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Research Brief

Managing The Treatment Of Sex Offenders: A Canadian Perspective

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MANAGING THE TREATMENT OF SEX OFFENDERS: A CANADIAN PERSPECTIVE

The management and treatment of sex offenders presents a number of perplexing challenges for corrections.

As social reaction and sensitivity to the problem of sexual offending has heightened, we have witnessed an unprecedented increase in the numbers of sex offenders who are becoming correctional clientele. It has been estimated that the number of sex offenders in State jurisdictions in the U.S., for example, has grown from 25,000 in 1983 to 58,000 in 1988 (Corrections Compendium, 1988). If we include those "hidden sex offenders" who are serving sentences for non-sexual offences or who have plea bargained to lesser crimes, it has been suggested that sex offenders account for as high as 25 to 30 % of U.S. prison populations.

Canada has had a similar experience. Over the past decade, the percentage of offenders admitted to Federal correctional institutions for an offence that was sexual in nature has increased from 7.1 % of total admissions in 1979 to an average of 11.4 % annually from 1985 to 1989 (see chart 1). The number of sex offenders incarcerated in federal penitentiaries rose from 871 at the end of 1984 to 1,574 at the end of 1989; an increase of 44.6 % in just five years. At the same time, the total offender population in federal penitentiaries increased by only 3.5%.

The pressure of numbers for this category of correctional clientele, that is neither very well accepted by other offenders nor very well understood by correctional staff, creates a host of challenges for assessment, institutional management, staff training, treatment, and eventual reintegration and appropriate supervision in the community.

Beginning in the mid-seventies, the Correctional Service of Canada pioneered the development of specialized intensive treatment programs for sexual offenders to service different regions of the country; the our regional psychiatric treatment centres in Abbotsford, British Columbia; Saskatoon, Saskatchewan; and Kingston, Ontario (for a description of some program characteristics, see Borzecki and Wormith, 1987).

Although varying to some extent in approach and duration, each of the programs adopts a comprehensive behavioral and cognitive orientation in targetting particular risk factors for sexual offending (e.g., low self-esteem, communication and social skills, attitudes towards sexuality and women, deviant sexual arousal patterns). The programs have become well-entrenched and are generally highly regarded by correctional staff in "feeder" institutions where referrals originate.

However, a recent review of our programs and services for sex offenders has underscored the fact that a more coordinated strategy is needed, with a range of both institionally-based and community follow-up programs, and a complimentary and systematic assessment and recruitment strategy that focuses on matching offenders to programs based on those risk and needs factors that relate most consistently to sexual offending.

We are currently developing such a strategy along the lines that are discussed below.

MATCHING OFFENDERS WITH PROGRAMS

Although it can be argued that all sex offenders should receive some form of treatment, it can be argued equally that not all sex offenders should receive the same intensity, duration, or type of treatment.

In the field of sex offender treatment generally, a variety of treatment techniques and therapies are employed. For example, one review of institutional sex offender programs in the U.S. remarked that in the 73 programs that were examined, 785 different therapies were employed (see Sapp and Vaughn, 1989). Clearly, neither the research nor clinical literature is yet definitive regarding exactly how sex

offenders should be treated, although there is mounting evidence that behavioral and cognitive approaches have the edge in terms of expected risk reduction (Furby, Weinrott & Blackshaw, 1989).

Whatever type of program is provided, it is critical to ensure that specific risk and need factors are targeted, and to assess degree of impact through systematic program evaluation. Moreover, however, important decisions have to be made in terms of optimal and effective utilization of available program options, particularly with regards to which sex offenders should be priorized for the most intensive programming.

A major difficulty arises if only a few specialized and intensive programs are available and if sex offenders are considered as "treatable" only within these programs. Correctional staff begin to ignore variation in risk and needs as they vie to refer **their** particular cases to **the** treatent option. Waiting lists get longer, sex offenders who have not been treated are not considered for parole release, and the pressure on specialized programs increases.

Sex offenders are a diverse group. They differ in their personal and offence-related histories, the pattern of circumstances surrounding their offences (e.g., use of alcohol), the age and sex preferences of their victims, the attitudes and beliefs that support their deviant behavior, and the degree to which they have demonstrated particular brutality and use of force.

Sex offenders also vary considerably in their risk for re-offending. The point is illustrated in the table below which shows follow-up data, for a minimum of a three year period, for sex offenders released from Canadian federal correctional institutions between 1985 and 1987.

Out of the total group of 1,164 offenders, 6.2 % were readmitted within three years for another offence that was sexual in nature, 13.6 % were readmitted for a variety of other non-sexual offences, and a further 11.3 % for some form of violation of release conditions.

These data highlight two important observations: a) that the rate of sexual re-offending, or at least the rate of officially recorded sexual re-offending, is generally not very high; and b) that a significant proportion of sex offenders are also criminally inclined in other ways and therefore at risk for non-sexual re-offending.

Perhaps what is most striking, however, is the evidence of a substantial increase in the risk for sexual re-offending for that group of offenders with a prior history of sexual convictions.

Sex offenders with a prior history were more than twice as likely to commit further sexual offences (14.6 % versus 6.2 %), more likely to re-offend with a violent non-sexual conviction (8.5 % versus 5.9 %), and much more likely to violate release conditions (21.9 % versus 11.3 %).

We can conclude that, at a minimum, an effective correctional strategy for matching sex offenders with appropriate programming should provide for:

- **higher priority for specialized intensive treatment for those sex offenders with a history of persistent sexual offending;**

- **differential programming addressing risk and need factors common within the general offender population (e.g., alcohol and drug abuse, histories of sexual abuse, poor social skills) for those sex offenders with a mixed criminal profile;**

Although a number of sophisticated categorizations can be found in the research literature on sex offenders, in our experience a useful differentiation for programming decisions is as follows.

PEDOPHILES: These individuals have committed offenses against children outside of the family unit. Historically, they tend to have more convictions for sexual offending and fewer convictions for nonsexual offenses than do rapists. As a group, they are more likely to admit to their offenses and recognize the need for treatment. However, they also tend to downplay the severity, intensity and duration of

their deviance and minimize the impact of their behavior on their victims.

RAPISTS: These men have committed sexual offenses solely against adults, typically females. They are more likely to deny their offenses or claim that their actions were not "rape". This denial may reflect genuine but distorted perceptions that their terrified victim didn't struggle, scream or say "no" and therefore it couldn't have been rape. Rapists are more likely to have a history of nonsexual criminal offenses, although some have also committed previous rapes; these latter may deserve to be subcategorized for treatment priorization purposes.

INCEST OFFENDERS: These are men who have committed sexual offenses solely against children in their immediate family. It is important to differentiate these men from those pedophiles who "infiltrate" a family in order to gain access to children. These latter may demonstrate a history of step-parenting across a number of families, all of whom are likely to have children of an age and type preferred by the offender.

SELECTING TREATMENT TYPE AND SETTING

The kind of sex offender we are dealing with has important implications for determining the type and location of treatment.

Although our research to date is not conclusive, it appears likely that pedophiles, especially those men who offend against young boys, are at greater risk to recidivate sexually than are rapists (19% vs 8%). These data suggest that pedophiles should be our highest priority to receive treatment if our primary goal is to reduce sexual recidivism. However, rapists are more likely to use greater violence if they do reoffend, and are more likely to commit additional nonsexual offenses (40% of rapists vs 16% of pedophiles).

About 8% of our treated rapists have been convicted of further sexual offenses while 40% commit additional nonsexual offenses. Our data do suggest, however, that men who have a longer history of sexual aggression prior to treatment are at greater risk to commit future sexual offenses. These "hard core" rapists generally present as more deficient and deviant on a number of dimensions and may require additional and more intensive treatment, as well as more structured follow-up following release.

One might argue that specialized programs should accept responsibility for the highest risk offenders, in this case the pedophiles. These men require the most intensive treatment, particularly in terms of sexual arousal treatments. They also require the most extensive training in a variety of adaptive skills as well as attitude restructuring. Finally, they are most likely to commit future sexual offenses.

Pedophiles tend to display an attitudinal system that supports their deviance (i.e., they believe that sex with children is not harmful to children and that it may even be beneficial), and these attitudes and beliefs must be challenged and restructured during treatment. As is the case with other groups of sexual offenders, most pedophiles report having been sexually/physically abused as children and the long-term effects of this abuse should be one focus of treatment. These men also generally tend to be underassertive in their dealings with others and aggressivity may appear as covert hostility and passive aggression (i.e., they may tend to whine, complain, sulk and be generally obstructionist). Assertion training and social anxiety reduction procedures are often warranted.

On psychosexual testing, pedophiles tend to show significant arousal to young children. They are typically unable to voluntarily inhibit this deviant arousal and must be specifically taught self-control skills. The assessment and treatment of sexual preferences and fantasies is an essential component of treatment for these men.

Rapists might best receive treatment within the institutional setting. In most respects, rapists seem not different from other nonsexual offenders in terms of personality, social skillfullness, sexual knowledge and attitudes and sexual arousal patterns. Thus, they tend to be somewhat impulsive, have poor problem solving skills, maintain attitudes that promote sexual and interpersonal violence (e.g., most women "ask"

for it), show anger, and may be more resistant to treatment. The fact that they resemble the average "solid convict" does not suggest that treatment cannot be beneficial. Many of our currently available institutional programs (e.g., anger management, problem solving/cognitive restructuring training, stress management, substance abuse, etc.) may be appropriate for these men. In addition, one might focus more on sexual and interpersonal attitudes, increasing victim empathy, and work more directly to define each invidivuals' "crime cycle" (i.e., pattern of emotional, cognitive and overt behaviors that preceed and predict offending). Resources for sexual arousal assessment and treatment would also be required.

Historically, rapists have been thought to demonstrate distinct patterns of sexual arousal. However, more recent evidence demonstrates that, as a group, rapists do not differ from non-rapists in terms of their sexual preferences. As a result, sexual arousal reconditioning is usually not required for these men as it typically is for pedophiles. If these men are unable to demonstrate voluntary control over their arousal, they must be taught self-control skills, usually in conjunction with techniques aimed at modifying sexual fantasies. Moreover, some rapists show arousal to children even though they have not been convicted of pedophilic offenses. When confronted with these results, these men may acknowledge sexual interest and involvement with children, and they often must complete sexual arousal reconditioning. Thus, even though sexual arousal testing and treatment is of secondary concern with rapists, the resources to provide such services remains essential.

Finally, those rapists who do not show sufficient gains through treatment and those at highest risk to recidivate (i.e., men who have a lengthy history of sexual crimes) might additionally be referred to specialized programs prior to their release.

Incest offenders present a particular dilemma. They typically present the least risk to recidivate (sexually and non-sexually) and might thus be seen as deserving the lowest priority for scarce treatment resources. On the other hand, there is an increasing expectation from the community and the justice system that these men will receive treatment during incarceration.

The incest offender is typically somewhat passive and has difficulty relating easily to adults in purely social and more intimate situations. They may appear very skilled in "work" related settings (e.g., many of them have held very responsible jobs and community related positions), but become more anxious and inadequate when dealing with less structured social situations. Difficulties related to inadequacy, poor communication and problem solving skills, and distorted attitudes about relationships and sexuality typify their marriages. These factors must be addressed during treatment.

Incest offenders typically do not have extensive criminal histories prior to the current charges, and most are being incarcerated for the first time. They are by far the most minimizing and denying of the sexual offender types and will insist that it happened "only once", that the child "seduced" them, that it was the fault of alcohol, and that their victims (who typically are terrified of the offender) still love them and are eager to reestablish a parent-child relationship.

Breaking down this system of denial and distorted perceptions is essential and can perhaps best be accomplished in conjunction with family-based therapy. Within a correctional institutional setting, efforts must be made to access the family and/or social service networks dealing with the family in order to effectively confront the offender. Unfortunately, such contacts are typically difficult to establish while the offender is incarcerated.

Although community treatment should be provided for all sexual offenders, many incest offenders might best receive formal treatment from such sources as part of a parole release. In this way, the family could more readily be incorporated in the treatment process. This aspect is obviously essential if the offender plans to reunite with his family. Alternately, the incest offender might receive some institutional treatment aimed at increasing his sense of responsibility for the offense and empathy for his victims prior to engaging in the treatment process in the community. In either case, and on the basis of

risk, treatment might best be delivered from an institution as opposed to a specialized treatment centre.

CONTINUITY AND FOLLOW-UP

There are two prominent issues in addressing continuity and follow-up treatment for sex offenders.

First, there is increasing evidence that treatment follow-up in the community is necessary to optimize the effects of institutionally-based programming. Thus, we must not only coordinate the use of programming resources during incarceration, but must ensure that community follow-up exists AND that it complements the process initiated within institutions. For example, if we adopt an approach that focuses on skills, attitudes and sexual arousal patterns, we should not expect maximum benefits if we refer treated offenders to a community program that provides unstructured counselling and psychotherapy. The impact of efforts at providing community follow-up may be reduced by the very uneven quality and orientation of community based services.

A second and potentially more troubling issue relates to responsibility for sexual offenders within the larger context of the criminal justice and mental health systems.

It is possible, first, that by attempting to rationalize and increase our services for currently incarcerated offenders, we may dramatically increase the number of offenders we must deal with. For example, it has been our experience in some regions of the country that many judges are increasingly expecting that convicted incest offenders should receive treatment as part of their sentence. When they realize that such services may not be available through probation or other community corrections options, they may impose a custodial sentence so that the offender may gain access to treatment. One might argue that if there are more institutionally-based programs than there are community-based alternatives, we may see an increasing number of sex offenders, particularly incest offenders, sentenced to custodial terms unnecessarily.

A related issue stems from the fact that sex offenders, who have been incarcerated and then managed under supervised release programs, may remain at risk long after their sentences are completed. In the follow-up release data that was described above, it was observed that of those sex offenders who recidivated with another sex offence, 50 % recidivated after their sentence expiry.

Sex offenders cannot remain solely a correctional problem. We would argue that, as part of its long term planning for dealing with sexual offenders, correctional jurisdictions must enter into discussions with the courts, and with community mental health and social service agencies to ensure coordination of treatment and services for sexual offenders, perhaps in some cases over the course of many years until public safety is no longer threatened.

CHART AND TABLE

Chart 1

Percent Of New Admissions For Sex Offences 1979 - 1989

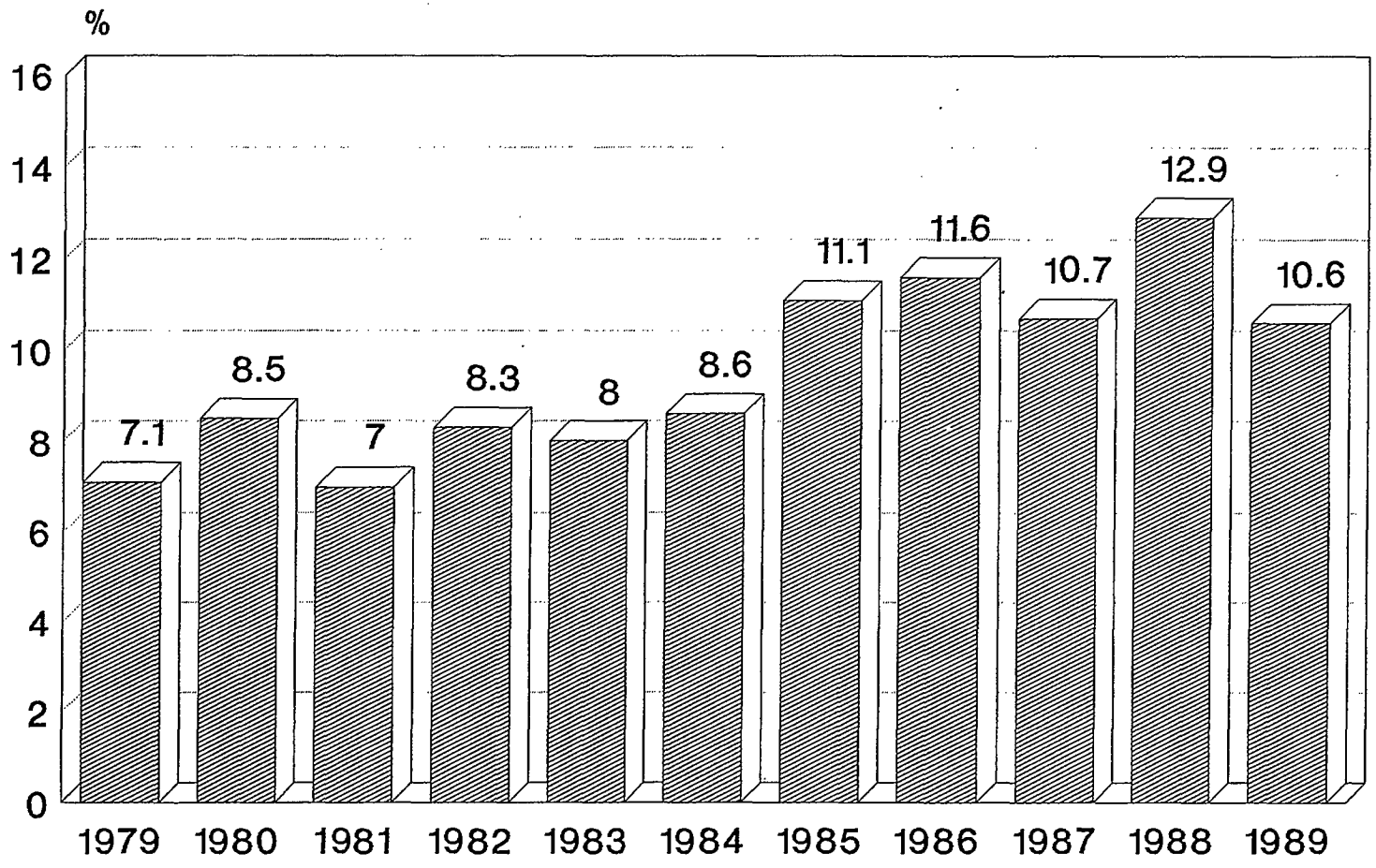

Table 1

THREE YEAR FOLLOW-UP OF SEX OFFENDERS RELEASED BETWEEN 1985 AND 1987

Outcomes	All Offenders %	Offenders With Prior Sex Offences* %
New Sex Offences	6.2 (72)	14.6 (12)
New Violent Offences	5.9 (69)	8.5 (7)
New Non-Violent Offences	7.7 (90)	6.1 (5)
Technical Violations	11.3 (132)	21.9 (18)
No Readmission	68.8 (801)	48.8 (40)
Totals	100.0 (1164)	100.0 (82)

* Offenders with a prior federal term for a sex offence.

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