatment of the Offender. *(New York: Plenum Press, 1990).*

[10] *H. Pearson, "Paraphilias, Impulse Control and Serotonin,"* Journal of Clinical Pharmacology, *10 (1990): 133-134.*

[11] *H.E. Barbaree and W.L. Marshall, "Treatment of the Sexual Offender," in R.M. Wettstein (Ed.),* Treatment of the Mentally Disordered Offender. *(New York: Guilford Press, at press).*

[12] *W.L. Marshall and H.E. Barbaree, "Outcome of Cognitive-Behavioral Treatment," in Marshall, Laws and Barbaree (Eds.),* Handbook of Sexual Assault: Issues, Theories and Treatment of the Offender.

In most cases, treatment for released offenders can be limited and need involve only one or two components to address problems that were treated in the institution. For most released offenders, relapse-prevention training is the most critical feature of treatment. It has recently been added to most comprehensive programs for sex offenders.

The first step in relapse prevention is to have offenders recognize the factors that led to their offences and that might put them at risk in the future. Some of the more common factors identified in this stage of relapse-prevention training are: stress, interpersonal or relationship problems, use of intoxicants, distressing emotional states, deviant or distorted thinking, an idle or aimless lifestyle, or situations in which one is alone with children or in a place where one may encounter a lone woman. Each individual is assisted in developing a personal list of risk factors. In addition, help is given on how to avoid these risks or to deal with them when they are unavoidable.

Most of relapse-prevention training is best done in the institution, where the list of risk factors and strategies for dealing with them can be prepared as part of the offender's postrelease plan. The relapse-prevention plan can then be shared with those who will treat and supervise the offender on the street.

The community treatment program can then help the offender effectively to implement and, if necessary, modify the relapse-prevention plan when confronting the reality of life back on the street. Parole officers can also effectively help the offender by using the relapse-prevention plan to identify particular issues that need to be watched.

Lack of compliance in treatment is a common problem in community programs. All too often, offenders believe that once they are released from jail, they only have to go through the motions without properly participating in treatment. Offenders may object to the manner in which treatment is conducted and ask to be referred elsewhere. The most common complaint we hear from offenders is that they do not like group therapy or that we are too confrontational when dealing with their denials, minimizations and distortions of the offence.

When offenders fail to participate or request to be referred elsewhere, our response must be carefully considered. If it is "soft," offenders will see no reason to make an effort to deal with their problems. Offering an alternative treatment is likely to encourage offenders to believe that they can simply run away to another therapist whenever they feel uncomfortable in treatment. If there are no significant consequences for failure to co-operate with treatment, offenders will not be encouraged to participate meaningfully.

It is very important that it be possible to reverse an offender's progress through the stages of release and reintegration. Unco-operative offenders should be told that their stay in a halfway house or on their own in the community depends on full and proper participation in the treatment program to which they have been referred. Offenders who still do not comply should be returned to the next stage back in their release program (i.e., to the halfway house if they are on their own, or to the institution if they are in the halfway house). Once offenders demonstrate a determination to comply, they can be released again into the community.

Summary

The rehabilitation of sex offenders should be seen as a staged process, each step of which is vital to reducing the risk sex offenders pose when they are returned to the community.

An essential link in this process is postrelease assessment and treatment, both of which should be incorporated in the release plan prepared in the institution. Assessments done in the community may reveal a loss of institutionally based treatment gains and may indicate a need both to treat these problems and to modify relapse-prevention plans. Community treatment can continue and elaborate upon the processes initiated by institutional treatment, can correct community-induced reversals or new problems and can begin implementing the offender's relapse-prevention plan.

The ability to move the offender readily and quickly back to more secure settings will help resolve problems arising in community treatment.

Finally, our hope is that the Correctional Service of Canada will continue to expand current efforts to fund community-based treatment of released sex offenders. Such efforts will go a long way to reduce the risk these men pose to innocent women and children in our society. ■

A Word on Early Intervention...

"Although significant differences exist in the theories of etiology and change on which different treatment approaches are based, there is common agreement that a substantial number of sex offenders begin their sexually assaultive behavior as adolescents, that sexual offenders develop patterns of assaultive behavior that are chronic and habitual, and that the earlier intervention begins, the greater the potential for disrupting these patterns of behavior."

From: *L.L. Lockhart, B.E. Saunders and P. Cleveland, "Adult Male Sexual Offenders: An Overview of Treatment Techniques,"* Journal of Social Work & Human Sexuality, *7, 2, (1988): 1-32, p. 4.*

Community-based Treatment for Sex Offender Programs: Recent Initiatives in the Ontario Region

by Lynn Stewart, Ph.D., C.Psych.*

Since the mid-1970s, the Correctional Service of Canada has provided a comprehensive specialized treatment program for sex offenders in the Ontario region through the Regional Treatment Centre in Kingston and through a satellite program in Kingston Penitentiary. Over the years, the demand for the service has outstripped available resources, creating a need for a second program which, for the last three years, has been run out of Warkworth Institution.

Together, these two programs currently treat about one third of all sex offenders in the Ontario region. The remaining untreated population consists of sex offenders who refuse treatment, those who reach their release dates before they can be offered treatment and those who are assessed as not requiring treatment.

The progress of graduates of the institutional programs has been informally followed by their therapists after they returned to their parent institutions. Once released, however, it was rarely possible to arrange suitable aftercare in the community. Existing community-based programs were usually offered through hospitals where the requirement for a provincial hospital insurance number rendered the programs inaccessible to offenders on day parole. For offenders on some other form of conditional release, program acceptance criteria were often so narrow that most federal offenders would be excluded.

With funds provided to support recommendations made by the Task Force on Community and Institutional Programs, community-based sex offender programs have been established in four centres in the Ontario region: Ottawa, Kingston, Hamilton and Toronto.

* District Psychologist, Central District Parole, Ontario Region

A recent review of federal correctional programs for sex offenders recommended a co-ordinated treatment strategy that would complement institutional programs with community-based programming.[1] There are many arguments to be made in support of community programs. Several recent studies underscore the importance of maintenance programs following the intensive phase of treatment. These maintenance programs act as booster sessions, reinforcing skills and insights gained in treatment.[2]

Community-based programs provide a treatment option that reduces unnecessary and expensive incarceration for certain types of offenders. These might include such federal offenders as incest perpetrators who are assessed as low risk to reoffend and federal offenders who have received relatively short sentences and might not be granted early release because treatment could not be offered before their parole eligibility dates.

Establishing programs in locations close to communities where the offenders originate makes it possible to supplement treatment with family support and, where appropriate, even to include family members in the therapeutic process.

Finally, treating offenders in the community allows the offender better access to extended community resources (e.g., vocational counselling, substance abuse treatment). These resources address other contributing factors to the offending behaviour.

This brief review will look at the community-based sex offender programs established in Toronto and Hamilton.

Program Description – Toronto

The Toronto project was designed to be a comprehensive program providing a full range of assessment (phallometric, physiological, neurological and psychometric) and treatment options (group and individual).

Individualized treatment modules include: substance abuse management, anger management, assertiveness and life-skills training, defensiveness reduction, medication to reduce sex drive, relapse prevention, treatment for mental illness and treatment for specific medical problems affecting the offending behaviour.

For those who have completed treatment in an institution, the program focuses on continued maintenance using a relapse-prevention model. For those who receive their first intervention on release, a full program of suitable components from the modules listed above can be tailored to the needs of the client.

It was projected in the proposal that the program could assess and treat 75 sex offenders in one year.

There are no criteria for acceptance into the program. Every sex

[1] *Solicitor General of Canada, "The Management and Treatment of Sex Offenders."* Report of the Working Group: Sex Offender Treatment Review. *(Ottawa: Minister of Supply and Services, 1990).*

[2] *G. Glancy, "Rehabilitation of Sex Offenders: A Long Term Model." Paper presented at the meeting of the Ontario Psychiatric Association, January 1991. See also W. Pithers, "Relapse Prevention with Sexual Aggressors: A Method for Maintaining Therapeutic Gain and Enhancing External Supervision," in W.L. Marshall, D.R. Laws and H.E. Barbaree (Eds.),* Handbook of Sexual Assault: Issues, Theories and Treatment of the Offender. *(New York: Plenum Press, 1990) 343-361. And see B.M. Maletzky,* Treating the Sex Offender. *(New York: Sage Publications, 1990).*

offender referred to the program, who agrees to attend, will be accepted. For those who refuse treatment, the program provider has agreed to act as a consultant to the parole officers to help them manage these cases.

Parole officers and agency staff involved in parole supervision refer all newly released sex offenders for an initial assessment of treatment suitability. In most cases, the referral is made directly to the program provider. Recently, the program has received referrals from some local federal institutions. These referrals are generally co-ordinated by the parole district psychologist.

Program Description – Hamilton

The Hamilton program is also designed to provide a full range of treatment services for sex offenders who have already been treated and for those who will be treated for the first time in the community. Each offender undergoes a full assessment which includes phallometrics. Treatment is largely based on a group format, focusing on anger management, sex education, communication, role playing and cognitive restructuring. Participants are expected to continue in the maintenance sessions until the end of their sentence.

Individual interventions are offered to clients who need marital counselling, behavioural reconditioning or medical intervention, in particular, anti-androgen medication to control sexual arousal.

To be accepted into the program, participants must be of average intelligence and are expected to acknowledge that they have a problem with their sexual behaviour.

It was projected in the program proposal that service would be provided for between 15 and 30 offenders over an 18-month period.

Unlike the Toronto program which serves five area parole offices, one office supervises all sex offenders in the Hamilton program. A parole liaison officer, trained in relapse-prevention techniques, co-ordinates all referrals to, and maintains weekly contact with, the program provider. This officer is also responsible for contacting the institutions and, in particular, institutional programs that are graduating offenders to be released in the Hamilton area.

Preliminary Data – Toronto

Both the Hamilton and Toronto programs are undergoing the first phase of an evaluation to be completed in 1992. Preliminary data on client characteristics and program participation rates are provided here.

Forty-five referrals have been made to the Toronto program from its inception on 1 November 1990 until September 1991 (see figure). All 45 have had some form of assessment. Of these, four are still in the institutions awaiting release, one is in the community awaiting treatment and 30 are currently in treatment. Two have had their conditional release suspended – one for incurring new charges of a non-sexual nature and the other for new charges of a sexual nature. While both of these clients had been through the initial assessment, neither had actually commenced the program. The two who have completed the program have successfully reached the end of their sentence without new charges. Five have refused treatment or were considered unsuitable for treatment. Only one has dropped out of the program and was transferred to another District.

The average age of the Toronto sample is 36.3 years. Most (65%) are serving sentences of four years or less with an average sentence of 48.4 months (omitting one life sentence from the calculation). More than half of those referred have been treated in the institutions before release. Most (73%) have a history of substance abuse, 59% are learning disabled, and 11% of those referred are psychotic.

Of those referred to the Toronto program, 73% were charged with sexual assault, most for sexual assault with a weapon. Another 24% have charges of incest, although some of the other sex offences are offences against family members.

Preliminary Data – Hamilton

The Hamilton program assessed 12 sex offenders between January and September 1991. As of September 1991, four offenders were in treatment, none had completed treatment, none had dropped out once in treatment but three refused treatment and one was assessed as not requiring the service. One offender was transferred to another District, and three had their conditional release suspended. According to community assessment requests, there are approximately 30 offenders on the waiting list, almost all of whom are still in the institutions.

The average age of the assessed offenders is 39.7 years (skewed by the

Participation and Suspension Rates

	Assessed	In Treatment	Completed Treatment*	Dropped Out	Suspended**	Waiting List	Unsuitable for Treatment
Toronto Referrals (N=45)	45	30	2	1	2	5	5
Hamilton Referrals (N=12)	12	4	0	1	3	30	4

* Reached warrant-expiry date (end of sentence) successfully.

** Includes: new charges – sexual (Toronto 1, Hamilton 1)
new charges – non-sexual (Toronto 0, Hamilton 1)
technical violations (Toronto 1, Hamilton 1)

inclusion of two who were in their mid-50s). Half of the 12 in the program are serving sentences of four years or less.

Problems

Establishing a treatment program in the community poses problems that are not shared by institutional programs. Both the Hamilton and Toronto programs have experienced start-up difficulties: some could not have been anticipated, and others are the expected challenges of any new program.

Treatment delivered in a group format assumes a certain level of compliance and homogeneity of client characteristics. In the institutions, where programs tap a large pool of offenders eager to participate in a program that might strengthen their chances for early release, it is possible to conduct group therapy geared to specific needs of participants.

However, since the client base for the community programs depends on new releases, it has taken longer than anticipated to accumulate enough referrals to establish the groups. The offenders who participate have various offence histories. Their levels of treatment sophistication and cognitive skills also vary. Most are mandated to treatment, and can be unwilling and even disruptive participants. These problems require a flexible treatment plan on the part of the service providers, the application of several case management options and the close collaboration of parole officers and clinicians.

Co-ordination of referrals to the community from the institutions has been slow in developing. For sex offenders released on mandatory supervision, often among the highest-risk cases, the community service providers may receive little advance notice of their arrival in the community. For those who have already been treated in the institution, the referral process from the institutional program to the community has been smoother. Ultimately, it is hoped that the referral process will begin when the community assessment is completed before the offender's parole hearing. Recommendations for community treatment by the case management preparation team at the time of the hearing will give offenders an opportunity to understand the terms of their release and the nature of the community treatment program they will be required to attend.

The response of parole officers, agency staff and management to the development of these specialized community-based programs has been generally favourable. In the Ontario region, there is a commitment to training as many line staff and managers as possible on the relapse-prevention model. The purpose of this is to make staff and managers aware of the clues indicating offenders' deterioration into the offence cycle and to allow them to feel confident that they are sharing a common vocabulary with therapists which facilitates discussion of the case.

The newly-implemented Regional Community and Institutional Sex Offender Management Committee has a mandate to improve the regional co-ordination of the programs. Committee members are discussing the standardization of the assessment battery for the institutional programs and will eventually look at the community programs. Their work should ensure that institutional and community programs share a common approach to treatment and that there will be effective transition from one program to the next.

The completed evaluation of the programs, scheduled to be released in 1992, will provide outcome data testing the effectiveness of the programs to help us to better manage sex offenders in the community. The results of the evaluations will influence whether the Correctional Service of Canada continues to support the programs as standard elements of aftercare.

The Correctional Service of Canada's corporate objectives include the promotion of public safety by "safely reintegrating a significantly larger number of offenders as law-abiding citizens while reducing the relative use of incarceration as a major correctional intervention," and the reduction of recidivism of specific groups of offenders with unique needs or problems. Given these, it would seem that the provision of community treatment in some form for sex offenders is a direction that the Correctional Service of Canada has chosen and will not reverse. ■

A Word on Mental Disorders...

"Researchers should collaborate with practitioners who are exploring ways of adapting standard sexual offender treatments for use with mentally retarded populations. A lack of sexual knowledge and experience may contribute to sex offenses by mentally retarded persons, and approaches that attempt to remedy these deficits in the context of sexual offender treatment should also be tested."

From: *R.F. Schilling and S.P. Schinke, "Mentally Retarded Sex Offenders: Fact, Fiction, and Treatment,"* Journal of Social Work & Human Sexuality, *7, 2 (1988): 33-49, p. 44.*

Risk Factors in Sexual Offending

In January 1988, a woman was sexually assaulted and killed in Toronto by an offender who was at the time in breach of the conditions of a 48-hour temporary absence from a community residential facility (a halfway house). A Board of Investigation chaired by Jane Pepino was established to look into the circumstances of this tragedy.

One of the recommendations of the Board was that a comprehensive evaluation be done to determine the effectiveness of sex-offender treatment programs. The Solicitor General established a working group for this purpose with representation from federal and provincial corrections.

Last year the working group presented its report, "The Management and Treatment of Sex Offenders." *Report of the Working Group: Sex Offender Treatment Review.*

This article presents the findings of the working group with respect to risk factors in sexual offending. The full report of the working group addresses a host of other treatment issues, covering a vast amount of literature in the area. Readers are encouraged to review the full report as this article provides only a snapshot of the information available.

Risk factors in the perpetration of sex offences may be found in various offender and offence characteristics and in situational variables.

Historical factors, particularly information about an offender's previous offences, have the strongest empirical support. These factors include:

- previous sex offences
- previous non-sexual offences
- multiple sexual deviancies
- use of force
- boy victims
- young victims
- strangers as victims
- exhibitionism

Although treatment cannot change historical factors, it can address other related risk factors. For example, the finding that an offender has a history of victimizing young boys suggests that he or she has deviant sexual preferences. These deviant preferences could be targetted by treatment.

While risk factors that can be addressed by treatment or supervision have not been clearly defined, some have been identified through research. These are listed in the table and include individual characteristics that may motivate sexual offending; factors that can block opportunities for normal sexual gratification; factors that can disinhibit offenders and thus promote their acting upon deviant sexual fantasies; and factors that can inhibit deviant sexual arousal.

Many of the risk factors listed here are not unique to sex offenders. Substance abuse, marital difficulties, poor social skills and histories of sexual abuse are also common among inmates and mental health patients. However, two of these factors are unique to sex offenders: deviant sexual preferences and cognitive distortions that support their deviant sexuality.

Source: *Solicitor General of Canada, "The Management and Treatment of Sex Offenders."* Report of the Working Group: Sex Offender Treatment Review. *(Ottawa: Minister of Supply and Services Canada, 1990).*

Risk Factors in Sexual Offending – Potential Targets for Intervention

1. Motivators

- sexual desire
- emotional needs and conflicts (e.g., dominance, hatred, acceptance, aggression, nurturance)
- deviant sexual desire

2. Blocks to Legitimate Sexual Outlets

- low I.Q.
- unattractiveness
- unassertiveness
- restrictive views on sexuality
- unavailability of appropriate sex partners
- sexual dysfunction
- little knowledge of sex
- marital difficulties
- poor social skills

3. Disinhibitors

- alcohol and drug abuse
- cognitive distortions
- brain injury or pathology
- models (childhood victimization)
- deviant sexual attitudes (belief of rape myths, blaming the victim)
- use of pornography
- antisocial lifestyle
- psychosis
- psychopathy
- attitudes supportive of violence

4. Inhibitors

- moral values
- aversion to violence
- legal penalties
- unavailability of potential victims
- empathy for victims
- fear of consequences
- incarceration
- resistance of victims

Relapse Prevention with Sexual Aggressors

by William D. Pithers, Ph.D.*

Sufficient evidence exists to conclude that efforts to change sex offenders' behaviour through the use of traditional mental health interventions are ineffective.[1] While the shortcomings of traditional treatment approaches have been documented, evidence that specialized interventions can reduce the recidivism rate of at least some sex offenders is accumulating.[2] These treatment programs have a number of important components in common. Among the aspects of sex offenders' functioning addressed by these programs are sexual arousal disorders, social competence, emotional management, victim empathy and resolution of personal sexual victimization.

Relapse prevention has gained increasing recognition as one essential component to include in comprehensive treatment programs for sex offenders.

* Director, Center for the Prevention and Treatment of Sexual Abuse, State of Vermont Agency of Human Services

Few topics generate as much emotional opinion as sexual abuse and treatment of the abusers. The immediacy and power of society's emotional response, though understandable, can impede efforts to create empirically based programs fostering therapeutic changes in sex offenders and enhancing the safety of society.

It is unreasonable to expect an empathetic society to respond without emotion to sexual abuse. Rather than using our emotional vigour to condemn sex offenders as hopelessly depraved monsters, we should use this resource to fuel our determination to search for appropriate treatments.

Researchers intent on creating such solutions must be cautious not to make deceptive promises. Sexual abuse is a purposeful behaviour that is the result of choice, not a behaviour symptomatic of a medical or psychiatric disorder. Since no existing form of humane treatment can remove the power of an individual to make choices, some sex offenders who appear to have been treated effectively will choose to abuse others again. When a reoffence occurs, we must avoid condemnation of treatment programs with demonstrable histories of success. Rather, we should dedicate ourselves anew to refine the available treatments so that the incidence of recidivism can be diminished.

Relapse prevention (RP) was initially developed for substance abusers but was modified for sex offenders.[3] There are two distinct aspects of RP: the Internal, Self-Management Dimension and the External, Supervisory Dimension. Together, these aspects of RP have been linked with greatly reduced recidivism rates among pedophiles and, to a lesser extent, rapists.

This article outlines the fundamental assumptions of the RP model and summarizes early recidivism data.

Two Dimensions of Relapse Prevention

The Internal, Self-Management Dimension assists sex offenders to

- identify high-risk situations leading to abuse;
- analyse seemingly unimportant decisions that allow them to be put into high-risk situations; and
- develop strategies to avoid, or cope more effectively with, these situations.

Since sex offences result not from psychological or medical disorders but from conscious choices, these skills provide offenders with resources that enable them to make better choices in the future.

Offenders are informed that if they learn to recognize high-risk situations and enact alternatives, they will be less likely to choose to abuse. However, since no known form of treatment removes the offender's ability to make choices, some offenders who have taken part in effective treatment programs will choose to reoffend.

The External, Supervisory Dimension of RP facilitates supervision of sex offenders by probation and parole officers. The three functions of this Dimension are

- to enhance the efficacy of supervision by monitoring specific precursors to offences;
- to increase the efficiency of supervision by creating a network of collateral contacts which assists the probation officer in monitoring the offender's behaviour; and
- to create a collaborative relationship with mental health professionals conducting therapy with the offender.

[1] *L. Furby, M.R. Weinrott and L. Blackshaw, "Sex Offender Recidivism: A Review,"* Psychological Bulletin, *105 (1989): 3-30.*

[2] *W.D. Pithers and G.F. Cumming, "Can Relapses Be Prevented? Initial Outcome Data from the Vermont Treatment Program for Sexual Aggressors," in D.R. Laws (Ed.),* Relapse Prevention with Sex Offenders. *(New York: Guilford Press, 1989).*

[3] *W.D. Pithers, J.K. Marques, C.C. Gibat and G.A. Marlatt, "Relapse Prevention with Sexual Aggressives: A Self-Control Model of Treatment and Maintenance of Change," in J.G. Greer and I.R. Stuart (Eds.),* The Sexual Aggressor: Current Perspectives on Treatment. *(New York: Van Nostrand Reinhold, 1983) 214-239.*

The Relapse Process

Relapse prevention is based on the assumption that a variety of factors influence whether or not a sex offender will commit another abusive act. The interaction of these factors affects the probability of relapse.

By entering treatment, a sexual aggressor essentially declares an intent not to reoffend. As treatment continues, the aggressor becomes more confident of the ability to handle life's future difficulties. Occasionally, this attitude becomes unrealistic and overly optimistic, leading to a lack of attention to critical risk factors.

As a result of a series of what seem to be unimportant decisions, the offender may encounter a high-risk situation. High-risk situations are defined as circumstances that threaten an offender's sense of self-control and thus increase the risk of relapse.

When an offender deals effectively with a high-risk situation, self-management is reinforced. To the extent that the expectation of successfully handling future high-risk situations remains realistic, the probability of relapse decreases. Offenders are primed for relapse if they believe that surviving one high-risk situation means that they "have passed the test" and can now handle all high-risk situations. Should the offender fail to cope with a high-risk situation, self-management decreases, and there is a tendency to give in passively to the next high-risk situation.

One study examining precursors to sexual aggression found that there was a common sequence of behaviours in the relapse process.[4]

1. **Emotion** The first change in the offender's typical functioning was emotional. Typically, offenders found themselves unable to deal effectively with a change in their emotional state.
2. **Fantasy** The second change involved fantasies of performing sexual abuse. For example, angry offenders may attempt to deal with anger by visualizing themselves sexually degrading a person.
3. **Cognitive Distortion** Fantasies were converted into distorted thoughts in the third step of the relapse process. Offenders frequently made up rationalizations justifying their soon-to-be committed acts.
4. **Plan** As the relapse process evolved, offenders refined a plan in their minds that would enable them to carry out their fantasized behaviour. An essential element of the plan was to establish circumstances for the offence that might make the offender appear less culpable.
5. **Act** In the final step of the relapse process, the plan was acted out.

In this relapse process, the initial change that reliably differentiates sexual aggressors from others is the predominance of deviant sexual fantasies. Thus, for most sexual offenders, the initial return of deviant sexual fantasy is defined as the earliest identifiable lapse.

So far, the relapse process has been described from the point at which a person encounters a high-risk situation. However, RP also examines events preceding high-risk situations. Although some sex offenders lapse in situations that would have been difficult to anticipate, the majority set the stage for lapses by putting themselves into high-risk situations.

Offenders can set up a lapse by making a series of seemingly unimportant decisions, each representing another step toward a tempting high-risk situation. Any single decision may appear unrelated to reoffending but, in reality, each choice brings the aggressor closer to the high-risk situation where the final decision to offend again or not is made.

If sexual offenders have not been prepared to deal with lapses, they may attempt to hide their errors from therapists and parole officers. They may believe that admitting even a momentary deviant fantasy will be considered an indication that they are totally out of control. Any effort to bury a lapse typically leads to additional lapses that are closer still to offending again.

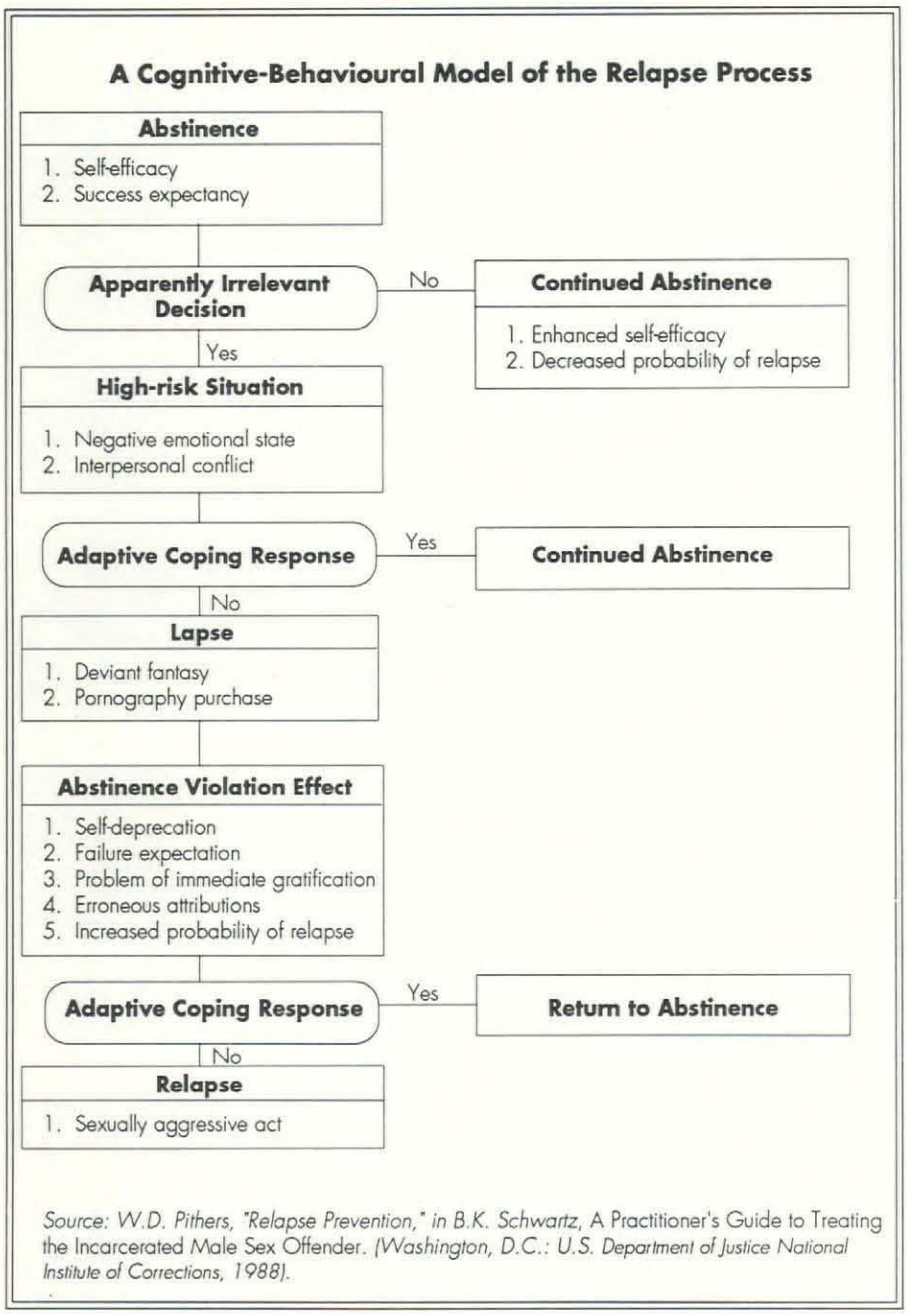
In the RP model, a relapse is the recurrence of deviant sexual behaviour. Several factors, encompassed by the term "Abstinence Violation Effect," influence whether or not a lapse becomes a relapse. A major component of the Abstinence Violation Effect is the conflict between an offender's self-image as an abstaining sex offender and the recent experience of a lapse. This dissonance may be resolved by offenders' deciding that their treatment has failed and that they remain sexual offenders.

Attributing lapses to personal weakness heightens the Abstinence Violation Effect. If lapses are considered personal failures, the expectation for continued failure develops, possibly ending in the ultimate defeat: relapse. The Abstinence Violation Effect is also amplified if the offender selectively recalls only the positive aspects of sexually abusing victims in the past and forgets about the delayed negative consequences.

If aggressors selectively remember positive outcomes of previous offences but neglect the delayed negative consequences (e.g., arrest, incarceration), the probability of relapse increases. Due to the strength of this phenomenon, it has been named the "Problem of Immediate Gratification" or the PIG phenomenon.

A final factor affecting the Abstinence Violation Effect is the individual's expectation about the likelihood of lapsing. For offenders who believe that treatment should erase all vestiges of their deviant desires, a momentary loss of control may be interpreted as an irreversible trend. In contrast, an offender may

[4] *W.D. Pithers, G.F. Cumming, L.S. Beal, W. Young and R. Turner, "Relapse Prevention: A Method for Enhancing Behavioral Self-Management and External Supervision of the Sexual Aggressor," in B. Schwartz (Ed.),* Sex Offenders: Issues in Treatment. *(Washington, D.C.: National Institute of Corrections, 1989).*



Source: W.D. Pithers, "Relapse Prevention," in B.K. Schwartz, A Practitioner's Guide to Treating the Incarcerated Male Sex Offender. *(Washington, D.C.: U.S. Department of Justice National Institute of Corrections, 1988).*

view a lapse as an expected event representing an opportunity to refine self-management skills through analysis of reversible mistakes. In the latter case, lapses can yield productive outcomes. In such cases, an offender acquires enhanced coping skills and maintains greater vigilance for the earliest signs of relapse.

Internal, Self-Management Dimension of Relapse Prevention

Relapse prevention begins by dispelling an offender's misconceptions about the outcome of treatment and by describing more realistic goals.

It continues with an assessment of the offender's high-risk situations, which are the conditions under which relapse has occurred or is likely to occur in the future. The initial assessment also examines the offender's coping skills, since situations are considered high risk only to the extent that the person has difficulty coping with them.

After high-risk situations have been identified, interventions are designed to train the offender to minimize lapses and keep them from evolving into a full-blown relapse.

When introducing RP to offenders, we emphasize the development of realistic expectations about therapy and encourage an active, problem-solving approach on their part. We inform them explicitly that there is no cure for their disorder. They are told that treatment may diminish their attraction to abusive sexual behaviour, but that fantasies about this behaviour are likely to recur in the future.

Sex offenders are told that the return of a deviant fantasy does not necessarily signify that they are going to offend again, and that a critical part of treatment involves learning what to do when they feel drawn to repeat abusive sexual activity.

We tell offenders that they will discover a variety of situations in which they will make seemingly unimportant decisions. These decisions will either lead them closer to offending again or take them away from that danger. They are told that developing the ability to recognize these situations and enact alternatives will reduce the likelihood of acting out their deviant fantasies.

Initially, we recommended introducing the offender to RP concepts during the first therapy session. However, we have since discovered that the highly cognitive strategies of RP can heighten offenders' defences against recognizing the harm inflicted upon victims.

Empathy for victims represents a critical source of motivation for the offender's treatment and maintenance.[5] To avoid having RP viewed by offenders as an interesting intellectual exercise with little relevance to their

[5] *D. Hildebran and W.D. Pithers, "Enhancing Offender Empathy for Sexual Abuse Victims," in D.R. Laws (Ed.),* Relapse Prevention with Sex Offenders. *(New York: Guilford Press, 1989).*

lives, we introduce it only after victim empathy has developed.

Relapse-Prevention Assessment Procedures

Since RP is a highly specialized approach to therapy, thorough assessment is necessary to determine issues to focus upon in treatment.

Assessment in RP includes three major tasks:

- specification of the offender's high-risk situations (including seemingly unimportant decisions creating those situations);
- identification of existing skills for coping with identified high-risk situations; and
- analysis of early antecedents to the offender's abusive acts.

Analysis of case records, structured interviews, self-monitoring, direct observation and self-report measures are among the methods used to identify risk factors.

Shortcomings of the Internal, Self-Management Dimension

While this dimension of RP often works well, sexual aggressors may not use their newly acquired skills. Furthermore, although the importance of acknowledging lapses to therapists and probation and parole officers was repeatedly stressed, offenders sometimes neglected to do so.

Generally, the Internal, Self-Management Dimension of RP was beneficial in enhancing self-control. However, at critical moments that determined the difference between lapse and relapse, this dimension sometimes proved inadequate. A new dimension was therefore created.

External, Supervisory Dimension of Relapse Prevention

Since offenders are sometimes unreliable informants, it was considered essential that other methods of gaining access to information about their functioning be created. To enhance community safety, an External, Supervisory Dimension of the RP model was developed.[6]

Traditionally, probation supervision of sex offenders has been a challenging enterprise, because probation violations noted frequently among many other offenders (e.g., intoxication, neglect of supervision appointments) were rarely noted among sex offenders.

Specification of the precursors to offences and of high-risk factors provides parole officers with identifiable indicators of impending danger of relapse for an offender. Since parole officers monitor specific risk factors related to the offender's sex offences (rather than attempting to monitor all the offender's behaviours, many of which are irrelevant), the efficiency of supervision is increased.

Whenever parole officers detect such a precursor, they determine that the sex offender is involved in a relapse process. Since offence precursors often appear in a distinct sequence (i.e., emotion-fantasy-cognitive distortion-plan-act), the type of precursor exhibited provides an indication of the imminence of potential relapse. The parole officer may then determine the type of intervention required by the offender's lapse (e.g., additional condition of parole, consultation with offender's therapist, parole revocation).

A second element of the External, Supervisory Dimension entails teaching the principles of RP to offenders' collateral contacts. They learn that helping the offender identify factors involved in the relapse process increases the likelihood that the offender will avoid a reoffence. In the offender's presence, network members are encouraged to report lapses to the parole officer or therapist.

Even in sparsely populated regions where meetings with collateral contacts are impractical, information from the network may still be obtained. A checklist of the offender's risk factors can be completed weekly by collateral contacts and mailed to the therapist or supervisor.

Care must be taken in evaluating the ability of collateral contacts to serve this function. For example, a spouse is unlikely to disclose information about her husband if she fears abuse. Employers who treasure the compulsive work habits of some sex offenders may be reluctant to mention information that could lead to the loss of a good employee.

We require the offender to inform network members about offence precursors and risk factors. The probation or parole officer later asks network members to summarize what they were told.

This procedure accomplishes two goals. First, the accuracy and completeness of information presented by the offender can be evaluated, enabling the parole officer to estimate how well the offender understands offence precursors and the importance of others in behavioural maintenance.

Second, informing the extended network about offence precursors destroys the secrecy necessary for commission of sexual aggression. Behaviour that once may have seemed unimportant to others, but which was centrally involved in the relapse process, can then be recognized as signals for concern.

The final element of the External, Supervisory Dimension of RP is the liaison between the probation officer and the mental health professional. Regularly scheduled meetings between these two are essential.

During these meetings, the extent and consistency of the offender's disclosures can be compared. In addition to ensuring that each professional possesses all available information, these meetings also enable detection of the offender's efforts to create conflicts within the supervisory team. Since scheduled

[6] *W.D. Pithers, K.M. Kashima, G.F. Cumming, L.S. Beal and M.M. Buell, "Relapse Prevention of Sexual Aggression," in R.A. Prentky and V.L. Quinsey (Eds.),* Human Sexual Aggression: Current Perspectives. Annals of the New York Academy of Sciences, *528 (1988). (New York: New York Academy of Sciences, 1988).*

meetings allow exchange of routine information, any telephone calls and messages between meetings are considered indications of critical events to be dealt with immediately as opposed to needlessly annoying disruptions in an overburdened schedule.

The combined functions of specially trained probation and parole professionals, collateral contacts and the collaborative relationship between probation and mental health professionals are referred to as the External, Supervisory Dimension of the RP model. Since offenders are not consistently reliable informants, these additional resources are vital to adequate treatment and supervision and, therefore, to the safety of potential victims.

Taken together, the Internal and External Dimensions of RP offer improvements over traditional treatment approaches for sex offenders.

Effects of Relapse Prevention on Rapists and Pedophiles

Of the 20 rapists in our follow-up sample at the Vermont Treatment Program for Sexual Aggressors, three (15%) committed an additional sexual assault during the six-year follow-up period. In comparison, of the 147 pedophiles, four (3%) have committed new offences.

A comparison of the proportion of relapses relative to sample size for each of the two offender subtypes (pedophile and rapist) revealed a statistically significant difference [X^2 (1, N = 167) = 3.91, $p<.05$ (statistic corrected for continuity due to low expected frequency of relapses)]. Put simply, in comparison to their overall representation in the study sample, more rapists than expected have relapsed, while fewer pedophiles than expected have relapsed.

In 1978, Sturgeon and Taylor[7] examined the recidivism status of every sex offender released from treatment in 1973 at California's Atascadero State Hospital, an institution which employed a standard peer-group milieu therapy at that time. Their data revealed that rapists' higher risk of relapse occurred within the first year after release from institutional treatment. In contrast, recidivism among pedophiles was most frequent two to three years after discharge.

Further analysis of Sturgeon and Taylor's data revealed that the proportion of rapists that offend again during the first year after release was significantly larger than the proportion of pedophiles relapsing during that first year [X^2 (1, N = 200) = 4.71, $p<.05$]. Thus, rapists appeared to offend again sooner than pedophiles after discharge from treatment. One might question, though, whether these short-term differences in treatment outcome faded with prolonged exposure to risk factors and potential victims.

Analysis of Sturgeon and Taylor's data also revealed that, at the conclusion of the five-year follow-up, rapists and pedophiles had reoffended at nearly the same rate. A statistical comparison of the proportion of the two reoffending groups revealed no significant difference in relapse rates [X^2 (1, N = 133) = 0.62, $p<.80$].

Thus, when RP was not used, rapists and pedophiles had similar reoffence rates by the end of the fifth year after their institutional release. Since differential reoffence rates were found for rapists and pedophiles in our sample at the Vermont Treatment Program for Sexual Aggressors after a six-year follow-up, with pedophiles reoffending at a significantly lower rate than rapists, the discrepancy in these rates appears attributable to relapse prevention.

Theoretical Basis for Differential Effect of Relapse Prevention

Differences in the dynamics of rapists and pedophiles may explain both the greater frequency of relapses among rapists during the first year after release from treatment and the discrepancy in the impact of RP on the two offender subtypes.

The highest frequency of rape relapses during the first year after release may reveal the influence of anger and power as the predominant motivations for sexual violence. In individuals who have difficulty dealing with anger and feelings of disempowerment, loss of behavioural control can occur very quickly, and few precursors to an offence may be observed. Thus, rapists may move from adequate self-management to relapse in a relatively short time.

The finding that pedophiles relapse with the highest frequency several years after discharge may be a reflection of their efforts to develop intimacy and relationships. Development of any human relationship, even the profoundly disturbing and coercive interaction of a pedophile and victim, takes time. Pedophiles are more likely than rapists to display precursive risk factors over a relatively long time. These characteristics allow greater opportunity for identification of precursors, therapeutic intervention and restoration of self-control.

Advantages of Relapse Prevention over Traditional Treatment

While no constellation of interventions prevents relapse, RP appears to hold considerable promise for reducing sex offender recidivism.

Some advantages that RP offers over traditional approaches to sex offender treatment follow:

- a more realistic therapeutic goal of control versus cure;
- reliance on multiple rather than single sources of information about offender behaviour;
- integration of mental health and probation or parole professionals; and
- definition of behavioural maintenance as a continuum rather than an abstinence-relapse dichotomy. ■

[7] *V.H. Sturgeon and J. Taylor, "Report of a Five-year Follow-up Study of Mentally Disordered Sex Offenders Released from Atascadero State Hospital in 1973,"* Criminal Justice Journal, *4 (1980): 31-63.*

A Summary of an Evaluation of the Community Sex Offender Program in the Pacific Region

by Marylee Stephenson, M.A., Ph.D.[1]

The Pacific region of the Correctional Service of Canada has provided community-based sex offender treatment programming since 1984. In most cases, the service is a combination of weekly group therapy with individual therapy sessions of at least 30 minutes every six weeks.

The evaluation of the Pacific region's community-based program for sex offenders is part of a wider initiative of the Correctional Service of Canada to examine sex offender programs of all types across the country. More specifically, it was a part of the initiatives undertaken by the regional section of the Community and Institutional Programs Task Force. The evaluation began in June 1990 and ended in May 1991.

Because of the complexity and scope of the evaluation, the project consultants took a team approach. Along with the project director and research associates, a forensic therapist, who specializes in the treatment of sex offenders and victims of sexual abuse, was an integral part of the team throughout all phases of the evaluation.

There are eight community-based sex offender programs (which means eight contracting therapists, though two use subcontractor therapists) in the province. The first program was established in Vancouver in 1983. A program followed in Chilliwack, east of Vancouver, in 1984, and in Abbotsford, near Chilliwack, in 1985. Prince George, in the north part of the province, and Victoria, the provincial capital, followed suit in 1986. The interior communities of Kamloops and Kelowna began programs in 1987, and Vernon by 1989.

Administrative centres for the various services have evolved over the years. The most significant change was the devolution, in 1988, of direct contracting authority to the districts from the region (under the supervision of the chief psychologist of the Regional Psychiatric Centre).

There are four districts. The Northern District has four contractors (one works with a subcontractor); the Abbotsford/Chilliwack District has two; Vancouver has one (who works with two subcontractors); and Victoria has one.

Regional headquarters retains ultimate responsibility for contract approval, but since 1988 this has tended to be a formality rather than an active management role.

Framework of the Evaluation

The evaluation addressed three components of the community-based sex offender program (CSOP): administration; treatment content, delivery and outcome; and the therapists' service to parole. The first and third elements were included because treatment per se is only one part of sex offender programming in the area of corrections.

First, the CSOP is one of thousands of programs provided by the federal government and, as such, administration at every level is accountable for its rationale, administration, content and outcome.[2] Thus, evaluation of administrative aspects of the program is crucial.

Second, the parolees are being treated for behaviour that is viewed very negatively, and a great burden is placed both on the therapist and on corrections to provide treatment that will reduce or prevent reoffending. Therefore, treatment content, delivery and outcome must be evaluated.

Third, treatment can be seen as a service to parole staff because the therapists must provide any information about the parolee's behaviour that could lead to reoffending.[3] Parole staff are to use this information as an integral part of ongoing parolee supervision and monitoring. As well, therapists' immediate contracting authority is parole services – that is who they work for. Thus, this service to parole must be evaluated.

Evaluation Methodology

The evaluation methodology was designed to capture both qualitative and quantitative data on the three main components of the program. The evaluation data-collection strategy was very complicated because of the program's size and complexity and the necessity of an analysis of recidivism.

The evaluators elicited data from several perspectives on any given aspect of the program – an extended triangulation approach to data collection. In order to learn more about administrative processes, evaluators interviewed key senior administrators at the regional, district and local office levels about their

[1] *The consulting company was CS/Resors Consulting, Ltd. Project Director was Dr. Marylee Stephenson. Senior research associate was Dr. Janie Cawley, forensic therapist was Dr. Chris Gingell and David Groden was responsible for data-base management and statistical analysis. Research associates were Laurie Henderson and Richard Floyd. There were five file reviewers who assisted three of the team members in this task. Contracting authority was Colin Shepherd at the Correctional Service of Canada's Pacific Regional Headquarters.*

[2] *Office of the Comptroller General of Canada, Program Evaluation Branch,* Guide on the Program Evaluation Function, *(Ottawa, 1981).*

[3] *The contracts of the therapists make this clear, as do those policy statements that exist.*

management approach and, particularly, about the contracting and supervisory functions they performed for the CSOP. All contracts and related documents for each district's program were intensively reviewed. Also, interviews with the service-providing contractors, senior administrators and local parole officers included questions about their views on the administrative process.

To learn about program content, delivery and outcome, the evaluators first reviewed the few documents that discussed the history of the initiative or described local or district program goals and content. Interviews with senior administrators included questions about program content, delivery and outcome. The contractors themselves were interviewed by the forensic therapist about their background in the field, their treatment philosophy, treatment goals and techniques, their record-keeping and reporting activities and their assessment of their own efficacy. They were also asked for suggestions for improving the service.

The forensic therapist and another senior team member observed at least one group therapy session delivered by each therapist. (Since not all districts offered group therapy, this was not always an option.) At the end of these sessions, the contractor therapist left, and the evaluators conducted focus-group discussions with participants about the nature and usefulness of the individual and group therapy they received.

Recidivism rates are an important measurement of treatment success. The review of recidivism among CSOP and non-CSOP sex offenders was the single, most demanding aspect of the evaluation because no one data source at the national or regional level identifies sex offenders or combines information on offence, criminal history and treatment history. Given the differing information needs of each agency or department, the lack of such a single source is not surprising, even if it is frustrating for the evaluator.

The sources reviewed for information on recidivism were the Correctional Service of Canada's Offender Information System (OIS); Canadian Police Information Centre (CPIC) data; contractors' lists of those in treatment; parole files (archival and current); and an array of other lists used to cross-check whether a parolee was in fact a sex offender, was ever in treatment or was currently in treatment. These latter sources included parole office supervision lists, duty officer log books, police reporting lists, CSOP attendance lists and Correctional Service of Canada incarceration/supervision lists.

Various respondents were often surprised to learn that parole files did not contain the above information, and that other sources had to be tapped for information on recidivism. But to those experienced in conducting this type of research, it comes as no surprise. It was not even possible to identify every person who was in the CSOP over the years of an individual contractor's service, or over the life of a local or district program, because many of the contractors did not have an accurate list of those served. One or two were nearly complete, but some were woefully inadequate.

There were several cases where a person listed on a contractor's treatment list was not in police or Correctional Service of Canada records as an offender. There were instances, too, of a person on a treatment list being identified from Correctional Service of Canada records as incarcerated at the time of treatment. The evaluators took this to be a problem in record keeping rather than something more disturbing, but the dilemmas for data collection on recidivism and time-at-risk cannot be overemphasized.

Because of these identification and data-retrieval obstacles, fully one third of evaluation resources were allotted to the recidivism segment of the study.[4] However, it was ultimately possible to build a verified data base of 449 CSOP participants and 181 non-CSOP individuals (a modest control group). This was the remainder of an initial count of 997 sex offenders either in the CSOP at any time in the life of the programs or convicted of a sex offence in the province since 1984. (At the time of the evaluation, 226 were still in prison and there was insufficient information on 141 individuals to allow inclusion in the study.)

To evaluate the contractors' services to parole, much of the data was drawn from in-depth interviews with the parole officers. Those with at least two sex offenders on their caseload were interviewed about how they believed the CSOP service helped prevent reoffending, and about the nature and usefulness of the therapist's service to parole. Treatment effectiveness was one element of that service. Another element was whether the therapist's written and verbal reporting to respective parole officers was useful to the officers in their monitoring and supervision of parolees. The evaluators explored this in some detail.

Senior administrators in each local and district office were asked similar questions about the service of therapists to parole. The parolees were also asked about the nature of communication between their therapists and their parole officers, and in what ways they were included in the interaction.

The numbers and categories of key respondents interviewed in person or in focus groups are as follows:
Regional level: 3
District/local office levels:

- Senior management, contracting officers: 11
- Contractors/subcontractors: 11
- Group therapy observations: 11
- Parole officers: 32
- Parolees (as an average of six per focus group): 66
- Other (police liaison officer): 1

[4] *Other researchers or corrections staff are invited to contact Regional Headquarters, Pacific Region, to reach the evaluators to discuss these issues in more detail.*

The relationship of the evaluation questions, data-collection strategies and subsequent analysis are summarized in the table.

Evaluation Findings

The full evaluation report dealt with a broad range of issues. Because of limited space, this article must limit its focus to the evaluation of treatment content and delivery. Administration and service to parole can be dealt with only very briefly here.

Though the evaluation report itself presented findings at the level of individual contractor performance, and of administrative and parole issues at a local and district level, this overview will report on the results at a broader district and regional level. Individual districts or contractors will not be identified here.

Relationships of Evaluation Questions, Data Sources/Collection Strategies and Analyses

Evaluation Question	Data Source	Data Collection Strategy	Data Analysis
1. Context of CSOP	CSC senior administrators	in-person interviews	content analysis
	program document	review documents	content analysis
2. Program Components & Function	contractors	interviews and observations	content analysis
	program documents	review documents	content analysis
	CSC senior administrators	in-person interviews	content analysis
	district administrators	in-person interviews	content analysis
	parole officers	in-person interviews	content analysis
	parolees in programs	focus groups and observations	content analysis
3. Program Outcome			
a. process/ personal growth	contractors	interviews and observations	content analysis
	district administrators	in-person interviews	content analysis
	parole officers	interviews	content analysis
	parolees in programs	focus groups and observations	content analysis
b. recidivism	case records: current and archived parole files, OIS, CPIC & contractors	review hard copy of current and archived parole files; download electronically stored OIS/CPIC files	descriptive and statistical analysis

The presentation of findings on each evaluation component begins with an overview of the criteria against which each was compared. The evaluators were well aware of the difficulties of implementing a region-wide program for sex offender treatment. Thus, care was taken that the criteria reflect standards that were real, not ideal. The program was compared with what could realistically be accomplished in the present context, particularly with reference to the levels of treatment that could be expected for a community-based program for sex offenders on parole.

Administrative Components of the CSOP

The evaluative criteria called for comparable program standards among all districts; adequate supervision and monitoring of all aspects of the program; special attention to comprehensive and open contracting processes that would define treatment content, delivery and standards of record keeping; and reporting by contractors and administrators.

No comparability of program standards or of contracts across the region was found. Neither was there continuous, thorough supervision of the CSOP services at the local office, district or regional levels.

At the regional and district levels, the contracting process did not meet the evaluative criteria – a condition which correlates highly, the evaluators believe, with the findings on problematic areas of program content and delivery to be discussed below. Contracts were generally not tendered. Though it is recognized that there may not be a pool of qualified or interested therapists to choose from in outlying districts, the weight of habit and custom appeared to figure very heavily in administrators' not making efforts to put contracts out for tender.

Contract content was very vague, and specificity diminished over time. It would be impossible to discern from the contracts across the region what treatment approach the contractor was expected (and, indeed, required) to

take, how it might differ in group and individual therapy, whether and how therapists would assess participants, and what progress the parolee made in treatment. Record-keeping and reporting requirements were also extremely vague. This was true both for recording and reporting of treatment activities and for the contractors' own financial administration of their services.

Formal evaluation of contractor performance was not built into the contract, and it did not occur. Many front-line parole staff members were frustrated at the lack of a formal mechanism for providing feedback on the service and at the lack of consultation on the contracting process, from participation in defining service needs, through input on contractors' treatment approach, to the reporting activities of contractors.

The evaluators' recommendations for improvement of administration were numerous and detailed, emphasizing ways to use the entire contracting process to improve the quality of programming.

Treatment Content, Delivery and Outcome

The evaluative criteria for this component addressed assessment timing and techniques, treatment planning, treatment content and modes of delivery, ground rules for therapists' relationships with parolees and with parole services, and standards for contractors.

It may be useful to describe these criteria in more detail, not only because it may provide a better understanding of the context of the evaluative assessments, but also because this evaluative model could be implemented elsewhere in similar circumstances. Furthermore, the fact that one of the districts does largely meet the above criteria speaks to the practicality of the model.

The evaluative criteria for treatment included these elements of the therapist's approach to service:

a) Treatment approaches should be primarily cognitive-behavioural but eclectic enough to incorporate additional approaches (e.g., educational, psychodynamic).

b) Treatment content should include, but not be restricted to:
- the identification of "deviant sexual drive" or "deviant sexual arousal patterns" that lead to offences;
- the identification of the "crime cycle" of the offence;
- the delineation of the "pathway to the offence";
- the provision of ways for the offender to stop or divert himself from the pathway to a reoffence and the teaching and practising of various coping techniques;
- the provision of relapse-prevention training;
- awareness and therapeutic response to disorders and lifestyle characteristics that may contribute to risk of reoffending.

The delivery was expected to be tough-minded and confrontational yet able to build trust on the part of the parolee.

The criteria further stated that:

c) There must be a strong focus on countering denial, rationalization, and minimization of responsibility for the offence.
- group therapy must be available wherever numbers warrant;
- individual therapy should be offered for all program participants if group therapy is not feasible **and** as an essential supplement to group therapy where this is offered;
- individual therapy is an ideal opportunity for the treatment of the deviant drive through using behavioural modification techniques (i.e., covert sensitization).

For the therapeutic relationship, the therapists would be expected to make clear to participants the nature and limits of confidentiality in this particular setting, and to provide parole staff promptly with information on treatment progress and on the parolee's risk of reoffending.

In terms of selection standards for therapists, only those with experience in providing treatment to sex offenders should be considered. They must also be able to administer the program efficiently and keep detailed treatment and financial records.

Based on these criteria for treatment, contractor eligibility and contractor service administration, it was clear that only one of the four districts ("District I," for convenience's sake) met the majority of the evaluation standards.[5]

It was a reassuring confirmation of the triangulation research methodology that the evaluators' perspectives tended strongly to reinforce each other. Furthermore, the recidivism results tended to confirm the interview and observational data.

In District I, it was clear that, in each of the groups observed, denial simply was not tolerated. The group began with members stating their name, sentence and offence. Therapists were offence-oriented in their approach, and every opportunity was taken to link discussion to understanding offending behaviour and to learning how to avoid it. Participants had homework to do and were expected to do it.

No district had a very elaborate assessment of parolees or extensive case planning, but the contractors in District I did prepare a pretreatment assessment and plan, and did tend to update it with parolees over time.

Even though this clearly was the most demanding of the district programs, parolees expressed respect for the therapists and generally seemed to feel that they were getting a square deal. They were fully informed of their rights, the plan for their treatment and the limitations of confidentiality.

Senior staff members had close, regular contact with the contractors and were quite well informed about

[5] *Though there were four contractors in this district, their approach was similar and comparable. Thus they may be grouped as* ***the*** *district program.*

the treatment delivered and the status of parolees in treatment. Senior staff expressed reasonable confidence in contractors, and front-line staff also tended to rate their performance positively.

The contractors were weak in their reporting. Some parole officers would have preferred more detailed reports, but the levels were nonetheless seen as adequate. The record keeping of District I contractors was the most complete and accurate overall.

This treatment approach and reporting activity may seem to be quite basic and even modest as a treatment program, but the difference between District I and the other three districts was striking. In no other group was there a treatment plan – for the group or individuals. Contractors were not tough-minded in their approach, and denial was extremely common. Discussions were not offence-oriented, and elements of the crime cycle were not identified or followed up. Behaviour in the groups was often disruptive, and considerable disrespect was expressed toward some therapists, even during the sessions.

The evaluators reviewed the records of participants to see whether any one district had offenders that could be considered to be more resistant to treatment, with possible indicators in such factors as type of crime or length of sentence. There were no significant indicators of this sort.

In the other three districts, a significant proportion of staff, especially the parole officers themselves, expressed little confidence in the service. Assessments of the treatment approach were generally neutral to negative. Parole officers were generally very dissatisfied with the level of service provided to them in their supervision and monitoring of parolees. Contractors' record keeping and reporting to parole staff were also generally very poor.

An aspect of the treatment programs that overlaps heavily with the administrative aspect is cost. Over the years, District I has had the most modest costs per client of each of the four districts. Furthermore, invoicing by District I contractors related directly to the slight increase or decrease in the number of offenders they served over a given contract year.

In contrast, the other three districts have had dramatic increases in invoicing by contractors though there has not been a concomitant increase in numbers of parolees in the service. There has been some increase in group and individual therapy sessions in some cases, but no appreciable increase in numbers of those served.

This leads full circle to the issue of the program, as a whole, needing clearer contracts, closer supervision by administration and more careful record keeping and reporting of all service activities by contractors and the Correctional Service of Canada administration.

Recommendations were that future programming be designed to meet these evaluative criteria, with appropriate modifications to meet local conditions. Monitoring of progress at every level of administration would be essential to long-range goal achievement.

Treatment Outcome as Measured by Recidivism Rates

It is not possible in this article to go into sufficient detail about the strengths and limitations of the recidivism methodology. Two factors give rise to a conservative approach to the findings: the number of participants in individual contractors' programs ranged from three to more than 200, and only three years of time-at-risk could be reviewed for both the CSOP and non-CSOP cases.

However, the finding that does help assess the effectiveness of the various districts' programs is that the recidivism rate in District I, calculated by combining the rates of the district contractors, was 4%. This is only about a quarter of the rates in each of the other districts.[6] When the rates of contractors in each of the other districts are calculated and combined, we find average recidivism rates of 12%, 10% and 13% (figures rounded up). The highest recidivism rate of an individual contractor in the region was 14.06% (with more than 60 cases). In District I, though, two of the four contractors had no recidivists (with a combined total of 18 cases between these two).

Since there is no significant difference between programs in type of parolee served and little difference in the intensity of administrative awareness and control over the local programs, the evaluators have concluded that the appreciably lower recidivism rate in District I is most likely accounted for by treatment content and delivery.

It appears then that a rigorous, tough-minded approach has a measurable positive effect on recidivism rates. Furthermore, District I provides this type of service with the lowest cost per parolee and with any changes in cost linked directly to numbers served.

Service of Contractors to Parole

The key evaluative criteria for service to parole were twofold: comprehensive, up-to-date record keeping on all aspects of treatment and on all financial aspects of services delivered; and timely, sufficiently detailed oral and, especially, written reporting to parole officers on parolee status as it relates to risk of reoffending.

These areas of contractor performance tended to be sources of frustration in all districts, but it was much less intense in District I. In

[6] *It may be of interest to know that the recidivism analysis took place at the very end of the project (though the file review had taken place for many months), and that all analysis and writing of the findings from the interview and observational data had been completed by that time. Thus, these recidivism results could not shape the interpretation of the qualitative data.*

District I, the parole staff reported that they received written reports at expected intervals and that the information was adequate. They found the contractors to be generally accessible for informal consultation.

This was much less the case in the other districts where it was common for a parole officer not to have received written reports for many months or even years.

It was recommended that the contract be used to clarify the expectations for reporting and to encourage administration to insist that these standards be met.

Conclusion

The Pacific region's Community Sex Offender Program is a large one, of which much has been expected. The evaluators have concluded that most expectations have not been met.

At the same time, it is clear that it is indeed possible to provide an effective program, both modest in scope and demanding in approach. Furthermore, the program can be effective in terms of outcome, cost and level of service to parole.

The evaluation therefore does not suggest that the region, or the Correctional Service of Canada, take a whole new tack in community-based sex offender programming. Rather, it is a matter of affirming the approach which appears to be effective and working to extend this type of programming throughout the region. ■

Denial and Minimization among Sex Offenders: Assessment and Treatment Outcome

by Howard E. Barbaree, Ph.D.*

For clinicians and professionals working with sexual offenders, it comes as no surprise that many offenders deny their offences. Denial is generally regarded as a main impediment to successful therapy and, as a consequence, most treatment programs exclude offenders who steadfastly deny their offence.

With denial, the offender often concludes that he has no problems and that there is no reason for him to enter treatment. Even if the offender admits to an offence, he is very likely to distort the truth by minimizing the frequency, severity and variety of his criminal sexual behaviour.

* Department of Psychology, Queen's University and the Warkworth Sexual Behaviour Clinic

In a non-random[1] survey, 114 incarcerated rapists were divided into those who admitted to the offence for which they had been convicted (41%) and those who denied it (59%).

Both groups presented justifications which were intended to support their denial or to minimize responsibility for the offence. For example, among those who denied their offence, 31% reasoned that they had not committed an offence because the victim provoked them by being seductive. About one third of those who denied their offence (deniers) and one quarter of those who admitted their offence (admitters) argued that their victims meant "yes" even though they said "no." Of the deniers, 69% claimed that their victims eventually relaxed and enjoyed the rape. The same argument was put forward by 20% of the admitters. Sixty-nine percent of the deniers and 22% of the admitters alluded to the victims' unsavoury sexual reputations as excuses for their crimes. Seventy-seven percent of admitters and 84% of deniers excused their behaviour by attributing it to alcohol intoxication, while 40% of deniers and 33% of admitters explained their crimes by pointing to emotional problems caused by an unhappy childhood or current marital conflict.

Similar findings have been reported for child molesters. A recent Canadian study[2] of child molesters focused on the thematic content and logical structure of the excuses of child molesters. More than 250 justificatory statements were taken from the records of 86 child molesters referred for psychiatric assessment and submitted to analysis. Twenty-one distinct excuses and six themes in these excuses were identified. The authors were able to devise an "excuse syntax" to define the structures of the offenders' reasoning about their sexual improprieties.

These denials and distortions compromise both the accurate assessment and the effective treatment of these offenders. Therapists depend on offenders' truthful descriptions of events leading to past offences in order to determine which behaviours need to be targetted in therapy. In assessing progress in therapy, the therapist depends on faithful accounts of the offender's ongoing fantasies and sexual behaviours.

Since the results of assessment often have important consequences for sentencing, parole decisions and child

[1] *D. Scully and J. Marolla, "Convicted Rapists' Vocabulary of Motive: Excuses and Justifications,"* Social Problems, *31 (1984): 530-544.*

[2] *N.L. Pollock and J.M. Hashmall, "The Excuses of Child Molesters,"* Behavioral Sciences and the Law, *9 (1991): 53-59.*

custody and access disputes, offenders often lie about their offences as a self-protective strategy. While denial of the offence, cover-up of the facts and suppression of responses during assessment are conscious components of the offenders' denial, there may also be aspects of this denial that offenders do not purposefully control and of which they are at best only marginally aware.

Denial and minimization are the results of a psychological process involving distortion, mistaken attribution, rationalization and selective attention and memory. The process serves to reduce the offenders' experiences of blame and responsibility for their offences. It also seems to be successful since only 14% of sexual offenders report being remorseful for their offence.[3]

Denial and minimization are both products of the same self-serving cognitive processes, but they differ in two ways. First, denial and minimization represent different degrees of the process. Whereas denial is extreme and categorical, minimization is graded. Second, denial usually concerns either the facts in the case or whether or not the offender has a problem that needs treatment. Minimization, on the other hand, concerns the extent of an offender's responsibility for the offence, the extent of their part in offending and the degree of harm their victims have suffered.

We have developed the following typology of denial and minimization, presented here in brief, that is applicable to both child molesters and rapists.

Denial

Denial of the facts can take different forms. First, offenders may deny that they committed the offence at all, claiming that they never had sexual relations with the victim. They may rationalize the fact that they have been convicted in a court of law by saying that they were framed, that the victims or the police were out to get them.

Second, they may claim that although they did have sexual relations with the victims, it was not an offence because they consented or did not resist, or because the victims somehow received some emotional benefit from the sexual experience or because the offenders were tricked into believing that the victims were older.

Finally, offenders will admit to the act they are alleged to have committed but deny that the interaction was sexual in nature. For example, they may claim that they were touching the victims for some legitimate reason (e.g., applying skin medication to a child) or that the assault was non-sexual.

Minimization

Minimization can take three basic forms. Offenders will minimize the harm done to their victims, the extent of their previous offensive behaviour and the extent of their responsibility for the offences.

In minimizing victim harm, offenders will argue that the victim will recover and not suffer any long-term effects, that the victim had so many previous partners that the offence was of no consequence or that the benefits the victim received from the experience outweigh the harm.

In minimizing the extent of their previous offensive behaviour, offenders may underestimate the numbers of their past victims, the frequency of their past offences, the degree of force they have used and the intrusiveness of the offensive behaviour they have committed.

Offenders minimize their own responsibility for their offences in three ways: attributing blame to the victim, making external attributions and making irresponsible internal attributions. Offenders may absolve themselves of any blame by attributing their behaviour to external or situational factors, such as alcohol intoxication, stressful circumstances, social pressure or provocation. Offenders will absolve themselves of blame by pointing to non-sexual personal problems which led to the offence, such as their past victimization, their deprived childhood, their hormones or sex drive. In this category, some offenders will make religious references involving the devil or Satan.

Perhaps the most important way in which offenders absolve themselves is by blaming the victim. Offenders will claim that the victim was sexually provocative or that the victims made them angry and therefore deserved their fate.

Assessment and Treatment

Based on the above typology of denial and minimization, we have developed the Denial and Minimization Checklist for use in the Warkworth Sexual Behaviour Clinic. The checklist, designed for use with both child molesters and rapists, is completed by group therapists after each disclosure of offences made by men in the therapy program. On the checklist, the therapist indicates whether or not the offender denies the offence. If so, the therapist indicates the appropriate subcategory of denial. If the offender accepts that he has committed a sexual offence but minimizes it, the therapist indicates how the offender does this by checking the appropriate subcategories.

According to our use of the checklist, there is only one kind of denial checked for each man, but there can be several forms of minimization for each offender.

Table 1 presents the frequency of each type of denial and minimization in a group of child molesters and rapists. Between 50% and 60% of the offenders in these groups deny that they are sexual offenders. The vast majority of the remainder minimize their offences in some way. Very few describe their offences in a way that accepts responsibility for the offence and its consequences.

[3] *J.S. Wormith, "A Survey of Incarcerated Sexual Offenders,"* Canadian Journal of Criminology, *25 (1983): 379-390.*

Table 1

Denial and Minimization Among Child Molesters and Rapists In Treatment at the Warkworth Sexual Behaviour Clinic

	Child Molesters (N=15)		Rapists (N=26)	
Denial	10	(66%)	14	(54%)
Denial of any interaction	3		3	
Denial interaction was sexual	0		4	
Denial interaction was offence	7		7	
Minimization	5	(33%)	11	(42%)
Of Responsibility				
Victim blame	0		2	
External attributions	4		10	
Irresponsible internal attributions	1		7	
Of Extent				
Frequency	0		0	
# previous convictions	0		0	
Force used	1		9	
Intrusiveness	0		9	
Of Harm				
No long-term effects	0		5	
No Denial or Minimization	0	(0%)	1	(4%)

Because of the high percentage of denial in our offender population, we have had to design our therapy to take denial into account. Rather than excluding from treatment offenders who deny their offences, we focus on denial in our first stage of therapy.

This treatment is accomplished in the context of group therapy. Each offender gives an initial disclosure to the group. In response, the group therapist gives an account of the official version of the offence based on the police reports and victim statements. Then, the group is asked to list the discrepancies between the inmate's version and the official version. The offender is asked to account for the discrepancies, while the group is encouraged to challenge the offender on his account of the discrepancies.

The group therapist provides the offender and the group with reasons why offenders might deny their offences, including shame, avoidance of legal consequences and fear of losing the love and support of friends or family. The offender may give several subsequent disclosures, with the group and therapist challenging him on each account.

Work on each inmate may extend over several hours of group therapy, with a typical duration of six hours.

After the final disclosure of each inmate, the therapist completes the denial and minimization checklist with respect to the specific information contained in the most recent disclosure.

Of the 41 offenders presented in Table 1, 40 required treatment targetting denial and minimization. Of these, three men dropped out of treatment and did not complete a final disclosure. For all three, the reason for dropping out of treatment was a continuing and steadfast denial of the offence.

Table 2 presents both pre- and post-treatment checklist results for those who initially denied their offences. Table 3 presents checklist results for those who initially minimized their offences.

Of the 22 men who initially denied their offences but who completed treatment, three continued to deny their offences after treatment. Of the remainder, 15 accepted that they had committed a sexual offence but minimized the offence. Four who initially denied their offence(s) gave a final disclosure that accepted full responsibility for their offence(s).

Of the 15 men who initially minimized their offences, 12 continued

Table 2

Denial and Minimization at Pre- and Post-treatment Among Men Who Denied Their Offences Before Treatment

	Pre-treatment (N=22)	Post-treatment (N=22)
Denial	22	3
Denial of any interaction	14	1
Denial interaction was sexual	16	2
Denial interaction was offence	15	1
Minimization	0	15
Of Responsibility	0	5
Victim blame	0	2
External attributions	0	1
Irresponsible internal attributions	0	4
Of Extent		15
Frequency	0	1
# previous convictions	0	1
Force used	0	15
Intrusiveness	0	15
Of Harm	0	1
No long-term effects	0	1
No Denial or Minimization	0	4

Table 3

Minimization at Pre- and Post-treatment Among Men Who Minimized Offences Before Treatment

	Pre-treatment (N=15)	Post-treatment (N=15)
Minimization	15	12
Of Responsibility	15	5
Victim blame	1	0
External attributions	14	1
Irresponsible internal attributions	8	5
Of Extent	9	11
Frequency	0	1
# previous convictions	0	0
Force used	9	11
Intrusiveness	9	10
Of Harm	5	0
No long-term effects	5	0
No Denial or Minimization	0	3

to do so after treatment but with fewer instances of minimization. Of the 15 minimizers before treatment, three gave a final disclosure with no significant minimization.

All of the men who completed treatment also responded to the Multiphasic Sex Inventory (MSI), a 300-item questionnaire specifically designed to assess denial, minimization, cognitive distortions and treatment motivation among sexual offenders. The scoring of the questionnaire is not obvious or apparent, and the test is designed to minimize the offender's ability to fake "good" responses.

Table 4 presents the average scores before and after treatment on the subscales of the MSI. Changes in the subscale scores from pre- to post-treatment were statistically significant in five of the six scales. The direction of the changes indicates decreased denial and minimization and increased treatment motivation.

While not conclusive, these results indicate that denial and minimization among sexual offenders are amenable to treatment. Without treatment targetting such cognitions, offenders should not be excluded from treatment on the basis of denial and minimization. Further, targetting denial and minimization should be the first stage of treatment, to increase motivation for treatment and set the stage for further assessment and treatment. ■

Table 4

Average Scores on Subscales of the Multiphasic Sex Inventory (MSI) Before and After Treatment

Subscales	Pre-treatment	Post-treatment
Social/Sexual Desirability	26.09	29.75
Sexual Obsessions	2.86	5.70
Lie Scale	8.61	5.00
Cognitive Distortions and Immaturity*	5.45	5.68
Justifications	3.70	1.97
Treatment Motivation	3.88	5.50

* All changes in subscale scores are statistically significant ($p<.001$) except on the Cognitive Distortions and Immaturity scale where no significant change occurred.

A Description of the Westmorland Sex Offender Program with a Focus on Treatment Concerns and Research

by Kevin Graham, M.Sc.*

The program for sex offenders offered at minimum-security Westmorland Institution was developed from material associated with Dr. Patrick Carnes' sexual addiction model.[1] Although based on this model, the program is not restricted to it. Rather, the program is eclectic, borrowing from the cognitive-behavioural, psychodynamic and spiritual domains. In addition, the program is open to revision and change as new needs arise; since its inception, various components have been developed and added.

Begun as a pilot project in February 1988 for male sex offenders, the program was initiated at the institutional level with the support of the regional chaplain, prison psychologists and the institution's administration. As of January 1991, approximately 100 sex offenders had received treatment in the program.

* Program Co-ordinator, Sex Offender Program, Westmorland Institution (Atlantic); also affiliated with Acadia University.

The core program consists of 15 modules delivered over 15 weeks. The offender participates in three hours of group therapy and one hour of individual therapy per week. The groups are closed and accommodate four to eight inmates. Often the groups are made up of mixed offenders; that is, rapists and child molesters may be in the same group. The groups are led by a female-male co-therapist team.

Upon completion of the core program, selected inmates are given two weeks of relapse-prevention training. This part of the program is more intensive – the individual is in group therapy for eight hours each day.

At the end of the program, the offender has access to a follow-up program offered at the institution at six-week intervals. These groups are open to family members as well.

The Offender and Treatment Approach

Many clinicians who work with sex offenders are beginning to report much higher levels of physical and sexual abuse among this population than was previously thought to be accurate.[2]

Offenders' reporting of abuse is seen by some as an attempt to avoid taking responsibility for the offence.[3] Other studies report low rates of abuse among this population and tend to dismiss it as an insignificant factor in the development of the offence.

The Westmorland program takes an opposing view. Dealing with the victimization of the offender is considered crucial to the therapeutic process. Demographic information gleaned through the program reveals high levels of abuse: 51% of the offenders report having been physically abused, and 60% report sexual abuse. In almost three quarters of cases (74%), the abuser was male – most of the time a father or father substitute. The remaining quarter (26%) were abused by females – either the mother, older female relatives or babysitters.

The manner in which offenders deal with their abuse is related to their subsequent offending. Sex offenders use dissociation (or repression) as a defence and as a means to cope with the trauma of their own abuse.[4] They also tend to be more withdrawn and alienated in their relationships with others and with themselves.[5] These factors tend to remove the sex offender from the experience of both others and self.

[1] *P. Carnes,* Out of the Shadows: Understanding Sexual Addiction. *(Minneapolis, Minnesota: Compcare, 1983).*

[2] *N. Groth, "Sexual Trauma in the Life of Rapists and Child Molesters,"* Victimology, *4 (1979): 10-16. See also D. Tingle, G. Barnard, L. Robbins, G. Newman and D. Hutchinson, "Childhood and Adolescent Characteristics of Pedophiles and Rapists,"* International Journal of Law and Psychiatry, *9 (1986): 103-116. And see T. Seghorn, R. Prentky and R. Boucher, "Childhood Sexual Abuse in the Lives of Sexually Aggressive Offenders,"* Journal of the American Academy of Child and Adolescent Psychiatry, *26 (1987): 262-267.*

[3] *R. Langevin and R. Lang,* Incest Offenders: A Practical Guide to Assessment and Treatment. *(Etobicoke: Juniper, 1988).*

[4] *E. Bliss and E. Larson, "Sexual Criminality and Hypnotizability,"* The Journal of Nervous and Mental Disease, *173 (1985): 522-526. See also K. Graham, "Towards a Better Understanding and Treatment of Sex Offenders." Manuscript submitted for publication, 1991.*

[5] *J. Gilgun and T. Connor, "Isolation and the Adult Male Perpetrator of Child Sexual Abuse: Clinical Concerns," in A.L. Horton, B.L. Johnson, L.M. Roundy and D. Williams (Eds.),* The Incest Perpetrator: A Family Member No One Wants to Treat. *(Newbury Park: Sage, 1990) 74-88. See also K. Graham, "An Investigation of Personality Characteristics of Sex Offenders." Unpublished manuscript, Acadia University, Department of Psychology, 1989. And see Graham, "Towards a Better Understanding and Treatment of Sex Offenders."*

Inappropriate sexual behaviour is viewed as an expression of various needs that have become displaced.

Focusing on the offender's own victimization experience can help him begin to recover the repressed emotions associated with the trauma. Once able to relate to their own experience, offenders are better able to relate to the experience of others, especially their own victims. One offender, when confronted with the harm done to the victim, expressed the following sentiment: "If I don't know how I feel, how do you expect me to know how she feels?" Focusing on the offender's victimization experience is also a productive means of establishing victim empathy.

To ease this process, the tendency of the offender to become alienated or isolated must be addressed. One of the main foci of the therapeutic process is to create an environment of trust, enabling the offender to bond or take part in a meaningful relationship with both the therapist and the group. It is within this trusting relationship that offenders can begin to discover and integrate aspects of themselves that had previously been disjoined. Offenders need to experience being cared for as well as being confronted with the reality of their offending. If the offender does bond in these relationships, it is the beginning of a process of self-development that can generalize to relationships back in the community.

Inappropriate sexual behaviour is viewed in the program as an expression of various needs that have become displaced. These include the need for intimacy, for power and for the expression of anger and hostility. Once the line has been crossed and offenders begin to fulfill these needs through inappropriate sexual gratification, they can become strongly attached, addicted or compulsive about this sexual expression – so much so that they lose control, and the desires begin to control them.

One of the goals of the program is to facilitate more creative expression and fulfillment of these basic needs. The relapse-prevention program focuses on enabling offenders to have more control of their sexual behaviour.

A final comment with regard to the program description: the psychological demands placed on the therapists who are delivering such programs are heavy. Therapist supervision has been, and continues to be, a cornerstone of this program with each therapist receiving between one and two hours of supervision per week.

The program is helping the offender to better express emotion, to become less alienated and to have more of a sense of control.

Research

The research component of this program focuses on three areas. The first is program evaluation. Pre-post test measures (taken before and after the treatment to determine whether there were changes in any areas) have been used since the beginning of the program. A measure was also developed to evaluate offenders' progress while in the program. The second area of research identifies some of the personality characteristics of this group. Three such studies have been done. The third research focus is on demographic information. Some of the findings from each of the areas are presented below.

The original purpose of the pre-post testing was to evaluate whether the program was having the desired effects on the offender. The following measures were used: the Millon Clinical Multiaxial Inventory (MCMI); the IPAT 8 State Questionnaire (8SQ); Minnesota Multiphasic Personality Inventory (MMPI) subscales for alienation, denial and social desirability; a measure of emotional empathy; a measure of locus of control; and a measure of dissociation.

The results of the testing demonstrated significant changes in the desired direction on seven of the eight scales of the 8SQ, a significant reduction in alienation and a significant movement to an internal (as opposed to external) locus of control. These results indicate that the program is helping the offender to better express emotion, to become less alienated and to have more of a sense of control with respect to impulses, feelings, social relationships and their fate.

The second aspect of program evaluation has been the development and implementation of the Participation Assessment Measure. This measure consists of 45 questions related to the following 11 subscales: defensiveness, acceptance of powerlessness, coping with shame, insight, capacity for empathy, degree of bonding and alienation, forgiveness, acceptance of responsibility, assertiveness, expression of emotion and impaired thinking. The measure is administered by the therapists at the middle and end of the program. Progress feedback is given to the offender. The scale shows consistent reliability.

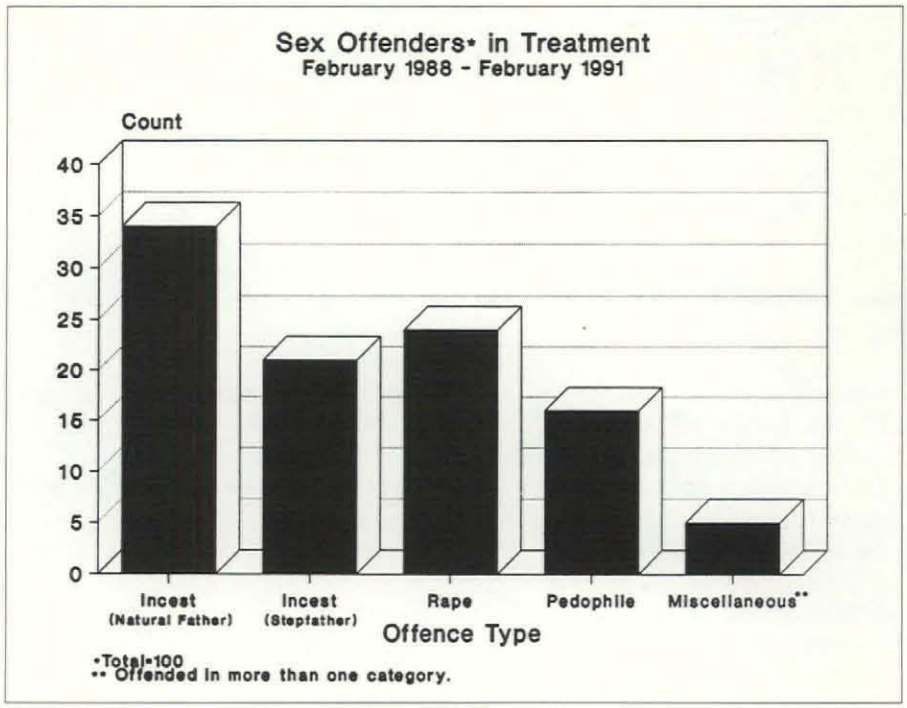
The evaluative research is beginning to demonstrate some predictive results. At present, these findings are tentative, and more time is needed to establish their validity firmly. Recently, two offenders quickly returned to prison. One had reoffended very soon after release, and the other was deemed to be near relapse. Upon examination of their pre-post test results, both had scores that were significantly different from other offenders. Both had also scored

This population is more alienated and dissociative, and more likely to have an external locus of control.

significantly lower on the Participation Assessment Measure. Although the sample size is small, the results may help to identify those who are high risks for quickly reoffending upon release.

As mentioned above, three studies have been done to understand the sex offender better. The findings indicate that this population is more alienated and dissociative, and more likely to have an external locus of control than other offenders and men in the general population.[6] The trends in one study indicated that these sex offenders may be more capable of empathy than other offenders.[7] The final study demonstrated a high level of addictive personality among this group of offenders.[8]

The final area of research has looked at program demographics. Data on various topics are being accumulated and analysed. The following issues are of concern: recidivism, length of stay in the prison after program completion, offender history issues, percentage of sentence served compared to non-treated sex offenders and type of offender treated. The figure presents data by offence category on sex offenders treated during the first three years of the program.



Conclusion

Information has been presented on the nature of the treatment and research approach of the program for sex offenders at Westmorland Institution. There are other components not discussed in this paper. One aspect is the development of a community-based follow-up program, for which there is a strong need.

A central philosophy of this program is that a process of recovery can be started in treatment within the prison, but this process also extends beyond the institution. We do not advocate a cure, but rather recovery over time. The offender will wrestle with the temptation to act out over and over again and is most vulnerable once back in the community. There is a need for long-term support after the end of the sentence for those offenders who really want to continue the recovery process. ■

[6] *Graham, "Towards a Better Understanding and Treatment of Sex Offenders."*
[7] *Graham, "An Investigation of Personality Characteristics of Sex Offenders."*
[8] *K. Graham, "Addiction: A Possible Component of Sexual Offending,"* American Journal of Preventive Psychiatry & Neurology, *3 (1991): 54-56.*

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

by Robert J. Konopasky, Ph.D.,* Steve S. Cann, M.A.** and Daniel T. Curry, M.Sc.***

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

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

* Professor, Department of Psychology, Saint Mary's University
** Correctional Service of Canada, Nova Scotia District
*** Instructor, Department of Physical Education, Saint Francis Xavier University

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

Additional objectives of the clinic were:

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

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

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

The contract provided the clinic with funding for the assessment of 39 offenders and for the provision of three cycles of 16-week group therapy.

Assessment

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

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

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

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

- **Test Battery** A comprehensive test battery, consisting of some 22 scales and questionnaires, was administered. This included the following: Clarke Sex History Questionnaire, Michigan Alcohol Screening Test,

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

Drug Use and Suicide Risk Test, Abel and Becker Cognitive Distortion Scale, Wilson Sexual Fantasy Questionnaire, Attitudes Towards Women Scale, Hostility Towards Women Scale, Clarke Violence Scale, Clarke Gender Identity Scale, Clarke Parent/Child Questionnaire, Minnesota Multiphasic Personality Inventory-2, Millon Clinical Multiaxial Inventory-II, Wechsler Adult Intelligence Scale–Revised, Social Response Inventory, Social Avoidance and Distress Scale, Social Self-Esteem Inventory, Marlowe-Crowne Social Desirability Questionnaire, Short Marital Adjustment Scale, Waring Intimacy Questionnaire, Neuropsychological Screening Questionnaire, Halstead Reitan Neuropsychological Test Battery (as required) and the Wechsler Memory Scale (as required).

- **Phallometric Testing**[2] Level of sexual arousal was measured in response to various sexual stimuli by recording changes in air pressure in a glass tube covering the offender's penis.[3]

  A sophisticated hardware and software package was used to analyse changes in penis size (including the offender's minimum and maximum response and the time it took for the offender to "recover" from the state of arousal) in response to the sexual stimuli (e.g., video material, audio material, slides) which varied the nature of the sexual activity portrayed, and the age and gender of subjects featured, etc. The program also recorded personal information about the offender (e.g., employment status, previous offences, I.Q.).

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

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

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

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

Treatment

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

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

The purpose of the relapse-prevention plan is to make offenders aware of any pattern of behaviour they exhibited before committing an assault.

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

Participants were told that their parole officers would be contacted if they reported having engaged in assault or other criminal activity; reported plans to commit an assault; missed a meeting without having a documented and appropriate excuse; were not participating in the group; showed a clinically significant change in mental status; reported plans to commit suicide; were intoxicated when attending the group; or reported a breach of a condition of abstinence.

Treatment included individual and

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

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

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

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

The focus of treatment in this program was specifically to:

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

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

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

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

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

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

Evaluation

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

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

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

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

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

All offenders were tested after treatment for psychopathology, self-esteem, anxiety in social situations and capacity to form healthy and intimate adult relationships. The only

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

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

Pre- and Post-test Mean Scores on the Test Battery

Number of Subjects	Test	Before Treatment	After Treatment	Probability
10	ABC*	127.90	134.30	.028
9	ATW**	23.20	14.89	.029
9	SRI**	-4.11	-3.25	.034
9	SSEI*	122.20	123.29	.260
9	SADS**	15.90	10.43	.104
9	WIQ**	21.89	20.33	.207
9	HTW**	6.56	5.33	.575

ABC – Abel and Becker Cognitive Distortion Scale
ATW – Attitudes Towards Women Scale
SRI – Social Response Inventory
SSEI – Social Self-Esteem Inventory
SADS – Social Avoidance and Distress Scale
WIQ – Waring Intimacy Questionnaire
HTW – Hostility Towards Women Scale

* Movement to higher scores indicates improvement
** Movement to lower scores indicates improvement

subgroup of offenders with more than five subjects was child molesters. Accordingly, test scores before and after treatment are reported only for this group of 10 child molesters.

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

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

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

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

Summary

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

Coming up in *Forum on Corrections Research...*

The next edition of FORUM will focus on staff commitment and other issues related to staff.

For future editions, the editors of FORUM are soliciting articles on the following topics:

- long-term offenders;
- violence and suicide in correctional institutions;
- the role of punishment in corrections; and
- women and crime.

We welcome your suggestions regarding specific research in these and other areas that could be profiled in future issues of FORUM.

If you wish to submit a full article or a research brief to FORUM, please write to us at:

Research and Statistics Branch
Correctional Service of Canada
4B - 340 Laurier Avenue West
Ottawa, Ontario
K1A 0P9

JOIN US...

The **Association for Correctional Research and Information Management (ACRIM)** is dedicated to improving and providing knowledge, experience and leadership in correctional research and statistics in prisons, jails and juvenile detention centres throughout America.

ACRIM invites you, your colleagues and friends to join us in the task of establishing a viable constituency in support of high-quality professional research for corrections.

The major objectives of the Association are to promote more effective research and statistics programs and the fullest use of research data for the prevention, control and treatment of crime and delinquency. To accomplish this, the Association, working with other groups and using the capacities, experiences and resources of its members, shall:

- study, recommend and act to achieve improvements in research and statistics methods and programs in general;
- study, recommend and act to achieve more effective use and dissemination of research findings; and
- determine policies and set its goals and course of action in harmony with the general policies and objectives of the majority of its members.

Membership

Membership is encouraged for anyone interested in the objectives of the Association and is open to all persons interested in improving correctional research services.

Annual dues of $5 (U.S.) entitle each member to receive the ACRIM newsletter, advance notice of conferences, minutes of the Association's meetings and reports of the annual conference and workshops.

Simply send an application with your name, organization or affiliation, position, area of specialty and mailing address, along with a $5 (U.S.) cheque or money order made out to:

ACRIM
Lawrence A. Bennett, Ph.D.
Consultant in Criminal Justice
950 Fulton Avenue, Suite 145
Sacramento, California 95825

Canada