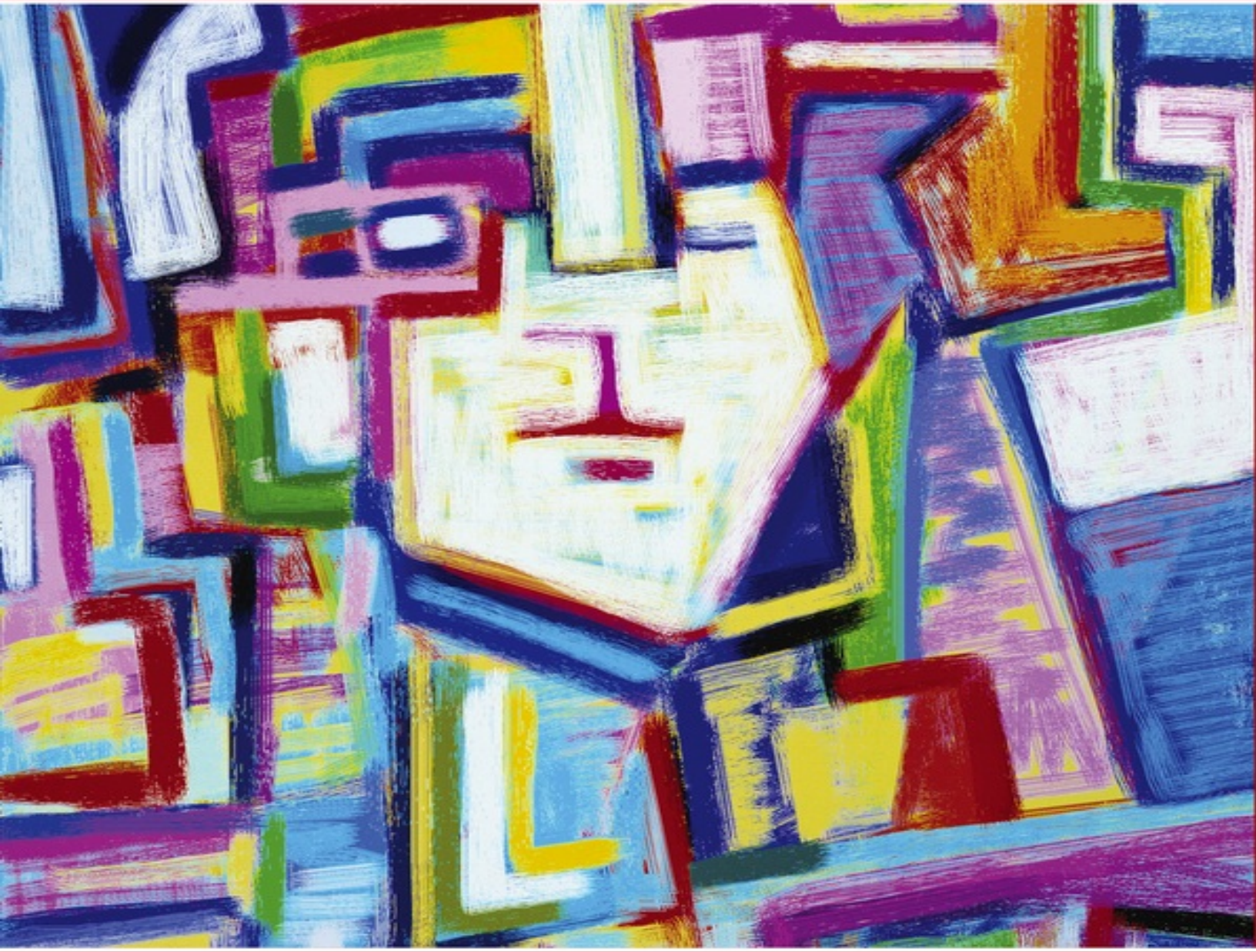
Jeffrey Abracen and Jan Looman



# Treatment of High-Risk Sexual Offenders

## An Integrated Approach

WILEY Blackwell

# Table of Contents


- Cover
- Title Page
- Acknowledgments
- Introduction
- 1 Background and Definitions
- 2 The Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP)
- 3 Treatment Outcome for High-Risk Violent and Sexual Offenders
  - Efficacy of programs for high-risk sexual and violent offenders
  - Recent research evidence
  - Conclusion
- 4 Therapist and Setting Characteristics
  - Therapist characteristics
  - Psychopathy as a responsivity factor
  - Characteristics of the treatment setting
  - Conclusion
- 5 The Integrated Risk–Need–Responsivity (RNR-I) Model
- 6 Etiological Factors
  - Attachment theory
  - Complex post-traumatic stress disorder
- 7 Combining Attachment Theory and Complex Post-Traumatic Stress Disorder and Theories of Sexual Offending
  - Mental illness
  - Summary
- 8 The Good Lives Model and Sexual Offending
  - The RNR approach
  - The Good Lives Model
  - GLM vs. RNR
- 9 Therapeutic Orientation and Relevance to Assessment
  - Actuarial risk assessment
  - Psychometric assessment battery
- 10 Self-Management Component

Introductory module
Autobiography and disclosure
Cognitive distortions
Emotions management
Behavioral progression
Self-management
11 Social Skills and Individual Therapy
Individual vs. group therapy
Social skills deficits
Social skills component
12 Alcohol Abuse, Drug Abuse, and Sexual Offending
A review of the empirical literature regarding substance abuse and recidivism among sex offenders
The RNR-I, alcohol abuse, and sexual offending: theoretical considerations
13 Deviant Sexual Arousal
Sexual preference hypothesis
Phallometric testing
Phallometric testing at the RTCSOTP
Conclusion
14 The Integrated Risk–Need–Responsivity Model (RNR-I)
Summary and conclusions
15 A Model for Community Management
Community-based research with high-risk offender populations
Process of initial assessment in the community
A comment about the Good Lives Model, RNR, and community assessment
Integrated care: building on institutionally based treatment programs in community settings
Central District (Ontario) Sex Offender Maintenance Program: model for program delivery
Community-based outcome research in Central District (Ontario) Parole
16 Summary and Conclusions
Appendix I: Decision Matrix
Appendix II: List of Pre- and Post-treatment Measures
Paulhus Deception Scales (PDS; Paulhus, 1998).
Multiphasic Sex Inventory (MSI-II) (Nichols & Molinder, 2000).

Bumby RAPE scale (Bumby, 1996).
Bumby MOLEST scale (Bumby, 1996).
Miller Social Intimacy Scale (MSIS; Miller & Lefcourt, 1982).
UCLA Loneliness Scale – Revised (Russell et al., 1980).
Adult Self-Expression Scale (Gay et al., 1975).
Buss–Durkee Hostility–Guilt Inventory (Buss & Durkee, 1956).
Coping Using Sex Inventory (CUSI; Cortoni & Marshall, 2001).
Relapse Prevention Assessment (Abracen et al., 1998).
High-Risk Situations Test (HRST; Marques et al., 1991).
Michigan Alcohol Screening Tool (MAST; Selzer, 1971).
Drug Abuse Screening Test (DAST; Skinner, 1982).
Appendix III: Goals for Professional Growth and Development
References
Index
End User License Agreement

# List of Tables

Chapter 06
Table 6.1 Features of the different insecure attachment types
Chapter 09
Table 9.1 Pre–post changes on psychometric measures

# List of Illustrations

Chapter 07
Figure 7.1 Integrated Risk–Need–Responsivity (RNR-I) Model

# Treatment of HighRisk Sexual Offenders

## *An Integrated Approach*

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This text would not be possible without the ongoing support of my partner Karen, who has always offered support and encouragement both while writing this book and for all of our research efforts that have contributed to our thinking about forensic matters. This book is also dedicated to the memory of my mother, Margaret Abracen, a guidance counsellor whose thinking has always been influential in the development of my own work.

Jeffrey Abracen

I would like to dedicate this book to my children, who provide an incentive to do better. Also, to the memories of both my parents, who taught me never to be satisfied with “sufficient.”

Jan Looman

# Introduction

This book is a reflection on where we have got to as both researchers and clinicians working with high-risk, high-need sexual offenders for many years. We do not intend this text to represent a new theory in relation to sexual offending, though we will spend time discussing some of the more contemporary theories related to working with sexual offenders. Nor do we consider this text a detailed clinical manual for the treatment of high-risk sexual offenders. That said, where appropriate, we will certainly discuss techniques we have used with sexual offenders both in the institution and in the community. In practice, we think of this text as a very practical guide for professionals who work with sexual offenders in one of any number of capacities, be it as case management or parole officers, mental health professionals or as students interested in pursuing this area of psychology. Given the audience for whom this text is designed, where possible, we will avoid discussing detailed statistical findings in favor of descriptions of relevant research and the results of these studies. We will refer the reader to the relevant articles or books as appropriate. The purpose of this text is specifically to address the needs of professionals working with high-risk sexual offenders and specifically those sex offenders who might be deemed psychopathic or who might be referred for commitment proceedings in jurisdictions that have enacted such legislation (e.g., various states in the US). In particular, the focus of this book will be on how to manage high-risk sexual offenders in a comprehensive system of assessment and treatment from intake to the end of their sentence and beyond.

We believe that the orientation provided in this book will be of value to those working with high-risk violent offenders more generally as well. Much of the information contained herein is relevant to the treatment of psychopathy and multi-recidivist violent offenders more generally. Although we will detail what is meant by the terms risk, need, and psychopathy shortly, it seems reasonable to begin with an explanation as to why we decided to write this text in the first place.

Although it may seem an odd thing to say, neither of us wanted to write this book and we have assiduously avoided writing a book on the treatment of high-risk offenders for several years. We kept on hoping that somebody else would take up the mantle and write a practical guide to working with high-risk sexual offenders. Further, we hoped that the person(s) writing the book would have sufficient practical experience of managing sex offender treatment programs both in institutions and in the community to make the advice that they were offering germane to those who work with these populations on a day-to-day basis. Although we have seen some articles on the treatment of high-risk sexual offenders, we have not seen a text that directly confronts these issues, written from the perspective of someone who works with such groups on an ongoing basis. It is for this reason that we have decided to write this book.

We have become increasingly concerned about some newer approaches to the treatment of sexual offenders, in particular the Good Lives Model (GLM). Although we believe there are some very positive aspects to the GLM, we also believe that, as applied to high-risk offenders

typically seen in the institution and the community, this approach may obscure the focus from specific treatment targets that have been identified in the literature over the past number of years. The focus of treatment, in our view, becomes less on specific criminogenic needs from a GLM perspective. Rather, several laudatory but poorly defined goals, such as achieving "happiness," become the emphasis within this model. To some degree, we think that the proponents of the GLM have "thrown the baby out with the bath water" as it were. In the following chapters, we will outline what we mean in detail by the this statement.

However, prior to a discussion related to issues associated with the theory and practice of working with high-risk violent offenders, we believe that some introductory information is necessary. First, we will begin by describing our background in working with sexual offenders in both the institution and the community. We will then present some definitions of the terms that will be used throughout this text. Following this, we will describe the populations of sex offenders with whom we have worked in some detail. There are a variety of reasons why we feel it important to discuss the nature of high-risk, high-need populations beyond simply providing relatively dry and technical comments alone. First, the definitions that we will provide, although important, do not do justice to the full clinical picture that we are typically presented with. Even some of the best texts that have been written (e.g., Andrews & Bonta, 2003), though they clearly discuss the complexity of human behavior, proceed to focus on individual risk factors for offending without detailed discussion of the complexities actually seen in individual cases. Further, there has been relatively little discussion in the literature as to how to work with the variety of risk factors that have been shown to be related to sexual offense recidivism as they present in high-risk, high-need offenders. Although some authors have made an attempt to discuss the complexity of working with high-risk sexual offenders (e.g., Whitehead et al., 2007), these attempts have, to some degree, highlighted the failures that clinicians have had working with such populations. Further, we are not aware of any research group that has completed a series of long-term outcome studies on large groups of high-risk sexual offenders treated both institutionally and in the community. The approach suggested in this text is based on a series of studies by the authors that have demonstrated long-term efficacy in the treatment of high-risk sexual offenders both institutionally and in the community. We will argue for the need for an integrated system of assessment and treatment when working with groups of high-risk offenders.

# 1
# Background and Definitions

Both of the authors have had extensive experience in the assessment and treatment of sexual offenders. Jan Looman (J.L.) has been the Clinical Director of the Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP) since the mid-1990s. He has overseen several updates to the RTCSOTP treatment manual (e.g., Looman & Abracen, 2002), including a recent version which was submitted to an international panel of experts as part of accreditation procedures for program development in the Correctional Service of Canada (CSC). Jeffrey Abracen (J.A.) worked at the RTCSOTP from 1995 to 2001 and then, in 2002, began working in the Toronto, Ontario, area with sexual offenders released to the community. From 2005 to 2009, J.A. was the Clinical Director of the National Maintenance Sex Offender Treatment Programs operated in Central District (Ontario), which includes the greater Toronto area. Recently, J.A. has taken positions as the Chief, Community Correctional Research, with Research Branch at CSC and currently works as the Chief Psychologist in Central District (Ontario) Parole. Both J.L. and J.A. have been involved in the assessment and/or treatment of sexual offenders for approximately 20 years. Both of us have been employed by the CSC on a full-time basis since the early to mid-1990s.

This is all to say that we have been lucky enough to have accumulated a wide variety of experience in working with sexual offenders in a number of contexts. We have also adopted the position that if you are going to invest the effort in treating high-risk groups of clients than you should also determine the efficacy of the work that is being done. In the area of forensics, perhaps the most significant indication of whether treatment is useful is if it reduces the risk of recidivism. We believe that the results of our research, as well as the results of a number of other dedicated teams, all converge on the same conclusion. That is, contemporary approaches to sex offender treatment appear to have a clear and significant impact on recidivism in the hoped-for direction. In short, appropriate treatment does seem to reduce the risk of recidivism, even among high-risk offenders. We will discuss the evidence in support of this conclusion below. However, before moving on to the topics outlined earlier, we think it important to define some of the terms that will be used throughout this book. What follows is a list of some of the more commonly used terms in this book and a discussion of the basic concepts associated with these terms.

Throughout the text, we will be referring to high-risk, high-need sexual offenders. As a shorthand manner of describing this population we will typically only use the term high-risk populations or refer to offenders treated at the RTCSOTP, who, for the purpose of this discussion, represent a group of high-risk sexual offenders. When referring to risk, we are referring to assignments based on the results of actuarial assessment instruments specifically designed to assess risk of sexual or violent recidivism. Actuarial instruments are measures that have a specific set of items and clear directions for scoring those items. The scores on the individual items are tallied in a pre-defined manner such that the assessor arrives at an overall

risk score for general, violent or sexual recidivism. The best of these measures have been shown in a number of studies, using a variety of different groups of offenders, to be accurate predictors of risk (e.g., Hanson & Morton-Bourgon, 2009; Hare, 2003; Quinsey et al., 2006). A few of the better known (and more extensively researched actuarial instruments) are the Static-99/99R, developed by Hanson et al. (2000; Helmus et al., 2012), the Violence Risk Appraisal Guide (VRAG), and the Sex Offender version of the VRAG (SORAG; Quinsey et al., 1998, 2006).

The Hare Psychopathy Checklist-Revised (PCL-R; Hare, 1991, 2003) was developed as a measure of personality to assess the characteristics thought to be prototypical of this condition. The measure initially included the assessment of two factors, the first of which is thought to be related the personality traits associated with psychopathy in the literature. These so-called "Factor 2" traits include such features as glibness/superficial charm, grandiose sense of self-worth, conning and manipulative behaviors, lack of remorse, lack of empathy, and failure to accept responsibility for one's own actions. "Factor 2" items are related to criminal lifestyle issues. Examples of Factor 2 traits include the need for stimulation/proneness to boredom, parasitic lifestyle, impulsivity, juvenile delinquency, and revocation of conditional release. Recent research suggests that the 20 items that comprise the PCL-R are best conceptualized as either three (see Cooke et al., 2006) or four factors (Hare, 2003). Each of the 20 items are scored either 0, 1, or 2. Items are scored based on whether the individual exhibits traits that are similar to the descriptions provided in the manual for that item (in which case the individual would receive a score of 1 or 2) or not (in which case the individual would be given a score of 0). Individuals who score above 30 are typically considered to meet the diagnostic criteria for being a psychopath. When referring to psychopathy or individuals with psychopathic traits, we are referring to the Hare PCL-R score in this text. Although terms such as sociopath are similar in nature to the term psychopath, these terms are not interchangeable.

In addition, there has been some confusion in the literature as to whether antisocial personality disorder (APD) is synonymous with the term psychopathy. The criteria for a diagnosis of the latter, listed in the *Diagnostic and Statistical Manual* (DSM 5; American Psychiatric Association, 2013), serve to identify individuals who have been persistently antisocial. However, many of the individuals who meet the diagnostic criteria for APD would not meet the stricter criteria for psychopathy as measured with the PCL. With reference to forensic populations, the base rate for psychopathy (15–25%) is much lower than the base rate for APD (50–80%; Hare, 1998, 2003). As Rogers et al. (2000) noted, the DSM relegates the personality features of psychopathy (e.g., lack of concern for the suffering caused to others) to associated features of the disorder. These authors also caution that it is unlikely that the PCL-R and APD measure the same construct. Hare (2003) acknowledges that these constructs are highly correlated, but argues that this does not amount to saying that they are the same clinical disorder.

Hare (2003) has also noted that arguments have been made that question the evidentiary reliability of APD for forensic evaluations and testimony. Given the evidence in favor of reliability and validity regarding the PCL-R, as well as the very clear scoring criteria that exist for the measure, it is hard to argue with the psychometric properties of the scale (see Hare,

2003 for a detailed discussion of these matters). With reference to high-risk sexual offenders, we have found that, among those offenders treated at the RTCSOTP, offenders who scored high on the PCL-R (defined as a score at or above a cut-off of 25) recidivated at significantly higher rates than sexual offenders scoring low on the PCL-R (Looman et al., 2005b). However, we have failed to find significant differences in terms of recidivism among those with or without a diagnosis of a personality disorder (Abracen & Looman, 2006). In our view, these findings are not surprising in that the diagnosis of APD is hardly informative with reference to the RTCSOTP. Given the many convictions typically found on the official summaries of these offenders' criminal histories and the many years of antisocial behavior that have been associated with such behavior, a diagnosis of APD could likely be applied to the majority of the offenders attending the RTCSOTP. As such, the diagnosis would be of little value in distinguishing between recidivists and non-recidivists.

A review (Seto & Quinsey, 2006) of research on treatment with psychopaths chose to discuss studies related to both APD and psychopathy. These authors argue that evolutionary perspectives may be best able to account for psychopathy and argue that psychopaths are a discrete natural class (taxon – for discussions, see Harris and Rice, 2006; Quinsey et al., 1998). Seto & Quinsey (2006) rationalize their approach by noting that there are few controlled treatment outcome studies with reference to psychopathy and that they are therefore justified in discussing the literature on both psychopathy and APD when evaluating the research on psychopathy. From our perspective, it is problematic to argue that psychopathic offenders represent a discrete taxon (i.e., they are qualitatively different), but that the literature related to the majority of offenders (i.e., those with a diagnosis of APD) is relevant to the assessment of whether psychopathic offenders can be treated.

Before we leave the issue of risk, it is important to note that when discussing risk Andrews and Bonta (1998, 2010) highlight the need to include only moderate- and high-risk clients in high-intensity programs. We potentially make low-risk clients worse when these clients are placed in high-intensity programs. For example, these clients may be exposed to certain criminal values or discussions related to deviant fantasies that may result in them developing problems that were not present when they were first incarcerated.

We will also be referring to need areas throughout this text. Need refers to criminogenic needs as defined by Andrews and Bonta (2010). Criminogenic needs are simply treatment targets that the literature has shown to be related to recidivism and which, at least in theory, are subject to modification. According to Andrews and Bonta (2010) the "Big 8" criminogenic needs are as follows: Criminal history (early involvement in a number and variety of antisocial activities), criminal associates, criminal thinking, criminal personality, problematic circumstances at home (family/marital), problematic circumstances at school or work, few if any positive leisure activities, and substance abuse. Mann et al. (2010) identified dynamic risk factors specific to sexual offenders such as deviant sexual interests, emotional identification with children, and attitudes supportive of sexual assault. Non-criminogenic needs such as mental health issues are viewed as potentially important treatment targets but are not necessarily related to reductions in recidivism. Therefore, such issues as mental health and self-esteem are viewed as less relevant in the context of forensic treatment. However, it is important to note that for some

higher-risk offenders, mental health issues may be seen as important in terms of predisposing an offender to criminal activities. Thus, for the high-risk sub-group, this broader statement regarding mental health issues being non-criminogenic may not be accurate (see Chapter 5 for a complete discussion). Tony Ward and his colleagues (e.g., Ward & Stewart, 2003; Ward & Maruna, 2007; Yates & Ward, 2009) have criticized the emphasis on so-called criminogenic needs and have suggested that a focus on basic "human goods" is also critical in the treatment of offender populations. We will discuss the "Good Lives Model" and its relevance to the treatment of high-risk offenders later in the text.

With reference to responsivity factors, Andrews and Bonta (2010) simply define this term as delivering treatment in a style and mode that are consistent with the client's abilities and learning style. Andrews and Bonta (2010) suggest that, as cognitive-behavioral treatments have been shown to be very effective with offender populations, these are the procedures that should be employed with offenders. They also note that such issues as level of anxiety, verbal intelligence, and cognitive maturity may impact on an offender's ability to benefit from one type of treatment program or another. These authors note that the principles of risk, need, and responsivity should be thought of as guides but that professional judgment will need to be made in particular circumstances and that our clients cannot be treated in a formulaic fashion (Andrews & Bonta, 2003, pp. 264–265).

We will also refer to the use of phallometry and phallometric assessment at various points in this book. Phallometric assessment (also colloquially referred to as PPG assessment) refers to the physiological assessment of sexual arousal to depictions involving either neutral or sexually charged stimuli. Typically the offender is placed in a room and is provided with slides depicting either clothed or naked children or adults or audio-only stimuli. Arousal to these stimuli is monitored by a device that translates changes in physiological arousal to data that can be quantified. One method of assessing physiological arousal, for example, is by means of a mercury-in-rubber strain gauge which the offender places around his penis. Changes in the circumference of the strain gauge are translated into electrical signals that are than available for analyses. Phallometric testing and related issues are discussed in detail in a later chapter.

With reference to mental health, when we refer to a mental or psychiatric disorder, we mean diagnoses and the associated criteria that are present in one of the editions of the DSM. One notable exception to this is the use of the term psychopathy by which, as noted earlier, we refer to the offender's score on the PCL-R.

We hope that this brief outline of some of the terms that we will be using throughout this book has been of value. Our starting point in the treatment of high-risk offenders is that the perspective outlined by Andrews and Bonta (2010) is of central importance to the practice of assessment and treatment of high-risk populations. Although we agree with others, such as Ward and his colleagues, that the so-called risk–need–responsivity model outlined by Andrews and Bonta is not without its problems, we believe that these problems are surmountable.

Andrews and Bonta noted that their theory would require elaboration and that it would need to be adapted to work with particular groups of offenders. In short, a certain amount of

professional discretion would be needed. We hope to offer such elaboration of their model as applied to high-risk sexual offenders. We disagree with others (e.g., Ward & Maruna, 2007) who have suggested that a new model is necessary (e.g., the Good Lives Model), especially a model that is no longer based on the assumptions of cognitive-behavioral interventions which have been shown to be the most effective techniques used to date with various groups of offenders. Before abandoning a model that has resulted in many positive changes in the treatment of offenders, clear evidence of efficacy of the competing approach(es) is necessary. At present, such evidence seems to be lacking. That being said, the model outlined by Andrews and Bonta needs to incorporate specific issues that are germane to high-risk groups of offenders. For example, as we will argue, with high-risk groups of sexual offenders, issues associated with negative emotionality probably represent criminogenic risk factors in spite of the assertion by Andrews and Bonta that mental and emotional health are not of criminogenic relevance. This does not mean that the model should be abandoned – as much as we would like to take credit for developing a new model, it only means that we need to add a few pieces to the puzzle.

# 2
# The Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP)
## *Description of Group Characteristics and the Treatment Program*

Before entering into a detailed discussion of the strategies that have been employed in the RTCSOTP, a description of the population and an overview of the program is necessary. The RTCSOTP was designed to be one of a series of sex offender treatment programs offered by the Correctional Service of Canada (CSC) within the Ontario Region. The CSC is mandated to supervise all offenders given sentences of 2 years or more. Sexual offender treatment programs were offered at the low-, moderate-, and high-intensity levels within the institutional context. Maintenance treatment is also offered, but typically these programs are delivered once offenders are released into the community under some form of conditional release.

Significant changes to the way in which sex offender treatment has been delivered over the last few years have resulted in the closing of the RTCSOTP in 2011–2012. Currently psychology staff are no longer responsible for the delivery of group-based sex offender programming in the CSC. Such programs are currently being offered by programs officers who are trained in the delivery of the sex offender program, but who otherwise have no specific training in iusses related to sexual offender assessment and treatment. However, individual treatment of sexual offenders presenting with significant mental health concerns is still being offered by mental health staff. Moreover, low-risk sexual offenders (as defined by scores on an actuarial assessment instrument) are currently deemed not to require any specific sex offender treatment.

Sex offenders entering the Ontario Region of the CSC were first screened at an assessment center located at Millhaven Institution (the Millhaven Assessment Unit [MAU]). Based on the results of the MAU assessment, which included a clinical interview, psychometric testing, and the scoring of risk assessment instruments, offenders were assigned to either low-, moderate-, or high-intensity treatment programs. We have previously demonstrated that those attending low-, moderate-, and high-intensity programs differ significantly from one another based on a variety of actuarial assessment instruments, including the Level of Service Inventory (LSI) and the Psychopathy Checklist-Revised (PCL-R; Mailloux et al., 2003). Those attending the RTCSOTP (at the time of writing, the only high-intensity program offered in the Ontario Region of CSC) were found to have significantly higher scores on the LSI and the PCL-R than those attending lower-intensity treatment programs.

We have published a number of studies using samples taken from the RTCSOTP. These studies highlight the high-risk/high-need nature of the RTCSOTP population. For example, Looman et al. (2005b) investigated 154 consecutive admissions to the RTCSOTP. They found that the average number of sexual convictions among those included in the study was 3.84 (standard

deviation [SD] = 5.81). The average number of violent convictions listed on the Royal Canadian Mounted Police (RCMP) Finger Print Service report (FPS Sheet), which represents an official record of all charges and convictions registered in any province in Canada, was 5.35 (SD = 5.27). The sample also registered an average of 11.88 (SD = 11.68) non-violent convictions on their FPS sheets. The average PCL-R score for the sample was 22.5, which is quite close to the recommended cut-off for psychopathy when the PCL-R is used in research studies (for a discussion, see Quinsey et al., 1998). In a more recent study we observed, among a sample of rapists attending treatment at the RTCSOTP, that the mean PCL-R score for this group was 25 (*n* = 31) and that for a group of 31 child molesters the mean score was 19 (Abracen et al., 2006).

With reference to psychiatric history we have examined this issue in a study of a sub-sample of the RTCSOTP that scored 5 or higher on the Static-99 (*n* = 188, in short, a high-risk group of sexual offenders). The average PCL-R score for this sample was 23.7. The sample registered an average of 4.0 (SD = 5.2) sexual convictions on their FPS sheet. The total number of convictions listed on the FPS sheets for subjects included in this sample was 21.7 (SD = 14.8). Approximately 75% of the offenders included in this sample met *Diagnostic and Statistical Manual* (DSM)-based criteria for a personality disorder. Ninety-two offenders (43.6%) met the criteria for one or more paraphilias (i.e. the DSM-IV-TR based diagnoses for sexual deviations). Sixty-three (33.5%) of the offenders met the criteria for both a personality disorder and a paraphilia.

With reference to substance abuse disorders, we have administered the Michigan Alcohol Screening Test (MAST; Selzer, 1971) and the Drug Abuse Screening Test (DAST; Skinner, 1982) for many years at the RTCSOTP. Langevin & Lang (1990) demonstrated, using factor analysis in a large sample (*N* = 461) of male sexual offenders, that both the MAST and the DAST could be treated as single-factor tests. Alpha reliabilities for the MAST and the DAST were found to be 0.89 and 0.90 respectively. Further, both of these measures have also been found to have good reliability and validity. In a recent study (Abracen et al., 2008), we observed that 21.5% of the sample had elevated scores on the DAST, whereas 38.4% of the sample had elevated scores on the MAST. The sample consisted of 380 sexual offenders treated at the RTCSOTP.

It should be noted that we have adopted a much more conservative strategy of scoring the MAST at the RTCSOTP than was originally proposed by Selzer (1971). At the RTCSOTP, all items on the MAST are scored as 0 or 1, as opposed to the initial scoring system proposed by Selzer (1971) where offenders could be assigned scores > 1 for answers indicating symptoms prototypic of alcohol problems. This is to say that the observed scores on the MAST represent a very conservative estimate of the presence of substance abuse in the RTCSOTP population. In practice, we have observed that the majority of offenders attending the program have experienced at least minor problems related to substance abuse. More typically, those attending the program have experienced at least moderate levels of substance abuse disorders. This issue will be addressed in much more detail in Chapter 12.

The RTCSOTP has undergone a number of significant changes since its inception in the early

1970s by Drs. William Marshall and Sharon Williams.[1] The early iteration of the program consisted primarily of social skills training (heterosocial dating skills, assertiveness, anger manager) and arousal reconditioning (Davidson, 1984). In addition, psychotherapeutic groups to address issues related to denial and empathy toward victims were conducted. In the early 1990s, issues associated with relapse prevention were incorporated into the program. In 2001–2002 additional changes were made to the manual to incorporate recent developments in sexual offender treatment (e.g., addressing intimacy deficits). In the 2002 version of the manual (Looman & Abracen, 2002), some of the essential features of relapse prevention were maintained; however, the relapse prevention model included in the manual was a very simplified version and incorporated suggestions from the newly developed self-regulation model of sexual offending. Two issues were related to the changes that were implemented with reference to how the relapse prevention material was presented. First, the relapse prevention model was initially applied to substance-abusing populations and it was later adapted for use with sexual offenders. Criticism of the model as applied to sex offenders began to emerge in the literature (e.g., Ward, 2002; Ward & Brown, 2003). In addition, many of the clients attending our groups appeared to struggle with some of the more complex aspects of the model. We came to believe that this wasn't simply resistance on the part of the clients attending our groups, nor was it an attempt to simply avoid the completion of certain assignments due to lack of interest in the material. Rather, the problems resided with the manual itself. The simplified version of the relapse process, with a focus on the identification of internal and external risk factors and the identification of lapses into pre-offense/offense behaviors became a much more reasonable way of presenting the material to clients, at least from our perspective (this is discussed in more detail later).

In addition, two parts of the program were further refined. Treatment related to social skills deficits and communication style were integral to the program well before our arrival. However, in the 2002 version of the manual we refined what was being presented in these two parts of the treatment program manual. The program was conceptualized (Looman & Abracen, 2002) as consisting of two primary components. The first component was referred to as the self-management component, with the central theme to this component of the program including three major assignments. In the first assignment, the autobiography, the client is asked to describe his upbringing and the factors that ultimately led to his current incarceration. A detailed questionnaire was provided to all clients as a guide to the types of information that we hoped to discuss in group (see Appendix 1). It should be emphasized that both the client's strengths and weaknesses were to be discussed as part of his autobiography. Clients might discuss a history of neglect and long-standing issues with substance abuse, but they were also encouraged to discuss any significant intimate relationships they had been involved in and any significant work history they had. Any periods of prolonged pro-social behavior were also presented, as well as the factors that the client felt were related to maintaining non-offending behavior. Any issues the client required help with in terms of preparing the autobiography could be discussed in the context of individual therapy as well.

Given the many deficits typically experienced by the clients attending the program, individual therapy was tailored to their individual needs. As clients typically felt more secure in

individual therapy, at least at the beginning of the program, these sessions could be used as a venue to "try out" what they might say in group. For clients with numerous psychopathic traits and entrenched criminal values, the sessions could serve as a venue to discuss their reluctance to complete the assignment in a meaningful way and to challenge any arguments they might have about how irrelevant the assignment was. It should be emphasized that, in the RTCSOTP, clients were always challenged in an assertive but non-confrontational manner. Therapists were always encouraged to think about the situation from the client's perspective. The client might have very good reason to be skeptical of this type of assignment. We have had numerous clients comment, for example, that they had seen psychologists and psychiatrists since their very early years. Their memory of such experiences was that they were seen for a few sessions and then a report, typically used against them in court proceedings, was produced. Resistance, to be expected in any group of clients, would likely be even more pronounced in a group with experiences such as those described above. The individual sessions have proved very effective in helping clients with this first, and in some ways more difficult, assignment.

The second assignment at the core of the self-management component was the offense chain (or behavioral progression) assignment. As noted earlier, the nature of this assignment has changed over the years. In the 2002 version of the manual, clients were essentially asked to review all the information contained in their biography and to develop a chain of events, and consequent thoughts and feelings that resulted in either a single offense or a series of sexual offenses. Clients were encouraged to think about "background factors," such as their previous history of offending (e.g., as a juvenile offender), adverse childhood experiences, chronic substance use, and so on, and how these issues might have contributed to their current circumstances. As part of the assignment, clients were encouraged to develop a list of internal and external high-risk situations. Internal high-risk situations were defined as thoughts and feelings that were related to the development of problematic behavior. For example, deviant fantasies or ongoing problems with anger management might be listed under this heading. External high-risk situations were defined as persons, places, things, or situations that represented a risk to the client. Examples of external high-risk situations might include the use of drugs, hanging out with others who typically engaged in criminal behavior, and going to bars. We have used a very general definition of lapses and encouraged clients to think of situations that, at least looking back, continued them on the path towards their current sexual offense (or series of sexual offenses). This might include various "lapses" related to having committed property offenses or any of a number of assaults on their record or beginning to fantasize about children. The essential feature of a lapse, from our perspective, was a situation that, looking back, would act as a type of warning signal that they were clearly moving in the wrong direction. In addition, we wanted the clients to see the connection between some of the behaviors that they may previously have thought of as irrelevant to sexual offending (hanging out with certain associates, occasionally/frequently getting into bar fights) and begin to help them see the connection with their current circumstances (i.e., having been convicted of a sexual offense or series of offenses).

The last assignment of the self-management manual involved the development of a self-management plan. In this assignment, clients are asked to list the internal and external high-risk

situations they have struggled with over the years and to develop a meaningful plan to address these risk factors. Clients are also asked to consider goals they might wish to accomplish in the short term, as well as over the course of the next several years, which may motivate them to maintain change. Although more recently the language used in the program has reflected a more positive and forward-looking perspective (e.g., the use of the phrase “self-management plan” and not “relapse prevention plan”) in keeping with the Good Lives Model, in essence what has been done in the program reflects the same approach to treatment that has existed since 2002. Although modules have been added to the program, the orientation has always been cognitive-behavioral, with a focus on both criminogenic needs and the development of more refined relationship and communications skills.

In addition to these major homework assignments, within the “self-management” component of the program are two additional modules: cognitive distortions and emotions management. In previous renditions of the program there was also a “victim empathy/awareness” module, but this has been dropped and incorporated into the cognitive distortions module.

The cognitive distortions module of the program consists of discussions of cognitive distortions commonly endorsed by sexual offenders. Clients are required, through homework assignments and self-monitoring exercises, to identify their own distortions, related to both sexual offending and general criminality. These distortions are discussed in group and then effective self-statements to challenge the distortions are developed and practiced. In about 2005, as discussed earlier, the victim empathy module was discontinued and incorporated into the cognitive distortions module as a discussion of distortions that block empathy for victims.

The emotions management module includes sessions in relation to the identification of emotions based on the observation that many of the clients attending the program have a limited ability to identify the emotions they experience. The extent of the deficits in this area can hardly be overstated. For example, several clients with whom we have worked have noted that they were able to identify only two emotions: “tight” and “loose.” Needless to say, the terms “tight” and “loose” are not emotional terms. Summarizing all positive emotions with the term “loose” leaves much room for miscommunication. With reference to “tight,” the use of this term to represent all negative emotions simply presents a risk factor for our clients. Some clients have, for example, noted that they warned someone how they were feeling before they attacked the person, noting that they had warned the person that they were feeling “tight.”

Aside from the ability to identify emotions (both positive and negative), clients are given the opportunity to learn how to manage their emotions. Discussions in this module include identification and management of anger, depression, anxiety, and jealousy, as well as other commonly experienced emotions. In addition, managing sexual arousal is also discussed.

With reference to the social skills component of the program, there has been an emphasis on the development of relationship skills and communication since at least the early 1980s. Given that the majority of clients attending the RTCSOTP have experienced difficulties with management of emotions and the development and maintenance of intimate (or even close) relationships, it has been considered important to provide the clients attending treatment with information and skills in this regard. This component of the program relies heavily on role-plays in order to

develop and practice the skills being discussed.

With reference to relationships there are many sections of the social skills manual related to the initiation and management of intimate relationships. Sections related to the use of assertive communication (as opposed to passive or aggressive styles) are discussed and role-played at some length. In addition, in the communication skills component on active listening, skills are developed within the context of managing conflict in relationships. Individual therapy sessions are also used to explore these issues in a more personalized manner than would be possible in group.

Aside from the three basic components of the RTCSOTP (self-management, social skills, individual therapy), we believe that an inpatient-based program is best suited to the types of clients typically seen at the RTCSOTP. There are a number of reasons for this assertion. First, many sex offenders are concerned about being identified as sexual offenders and may be reluctant to attend sex offender-specific programming in institutions where the majority of offenders do not have a history of such offenses. By housing all the offenders who are attending the program on one unit, in a separate institution, as in the case of the RTCSOTP, nobody has anything to hide, at least in terms of being identified as a sexual offender. Clients are transferred from their "parent" institution to attend treatment at the RTCSOTP and are then returned to that institution following the completion of treatment. For those not wishing to disclose their participation in sex offender treatment programming, it is relatively easy to say that they had been transferred to another institution for a period of time.

Also, the nature of inpatient-based treatment allows the program and security staff to monitor behavior when the client is not in group. At the RTCSOTP, clients' behavior is literally monitored on a 24-hour basis. Any problematic behaviors are reported and quickly discussed among the program staff. With reference to pro-social behaviors, positive changes are also noted. Clients are routinely reinforced for positive behavior, and negative behaviors are viewed as opportunities to discuss how the client might learn to behave more appropriately.

Nevertheless, it is impossible to tolerate all behaviors. Although every effort is made to maintain all participants in treatment, when a physical altercation erupts, it is not uncommon to terminate at least the instigator of the fight (if it is clear who started the fight). That is not to say that these individuals are not invited back to attend a future treatment program at the RTCSOTP. In many cases, clients who are asked to leave the program are told that they will be allowed to participate in the next program should they wish to do so.

Persistent non-compliance with the assignments associated with group or individual therapy may also be grounds for termination from the program. It is important, however, to be mindful of the fact that the clients seen in the RTCSOTP present with varying levels of intellectual abilities. Some of the clients attending treatment also have very significant psychiatric histories. It is always relevant to consider the client's initial level of functioning in the context of assessing treatment compliance. An individual with a low-average level of intellectual ability and significant social anxiety cannot be expected to participate at the same level as someone with above-average intelligence and who has few, if any, significant psychiatric conditions. We are typically concerned with the question of whether the client is putting in a

reasonable level of effort given his limitations. We believe that it is unreasonable to assume that there is some absolute standard that all clients must reach at the end of a single treatment program. Our overriding goal is to help clients achieve as much progress as possible with reference to the treatment targets that are a focus of participation. The level of progress is, of course, relative to the offender. Both qualitative methods and paper and pencil tests before and after treatment are used to assess treatment progress.

It is not always easy to assess whether a client is being resistant to treatment due to motivational issues or psychiatric condition(s). For example, one client seen in the program initially presented as somewhat reluctant to participate in treatment. Further, he presented as somewhat non-compliant with the assignments that were given as part of both group and individual therapy. Upon further discussion it became obvious that the client had some significant difficulties in the area of obsessive-compulsive thoughts and behavior. He found it truly disturbing that his therapist's office was organized somewhat differently each time he entered (e.g., the chair had been moved a foot or two or the therapist's desk was more disorganized than usual). Once this issue had been identified, it became a point of discussion. Although some effort was made to accommodate the client's anxieties (e.g. the client was allowed to sit in the same general area of the group room and his therapist made at least some effort to clean up his desk prior to seeing the client in individual therapy), the client was progressively encouraged to tolerate his anxieties, which were explored in some detail in individual therapy sessions. As the program progressed, the client became more comfortable tolerating these anxieties. Perhaps not coincidentally the client also became more comfortable describing a long history of obsessively reading graphic and violent novels which later served to fuel a series of sexual fantasies where violence was a central theme.

## Note

1 It should be emphasized that the program described in the following paragraphs, and referred to throughout this book, is the program described in Looman & Abracen (2002) and not the High Intensity Sexual Offender program implemented in the CSC more generally.

# 3
# Treatment Outcome for High-Risk Violent and Sexual Offenders

## Efficacy of programs for high-risk sexual and violent offenders

Having presented a brief overview of the Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP), it would be reasonable to ask what the evidence is for the effectiveness of the program. More generally, questions can be asked about the efficacy of programs for high-risk sexual and violent offenders. After all, why would one wish to read the detailed description of the program materials that follow if there is no evidence that the RTCSOTP or other high-intensity programs are effective? In fact, one reason that we began doing outcome research on the RTCSOTP was simply to answer the this question (i.e., does the program work?). In practice, the clients who we were seeing seemed, and this is to put it mildly, rather resistant to treatment, at least upon initially entering the program. Given the antisocial orientation of many of these clients, it might not be surprising to the reader that these clients would not always share their displeasure with aspects of the program using subtle, assertive communication. In fact, it has not been uncommon for many of the clients attending the program to express frustration over one or more aspects of the program using rather aggressive communication styles. We have typically observed that, as the program progressed and clients began to see that the treatment staff were trying to help them (or for some other reason perhaps), they would become more assertive (as opposed to using more aggressive communication styles) and be more willing to examine the perspective shared by the treatment staff. Such observations hardly constitute evidence of a successful treatment program, however. Also, given the very lengthy history of violence typical of many of the clients attending the program, we sometimes wondered about the long-term efficacy of the program. Thus we decided to conduct what has become a series of outcome studies in relation to the RTCSOTP.

In order to evaluate the efficacy of the RTCSOTP, it is necessary to put the research conducted by our team in perspective. We have written several reviews which have discussed the issue of treatment efficacy with sexual offenders (e.g., Abracen & Looman, 2004, in press; Abracen et al., 2008; Looman & Abracen, 2013b). What follows is a discussion of some of the issues raised in these reviews. In addition, some new research by our team and others working for Correctional Service of Canada (CSC) will also be included.

There have been a number of efforts to review the efficacy of treatment of sexual offenders (e.g., Hall, 1995; Marshall & Anderson, 1996; Alexander, 1999; Marshall et al., 1999; Hanson et al., 2002; Lösel & Schmucker, 2005; Quinsey et al., 2006). One of the reasons that there have been a large number of such reviews is the ongoing debate regarding whether treatment of

sexual offenders is effective. Nonetheless, in all but the review by Quinsey et al. (2006) the authors concluded that there is reason for optimism regarding treatment of sexual offenders.

Other than Quinsey et al. (2006), the findings in fact appear to be remarkably consistent. For example, Hanson et al. (2002) observed that "current treatments" (defined as cognitive-behavioral in 13 cases and systemic therapy in two cases) were associated with reductions in both sexual recidivism (from 17.4% to 9.9%) and general recidivism (from 51% to 32%). The authors did note, however, that older forms of treatment (operating prior to 1980) appeared to have had little effect. Lösel & Schmucker (2005) performed a meta-analysis based on outcome evaluations published in five languages. These authors identified 69 studies containing 80 independent comparisons between treated and untreated offenders. Although both positive and negative treatment effects were observed, the majority of studies confirmed the benefits of treatment. Treated offenders showed six percentage points or 37% less sexual recidivism than controls. Effects for violent and general recidivism were in a similar range. Among the psychological treatment approaches examined, cognitive-behavioral approaches evidenced the most robust effect.

## *Critical review of recidivism research by Rice and Harris (2003)*

Rice and Harris (2003) provided a critical review of some of the available recidivism research. They offer the opinion that, in the Hanson et al. (2002) meta-analysis of sexual offender treatment outcome studies, very few studies meeting minimally acceptable criteria were included. They argue that "incidental assignment" studies, which describe the majority of the studies included in the meta-analysis, are insufficient to draw meaningful conclusion regarding treatment effectiveness. The authors conclude that a treatment effect has yet to be demonstrated in sexual offender treatment research. They opine that a minimally informative evaluation requires the measurement of officially recorded recidivism from at least two distinct, comparable groups of sexual offenders. They argue that the best method for this is random assignment to either treatment or no-treatment groups, or through matching on factors known to be related to recidivism. Matching designs, they argue, require that groups be comparable on static predictors of recidivism, jurisdiction and cohort and volunteering for treatment. They argue that this can be accomplished either by direct matching or through statistical procedures.

Rice and Harris (2003) illustrate their argument by discussing three studies using samples from the RTCSOTP in Ontario: an unpublished study by Davidson (1984), a study by Quinsey et al. (1998) and a more recent study by our group (Looman et al., 2000). Each is briefly discussed here:

- Davidson (1984) evaluated a group of 101 sexual offenders treated at the RTCSOTP between 1974 and 1982, using a matched sample of untreated offenders drawn from Ontario penitentiaries from the period before the program started, between 1966 and 1974. Comparison subjects were matched based on the victim's sex, age, and relationship to offender. Groups were equivalent on the number of previous sexual, violent and general convictions, as well as a number of other demographic variables (e.g., age, education). The

treated group recidivated at a lower rate than the comparison subjects in terms of any conviction and any violent (including sexual) conviction. However, for any sexual conviction there were no statistically significant differences observed. It should be noted, however, that while 6.9% of the treated group sexually recidivated, 12.9% of the untreated group sexually recidivated, a 47% difference. It was also noted that the treated group tended to have more arrests for subsequent sexual offenses than the comparison group, although this did not lead to further convictions. While in the treated group 22 men were charged, but only seven were convicted, in the comparison group 14 were charged and 13 were convicted. It was noted that the treatment program appeared to be more effective for child molesters than for hebephiles or rapists.

- Quinsey et al. (1998) examined recidivism in a sample of offenders assessed and/or treated at the RTCSOTP between 1976 and 1989. They included 213 men who completed the program, 183 men assessed as not requiring treatment, 52 who refused assessment and/or treatment, 27 who were assessed as unsuitable, and nine who were assessed as requiring treatment but did not receive it. These authors chose to compare the treated offenders with the offenders who were assessed as not requiring treatment, by performing a statistical procedure to control for pre-treatment levels of risk, using variables identified through regression analysis. For sexual recidivism, the regression equation accounted for approximately 16% of the variance, while for sexual/violent recidivism it accounted for approximately 13% of the variance. Re-arrests were used as the dependent measure, although the results were similar when only convictions were examined. They found that treated offenders reoffended at a higher rate than those assessed as not requiring treatment. Quinsey et al. (1998) concluded that treatment may have increased sexual recidivism.
- Looman et al. (2000) examined the outcome for 89 offenders drawn from the treated group employed by Quinsey et al. (1998), matching these offenders to an untreated group of sexual offenders with reference to age at index offense (within 1 year), date of index offense (within the same calendar year), and prior criminal convictions (plus or minus 2). The untreated sample was drawn from a database of offenders incarcerated in the Prairie Region of the CSC. While the matching was successful on the primary variables, the treated sample had more pre-treatment sexual offenses in their history (1.81 vs. 1.31, $p < 0.001$) and thus were more likely to be repeat sexual offenders ($p < 0.001$). Over an approximately 10-year follow-up, the treated group was approximately half as likely to sexually reoffend as the untreated group (23.6% vs. 51.7%, $p < 0.0001$, $d = 0.48$).

Rice and Harris (2003) contrast these three studies and point out that the Hanson et al. (2002) meta-analysis excluded the Quinsey et al. study as having the weaker design. Hanson et al. (2002) combined the results of Davidson (1984) and Looman et al. (2000) and found a beneficial treatment effect. Rice and Harris (2003), however, argued that the Quinsey et al. study was the stronger design. They point out that all groups in the Quinsey et al. study came from the same cohort and jurisdiction, the authors monitored the outcome of treatment refusers and those not offered treatment, and examined therapist ratings of performance and pre- and post-treatment psychometric evaluation results. They argue (as stated earlier) that subjects must volunteer for treatment to be included in a study, as a sample of offenders not offered

treatment will include a number of men who, had they been offered treatment, would have refused. Rice and Harris (2003) state: “Our criteria [for a minimally useful evaluation] do not permit the evaluation of treatment comparing sex offenders who complete treatment with a group not offered it” (p. 432), arguing that “there are clear *a priori* reasons to expect differences between the groups in recidivism” (p. 432). Rice and Harris (2003) also claim that the Looman et al. (2000) study (among others) included subjects who would have dropped out of treatment had it been offered in the comparison group. They opine that “sex offenders selected for having completed treatment are not comparable to sex offenders who are not offered treatment. Designs using such noncomparable groups are not informative about treatment effectiveness….” (p. 435).

## *Evaluation of review by Rice and Harris (2003)*

The points raised by Rice and Harris (2003) are considered in the following sections.

### *Cohort and jurisdiction*

While the Davidson (1984) study can be fairly criticized for differences in cohort, this same criticism cannot be applied to the Looman et al. (2000) study. Subjects in this study were matched for date of conviction precisely to control for this effect. The issue of jurisdiction was also mentioned. This refers to the fact that while the treated group in the Looman et al. (2000) study was drawn from the Ontario Region of the CSC, the untreated group was drawn primarily from the Prairie Region (i.e., the provinces of Manitoba, Saskatchewan, and Alberta). While these are different provinces of Canada, it is not accurate to argue that they are different jurisdictions. The laws relating to sexual offenses in Canada are national laws, and the Correctional and Conditional Release Act (formerly the Penitentiaries Act), which governs the operation of both the CSC and the National Parole Board, is also national legislation. There is no reason to assume that the enforcement or execution of this legislation will vary between regions any more than it will vary within regions. For example, while Alberta has traditionally been politically a right wing province, Saskatchewan and Ontario have both recently had social democratic provincial (i.e., left wing) governments. Thus, jurisdictional issues are unlikely to significantly impact on the results of the Looman, et al. (2000) study.

### *Refusers*

Rice and Harris (2003) place great emphasis on the issue of potential treatment refusers, and criticize the Davidson (1984) and Looman et al. (2000) studies for using a group of offenders who were never offered treatment. The problem, Rice and Harris claim, is that these subjects may have refused treatment had it been offered, or dropped out had they participated. As refusers and dropouts differ from those who accept and complete treatment, the groups are unequal and thus the study is “not informative about treatment effectiveness” (Rice & Harris, 2003, p. 435). What Rice and Harris (2003) are failing to acknowledge in this argument is that the Quinsey et al. (1998) study suffers from the same potential weakness. The comparison sample employed in that study was a group of men judged *not to require treatment*; thus treatment was never offered and they never had the opportunity to refuse. As they never

participated, the number who may have dropped out had they started is unknown. Thus, using Rice and Harris's (2003) own criteria for a minimally useful evaluation, the Quinsey et al. (1998) study must be excluded from the list offered.

In addition to the above, it seems to the current authors that the "what if" arguments presented by Rice and Harris (2003) can be applied to even the best-controlled study. For example, the Sex Offender Treatment and Evaluation Project (SOTEP) program (Marques et al., 1994a,b; Marques, 1999), which Rice and Harris present as a best practice, is vulnerable to these sorts of criticisms. Despite their best efforts, it was discovered that the treated group held more men who had been declared sexual psychopaths than the untreated group, and that the untreated group had more married offenders (Marques, 1999). In addition, as argued by Rice and Harris (2003), it is possible that, had the untreated group been treated, some of them may have dropped out of treatment.

One of the other studies identified as a minimally useful evaluation by Rice and Harris (2003) is worthy of discussion here, as it was also completed by their research group (Rice et al., 1991). Rice et al. (1991) describe a treatment evaluation involving 136 extra-familial child molesters assessed at the Penetanguishine Mental Health Centre between 1972 and 1983 who were subsequently released to the community. Of these, 50 men stayed and completed a sexual offender treatment program. In the paper Rice at al. (1991) do not explain why these men received treatment and the remainder did not, although the Hanson et al. (2002) meta-analysis described this study as assigning subjects to treatment based on need. Moreover, the treatment received was restricted to arousal reconditioning, with 16 subjects also receiving heterosocial skills training and 26 receiving sex education. Twelve of these 42 received both groups in addition to the arousal reconditioning. Thus, the program was not a cognitive-behavioral program and was not considered a "current" program in the Hanson et al. (2002) meta-analysis.

Rice et al. (1991) attempted to match the treated to the untreated subjects on total previous arrests, previous sexual arrests, and phallometric deviance index. They successfully matched 29 of the 50 subjects. The treated and untreated groups did not differ in recidivism rates. Noting that successful treatment was not related to recidivism in regression analyses, these authors conclude "it seems very unlikely that the present intervention had any effect in reducing recidivism rates" (Rice at al., 1991, p. 385).

Examining this study in light of Rice and Harris's (2003) criteria for a minimally useful evaluation, it is our opinion that this study also comes up short. First, the authors themselves note that "treated subjects differed from untreated patients on many of the variables studied so that, even after matching subjects on variables on which the groups differed, doubts remain about the comparability of groups" (Rice et al., 1991, p. 385). Secondly, given that no information was provided as to why over half the total sample did not complete treatment, we are unable to conclude that groups were equivalent on the criteria of volunteering for and completing treatment. Again, the conclusion appears to be that this study faces the weakness of having an unknown number of untreated subjects potentially refusing or dropping out of treatment, had they been offered the opportunity. Finally, in a 1993 description of the same

study the authors (Rice et al., 1993) describe this study as having a “relatively weak design” (p. 195) based on some of the weaknesses noted earlier. Given these weaknesses, which the authors themselves acknowledged in their writing at the time, it is somewhat surprising that, more recently, they have described this study as one of six minimally useful outcome studies available.

### *Evaluation of therapist ratings and psychometric test results*

The final strength of the Quinsey et al. (1998) study claimed by Rice and Harris (2003) is that Quinsey et al. reported the relationship between recidivism and therapist ratings, and the relationship between recidivism and various psychometric test results. While this is useful information in terms of potential dynamic factors, it is unclear how this makes their study a superior experimental design, which is the issue at hand. We concede that in this regard the Quinsey et al. (1998) study provided useful information (information that we, incidentally, used to modify our psychometric battery); however, when examining the issue of treatment outcome, such relationships are not informative. In planning our treatment evaluation (Looman et al., 2000), we simply asked and answered the question: “Was treatment effective in reducing recidivism?” Whether or not the Buss Durkee Hostility Inventory, for example, was predictive of recidivism was not at issue.

### *Criticism of Quinsey et al. (1998)*

In their discussion of the three studies mentioned above, Rice and Harris (2003) neglect to acknowledge the criticisms that have been offered of the Quinsey et al. (1998) methodology (e.g., Looman et al., 2000; Abracen & Looman, 2004). The primary criticism of this study, and the reason it was omitted from the Hanson et al. (2002) meta-analysis, is that the statistical matching procedures were inadequate to equate the samples. The primary comparison was between a group of offenders assessed as not requiring treatment and a group of offenders who completed treatment. Quinsey at al. (1998), as mentioned earlier, employed a statistical matching procedure, using regression analysis, to control for pre-treatment risk. They concluded that, as the treated group sexually reoffended at a higher rate than the offenders assessed as not requiring treatment, treatment was ineffective in reducing recidivism, and may have served to increase it. Note that throughout the article they refer to the “untreated group”, rather than the more accurate descriptor of “assessed as not requiring treatment”. To illustrate the extent to which the groups differed, the reader is referred to table 4 of Quinsey et al. (1998, p. 632), which indicates, for example, that the treated offenders had an average of 2.05 previous sexual offenses, compared with 0.47 for the offenders assessed as not requiring treatment ($p < 0.0001$); they were first incarcerated at 21.85 years of age on average, compared with 26.46 years for the men assessed as not requiring treatment ($p < 0.0001$) and their total hostility score on the Buss Durkee Hostility Inventory was 28.28 compared with 19.93 for the group assessed as not requiring treatment ($p < 0.0001$).

In order to control for these differences, the authors (Quinsey et al., 1998) employed a multiple regression procedure that accounted for 15.9% of the variance for sexual re-arrest, and 12.8% of the variance for sexual/violent re-arrest. Unfortunately, in our opinion, this is inadequate

when comparing groups that differ as extremely as the two described in the previous paragraph. While this procedure may account for some of the variables related to static risk, it makes no accounting of dynamic factors that accompany the offender's history. For example, offenders who have histories of repeat sexual offenses (as the average treated offender had) will necessarily differ in attitudes and cognitive distortions, as well as factors such as sexual compulsivity from offenders who do not have this history. This cannot be controlled for through statistical procedures. Such differences are much more likely to be accounted for in pairwise matching, such as that employed in the Davidson (1984) or Looman et al. (2000) studies.

In fact, we conducted a study to examine the extent to which the treatment and not-recommended-for-treatment groups differed on dynamic factors (Looman & Abracen, 2013c). In order to complete this task, the Stable-2007 was scored based on file information. Sufficient information was available for only 168 men, 25 of whom were in the not-selected-for-treatment group. The average score on the Stable-2007 was 15.1 for the treated offenders (i.e., within the high-needs range) while it was 11.5 for the not-selected-for-treatment group (i.e., moderate needs). Analyses concerning the psychometric tests included in the assessment battery indicated that the men selected for treatment scored more negatively on most measures; with the treated group scoring higher on hostility and lower on measures of assertion, having a greater external locus of control, and being more anxious, depressed, impulsive and aggressive. Thus the treated group was higher on a number of relevant dynamic factors than the group not selected for treatment, and these factors were not controlled for in the analysis conducted by Quinsey et al. When these factors were controlled for in a Cox regression analysis, the group not requiring treatment reoffended at about twice the rate of the treated group.

Thus, it is our opinion that Hanson et al. (2002) made the correct decision in discarding the Quinsey et al. study in favor of the Davidson and Looman et al. studies. By Rice and Harris's own criteria, the Quinsey et al. study was inferior as they did not have two comparable groups and "Designs using such noncomparable groups are not informative about treatment effectiveness" (p. 435). As we argued earlier, the Looman et al. (2000) study employed two comparable groups, matched on criminal history and date of offense. Jurisdictional issues are not a serious impediment to validity, and neither are "what if" arguments concerning the potential number of refusers or drop-outs.

As a general comment, Rice and Harris's (2003) skepticism regarding a significant effect for sexual offender treatment is troubling. This skepticism, in our opinion, runs counter to the accepted wisdom from the general criminological treatment literature. Andrews and Bonta (2010), for example, have demonstrated that properly designed, cognitive-behavioral treatment programs, which address criminogenic factors, delivered according to risk level, and accounting for general responsivity factors are effective in reducing recidivism. This result has been repeatedly demonstrated in a series of meta-analyses over the course of the last 15 years (for a summary, see Andrews & Bonta, 2010). While the research of Andrews and Bonta (2010) concerns non-sexual offenders, the results of the Hanson et al. (2002) meta-analysis are consistent with their results. In addition, Hanson et al. (2009) support the finding that the

principles of effective correctional programming apply to sexual offenders as well. These authors observed that sexual offender treatment programs that assigned offenders to programming based on the risk–need–responsivity (RNR) principles are associated with greater reductions in recidivism than those that are not.

Furthermore, the criminogenic factors identified for sexual offenders by Hanson and Morton (2004) and Hanson and Bussière (1998) are similar (with the addition of indicators of sexual deviance and possibly issues related to the development and maintenance of intimate relationships) to those identified for a general criminal population by Andrews and Bonta (2003). There is no reason, based on current knowledge, to suspect that an effective treatment for a sexual offender population would differ dramatically from effective treatment for non-sexual offenders. That is, a sexual offender treatment program based on a cognitive-behavioral model, addressing identified criminogenic needs, delivered according to risk level and accounting for responsivity factors should be effective. The results of the Hanson et al. (2009) meta-analysis confirm this by finding that current treatment (i.e., cognitive-behavioral) had a positive treatment effect.

The lack of consistent treatment effects in the six "minimally useful evaluations" identified by Rice and Harris (2003) can easily be explained with these same principles. As discussed earlier, the Quinsey et al. (1998) and Rice et al. (1991) studies were inadequate designs. In addition, the Rice et al. (1991) study was a behavioral treatment that addressed too limited a range of risk factors. Similarly, Romero and Williams (1983) was non-cognitive-behavioral in nature. The sample in the Marques (1999) study, according to the risk principle enunciated by Andrews and Bonta (2003), was too low a risk to expect a treatment effect (for a detailed discussion, see Abracen & Looman, 2004). The only appropriate treatment among these six was that of Bourduin et al. (2000), which had a significant treatment effect.

In summary, we believe that the criticisms of Rice and Harris (2003) directed toward the sexual offender treatment literature in general, and our study (Looman et al., 2000) in particular, are both unjustified and express an unwarranted skepticism about sexual offender treatment. The criteria elucidated by Rice and Harris for minimally useful evaluations are unrealistic, and they do not appear to apply these same standards to themselves when evaluating their own research.

## Recent research evidence

In an earlier review we argued that there is sufficient evidence to warrant optimism as to the efficacy of sex offender treatment (Abracen & Looman, 2004). We believe that the majority of clinicians and researchers in this area are of the opinion that contemporary treatment using cognitive-behavioral interventions has been shown to be useful in reducing sexual offending. We have also demonstrated that the RTCSOTP appears to be an effective program when the "typical" offenders who attend this program are compared with matched groups of untreated offenders. In our view, the more interesting question is with reference to treatment efficacy with the highest-risk groups of offenders and, in particular, psychopathic offenders. Fortunately

there have been a number of studies published that address this issue.

Prior to reviewing these data, however, it is important to differentiate between the concept of psychopathy and the more commonly used diagnostic category of antisocial personality disorder (APD), which is included in the latest version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013). As noted at the beginning of this text, the criteria used for the diagnosis of APD typically identify individuals who have been persistently antisocial. However, only a small proportion of those who meet the diagnostic criteria for APD would meet the more restrictive definition of psychopathy as measured by the PCL or one its derivatives.

In order to discuss the treatment literature with reference to high-risk sexual offenders, including those who are psychopathic, we have typically employed the definition of psychopathy based on the Psychopathy Checklist-Revised (PCL-R ) and its derivatives. The original PCL (Hare, 1985) and later versions were designed as a measure of particular personality traits, not as a risk assessment tool. However, a variety of reviews have shown that the PCL-R score is among the best predictors of both general and violent recidivism (Salekin et al., 1996; Hemphill et al., 1998; Leistico et al., 2008). The PCL-R is a 20-item measure, with each item rated between 0 and 2 and total scores ranging from 0 to 40. The PCL-R items assess two independent but related factors. The first of these includes the personality features that have been historically linked to psychopathy, such as shallow affect, manipulative behaviors, pathological lying, and lack of remorse or guilt. The behavioral correlates of the disorder, such as need for stimulation and proneness to boredom, parasitic lifestyle, impulsivity, juvenile delinquency, and revocation of conditional release, were described as a second factor. Hare (2003) recommends a cut score of 30+ for diagnosing psychopathy. However, Quinsey et al. (1998) have argued that a score of over 25 may also be used as a reasonable cut-off. Hare's (2003) most recent edition of the PCL-R manual reports analyses that separate both factor 1 and factor 2 of the PCL-R into two sub-components or facets: facet 1a (interpersonal, as evidenced by an arrogant and deceitful interpersonal style); facet 1b (deficient affective experience ); facet 2a (impulsive lifestyle, including irresponsible behavior); and facet 2b (antisocial behavior).

It should be noted that Cooke et al. (2006) argue that there are potentially other ways of organizing the facets of psychopathy. They argue, for example, that there may be a superordinate trait, psychopathy, which was underpinned by three highly correlated symptom facets. These authors have labeled these facets "arrogant and deceitful interpersonal style," "deficient affective experience," and "impulsive and irresponsible behavioral style." The authors note that there are several advantages to this three-factor model. First, the structure of the model is hierarchical with a superordinate structure that was sufficiently unidimensional to be regarded as a coherent psychological construct or syndrome. A second advantage is that the model encompasses only 13 of the 20 PCL-R items. The excluded items primarily reflect antisocial behavior rather than core traits of psychopathy. These authors note that Hare (2003) does not provide sufficient information to evaluate his two-factor/four-facet model. Although this discussion may seem of theoretical relevance only, as Cooke et al. (2006) poignantly argue, such discussions actually relate to whether there is a latent trait associated with the

disorder underpinned by various distinct facets or an array of related but conceptually distinct domains that are not unified by an overarching latent trait. By way of discussion as to the relevance of this topic, Cooke et al. (2006) note that items related to criminal behavior, when treated as a facet of psychopathy, actually degrade the measurement of psychopathy relative to results based on the three-factor model alone. If one is to be able to effectively assess and treat individuals who meet the diagnostic criteria for psychopathy, it is essential that the primary and more tertiary aspects of the disorder be understood in greater detail. At present, it is too early to say which model may be best at elucidating the latent trait of psychopathy and which factors, though potentially relevant clinically, are more tangential to the essential features of the disorder itself.

## *Treatment outcome for psychopaths*

There have been a number of reviews regarding treatment outcome with psychopaths (e.g., Lösel, 1998; Wong, 2000; Salekin, 2002; Hare, 2003; D'Silva et al., 2004; Abracen et al., 2008; Salekin et al., 2010; Wong et al., 2012; Olver & Wong, 2013). The objective of this section is not to critique these reviews or focus in detail on all of the studies included in them. The details of a few of these reviews will be discussed in more depth, as there has been some discussion in the literature about the conclusions derived from some of these meta-analyses/reviews. However, in other cases, only the overall conclusions derived from the review and the basic methodology employed will be discussed. It is our impression, based on the evidence included in the following, that there is a growing body of research that is beginning to show consistent findings to the effect that, with appropriate types of treatment (e.g., cognitive-behavioral incorporating RNR principles, and of sufficient length), highly psychopathic offenders are responsive to treatment as evidenced by lower recidivism rates.

This is not to say that treated psychopathic offenders are low-risk once they have completed treatment, only that their risk may well be moderated by appropriate treatment protocols. Earlier attempts at treatment with such groups (Harris et al., 1991) involving treatment methods that may have been considered current at the time (e.g., therapeutic communities with treatment largely being peer-driven, with little involvement from professional staff) have been shown to be largely ineffective or even counter-productive. More contemporary structured approaches, using cognitive-behavioral, skills-based techniques, and which have employed the use of clearly articulated manuals, have been observed to be considerably more effective than these earlier attempts at treatment. These programs have typically addressed issues associated with communication and relationship skills, emotions management techniques, and the development of comprehensive behavioral management plans, to name a few of the more important elements typically associated with them.

Although the details associated with the delivery of more effective treatment interventions will be discussed more comprehensively in the following chapters, the evidence also suggests that programs that have been associated with greater treatment effects have typically been run with significant involvement by mental health professionals. Given the range of deficits with which such high-risk groups typically present, we believe it important that those providing treatment be well versed in the literature on high-risk offenders, as well as more general issues related

to working with clients who present with co-morbid psychiatric conditions. In addition, familiarity with specific rapport-building techniques, which can be used with such challenging groups of clients, is essential. Data from Marshall et al. (2002), indicating that the influence of the therapist accounted for 40–60% of treatment change with sexual offenders, highlight the need for therapeutic interventions that are client-centered. Sandhu and Rose (2012) have also emphasized the importance of therapist characteristics such as flexibility, openness, and tolerance. Further, a meta-analysis produced by Martin et al. (2000) found that the therapeutic alliance is moderately associated with outcome. Martin et al. (2000), in keeping with Marshall's perspective, suggest that the therapeutic alliance itself can be associated with positive changes in therapy regardless of the specific techniques being used. It does seem reasonable, however, that techniques that have been shown to be effective in the treatment of particular populations would yield better outcomes than those with less empirical support, given the same quality of therapeutic alliance.

### *Findings from the extant research*

Although more research in this area is clearly required, several studies have recently been published that improve on some of the limitations inherent in the literature. For example, although Wong (2000) identified 75 studies in the literature that dealt with the treatment of psychopathy in adults, he eliminated all but four of these studies (involving three samples of subjects) as being inadequate based on the strict criteria he used to determine inclusion in his review (e.g., inadequate diagnostic criteria for psychopathy). Wong (2000) offered suggestions as to appropriate therapist characteristics (at a minimum having an undergraduate degree; counter-transference issues must be openly discussed and resolved with colleagues), a list of potential treatment targets (those that have been strongly and reliably associated with criminal behavior and should address a wide range of problematic behaviors), and suggested a duration of treatment (6–12 months). He concluded that it was premature to believe that treatment was ineffective with psychopaths. Clearly, the detailed suggestions that he provided imply that there was reason for optimism that, at least in theory, treatment could be effective with psychopathic offenders. More recently, Wong & Hare (2005) have outlined, in much greater detail, the elements of an effective treatment program that might be designed for psychopathic offenders generally. As well, Olver & Wong (2009) have recently contributed a research study (discussed later in this chapter) which suggests that psychopathic sexual offenders can be effectively treated, given appropriate interventions.

Skeem et al. (2002), in their review of the literature, provided a concise overview of a number of studies on which the prevailing clinical pessimism about treatment for psychopaths appears to be based. Among these, two studies involving the same sample of offenders (Harris et al., 1991; Rice et al., 1992) have been widely cited as evidence that treatment with psychopathic offenders is ineffective or, worse, counter-productive. It must be emphasized that the program as described clearly bears little or no resemblance to contemporary approaches within forensic contexts. As noted earlier, this program was described as being peer-oriented with little input from professional staff, and involved such activities as marathon therapy and the use of nude encounter groups (for a detailed discussion, see Wong, 2000). Suffice it to say that the

program would likely not be considered ethical by contemporary standards.

Salekin (2002) carried out a meta-analysis from which he reached the conclusion, based on 42 studies, that there is reason for optimism with reference to treatment outcome among psychopathic offenders. In order to compensate for the fact that many of these studies did not employ a control group, for his analysis, Salekin (2002) used the mean success rate of untreated psychopaths from the eight studies that did have a comparison group. He concluded that highly structured, intensive treatment programs could be successful in treating psychopaths. However, it should be noted that Salekin (2002) included case studies. Furthermore, most of the studies presented in the meta-analysis approached the treatment of psychopathy from a psychoanalytic orientation. The average success rate for psychoanalytic treatment was 59% based on 17 studies and 88 psychopathic individuals. Cognitive-behavioral therapies had a success rate of 62%, but these data were described as "robust" given that the results were based on five studies and 246 individuals. Unfortunately, the majority of studies reviewed for the meta-analysis did not use recidivism as their criterion for success (see Salekin, 2002, table 2). The three cognitive-behavioral programs that used reoffending as their criterion had a success rate of 0.62, consistent with the hypothesis that psychopaths can benefit from treatment.

It should be noted that Harris and Rice (2006) criticized Salekin's (2002) review on a number of grounds, including the fact that only four studies used the PCL-R, and less than 20% used criminal recidivism as the outcome. These concerns serve to highlight the methodological weaknesses of the literature and therefore the difficulties of drawing definitive conclusions concerning treatment effects among very high-risk groups of offenders.

In a contemporary study that followed a sample of 871 civil psychiatric patients with psychopathy scores assessed in acute inpatient facilities, Skeem et al. (2002) used a propensity score approach to control for the effect of non-random assignment to treatment groups and assessed treatment involvement and violent outcomes across 10-week intervals over a 1-year period post-discharge. Among the 121 patients classified as at least potentially psychopathic (PPP), these researchers found a significant relationship between treatment involvement at the first follow-up and violence at the second, with only 6% of those PPP patients who participated in seven or more treatment sessions committing a violent act compared with 23% of those PPP patients who participated in six or fewer treatment sessions (i.e., a dosage effect for treatment). The same pattern of results was observed across later follow-up times, although the differences were not significant. The same patterns of results were also found for the 72 psychopathic patients (PSY), although the differences were again non-significant. Average odds ratios across follow-up times indicated that for the PPP patients, those who participated in six or fewer treatment sessions were 2.5 times as likely to commit a future violent act as PPP patients who participated in seven or more sessions. The equivalent figure for the PSY patients was 3.5.

Harris and Rice (2006) questioned the conclusions drawn by Skeem et al. (2002). Among the criticisms offered by Harris and Rice (2006) are the fact that there is potential measurement bias built into the study design (from assessing psychopathy, treatment involvement, and violence in the same interviews) and the use of the propensity score approach employed by the

authors. Also, the range of therapies provided (verbal therapy, medication, drug and alcohol treatment, group or other, and some combinations of these) and the lack of detail given concerning these treatment approaches raise other potential difficulties. We agree that the study's central findings must be replicated before any firm conclusions can be reached. For example, future research must seek to illuminate what therapeutic approaches, treatment models, and program components are actually effective and demonstrate significant effects over considerably longer follow-up periods. Such concerns notwithstanding, Skeem et al.'s (2002) study represents an important contribution to the literature and is in keeping with the results of the research that has been produced since this study was published.

Salekin et al. (2010) reviewed findings with reference to both adults and juveniles in order to determine if either juveniles or adults with the disorder are responsive to treatment. These authors concluded that treatment for adults shows low to moderate success, with three of eight studies demonstrating treatment gains. Treatment of youth appeared to be more promising with six of eight studies showing treatment benefits. Nonetheless this review did not include a comprehensive review of the research produced either by our team or by Olver and his colleagues at least some of which was produced after this review was published. These data are discussed below.

## *Research on sexual offenders*

A description of the work completed at both the Warkworth Institution (the Warkworth Sexual Behaviour Clinic [WSBC]) and the Regional Treatment Centre (RTCSOTP, Ontario), both of which offer comprehensive treatment programs for sexual offenders under the direction of the CSC, is important, as these studies address some of the most significant concerns regarding treatment of psychopathic sexual offenders. Both of these programs offer well-defined programs for sexual offenders employing cognitive-behavioral techniques and well developed treatment manuals. Psychopathy is assessed by means of the PCL-R and is rated by staff well versed in the literature on psychopathy and actuarial assessments more generally. In addition, these programs have been run with significant on site input from mental health professionals with many years of forensic treatment experience. The programs both provide skills-based treatment related to domains that have been found to be criminogenic among sexual offenders (e.g., managing anger and negative emotionality, directly addressing issues associated with deviant arousal). The reader is referred to Mailloux et al. (2003) for a more detailed description of these programs and others offered in the Ontario Region of the CSC. These programs have been subject to a variety of evaluations, which have demonstrated their efficacy (e.g., Looman et al., 2000; see also Mailloux et al., 2003), some of which will be discussed below.

Seto and Barbaree (1999) examined a sample of 216 sexual offenders who participated in the WSBC program. They examined the relationship between serious recidivism (any violent, including sexual, reoffense) and ratings of behavior in treatment made by clinicians at the time of participation as well as by research assistants later using file materials. The WSBC meets contemporary standards for effective correctional treatment (Andrews & Bonta, 1998, 2003); it was cognitive-behavioral in orientation and involved daily group treatment sessions over a

period of 5 months. Despite this, the findings appeared to be quite discouraging. In the absence of a main effect for treatment behavior ratings on recidivism, the researchers divided their sample into four groups using the median score on their treatment behavior rating scale and the median score on the PCL-R for the sample, which was 15. Proportional analyses revealed that men who were higher in psychopathy and received more positive ratings of treatment behavior were almost three times as likely to commit a new offense of any kind and five times more likely to commit a new serious offense after release compared with the other three groups combined. Such data would seem to justify the pessimism arising from the treatment evaluations discussed earlier. However, using survival analysis to control for unequal times-at-risk, differences between the groups' failure rates fell short of a conventional level of significance. Furthermore, in a subsequent study with the same sample and treatment behavior ratings, Barbaree and his colleagues (Barbaree, 2005; Barbaree et al., 2001) utilized a more comprehensive source of recidivism data and found that for both the follow-up period used in the 1999 publication and an extended follow-up period, only the PCL-R score was associated with recidivism, in the expected direction. That is, treatment ratings were unrelated to outcome, and only the initial score on the PCL-R was predictive of recidivism. Of course, even these revised findings are hardly a source for optimism.

More recently, however, Langton and his colleagues (Langton, 2003; Langton et al., 2006), examining the WSBC program as well, revisited the issue and incorporated a number of methodological improvements over the Seto and Barbaree (1999) study. These authors increased the sample size to 418 sexual offenders who participated in treatment (202 of whom had been included in Seto and Barbaree, 1999 sample), and extended the follow-up period after release to an average 5.9 years. Other important features of the study were that these authors used a cut-off of 25 on the PCL-R (Seto & Barbaree, 1999 used a cut-off of 15, which is well below any conventional cut-off for psychopathy), and also revised and then re-scored the measure of response to treatment (due to problems replicating the inter-rater reliability coefficients with the original treatment behavior scale).

Using Cox regression survival analysis to control for unequal times at risk and using violent (including sexual) recidivism and sexual recidivism as outcomes, Langton et al. (2006) found no significant interaction between psychopathy and ratings of response to treatment in the prediction of violent recidivism (although psychopathy was a significant predictor, as would be expected). However, the converse was found using the outcome of sexual recidivism, with no main effect for psychopathy but a significant interaction between psychopathy and treatment ratings; among sexual offenders with PCL-R scores of 25 or higher, those with ratings reflecting a more positive response to treatment recidivated sexually at a slower rate than others.

Following Seto and Barbaree (1999), we also examined the relationship between psychopathy and treatment behavior using 154 consecutive admissions to the RTCSOTP (Looman et al., 2005b). In our study, we utilized a treatment behavior rating scale that was reasonably similar (victim harm awareness, insight into offense cycle, development of relapse prevention plan) to those coded in the Seto and Barbaree (1999) and Langton (2003) studies. Our ratings were made by the clinicians conducting the treatment program at the time it was being provided. The

treatment providers also made a global judgment as to whether each offender's risk of recidivism had been reduced following treatment. These global judgements were based upon all the available information, including the actuarial risk scores, behavior in group and behavior on the unit. As the RTCSOTP is an inpatient-based program, overall assessments related to risk could be based on the client's behavior over a period of 6 months to 1 year where behavior was monitored 24 hours a day. Given that team meetings were organized on a weekly basis, all the staff who were working with a particular offender would be informed of any important developments regarding a client on a consistent basis. Further, there were typically more frequent meetings regarding the behavior of clients who were engaging in ongoing inappropriate behavior.

As was the case with Seto and Barbaree (1999), a median split for the sample on our treatment behavior scale was used. With reference to the PCL-R, a cut-off of 25 was used. This produced four groups based on whether the client was considered psychopathic and whether they were considered to have performed adequately in group based on the behavior rating scales. Using survival analysis, and looking first at the PCL-R high and low groups, Looman et al. (2005b) found a main effect with high PCL-R offenders having the faster failure rate, as expected. However, among the four groups, the failure rate for violent (including sexual) recidivism for the high PCL-R/good treatment behavior group was significantly worse than either of the two low PCL-R/treatment behavior groups (although not significantly worse than the high PCL-R/poor treatment behavior group).

The interesting finding from our perspective was that the high PCL-R/poor treatment rating group did not differ significantly in terms of recidivism from either of the low PCL-R groups. In the published article, we suggested that high PCL-R offenders who showed resistance to treatment (i.e., they performed more poorly on the treatment behavior ratings) had nevertheless benefited from treatment, having a similar failure rate to the low PCL-R groups. We argued that resistance is to be expected in any therapeutic setting and that a group (such as psychopaths) identified on the basis of such characteristics as violent and antisocial behavior would be unlikely to be immune from such processes. In fact, one would expect these offenders to be generally aggressive and confrontational in their presentation. Psychopathic offenders who were essentially "going through the motions" (and thus not displaying resistance) may have received higher treatment behavior ratings but failed to internalize any of the important aspects of therapy. This hypothesis might explain why no differences were found between the high PCL-R/poor treatment behavior group and either of the low PCL-R groups.

It should be emphasized that much of the information necessary to complete the program assignments (on which the treatment behavior ratings were based) were explicitly discussed in detail during treatment sessions in the program. That is, offenders were provided with sufficient information to get reasonably high scores on the rating scale items. Those high PCL-R subjects who chose to be resistant may have benefited from the ensuing discussions with treatment staff. For example, some of the more confrontational clients with whom we have worked simultaneously refused to agree with some of the insights that we might try to offer but appeared to understand the material presented. For example, we might suggest that a client's non-violent pattern of offending was related to their having committed a sexual offense at a

later date. Under such circumstances, it was not uncommon for clients to seem interested in what was being discussed, become animated in their discussion about why they felt we were wrong, and yet end the discussion by saying that they could at least understand the perspective that we were taking. Perhaps over time these same clients began to internalize some of the information that was presented.

In our 2005 study, the global ratings of change in risk following treatment enabled us to incorporate staff observations of actual changes in interpersonal interaction patterns on the living unit. Using this comprehensive index, the results were more consistent with those reported in the studies by Langton and his colleagues. We found that the post-release violent (including sexual) recidivism rate of the group of high PCL-R offenders who were rated as having had their risk reduced did not differ from either of the two low PCL-R groups included in the study. The fact that a sub-group of high PCL-R subjects recidivated at similar rates to the low PCL-R subjects is certainly of interest and contradicts statements to the effect that psychopaths are untreatable. These data also reinforce the findings of Langton et al. (2006) who found a sub-group of high PCL-R subjects who may have been responsive to treatment. However, the high PCL-R offenders whose risk was not rated as having changed showed a significantly higher recidivism rate, as one would expect on the basis of their PCL-R score alone.

The findings of Langton et al. (2006) and Looman et al. (2005b) appear to be at odds in terms of which sub-group of psychopathic sexual offenders benefited from treatment. In the Langton et al. (2006) investigation, it was observed that those psychopathic offenders who were rated as having good treatment behavior recidivated at lower rates, whereas Looman et al. (2005b) observed that it was the psychopathic offenders who performed *worse* on the behavioral measures who seemed to benefit from treatment. The results of these two studies may not be as discrepant as a casual examination of the findings would seem to indicate. The two studies used different measures of offender participation, which may well have influenced the findings. The Langton et al. (2006) study used a much more inclusive measure of treatment behavior, which included measures related to attendance. Such differences in the way in which treatment behavior was measured may have, at least in part, accounted for the differences between the findings reported. In addition, it is important to emphasize that both of these studies observed that there was a sub-group of high PCL-R offenders who recidivated at lower than expected rates. In future research we hope to investigate whether the apparent contradiction in the findings between these two studies are simply related to the discrepant operational definitions of treatment behavior.

Other studies by our team demonstrating the efficacy of the RTCSOTP have been conducted by Looman (2006), who compared the observed rates of recidivism for the RTCSOTP against published norms for various risk assessment instruments. This study demonstrated that for higher risk levels, the RTCSOTP was particularly effective. This is precisely what one would expect to see based on the risk principle established by Andrews and Bonta (1998, 2010); that is, treatment should be most effective for the highest-risk clients, who are likely to show more significant improvement as a result of treatment, given the many treatment needs with which they present. By contrast, low-risk clients present with comparatively few treatment needs and

are therefore less likely to show equally marked improvement as a result of treatment. For example, for clients attending the RTCSOTP who scored six or above on the Static-99 (representing a high risk of recidivism of sexual offense) the recidivism rate associated with the developmental sample was 39%, compared with 11.9% for the RTCSOTP. As the 95% confidence intervals for these rates did not overlap, it can be concluded that the observed rate for the RTCSOTP was significantly lower than that associated with the Static-99 developmental sample.

Similar findings were observed by Abracen et al. (2011). This study compared a group of 64 sexual offenders treated at the RTCSOTP with 55 untreated sexual offenders. Groups were matched on age at index offense, PCL-R score, and type of sexual offender (i.e., intra-familial child molester, extra-familial child molester, and rapist). In addition, the Rapid Risk Assessment of Sexual Offense Recidivism (RRASOR) was scored on all subjects. The RRASOR is a predecessor to the STATIC-99 and contains four items that were later incorporated into the Static-99. Results indicated that both treated and comparison subjects evidenced low sexual offense recidivism rates (*c.* 10% over follow-up periods that extended beyond 9 years for both treated and comparison subjects). However, treated subjects who were rated as being at higher risk on the RRASOR evidenced substantially lower than predicted rates of sexual offending. Only two of 34 (5.9%) treated subjects who scored two or above on this measure recidivated sexually. For comparison subjects, two of 13 (15.4%) subjects scoring two or above on the RRASOR recidivated sexually.

Since the writing of our recent review of the psychopathy treatment literature (Abracen et al., 2008), several studies have appeared in the literature. Olver et al. (2009), in a follow-up to an earlier evaluation of the high-intensity Clearwater Sex Offender Treatment Program operated in the Prairie Region of the CSC (Nicholaichuk et al., 2000), found that treatment remained a significant predictor of outcome even after statistically controlling for age at release and prior sexual convictions. Treated offenders sexually recidivated significantly less than the comparison group over nearly 20 years of follow-up, even after controlling for the aforementioned variables. This program is cognitive-behavioral in orientation and contains many elements in common with the RTCSOTP. Although data on psychopathy were not included in this study, Olver & Wong (2009) reported on a group of sexual offenders who attended the Clearwater Sex Offender Treatment Program and who scored above 25 on the PCL-R. The sample consisted of 156 federally incarcerated sex offenders who were followed for 10 years. Although psychopathic offenders were more likely than their non-psychopathic counterparts to drop out of treatment, almost 75% completed treatment. Psychopathic offenders who failed to complete treatment were more likely to recidivate violently but not sexually when compared with completers. Overall, the results suggested that given the appropriate types of treatment, the majority of high PCL-R offenders can be retained in an institutional treatment program and those showing therapeutic improvement can reduce their risk for both sexual and violent recidivism. The results were also consistent with Andrews and Bonta's risk principle in that the benefits of treatment leading to risk reduction were most apparent among high-risk/high-need sexual offenders.

A more recent review completed by Olver & Wong (2013) regarding the treatment of high-risk

sex offenders focused mostly on a number of technical issues related to the treatment of high-risk sexual offenders. Nonetheless, these authors suggest that programs that attend to the principles of RNR and sound clinical practice are associated with non-trivial reductions in risk even among high-risk psychopathic offenders. These authors reviewed data from four international high-intensity sex offender treatment programs (one of which was the RTCSOTP) and discussed some of the limitations regarding this body of research. Wong et al. (2012) had recently concluded that appropriate treatment with psychopathic clients may well be effective at reducing risk of recidivism and therefore the review by Olver & Wong (2013) did not focus on this matter.

Olver & Wong (2013) make several salient comments regarding the treatment of sexual offenders that are clearly of relevance. They note that the failure to complete treatment is "endemic" (p. 585) and that efforts must be made to maintain clients in treatment. Further, these authors suggest that clear treatment goals should be set, and ways of achieving such goals clearly articulated based on the empirical literature. We certainly agree with this perspective and suggest that this approach runs counter to the Good Lives Model (GLM) with its focus on poorly defined concepts such as "happiness" or "knowledge," which would likely be defined differently for each member of a given group.

It is interesting to note that Olver & Wong (2013) refer to the RTCSOTP as a GLM-based program. We can certainly understand why the RTCSOTP is regarded as something more than a traditional relapse prevention-based program, given the range of treatment targets addressed. However, we believe that the specific and empirically supported treatment targets established for the program and the focus on both the principles of RNR as well as attachment, serious mental illness and complex trauma-related issues represent a model that is in many ways different from the GLM approach. It was with this in mind that we developed what we called an integrated approach to RNR (RNR-I), which is described in detail in Chapter 5.

### *Treatment of adolescent offenders with psychopathic traits*

Caldwell and his colleagues (Caldwell et al., 2006, 2007) conducted several studies on juvenile offenders with psychopathic traits. These authors have suggested that juvenile offenders with psychopathic traits may respond to treatment that is of sufficient intensity. Caldwell et al. (2006) compared two groups of PPP offenders using the Psychopathic Checklist: Youth Version (PCL:YV): one of which participated in an intensive treatment program and another that received "treatment as usual." Their results indicated that those attending the treatment as usual program were more than twice as likely to violently recidivate in the community during a 2-year follow-up as compared with those attending the intensive treatment program.

Caldwell et al. (2007) also employed the PCL-YV. Scores on the PCL-YV were computed and subsequently compared with treatment progress. Treatment progress was measured by means of a series of daily behavior rating scales and with a measure of institutional misconducts that required security interventions. The authors note that the evaluated program was specifically designed for youths who were unmanageable in conventional programs. The results indicated

significant improvement in both behavioral and security measures with treatment.

As noted by Caldwell et al. (2007), clients typically attended several individual therapy sessions with a psychologist, psychiatrist, or social worker. Teaching social skills, resolving mental health issues, and helping clients build positive relationships with their family members were all described as core elements of the program. It should be emphasized that the program was operated on the grounds of a state psychiatric hospital and the administration of the program was under the direction of a psychiatric case manager. Caldwell (2014) has also emphasized many of these aspects of the program in more recent descriptions of the Mendotta Juvenile Treatment Center. As we shall see when describing the RTCSOTP in more detail, these are all elements included in the RNR-I model (described in Chapter 5) as well as the RTCSOTP on which the RNR-I and community-based treatment programs that we deliver are based.

## Conclusion

Thus, overall we believe that there is reason to be optimistic regarding treatment outcome with men who score high on psychopathy. While early studies, which employed less than ideal treatment approaches, suggested that psychopaths cannot benefit from (and in fact may be harmed by) treatment, more recent studies suggest the opposite. Studies by our own group (Looman et al., 2005b) and others (e.g. Olver et al., 2008; Olver & Wong, 2009) suggest that appropriately designed treatment programs may have a positive impact on sexual offenders who score high on psychopathy. Of note, those programs with significant involvement of mental health professionals appear to be more effective when working with such high-risk, high-need groups of clients. These programs include the RPC Prairies Sex Offender Treatment Program, the Bath Sex Offender program operated by Dr. William Marshall and his colleagues, the RTCSOTP, and the Mendotta treatment program described by Caldwell and his associates. From our perspective, this should not be viewed as surprising. The complex histories with which such clients present cannot be reduced to eight criminogenic needs, as suggested by Andrews and Bonta (2010). Psycho-educational programs that focus on circumscribed treatment targets have been shown to be effective, but it is our view, based on the available evidence, that for higher-risk, higher-need groups of clients, a high-school diploma and 2 weeks of training (the minimum requirements for sex offender treatment providers in one correctional jurisdiction with which we are familiar) are not sufficient to meet the needs of the clients with whom we work.

# 4
# Therapist and Setting Characteristics

The overview presented in previous chapters would suggest that there are a number of high-intensity sex offender treatment programs as well as programs that have been offered to high-risk, high-need offenders more generally which have been demonstrated to be effective. Newer studies simply serve to reinforce these data, as these programs tend to have several important elements in common. The fact that many of the newer programs appear to have much in common is not a random occurrence, as many of them have adapted their techniques based on developments in the literature and the results of previous outcome studies. These programs tend to have a core of treatment targets in common and tend to be cognitive-behavioral in orientation. In later chapters, we will address the specifics related to achieving progress on a variety of treatment targets that have been supported by the literature.

We have found that many program descriptions available in the peer-reviewed literature (including some of our own) simply describe the program as being cognitive-behavioral in orientation and fail to provide much in the way of detail. The lack of discussion as to which specific treatment targets are the focus of treatment, and also the strategies that have been used to achieve progress with reference to these specific treatment targets may leave readers wondering what is actually happening in individual and/or group therapy sessions. At this point in time, we believe that simply noting that a program is cognitive-behavioral in orientation is not sufficient. Such statements are too general in nature to have much meaning for those who are actually tasked with the delivery of treatment to high-risk sexual offenders. However, typical page restrictions imposed by journal editors make it difficult to provide more informative explanations regarding the goals of therapy and the techniques used to help achieve these goals. It was with these limitations in mind that we decided to write this book.

## Therapist characteristics

We believe, in keeping with the writings of Ward and his colleagues (e.g., Ward, 2007), that one of the less frequently addressed topics in the delivery of treatment to offenders relates to therapist characteristics. From our perspective there is little point in discussing the minutiae of therapy without first discussing therapist characteristics. This perspective is supported by research findings in a variety of domains.

Perhaps the work that is most germane to the topic of therapist characteristics related to the treatment of sexual offenders is the work of Dr. Marshall and his colleagues (e.g., Marshall et al., 2002, 2003). Marshall et al. (2002) reported on two studies. In the first study, they demonstrated that trained raters could reliably distinguish 18 features on which therapists differed. In the second study, they investigated whether 17 of these features were related to outcome in sex offender treatment. The data indicated that empathy and warmth on the part of

therapists combined with directive and rewarding behaviors were the features most strongly associated with therapeutic benefit. These findings were strikingly similar to those reported by Marshall et al. (2003), who observed that such features as warmth and asking open-ended questions were positively related to client change and that a confrontational style was negatively related to increased competence in coping. Marshall et al. (2003) commented that there is an apparent contradiction between the use of such client-centered strategies, such as the use of open-ended questions, and more traditionally cognitive-behavioral techniques, such as directiveness. Both of these therapeutic skills were associated with positive movement in therapy. Marshall et al. (2003) suggested that both of these characteristics were related to the need for therapist flexibility. This particular therapist feature will be stressed throughout this book. Although we believe it is essential that therapy directed at high-risk groups be directive, with a clear emphasis on therapeutic goals, this in no way implies that therapy should be a sterile undertaking devoid of therapist warmth or flexibility. The research by Marshall and his colleagues underscores the need for both of these seemingly contradictory approaches (i.e., therapist warmth and the need to be directive). Needless to say, the application of such skills as applied to high-risk groups of offenders requires a certain degree of commitment and patience from staff involved in such programs.

## *Therapeutic alliance*

Marshall and his colleagues have produced several review articles related to the importance of the therapeutic alliance as it relates to change in general among clinical populations, and more specifically as related to offender populations (Marshall & Burton, 2010; Marshall et al., 2003, 2005, 2011). These reviews stress that confrontational approaches are the most damaging of therapist characteristics and that therapist style and orientation have been found to account for a large proportion of variance with reference to therapeutic outcome. They note that successful therapeutic outcomes depend on both the therapist's interpersonal skills and on specific techniques. For example, Marshall & Burton (2010) argued that the therapeutic alliance is actually more important than the actual technique used with reference to treatment outcome. Nonetheless, as discussed by Marshall & Burton (2010) there are few studies that have specifically addressed the relative contributions of these two admittedly important aspects of treatment efficacy at least as related to sex offender treatment.

Marshall et al. (2011) make several important observations regarding therapist characteristics from our perspective. They note that effective therapists need to have a strong foundation in the empirical literature. They note that these personal and interpersonal characteristics of the therapist are critically important in understanding outcome. Further, the use of overly didactic manuals probably runs at cross-purposes to establishing appropriate levels of rapport with clients. Unfortunately, the use of such manuals may be necessary with facilitators not well versed in the clinical literature.

## *Good Lives vs. risk–need–responsivity (RNR) approach?*

Recently, a number of authors have outlined a model of treatment which has become known as the Good Lives Model (e.g., Ward & Maruna, 2007). This approach to treatment with

offenders, based as it is on positive psychology, has been alternately described by these writers as being largely compatible with the RNR model adopted by Andrews and Bonta (e.g., Ward et al., 2007) or being in many ways at fundamental odds with this approach, which the authors view as being too reductionistic. For example, although Ward & Stewart (2003a) note that some aspects of the RNR model may be necessary for treatment gain, such approaches are not sufficient to achieve significant levels of treatment efficacy. Ward & Stewart (2003a) bluntly state that: "The strategies based on the risk-need model are appropriate; the problem resides in the underlying model of offender rehabilitation: it is too reductionistic, too negative, and not sufficiently attuned to the psychological reality of individuals' everyday lives, and the crucial role of human goods in such lives" (pp. 222–223). Such comments seem to imply that there are some fundamental problems with the RNR model that may be difficult to resolve in practice.

In Chapter 8 we offer a more detailed discussion of the Good Lives Model espoused by Ward and his colleagues. Much of this discussion concerns issues of theoretical relevance. These theoretical issues are of practical significance, however, as they inform what the targets of treatment should be. As we will discuss at the end of this text, we are critical of some of the relatively untested assumptions of the Good Lives Model, at least as they are applied in a forensic context with high-risk offenders. For example, we wonder about the parsimony of the assumption that all persons strive towards a set of "goods," some of which (e.g., happiness) are poorly defined, and that treatment should focus on the attainment of such goods. We have found that these concepts may not be sufficiently concrete or easy to grasp for the populations we have typically treated. Nonetheless, for the purpose of this chapter we will only say that some of the criticisms that Ward and colleagues have leveled against the RNR model are of relevance as they relate to the therapeutic alliance.

These authors have noted that the RNR model has not paid sufficient attention to the therapeutic alliance (e.g., Ward & Maruna, 2007). We agree with this criticism of the RNR model, but only to the extent that RNR proponents have not focused a great deal of research on this topic. It is important to note that the RNR model does emphasize the importance of therapist characteristics and therapist–client relationship. Andrews and Bonta (2003), for example, list two principles that are considered critical to interpersonal influence generally and formal treatment settings specifically. The first of these two principles, called the relationship principle, states that influence will be greatest in situations characterized by open, warm, enthusiastic, and non-blaming communication and by mutual respect, liking, and interest. The second principle, the structuring principle, involves the use of effective authority principles, anticriminal modeling and the use of differential approval and disapproval. As noted by these authors, these principles have a long history in psychology and are hardly unique to their theory. Further, these principles are subsumed under the banner of responsivity issues.

The characteristics listed by Andrews and Bonta (2003) and by Marshall (e.g., Marshall & Burton, 2010) actually seem quite similar and are hardly fundamentally at odds. Ward & Maruna (2007) note that: "In variance with the responsivity principle, the RNR model is often implemented in practice in a 'one size fits all' manner" (p. 23), which makes it difficult to accommodate the needs of individual offenders. Although the authors do not appear to offer

any specific examples of such programs, leaving open the possibility that their argument doesn't have much merit in practice, we believe, based on our experience, that this argument does, in fact, have some validity. However, such difficulties are not an indictment of the RNR model; rather they are a comment on the poor implementation of programs based on this model. That is, it is not the model that is "too reductionistic, too negative, and not sufficiently attuned to the psychological reality of individuals' everyday lives…" (Ward & Stewart, 2003b), it is the incorrect interpretation and implementation of the model that results in this state of affairs. It should be noted that we are aware of several programs that purport to offer Good Lives treatment and which, in our view, can be subject to the same criticisms that Ward & Maruna (2007) have leveled against RNR-based programs; that is to say, treatment needs to be offered by qualified staff who are dedicated to the application of treatment using the principles described by Marshall and colleagues and Andrews and Bonta, and as outlined in this text. Regardless of the soundness of the underlying theory, the poor implementation of a treatment program will result in less than hoped for outcomes. This applies equally to RNR- and Good Lives-based treatment programs.

## *Motivational interviewing*

We agree with all of the authors cited in the previous section that the therapeutic alliance and techniques whereby our clients might be encouraged to actively participate in treatment are of critical importance. Marshall and colleagues (e.g., Marshall et al., 2006; Marshall & Burton, 2010) have discussed the utility of motivational interviewing techniques and other procedures to help clients overcome resistance to therapy. Especially at the early stages of treatment, we believe that such techniques are quite useful. Rather than challenging the client about his position or labeling the client, these approaches encourage the client to explore his resistance in a non-threatening manner. For example, the counsellor and the client may explore the positive and negative aspects of maintaining a specific behavior (for a description of a motivational interviewing-based program in a prison setting, see Farbring & Johnson, 2008). As Porporino and Fabiano (2002) pointed out, such techniques must be integrated into cognitive-behavioral programs so that there will be less likelihood of clients feeling alienated from the treatment program. One technique we have found particularly useful in this regard is to ask the client to complete a "decision matrix" assignment. The client is asked to list both the short-term and long-term positive and negative consequences of engaging in a particular behavior. This results in a series of eight categories that the client needs to address. For example, at the beginning of therapy, clients may be asked to complete the assignment as it relates to sexual offending. This assignment therefore asks clients to discuss the positive aspects of sexual offending from their perspective. Although it would seem likely that the clients we see will be deceptive regarding such matters, more often than not we have found clients to be receptive to this approach. Clients generally discover that, although there may be some short-term positive consequences to committing sexual assault, there are very few if any long-term positive aspects to engaging in such behavior. The fact that our clients arrive at this conclusion by themselves in many cases serves to increase their motivation to engage in therapy. We have included a sample "decision matrix" as applied to the decision to engage in

sexual assault in Appendix 1.

Miller and Rollnick (2002) provide clinicians with many concrete suggestions as to how to apply the principles of motivational interviewing in practice. The reader is referred to this text for a detailed discussion of these techniques. Some of the techniques discussed by these authors that we have found helpful include spending time with clients in order to understand what they hope to gain in therapy and what the consequences of continuing on a particular course of action might be. Some clients we have seen have simply told us bluntly that they want to take the program because it will increase their chance of early release or, in the case of clients seen in the community, they will be suspended (i.e., sent back to jail) if they do not conform to their conditions. However, careful listening usually uncovers the fact that there is something that the client may want to achieve in therapy. For example, it is not uncommon in the beginning of therapy for these same clients to mention, almost as a passing thought, that they wouldn't mind being able to form some type of committed relationship should they choose to in the future. The issue of intimacy deficits and relationship skills more generally is a central theme of many sex offender treatment programs and it is easy for the therapist to be genuine when indicating that quite a bit of time may be spent on this issue over the course of treatment. It should be noted that this treatment goal has been supported by a wide variety of research (for a comprehensive review, see Marshall et al., 2006) and, from our perspective, is a legitimate goal of sex offender treatment. As Mann et al. (2010) have indicated, lack of emotionally intimate relationships with adults has been demonstrated to be a significant dynamic risk factor in meta-analyses.

Given the nature of the high-risk clients we see in treatment, the desire for change is not always expressed in a pro-social manner. Both of the authors have seen clients who have stated that they do not think it likely they will desist from doing all crime. For example, some offenders indicate that they are unwilling to give up smoking tetrahydrocannabinol (THC)-based drugs, but that they are upset at themselves for having committed a sexual assault. Rather than confronting the pro-criminal aspects of such statements, motivational interviewing stresses the importance of "rolling with resistance" and discussing the consequences of such decisions for the offender (and possibly others). In practical terms this may mean that the therapist accepts the client's position and agrees to work on strategies that might make it less likely for him to commit a sexual assault. The client may arrive at a point in therapy where he decides that smoking THC-based products is counter-productive. On the other hand, the therapist should be prepared for the client to potentially finish the program having made no commitment never to use THC again (although we hope that he may have learned how to reduce his risk of abusing drugs more generally should he wish to internalize these skills). Although such an approach may seem contrary to the goals of forensic treatment, the reality is that if, as clinicians, we try to force the client to make changes, it will probably result in few long-term modifications in behavior. Motivational interviewing presents clients with an opportunity to think about what they might like to change for their own personal, idiosyncratic reasons. As Miller and Rollnick (2002) state, motivational interviewing encourages clients to "take what you want and leave the rest" (p. 40). Contrary to the views of Ward & Maruna (2007) cognitive-behavioral programs, using the RNR model can focus on both positive treatment goals (e.g., forming

intimate relationships) and desistance strategies (anger management techniques).

Another principle that is central to motivational interviewing is to help the client create a discrepancy. That is, clients should be encouraged to come up with reasons why they might want to change, even if they are simultaneously ambivalent about whether they want to change. Some of the clients whom we have seen, for example, have said that they are tired of living a life of crime, but that the thought of working 8 hours a day for minimum wage is just as problematic when they can "easily" earn hundreds of dollars or more in a few hours by engaging in criminal behavior. One approach to creating a discrepancy in such a situation is to explore what the client means by the term "easy." It is not infrequent to hear in such conversations that the "easy" money is accompanied by the risk of being injured or killed and that, at present, they have little to show for their criminal behavior (e.g., the "easy" money was just as easily spent on a drug binge; the police seized the stolen goods; they have lost relationships). For such conversations to have meaning, however, the therapist must be non-judgmental and be genuinely interested in what the client is saying. The expression of warmth and empathy is critical to this process.

Many of the clients we see are all too familiar with the process of being labeled (more on that shortly) and have noted that they are typically seen for at most 1 or 2 hours by a mental health professional, who then writes a report indicating that they have one or more diagnoses and should be considered a high risk of recidivism if released. These same clients may not be provided with an explanation of what is meant by risk or an opportunity to discuss their feelings on such matters. Clinicians should therefore not be surprised when these clients enter an initial session with a skeptical, and sometimes outright hostile, approach. It is also essential that clients be encouraged in their attempts at establishing self-efficacy. Many clients may feel that there is little point in trying to change, as such efforts will certainly result in failure. Clients need to be encouraged to understand that the problems they are struggling with may have taken decades to develop to the point where the client is presenting in therapy. It is unreasonable to expect that they should be able to change such longstanding patterns of behavior in a very short period of time. Helping clients accept that they can change, but simultaneously emphasizing that this is a slow process that will involve effort on their part, is part of the art of therapy. It should be noted that Marshall et al. (2008) have recently evaluated the effects of a preparatory program for sexual offenders being housed in a Canadian federal penitentiary. This program is described as being cognitive-behavioral in orientation and incorporates elements of motivational interviewing as well as other techniques derived from positive psychology. Although the results reported are justifiably described as preliminary given the small sample size, the results support the utility of using such techniques as motivational interviewing to motivate clients to participate in treatment.

## *Therapist knowledge/training*

The strategies and skills discussed in previous sections have been discussed by a variety of authors and, as we have noted, such therapeutic skills are essential when working with clients struggling with a wide variety of issues. However, in working with high-risk, high-need offenders we believe that there are certain settings and therapist features that significantly

improve the odds of successful outcome. First, it is important that all therapists working with such populations be well versed on both theoretical and practical matters related to both the sex offender literature and the research related to working with psychopathic offenders. Without such an understanding, it is difficult to make sense of the treatment program that is offered. Why are large sections of the Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP) manual dedicated to working on matters related to the development and maintenance of intimate relationships and the necessary social skills to achieve such goals? Why are there sections of the manual that focus on the identification and open expression of emotion in a way that is respectful of other persons? Without knowledge of the literature, it is difficult to know why such aspects of treatment may be more prominent than others.

It might be argued that such knowledge is not essential. Proponents of such a perspective might argue that prospective therapists only need to know that these are important treatment targets. The problem with this approach becomes apparent when addressing typical comments made by clients attending our groups. Clients in our groups frequently make comments that reflect deficits in multiple areas and the therapist is left with a difficult decision regarding which of any number of topics to address. For example, a client may raise the issue that he hates working with women, and that the comment that one of the female nurses made about him is proof that his view of women is correct. Further, this statement may be made in a very aggressive manner with both verbal and non-verbal indications of anger. There are obviously any number of approaches that a therapist could take in addressing such comments.

We do not believe that there is one best way to react to such comments, but we do believe that, however the therapist responds, relevant issues from the therapeutic literature should occur to the therapist at this juncture. First, if the client has a history of assaultive behavior, especially if they have assaulted staff members in the past (which, although infrequent, certainly appears in the histories of some of the clients we see), the therapist must take certain steps to ensure his or her own safety. Given that many psychopathic offenders have difficulty with the expression of emotions, simply asking the offender if he is angry may not be sufficient or even relevant. That is, the client may only have one word to describe a very wide range of negative emotions. The term anger may well be taken to mean anything from mild frustration to rage. It may be more helpful for the therapist to ask the client to rate their anger on a scale of 1–10 and to help the client identify behavioral markers associated with at least a few of the points along the scale. It is, of course, best to have such discussions prior to the client becoming very angry (usually at the beginning of the therapeutic process if it becomes obvious that the client has difficulty expressing emotions). By asking the client to rate their anger on such a scale, the clinician can more accurately ascertain the actual level of anger being experienced by the client. If the level of anger is manageable (as is typically the case) the therapist may then help the client understand the thoughts behind these emotions and discuss the evidence for and against such thoughts using any one of a number of techniques well known to those with training in cognitive therapy. Following this discussion, the therapist might ask the client if his feelings have changed somewhat as a result of the conversation. Knowledge of cognitive therapy principles and techniques is obviously essential in working through such issues with

clients.

Alternatively, the therapist may choose to take a somewhat different approach. The available literature clearly indicates that the expression of emotion is important for progress in therapy (e.g., Howells & Day, 2006; Ross et al., 2008). Howells and Day (2006), for example, note that for violent offenders to successfully engage in treatment, they may need to both experience and accurately identify these emotions. Further, they must be willing to disclose these affective experiences to others. Given the prominent role that strong emotions have been found to play in the offense cycles of both violent and sexual offenders (Howells et al., 2004), it is important that these same offenders learn to access, clearly articulate, and share these feelings with others. Further, as suggested by both Howells & Day (2006) and Serran et al. (2003), affective arousal may be necessary to activate offense-relevant schema. Given this perspective, the therapist may try to understand the client's views of women while the anger is present, with the eventual goal of modifying the client's schema related to women.

The essential issue is not that there is one best approach the therapist can adopt, but that whichever approach is adopted, it should be based on an in-depth knowledge of the literature which the therapist can apply when he/she encounters a particular client behavior. There may be no time for the therapist to consult with colleagues or perform a literature review prior to reacting to the client's comments.

Marshall has recently written several articles outlining his difficulties with overly manualized approaches to therapy (e.g., Marshall, 2009; Marshall, & Serran, 2004). Marshall has noted that overly manualized programs reduce the therapist's ability to be flexible in treatment. It seems reasonable to believe that when therapists lack training in process-oriented issues associated with therapy (training typically provided in applied psychology and social work programs) and relevant theoretical knowledge, they will be more likely to rely on materials found in very detailed and prescriptive manuals. We have seen examples of such manuals, which provide very detailed direction to treatment providers, including comments about what the therapist should say at various points in the session. Even in cases where these same manuals state that therapists need to be flexible and engage in empathic communication, the probability of this happening is likely decreased if a therapist with little or no training in therapy is provided with a very prescriptive manual.

We believe that the positive treatment results which Marshall has reported (e.g., Marshall et al., 2006), as well as the results of our research demonstrating lower than expected rates of recidivism even with very high-risk sexual offenders, demonstrate the utility of groups being facilitated by trained mental health professionals. The meta-analytic work of Hanson et al. (2002, 2009) has demonstrated that contemporary treatment programs are more effective than older programs and that the more RNR principles that were followed, the better the outcome. As noted by Hanson et al. (2009), many of the sexual offender programs reviewed made special efforts to engage sexual offenders in treatment. Hanson et al. (2009) conclude that there is sufficient evidence supporting the RNR principles that they should be a primary consideration in the design and implementation of treatment programs.

With reference to the treatment of high-risk/high-need offenders, we therefore recommend that,

in order to meet the very complex responsivity needs of this population, experienced mental health professionals should be on site to supervise the program and trained professionals should be used in the delivery of programs. It is beyond the scope of this text to comment on the minimum necessary qualifications for staff facilitating lower-intensity programs but, for higher-intensity programs, we believe that mental health professionals should be directly involved in both clinical oversight and the actual delivery of treatment. Where treatment staff are also present in group who do not meet the qualifications for registration with a professional mental health licensing body, it is recommended that they be closely supervised by experienced mental health professionals.

These considerations are based on our belief that treatment geared toward high-risk, high-need offender populations should not simply be psycho-educational in nature. The intent of these programs should be to provide therapy. If high-intensity sex offender programs are viewed as therapeutic programs then the issues discussed here (e.g., the establishment of rapport, knowledge of mental health disorders, experience in working in mental health settings) are clearly of relevance.

Addressing the multiple concerns presented by high-risk, high-need offender populations is not the same as providing a 10-session group on leisure activities. This is not to say that groups related to leisure activities are not relevant. Quite the opposite is true, we believe. These groups provide important information to the clients we see and can be very informative. That said, these programs can be highly structured, and probably do not require experienced mental health professionals to be directly involved in the delivery of treatment. The goals of such programs are fairly circumscribed and the manner in which progress is assessed can be fairly straightforward (e.g., completion of assignments, pre-post test results). However, given the multiple treatment issues with which high-risk, high-need offender populations present, such programs are not sufficient if the goal is to effectively reduce recidivism. Again, the outcome literature (such as it is) with higher-risk populations seems to bear this point out.

Given the nature of therapeutic programs, it is difficult or impossible to produce very detailed manuals. We believe that program manuals are essential in the delivery of treatment. Such manuals allow for the delivery of treatment following a similar progression (e.g., addressing offense-supportive thinking is covered before the development of behavioral management plans) regardless of who is delivering treatment. Moreover, such manuals allow those conducting research on outcome to have detailed information as to what topics are covered in therapy. However, these manuals should not be prescriptive in nature and must allow for flexibility. In working with high-risk populations, it is sometimes difficult to estimate exactly how long it will take to cover a particular topic. In addition, there will be group sessions where the topic that is listed in the manual is not the one discussed (e.g., when confidentiality in group has been broken by a group member). Such flexibility is an essential element of therapeutic programs. That is not to say that every other group should be dedicated to a topic not listed in the manual; however, the program must be flexible enough to allow for such discussions as those related to important rule violations.

# Psychopathy as a responsivity factor

With reference to working with psychopathic offenders specifically, Wong & Hare (2005) have made several suggestions. For example, these authors have suggested therapist detachment when working with such groups. Ross et al. (2008) questioned this suggestion, arguing that there is no evidence at present to support this approach. We agree with Ross et al. (2008) that such a detached approach is potentially problematic. Although we have found that it is more difficult for psychopathic offenders to discuss emotionally laden issues and that remaining focused on treatment goals is a very reasonable approach with such groups, this is not to say that being detached is the best course of action from a therapeutic standpoint. Working with psychopathic offenders in treatment is very demanding work on the part of the therapist. For anyone familiar with the research on psychopathy (as briefly summarized in previous chapters) and who has worked with such populations, this statement will come as no surprise. Removing oneself from the therapeutic relationship is, however, not a solution to these difficulties. In fact, from our perspective, a detached orientation on the part of the clinician may well increase the risk to that person. We have found that even clients who present with a wide range of psychopathic traits are able to form some type of rapport with therapists (albeit sometimes in a more muted fashion). When difficulties arise in therapy (as they do with such clients, not infrequently), rapport can be a very powerful tool for defusing these sometimes difficult or potentially dangerous situations.

There have been occasions on which clients we have seen who certainly score over 30 on the Psychopathy Checklist-Revised (PCL-R; i.e., who meet the diagnostic criteria for psychopathy) have told us that they are becoming very angry about something we have said. In many instances, this relates to a misinterpretation of a comment made either in group or during individual therapy. These clients have then told us that they were only letting us know how they were feeling because they didn't actually want to become physically aggressive with us. When asked to discuss these issues in more detail, these clients have stated that they have had a great deal of difficulty controlling physically aggressive behavior in the past and were actually concerned for our safety. Although counter to the prevailing stereotype associated with such offenders, we believe that such comments derive from the development of some level of rapport. The reader should keep in mind that a number of the clients we see have never had a positive relationship with another person and many have been survivors of emotional, physical, or sexual abuse. For individuals with such traumatic histories, while they have not had a positive relationship, it is still something that these clients value. We have also found that there are as many differences as similarities among individuals who score high on the PCL-R (for a discussion, see also Tew et al., 2013). Again, although counter-intuitive, we have worked with several high PCL-R offenders who have experienced clinically significant problems with anxiety and/or depression. To deprive such clients of a therapeutic relationship that involves the development of rapport and warmth is both contraindicated clinically and potentially places the therapist at higher risk.

Therapists working with such high-risk groups should, of course, be aware that such clients can be quite manipulative. Rather than becoming angry in response to manipulation, therapists

should assume that such behaviors may occur and these behaviors should become the focus of therapy when necessary. For example, it is common for such clients to try to play one staff member against another. In such situations, rather than becoming angry with the client, it is best to organize a meeting with all the concerned parties in attendance. In this way, it is very difficult for the client to maintain that one staff member made a promise or statement that was contradicted by another staff member. Of course, in reality, sometimes staff members have in fact provided different opinions. In these circumstances, such meetings can be used to arrive at a compromise solution. By allowing the client to witness such discussions, the therapeutic team are modeling appropriate problem-solving behavior (at least we hope that this would be the case).

Providing such clients with concrete feedback regarding their progress in therapy, with specific behavioral references used to illustrate such points, is also very useful. Concrete information presented in a straightforward manner is generally the preferred manner of working with such populations. For example, many of the clients we see are not particularly pleased to read in their reports that they have been assessed as having a high risk of recidivism based on actuarial instruments. Rather than side-stepping such discussions, we have found that giving the client specific information about these measures and their interpretation in a respectful manner is a better approach. In many cases, clients themselves come to agree that the assessment accurately reflects the fact that they have a number of issues which should be addressed as treatment targets, even if they continue to maintain that they are not high-risk.

Ward and his colleagues have argued that therapists should not conduct risk assessments, as this potentially amounts to a conflict of interest (Ross et al., 2008). We believe that an integral part of a comprehensive treatment program is an assessment that includes actuarially derived estimates of risk. Although we will outline the assessment battery that we use at the Regional Treatment Centre (RTC) later on, for the purpose of the current discussion we believe that high-intensity treatment programs that cater to the needs of high-risk, high-need offender groups should include an assessment of risk using actuarial assessment instruments. If such instruments are carefully chosen, they can provide the therapeutic staff with ideas as to which factors should be addressed as treatment targets. In keeping with the ethical guidelines of various colleges, however (for a discussion, see Evans, 2011), we are not recommending that following the completion of therapy these same therapists should contract to do a new assessment specifically for the judicial system.

## Characteristics of the treatment setting

In terms of setting characteristics there are a number of site-specific suggestions that likely increase the probability of the provision of effective therapy to such groups of clients. First, with reference to institutionally based programs, it is probably more effective for such treatment to be offered in a specialized inpatient setting where the clients' behavior can be monitored while they are not in group (see Lösel, 1998; Wong & Hare, 2005). Some of the high-risk clients we see are able to portray pro-social behavior for the few hours a day that they participate in therapy. We have found that it is very unlikely that such clients maintain such

behaviors all day and all night unless they are making genuine efforts to change. The RTC is set up as an independent unit within a maximum security psychiatric facility. The clients attending the program are brought to the RTC from their parent institution for the duration of therapy. This approach not only allows for close monitoring of those participating in therapy but also results in an increased level of comfort for those attending the program. For example, any concerns that the client may have at being labeled as a "sex offender" (which may place the client at risk of violence in a traditional institution) are virtually eliminated, as, by definition, everybody living on the treatment unit has been convicted of a sexual offense or has documented issues associated with inappropriate sexual behavior. Further, as treatment is provided in a psychiatric facility, clients also have more readily available access to psychiatric and other health care-related specialists (e.g., social workers, occupational therapists). As many of the clients who are treated on the RTCSOTP have long medical and/or psychiatric histories, the ability to see health care professionals more readily is a significant inducement for attending treatment at the RTC.

Given that the RTC is a health care facility, every attempt is made to engage all staff members to view themselves as part of the health care team. We have found that occasionally challenges arise in enlisting the aid of non-treatment staff (e.g., security, institutional management). Although there may be no simple solution to motivating some staff members to engaging our clients in a therapeutic manner, every attempt is made to foster such a perspective. We have found that the combination of both formal and informal communication works best at accomplishing these goals. Furthermore, we have found that security and other staff members begin to see that the frequency of problematic behaviors decreases the longer that our clients participate in therapy. These changes in client behavior frequently provide concrete evidence for the approach we have advocated.

In community settings, it is not typically possible to provide inpatient treatment with 24-hour supervision. It is generally considered best practice that high-risk, high-need offenders receive treatment in an institutional setting such as that described before being released to the community. We believe that it is also important, however, that certain safeguards be put in place when these clients are released to the community. A structured release is almost always preferred with such groups. In the community where the first author (Jeff Abracen [J.A.]) was the director of sex offender treatment for a number of years, when high-risk sexual offenders are released from an institutional setting, they are typically required to reside in a structured residence where security personnel are present in the evening. Such clients are typically assessed very shortly after release to determine what their ongoing treatment needs are, and whether there are any immediate management concerns.

As some of these clients have been in an institutional setting for many years, there are a multitude of possible concerns. These may range from issues that many living in the community do not consider (concerns about simply walking down the street as these clients are unfamiliar with traffic) to those of a more traditionally forensic orientation (who will they be having contact with, and are there any potential risks related to that contact?). We have found that helping clients to navigate these issues, from the seemingly banal to more complex issues, helps to provide a sense that the therapeutic team is there to help them re-integrate and not

simply to find reasons to suspend them. It is important that the team members actually believe that the best course of action is, barring serious difficulties, to maintain the client in the community. High-risk clients, when released to the community, are generally suspicious of the motives of correctional staff. Every effort should be made to provide these clients with clear guidelines regarding expectations, as well as what services can be provided in a timely manner.

Concerns that clients may have when released to the community should be addressed as quickly as possible. For example, many high-risk offenders believe that it will be impossible for them to find work. These clients are encouraged to meet quickly with staff who specialize in résumé writing and helping clients find training and employment opportunities. Where clients are unable to work due to physical or psychiatric disability, volunteer and pastoral care opportunities are discussed in detail. This approach provides clients with concrete examples of what resources the community can offer and hopefully encourages them to maintain their motivation to reside in the community.

We do not believe that it is appropriate to suspend clients simply for such issues as the presence of inappropriate arousal as we have seen occur in a variety of jurisdictions. Clients should be encouraged to share any inappropriate thoughts that they have had, as well as the frequency of these thoughts and the degree of intrusiveness they present. We have adopted the principle common to cognitive therapy practitioners that clients are not responsible for their thoughts but rather what they do with these thoughts. For clients who have struggled with inappropriate arousal, these issues are addressed in therapy. We have dedicated a chapter to the management of inappropriate arousal later in the text. For readers interested in particular psychologically based interventions for use in addressing issues of inappropriate arousal, please refer to the relevant chapter. We have also used sex drive-reducing medication in the management of inappropriate arousal. Although we have found such medications useful in practical terms, a cautionary note is in order in relation to such approaches. Hanson et al. (2009) noted that none of the medical treatments for use with sexual offenders met the minimum criteria associated with the guidelines established for their meta-analytic review of the literature. The limitations inherent in the design of such studies make any definitive conclusions regarding the use of such medications impossible.

In community settings, we have found it useful to have high-risk offenders sleeping at facilities where their behavior can be closely monitored. Although it is relatively easy for such clients to be unlawfully at large (in which case a warrant is issued for their arrest), the ability to monitor such clients provides staff with important information (e.g., have they returned to the residence obviously impaired by some substance?). In the Toronto, Ontario, area, where J.A. works, the only community correctional center (CCC; a secure halfway house) in the city is located adjacent to a police station. CCCs provide more security than other types of sponsored residences in the community. Many (if not all) of the higher-risk sexual offenders released to the Toronto area are required to reside at this CCC at least until a period of stability is achieved. Clients are also required to meet regularly with parole staff. We provide more detail in terms of the community management of high-risk offenders in Chapter 15. Although these security measures are in place, the goal is always to help the client move from the CCC to their

own residence as soon as it is feasible. Most of the high-risk offenders who are required to live at the CCC actually agree (albeit sometimes while complaining about the requirement) that it is better to be provided with food and shelter than to be released with no residence and no job. These clients are usually released with a condition to be seen by a psychologist and/or a psychiatrist unless they are released at their warrant expiry date (i.e., the very end of their sentence at which point Correctional Service of Canada has no jurisdiction over such cases). However, for groups of mentally disordered offenders, a program offered in conjunction with the Centre for Addiction and Mental Health has been instituted and this has resulted in the possibility of ongoing community care for at least some of the mentally disordered clients who are seen in the community after their warrant expiry date. We believe that there is a need for ongoing care for such high-need groups and that, in the interest of both community safety and appropriate client care, every attempt should be made to establish such links with community resources where possible.

## Conclusion

In summary, we advocate a therapeutic approach to treating and managing sexual offenders, which sees motivating clients for treatment, expecting and working with resistance, and using a non-confrontational approach as essential. High-risk, high-need sexual offenders offer a unique profile that requires patience, understanding, and flexibility to manage successfully in treatment. This, by necessity, requires therapists who are knowledgeable and skilled at establishing and maintaining rapport. A rigid, manual-driven approach to treatment is not recommended with such a client group.

# 5
# The Integrated Risk–Need–Responsivity (RNR-I) Model

Over the last number of years we have come to view the various treatment models of sex offending (and with reference to the treatment of high-risk high-need offenders more generally) as being inadequate for our needs. Ever since we produced treatment manuals for the Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP) in 2002 (Looman & Abracen, 2002), which was a reflection of our thinking from the mid-1990s to the time when the manuals were prepared, we have believed that addressing the principles of risk–need–responsivity (RNR) was necessary but not sufficient to meet the needs of the clients with whom we worked. Aside from incorporating issues associated with new domains, we believed that, even with reference to the "Big 8" criminogenic needs (Andrews and Bonta, 2010), there was a lack of attention being paid to the way in which risk factors interact with one another. Given the manner in which these factors were presented, it probably encouraged (albeit unintentionally) the view that risk factors could be treated in isolation from one another – that is, one could provide, for example, separate substance abuse, criminal associates, and criminal thinking programs (to name but three of the Big 8 risk factors) and that it somehow didn't matter that these factors never work in isolation in the real world.

Our clients tended to spend time with criminal associates, became influenced by the views of these persons and were reinforced for drinking and committing crimes with these persons. It was, in fact, our clients who complained about how artificial the risk factor-specific program approach appeared to be. Although they may not have welcomed the challenges that we made in the process of discussing their criminal backgrounds, they seemed to begrudgingly admit that this is exactly what they needed – a treatment program that dealt with the many issues they faced and that treated them as the complex persons that they, like all of us, are. All aspects of our program were geared to the integration of these many complex domains. That being said, given the fact that our program was, of necessity, time-limited, we focused only on those issues that we believed were important if we were to reduce a client's risk of recidivism. Further, we assumed that clients would not be "cured" when they left our programs – only that they would have the necessary skills on which to build a better life should they be motivated. At the same time, we were keenly aware that simply setting a series of positive goals was not sufficient to meet the needs of our clients.

Issues associated with criminal thinking and associates, substance abuse, and deviant arousal needed to be directly addressed. It has been our experience that simply stating that, because our clients have established positive life goals, their many criminogenic needs will in some way dissipate is too simplistic. Entire modules of the RTCSOTP are dedicated to addressing the criminogenic needs established by Andrews and Bonta (1998, 2010). In addition, individual therapy was used to supplement these group-based sessions, as the majority of our clients needed to spend more time addressing one or more topics than the group process permitted.

In the next few chapters of the book, we will outline the RNR-I and hope to demonstrate how it builds on the work on Andrews and Bonta, but incorporates recent developments in the clinical and forensic literature. We have also borrowed the very heuristic design that Beech & Ward (2004) developed for an earlier model they proposed. Although many elements of the RNR-I differ from those suggested by Beech & Ward (2004), we very much liked the fact that even a casual glance at the diagram they developed shows that risk factors interact with each other in meaningful ways and that these interactions must be considered in any assessment and treatment program developed for offender populations.

Unfortunately, no model is sufficient to emphasize the importance of the therapeutic alliance in working with the clients we treat. That being said, when one expands the list of factors that require attention to include such issues as complex trauma, we hope that it becomes obvious that no treatment program is likely to be effective if our clients are treated in confrontational and demeaning ways. Such "tough on crime" approaches might be rationalized if the only relevant goals are stated to be factors such as criminal thinking (e.g., cognitive distortions) or criminal associates, but much harder to rationalize if our clients also present with serious issues associated with abuse, neglect or mental illness. Andrews and Bonta (2010) have argued that "personal distress" is not a criminogenic risk factor. They may be correct in this assumption. However, as the data reviewed in the following chapters will indicate, our clients present with much more than "personal distress," a poorly defined term that seems to allow clinicians to distance themselves further from the clients with whom they work.

We include a chapter on the Good Lives Model (Chapter 8) and explain why we do not believe it is adequate to meet the needs of the clients with whom we work. Nevertheless, one significant contribution of the model is that, like the RNR-I, it views the clients with whom we work as more than criminals. Our clients' needs cannot be reduced to eight treatment targets (i.e., the "Big 8"; Andrews and Bonta, 2010) that, once addressed, somehow suggest that the client is fixed. Although this approach has been associated with small to medium effect sizes in terms of the impact of such programs on recidivism, we believe that further progress is possible. As we argue later in the book, we believe that RNR-I represents one such way forward.

# 6
# Etiological Factors
## *Attachment Theory and Complex Post-Traumatic Stress*

While sexual offending is a multiply determined phenomenon, there are three factors in particular that inform our perspective on sexual offending. These are attachment theory (Bowlby, 1969 ; Bartholomew & Horowitz, 1991 ; Main, 1996 ), complex post-traumatic stress disorder (PTSD; Courtois & Ford, 2009 ), and a history of mental disorders. Each of these factors will be reviewed in detail in this chapter, as they are essential to our understanding of sexual offending. As we have noted in Chapter 5, however, the risk–need–responsivity (RNR) principles established by Andrews & Bonta (1998, 2010) and the "Big 8" dynamic risk factors are still important in understanding the genesis of violent and sexual offending. It is just that these risk factors have received a great deal of attention in the clinical literature and do not require additional attention, at least so far as establishing that they are clearly associated with risk of recidivism in the empirical literature. We discuss one of the Big 8 risk factors in Chapter 8, which is specifically dedicated alcohol and drug abuse. In discussing the program content we hope that it will be obvious how some of the other Big 8 risk factors (e.g., criminal thinking, criminal associates, criminal personality, family and marital situation) are addressed. Although Andrews and Bonta are to be credited for demonstrating just how important these factors are, they have not, at least in our view, shown how risk factors interact with one another. For example, the link between complex trauma, negative emotionality, and substance abuse has been examined by any number of researchers, yet the connection between these factors has not been discussed by Andrews and Bonta, presumably because they view such issues as complex trauma and serious mental illness as non-criminogenic.

It should also be mentioned that the model does incorporate issues associated with such factors as neurophysiological factors in the etiology of sexual offending. That said, we do not believe that such issues have been developed to the point where specific techniques deriving from this research can be applied in practice to typical high-risk offenders. These issues have been incorporated into the developmental factors of the Integrated Risk–Need–Responsivity (RNR-I) model. It should be noted that even Bowlby, in some of his earliest writings (Bowlby, 1969 ), emphasized that neurological issues are certainly involved in the attachment process. He suggested that future research will further develop links between neurological factors and attachment-related issues. Beech et al. ( 2012 ) provided a much more current review of the role that such neurological factors play with reference to forensic matters. Although these issues are not discussed in detail here, the reader should keep in mind that many of the issues that are discussed here regarding the details of the RNR-I are, in some way, related to neuropsychological and physiological issues. For example, the many health problems that our clients experience as they age may be in some way related to the desistance in offending that has traditionally been observed in the forensic literature. Alternately, the violent histories that

many of our clients present with may be associated with neurological injury, particularly in the temporal lobe, which has been associated with emotionality. Having noted that these developmental issues are relevant to understanding much of human behavior, we will begin by discussing the research that supports specific psychological factors about which there is clear evidence regarding their link with violent and/or sexual offending. We begin by discussing the role of attachment theory in the understanding of sexual offending.

## Attachment theory

Briefly, attachment theory was developed by Bowlby (1969, 1973, 1980) with children, though it has been refined and extended to adults. An attachment is "an affectional tie in which one individual takes another as a protective figure, finding increased security in their presence, missing them in their absence, and seeking them as a haven in times of alarm" (Main, 1996 ). When children form secure attachment bonds, they develop the necessary skills to establish close relationships and grow to desire intimacy with others. If these bonds are insecure, children do not develop the necessary skills and may grow either to fear intimacy or to seek intimacy in maladaptive ways (Bowlby, 1969, 1973). Although there are a variety of pathways to the development of insecure patterns of attachment, a history of abuse or neglect can be related to the formation of insecure attachment patterns.

Marshall (1989, 1993) has suggested that insecure patterns of attachment are related to the development of a number of difficulties later in life, including problems associated with intimacy and consequent feelings of loneliness. Marshall (1989, 1993) further suggests that men who eventually commit sexual assault may confuse intimacy with sexuality, thus compounding these difficulties. By confusing sex with intimacy, these men may display persistent promiscuity and may seek to expand their range of sexual behaviors or sexual targets. Difficulties associated with the development and maintenance of intimate relationships are therefore central to Marshall's perspective.

Marshall's perspective has been refined in subsequent years (e.g., Ward et al., 1995, 1996 ). Ward et al. (1995), for example, have argued that Bartholomew and Horowitz's ( 1991 ) model of adult attachment may provide a useful extension of Marshall's theory. Bartholomew & Horowitz ( 1991 ) suggest that there are four patterns of adult attachment – secure, preoccupied, dismissive, and fearful – which largely correspond to those observed among children and their parents.

Ward et al. ( 1997a ) have gone so far as to suggest that attachment patterns may be a better way of classifying sexual offenders than offense types. Ward et al. (1995) have suggested that specific insecure attachment patterns may be associated with particular patterns of sexual offending (see Table 6.1 for insecure attachment types). For example, the preoccupied attachment style might be related to sexual offenses during which the individual seeks to establish non-threatening, intimate relationships with victims. The fearful type of insecure attachment would identify sexual offenders who engage in impersonal and single contact encounters with victims. The last type of insecure attachment, the dismissive type, would be

predicted to engage in more aggressive forms of sexual violence, given their positive view of self and negative view of others (such individuals are also described as being uncomfortable with emotions).

Table 6.1 Features of the different insecure attachment types

| ***Insecure attachment types*** | ***Typical features*** |
|---|---|
| Preoccupied | A negative self-concept, positive view of others, and a proneness to having intense emotional relationships, but also to frequently changing partners |
| Fearful type | Negative self-concept, as well as a negative view of others combined with a fear of trusting, though such individuals would like to have emotionally close relationships |
| Dismissive style | Positive view of self, negative view of others; desire a high degree of independence |

There are a number of advantages to Marshall's theory and the elaboration provided by Ward et al. (1997). First, by linking sexual assault to attachment disorders in adults, the vast literature on attachment becomes relevant to an understanding of sexual assault. Further, many of the hypotheses derived from attachment theory lend themselves to empirical scrutiny. In fact, Marshall should be credited for undertaking a lengthy series of studies on aspects of this theory (for reviews, see Marshall et al., 2006, 2011 ; Ward et al., 2006 ). In addition, Marshall has provided examples of how concepts such as insecure attachment can be incorporated into contemporary, cognitive-behavioral treatment programs (Marshall et al., 2006 ).

Ward et al. ( 2006 ) noted that research regarding whether specific patterns of attachment are related to particular types of sexual offending has received mixed support in the literature. Perhaps some of the inconsistent findings are related to measurement differences, with some studies using brief pencil-and-paper measures of attachment style, whereas others have used comprehensive interview schedules such as the Adult Attachment Interview (AAI for a discussion, see Stirpe et al., 2006 ). Using the AAI, an interview-based measure of attachment with sound psychometric properties, Stirpe et al. ( 2006 ) compared groups of sexual, non-sexual violent and non-violent offenders. It was observed that child molesters were most likely to display a preoccupied pattern of attachment. Rapists, violent offenders and, to a lesser extent, incest offenders were more likely to be classified as dismissive. Although still most likely to be dismissive, non-violent offenders were comparatively more likely to be Secure. Ward et al. ( 1996 ), using several paper-and-pencil measures to assess attachment style, found that the majority of sex offenders were insecurely oriented to adult intimate relationships. However, these authors observed that this same finding applied to other groups of offenders and therefore likely represented a general vulnerability factor towards criminality. Nonetheless, Ward et al. did observe some differences between groups depending on the measure used. For example, they observed that child molesters were more likely to be classified as preoccupied than either violent or non-violent non-sex offenders, although there

were no significant differences between child molesters or rapists on this scale. Abracen et al. ( 2006 ) also observed a tendency for child molesters to be more preoccupied. In contrast to Ward et al. ( 1996 ) and Abracen et al. (2005), Sawle and Kear-Colwell ( 2001 ), using self-report data, observed a tendency for pedophilic offenders to be more dismissive in their attachment style.

From our perspective, the available evidence suggests that attachment disorganization generally, as opposed to a particular insecure attachment style, may characterize sexual offenders (e.g., see Burk & Burkhart, 2003 ). That is, the distinction between secure and insecure attachment may be the dimension of interest. Beech & Ward ( 2004 ) as well as others (e.g., Abracen et al., 2004 ) have suggested that sexual offending is multi-determined and that no one factor can account for the origins of sexual offending. Insecure attachment alone is not sufficient to produce sexual offending. Therefore studies that only examine patterns of attachment difficulties in sexual offenders and other high-risk populations will likely result in mixed results, though we suspect that research will continue to support an association between insecure patterns of attachment generally and sexual offending. A variety of other factors have clearly been linked with violent behavior generally and sexual offending specifically. It is likely that a constellation of factors account for specific patterns of sexual offending. For example, substance abuse has been found to be an important factor in sexual offending (see Chapter 12 for a detailed discussion). The fact that disorganized attachment (one type of insecure attachment) has been linked to the use of hard drugs, such as heroin, cocaine, and hallucinogens (Allen et al., 1996 ; Rosenstein & Horowitz, 1996 ), and neurological dysfunction (for a review see Creedon, 2009 ) suggests that attachment insecurity may be both directly and indirectly related to a variety of other known risk factors for sexual offending. Further, as discussed in the following section, physical and sexual abuse (which are strongly associated with the development of insecure attachment patterns) may be related to the development of deviant fantasies (Knight & Sims-Knight, 2004 ).

In keeping with our perspective, Ward et al. ( 2006 ) note that Marshall's theory regarding attachment style represents a single-factor theory and consequently cannot be viewed as a comprehensive discussion as to the causes of sexual offending. Although we agree with this critique, it should be noted that Marshall and his colleagues have, from our perspective at least, offered persuasive evidence that both negative emotionality and difficulties establishing and maintaining intimate relationships are, in fact, criminogenic needs which require both accurate assessment and specific treatment interventions. Both of these risk factors have been clearly linked to attachment difficulties and this position has been support by recent meta-analytic reviews (e.g., Mann et al., 2010 ). As such, our assessment battery contains measures that assess these domains.

Recent evidence underscores the idea that promiscuous sexual behavior may be related to sexual offending. Peterson et al. ( 2010 ), for example, observed that the number of one-night stands was associated with sexual aggression history even after controlling for age, alcohol use, and sexual excitation and inhibition. The sample in this study consisted of 1,240 self-identified heterosexual men who completed an online questionnaire posted on the website of the Kinsey Institute for Research in Sex, Gender and Reproduction (see also Långström &

Hanson, 2006 ). These data, along with other results discussed here, suggest that insecure patterns of attachment may be related to the development of promiscuous sexual behavior, the development of paraphilias, and ongoing issues with sexual aggression more generally. Although more work is clearly needed in this area, it may be that insecure patterns of attachment generally represent a risk factor for a variety of potentially problematic sexual behaviors, some of which may be related to sexual offending specifically.

A recent meta-analysis and two comprehensive reviews (one by researchers at the Centers for Disease control and Prevention [CDC] in the United States) have emphasized the important role that attachment disorders/history of abuse have with reference to violent offending. Ogilvie et al. ( 2014 ) examined whether attachment was associated with violent offending using meta-analytic procedures. The results of this study found that insecure attachment was strongly associated with all types of criminal behavior including sexual assault and domestic violence. Of interest, the authors note that all studies that examined mentally disordered offenders compared with psychiatric controls found findings in the expected direction (i.e., offender populations were more likely to be insecurely attached overall). The proportion of clients in each group were also found to differ. Offenders with mental illness were more likely to be classified as dismissing, whereas non-offending psychiatric controls were more likely to be classified as preoccupied.

A second review of the association between attachment and physical violence focused on children and adolescents (Savage, 2014 ). The findings were in keeping with the data reported by Ogilvie et al. ( 2014 ). As noted by Savage ( 2014 ), the findings overall suggest a very consistent association between indicators of insecure attachment and violent behavior. The association also held after a variety of variables were controlled for statistically (e.g., history of abuse, which is closely correlated with insecure patterns of attachment). As noted by Savage ( 2014 ), this finding applied to both males and females and across cultures.

Tharpe et al. (2013) completed a comprehensive review of the literature on risk and protective factors associated with sexual offending. These authors found that childhood abuse (which is highly correlated with insecure attachment) is strongly related to violence perpetration. With reference to sexual violence, these authors found that the link was most clear for emotional abuse, but only a few studies had been reported in that area. Issues associated with multiple sexual partners, sex drive, and arousal to deviant stimuli were also strongly related to sexual violence. Although several of these researchers are affiliated with the CDC, it is not clear from the manuscript whether these conclusions have been accepted by the CDC. If accepted by the CDC as being of etiological significance, we would consider this perspective to be very progressive and of relevance in moving the field forward given the influence of the CDC on public policy.

Recent research by McKillop et al. ( 2012 ) suggests that attachment may be somewhat more fluid than previously thought and that attachment insecurity must be understood in relation to situational factors in order to more fully understand the relationship between attachment and sexual offending. For example, these authors have suggested that more attention should be paid to acute or transient attachment problems. They also suggest that attachment may be both

directly and indirectly associated with offending behavior.

## Complex post-traumatic stress disorder

Although we are not familiar with any writings specifically linking Marshall's theory and its refinements to research in the area of complex traumatic stress disorders (complex PTSD; for a review of developments in this area, see Courtois & Ford, 2009 ), we believe that work in the area of complex PTSD offers a reasonable extension of Marshall's work in the area of attachment difficulties, at least as applied to high-risk, high-need offender populations. In fact, the links between complex trauma and attachment difficulties are specifically discussed in such literature (e.g., Brown, 2009 ). As we shall hopefully demonstrate, complex PTSD is relevant to the understanding of high-risk groups of sexual offenders. Further, if true, this will have implications for which assessment measures should be administered and the treatment program itself.

As noted by Courtois and Ford ( 2009 ), complex psychological trauma involves traumatic stressors that: are repetitive and prolonged; involve direct harm or neglect and abandonment by caregivers or ostensibly responsible adults; occur at developmentally vulnerable times in the victim's life; and have the potential to severely compromise a child's development. The consequences of such trauma are equally complex and may include difficulties in the area of affect regulation as well as identity and relational disturbances and disorganized attachment patterns. Somatic distress is also described as a common feature of such disorders. This is also consistent with our observation of the offenders being treated in our program. Anecdotally, these men present with many medical complaints, such that the nurses assigned to the unit have noted that they require a greater proportion of the physician's time than other offenders in the Regional Treatment Centre (RTC) in Ontario. The frequency of abuse and neglect that we have encountered in the population with whom we work is sufficiently large to suggest that, at least for a proportion of our clients, the concept of complex trauma provides a reasonable integrative framework for understanding the broad range of problematic behaviors that we have encountered. With reference to the RTCSOTP, we have presented data that demonstrate that having had a history of sexual abuse was significantly associated with number of sexual assault convictions (Looman & Abracen, 2013b ). Those clients who experienced sexual abuse (but not physical abuse) had an average of 5.51 previous sexual offense convictions, as compared with 2.94 for those with no history of physical or sexual abuse. These difference were statistically significant.

Common sequelae to complex PTSD include frequently encountered difficulties seen with high-risk, high-need forensic populations: a substantial problem with substance abuse disorders, a history of anger management problems, and diagnoses of personality disorders. Resistance to treatment is also characteristic of such populations. Many clients who are later diagnosed with complex PTSD suffer from a variety of co-morbid conditions.

Given such histories, it is not surprising that Brown ( 2009 ) has offered an attachment framework to help organize the assessment and sequelae of complex trauma. As noted by Ford

and Courtois ( 2009 ), the definition of complex trauma goes well beyond the classic clinical definition of what is traumatic and beyond the three symptoms classically associated with PTSD (i.e., intrusive re-experiencing of traumatic memories, avoidance of reminders of traumatic memories and emotional numbing and hyperarousal). Complex trauma disorders often involve a combination of other disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and often comprise both Axis I and Axis II disorders listed in DSM-IV-TR as well as Axis III physical health problems and Axis V psychosocial impairments.

Recent evidence suggests that complex or repetitive trauma is much more common than previously recognized (i.e., affecting as many as one in seven to one in 10 children) and often involves a fundamental betrayal of trust because it is perpetuated by someone known by or related to the victim (for an extended discussion see Ford & Courtois, 2009 ). Young children exposed to betrayal trauma (which may comprise various forms of abuse) by caregivers often develop a disorganized/dissociative attachment style in childhood and an adult attachment style described as fearful/avoidant/dissociative (Lyons-Ruth et al., 2006 ). These are just the attachment patterns typically observed in groups of high-risk, high-need offender populations. Although some contradictions in the literature exist as to which specific type of insecure pattern of attachment particular groups of sex offenders belong, there is consistency with reference to the finding that sex offenders tend to be insecurely attached.

Earlier attempts to distinguish between different groups of offenders based on differences in attachment pattern may not have resulted in inconsistent findings, due to the fact that so many of these offenders have experienced complex trauma. Given the variety of circumstances that may lead to complex trauma, it might be predicted that a variety of insecure patterns of attachment could result from diverse dysfunctional environments. It may be less relevant to use attachment pattern *per se* to classify groups of sexual offenders than it is to understand that complex trauma can lead to a variety of difficulties in the area of behavioral disinhibition and emotional dysregulation. A variety of idiosyncratic factors may result in different classes of violent behavior. Based on our review, we would suggest that that abuse and neglect that result in significant intimacy deficits and more broad-based difficulties in the area of emotional regulation and attachment disorders may be a predisposing factor related to ongoing problems with violent behavior. However, other known risk factors for criminal behavior generally (e.g., pro-criminal associates, attitudes, and personality features, past criminal history, poor employment history) would need to be evident for the repetitive pattern of violent and sexual offending seen in the populations that we treat.

# 7
# Combining Attachment Theory and Complex Post-Traumatic Stress Disorder and Theories of Sexual Offending
## *The Integrated Risk–Need–Responsivity (RNR-I) Model*

We believe that a new model of sexual offending is needed, one that incorporates issues associated with insecure patterns of attachment, intimacy deficits and serious mental illness, as well as the "Big 8" risk factors identified by Andrews and Bonta. We have called this new approach to assessment and treatment the Integrated Risk–Need–Responsivity (RNR-I) Model ( Looman & Abracen, 2013a; Abracen & Looman, 2013). As well as incorporating a variety of new risk factors, there is a renewed emphasis in the model on issues associated with the therapeutic alliance and respect for the client's mental state. We believe that these issues, although discussed by Andrews and Bonta, have been largely neglected both in the clinical literature and in the RNR Model specifically. Consideration of issues associated with a client's mental state become particularly acute if one considers serious mental illness and attachment difficulties to be as significant in the prediction of sexual or violent offending as some of the more traditional risk factors (e.g., history of antisocial behavior). We have included the RNR-I Model in Figure 7.1. For readers interested in a more detailed discussion regarding the origins of the model, we have published two reviews (Abracen & Looman, 2013; Looman & Abracen, 2013a) that specifically discuss our approach and why, at least in our view, it is more practical than alternative perspectives such as the Good Lives Model (GLM). In terms of the general organization of the RNR-I, some of the earlier work by Beech & Ward (2004) proved to be quite useful as a starting point. That said, as we shall demonstrate, issues related to complex trauma and serious mental illness as well as protective factors (e.g., social support) have been added to the model.

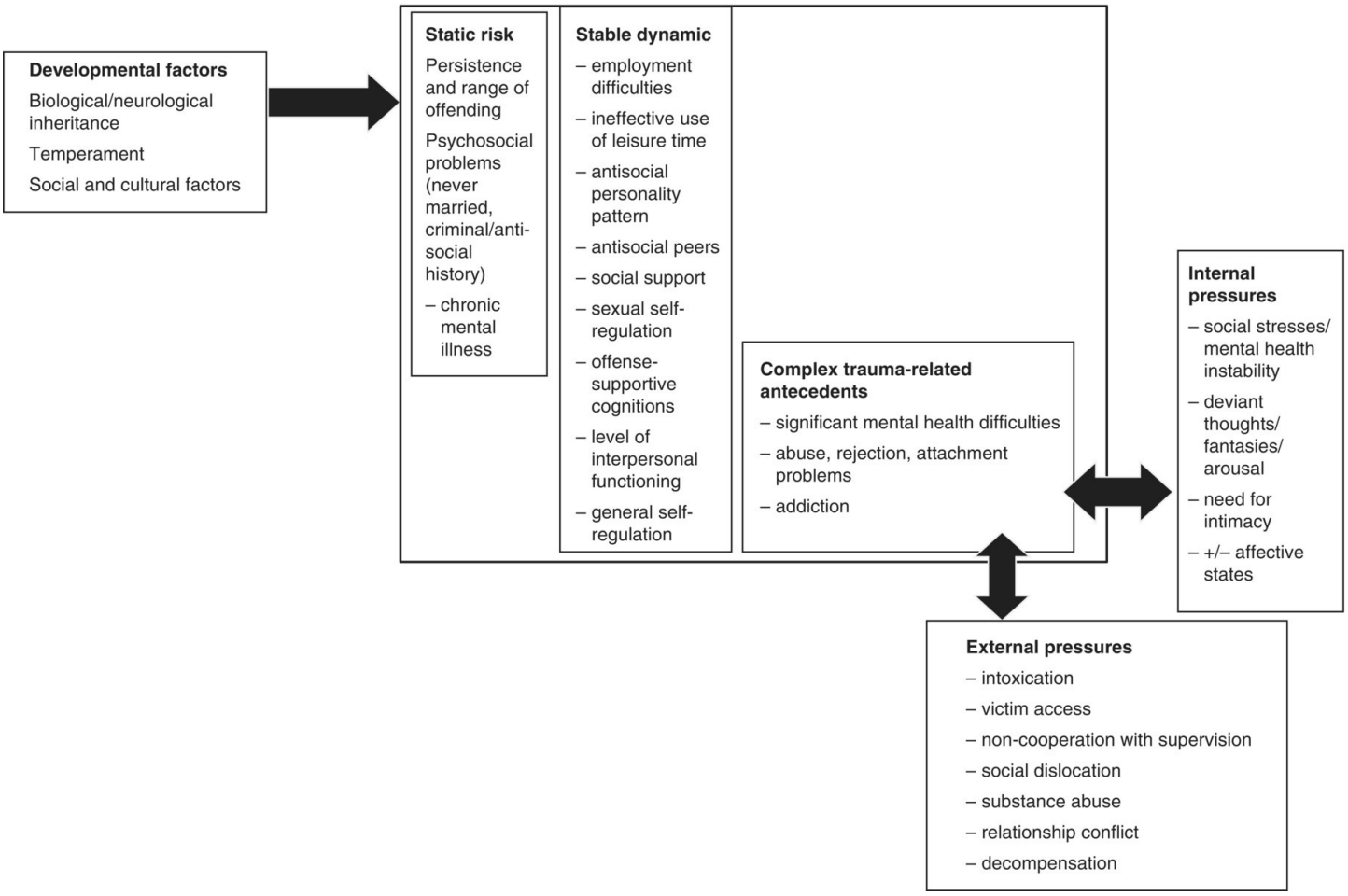


**Figure 7.1** Integrated Risk–Need–Responsivity (RNR-I) Model

Beech & Ward (2004) have provided a comprehensive etiological framework for sexual offending which we believe is quite heuristic. Beech and Ward's theory, which incorporates many of the strengths associated with previous models of sexual offending and addresses several shortcomings associated with these earlier models, identifies distal factors, vulnerability (trait) factors, and state factors which, in combination with triggering events, help to determine an offender's level of risk for sexual offending.

As opposed to single-factor theories of sexual offending, which focus on only one class of factors (e.g., issues associated with inappropriate sexual arousal, intimacy deficits, but see Ward et al., 2006 for a comprehensive discussion of single factor theories) Beech and Ward (2004) offer a broad-based perspective. In addition, the model incorporates situational factors, which we believe is a central issue in any perspective that hopes to be of value to those tasked with working with sexual offenders.

Although Beech and Ward have since developed new models of sexual offending (e.g., Ward et al., 2006), the newer approach developed by these authors, although potentially more comprehensive, does not offer enough detail regarding specific factors that need to be assessed when working with sexual offenders. The earlier model developed by Beech & Ward (2004) has the potential advantage (at least from a clinical perspective) of being more prescriptive in terms of which specific factors need to be taken into account when working with sexual

offenders. The newer model, in attempting to be theoretically more inclusive regarding what general topics are relevant to sexual offending, may not be sufficiently prescriptive regarding what specific issues actually need to be assessed when working with sexual offenders. It is also not clear how the newer model is linked conceptually with Ward's Good Lives Model (GLM; e.g., Ward & Maruna, 2007) of sexual offending.

With reference to the earlier model (Beech & Ward, 2004) the authors describe internal and external "triggers." We agree that dynamic and/or situational factors should be included in any clinical model of sexual offending. However, we do not agree with the use of the term "triggers." We have instead used the term "pressures" to describe these situational or dynamic risk factors that may be related to sexual offending. We also include items (e.g., in relation to serious mental illness, complex trauma) not included in Beech & Ward's model.

Although the difference between the term "triggers" and "pressures" may seem semantic to some, we believe that there are fundamental differences between these two perspectives. The use of the term trigger implies that when such a situational factor is present, the client is at immediate risk of committing a sexual offense. When one uses the term trigger, it implies that the situation must be managed very aggressively. To give a practical example of what we are discussing, both of the authors have been involved in situations (in at least two correctional jurisdictions) where clients are suspended (i.e., returning them to secure custody) for indicating that they had been experiencing deviant fantasies.

It is our perspective that immediately suspending a client for discussing deviant arousal is counter-productive for a number of reasons. From a purely behavioral perspective, we are punishing clients for disclosing the very thoughts that we are interested in hearing. It is not hard to see the connection between punishing clients for disclosing an inappropriate fantasy for which they are returned to prison and their refusing to discuss such matters with professional staff in the future.

As we discuss in Chapter 13, on deviant arousal, such fantasies may be indicative of difficulties in a number of important domains included in the RNR-I. Inappropriate fantasies may be used as a type of self-soothing to deal with more profound difficulties in the area of mental illness. Alternately, this may be the first sign that clients are experiencing issues with negative emotionality (e.g., loneliness) or have been placing themselves in high-risk situations (i.e., in proximity to children). These issues need to be explored therapeutically with clients. Although there are times when there are so many risk factors present that one has little choice but to suspend a client, this should be avoided whenever possible. Inappropriate fantasies represent an opportunity for treatment staff to intervene in moments where clients may be particularly sensitive to the feedback we have to offer. Doing so in a collaborative and sensitive manner offers clients an opportunity to grow in important ways. Of course, the opposite lesson can also be learned when we punish clients for disclosing such issues as negative emotionality or inappropriate fantasies.

It should also be emphasized that if we are to understand sexual offending in terms of both the Big 8 risk factors discussed by Andrews and Bonta and trauma/serious mental illness, then issues associated with the therapeutic alliance need to be considered very carefully. However,

the question as to how serious an issue is trauma for the clients with whom we work can be asked. In short, if the issue only applies to a small minority of our clients, then why should it be a focus in a model of sexual offending. We agree that this is a very reasonable question. We will turn our attention to this matter now.

In order to investigate whether complex PTSD applies to the population we work with, we have collected assessment data for many years related to a history of having experienced and/or witnessed physical or sexual abuse while growing up. Whether the abuse, be it experienced first-hand or as a witness, was a repeated experience or based on a single incident was also recorded. Data were available for 438 clients who were assessed and/or treated at the Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP). Over 40% of the offenders (42.2%, 185/438) reported having been the victim of sexual abuse, typically at an early age. Over 60%percent of those who reported sexual abuse, and for whom such data were available, indicated that there were multiple episodes of sexual abuse (63.3%, 119/188). Approximately 50% of clients reported a history of physical abuse (49.5%, 217/438). Virtually all of the clients who reported physical abuse, and for whom data were available, said they had experienced multiple episodes of abuse (96.4%, 212/220). When examining whether or not offenders reported both physical and sexual abuse, 29.3% reported having experienced both, while 66.4% reported experiencing either physical or sexual abuse. Even relative to the most liberal estimates of physical and sexual abuse reported among the population at large such data are alarming and underscore the relevance of assessing for a history of abuse when working with high-risk, high-need populations. Craissati and McClurg (1997) also reported that one of the strongest predictors of attrition in sexual offender treatment was a history of childhood sexual victimization, underscoring the importance of this issue. We are not alone in showing the association between a history of abuse and sexual offending. Jespersen et al. (2009) have produced a meta-analytic study showing the association between a history of sexual abuse and sexual offending. The authors conclude that there is support for the sexually abused sexual offender hypothesis based on their review of the literature. This conclusion was based on studies comparing sexual with non-sexual offenders with reference to history of sexual abuse.

Knight & Sims-Knight (2004) have also produced intriguing data related to adolescent sexual offenders, showing that a history of abuse may be indirectly associated with the development of inappropriate fantasies. The use of adolescent data by Knight & Knight (2004) is interesting in that allows for the examination of such issues at a closer proximity in time to when the individual may have experienced the abuse. Levenson (2014) notes that a history of child abuse is common among offender populations, although the prevalence rate can vary depending on how the variables are defined.

Ford et al. (2012) have also demonstrated that complex trauma appears to be associated with aggression in secure juvenile justice settings. Further, Ford et al. (2010) discuss the role that poly-victimization may play in psychiatric impairment and delinquency. These authors, using data from the National Survey of Adolescents in the United States, observed that poly-victimization was a stronger predictor of delinquency than even well-known risk factors such as alcohol and drug abuse. The authors summarize their findings by noting that “poly-

victimization thus is a distinct threat to adolescents' health and development" (p. 549). Farrington (2006) has also noted that physical abuse appears to be related to the affective dimension of psychopathy. In fact, data are reviewed from a longitudinal study conducted in London, England (the Cambridge Study in Delinquent Development), suggesting that physical neglect as a child is one of the strongest predictors of high levels of psychopathy as an adult and appears to be as powerful a predictor as having a father or mother who had been convicted of criminal behavior.

It is perhaps not surprising in this regard that some authors (e.g., Levenson, 2014) have suggested that sex offender treatment should begin to adopt trauma-informed care into evidence-based sex offender treatment programs. Among other reasonable suggestions offered by Levenson (2014) are the use of non-destructive means of managing emotional needs and the need for interpersonal skills training. These two topics (emotion management and interpersonal skills) have been core components of the RTCSOTP even prior to the production of the 2002 version of the treatment manuals used at the RTC (Looman & Abracen, 2002). Of course, trauma may also be related to criminal behavior indirectly via the impact it has on mental illness. We will now turn our attention to issues associated with mental illness with a view to understanding the important relationship between mental illness and criminal behavior. It is our perspective that in large measure, due to the insistence by Andrews and Bonta that mental illness does not represent a criminogenic need area, this important dimension has not been incorporated into contemporary models of offender management. We will now review the evidence in favor of our contention that mental illness does indeed represent a criminogenic need area.

## Mental illness

The rates of mental illness are also very high for our clients. From the same dataset as reported in the previous section, information was retrieved from health care and other available file information regarding psychiatric diagnoses. It should be emphasized that these percentages are probably underestimates of the true rate of mental illness among this population, as these data were based on file reviews, not actual diagnostic assessments, and not all of the clients who are treated at the RTCSOTP are assessed psychiatrically. With reference to having received any type of psychiatric treatment, data were available on 405 clients. Of these clients 39.5% ($n$ = 160) had no evidence of assessment or either inpatient or outpatient psychiatric treatment. Over 30% of the sample (33.6%, $n$ = 136) had at least a history of psychiatric assessment, whereas 21.5% of the sample ($n$ = 87) had a history of inpatient treatment. Approximately 5% of the sample had a history of outpatient treatment (5.2%, $n$ = 21). With reference to specific diagnoses listed on file, data were available for 395 clients listed above. For the clients for whom data were available, 65.8% met *Diagnostic and Statistical Manual of Mental Disorders* (DSM) criteria for a mental illness. Almost 30% met criteria for a personality disorder (28.9%, $n$ = 114) and almost 15% met criteria for both a personality disorder and a paraphilia (12.9%, $n$ = 51). Although the recorded rates for alcohol abuse disorder were quite low (approximately 6%), these data are almost certainly a dramatic

underestimate of the true rates of alcohol abuse disorder, as the forensic psychiatrists who typically complete these assessments seem to rarely make substance-related diagnoses despite the offender's significant substance use/abuse histories. For example, scores on the Michigan Alcohol Screening Test (MAST; Selzer, 1971) were available for 533 clients in the dataset. The mean MAST score (indicative of lifetime problems related to alcohol use) was 7.9. Scores of 4 and above are indicative of alcohol problems. That is, the average client seen had fairly substantial lifetime histories of alcohol abuse even using a more conservative scoring procedure than originally advocated for use with this measure (please see description of the MAST in Chapter 8). On the Drug Abuse Screening Test (DAST; Skinner, 1982; see below for a description of this measure), data were available on 535 offenders. The mean score on this measure (which assesses lifetime history of drug abuse) was 5.3, where scores of 6 and above indicate at least moderate difficulties with drug abuse.

The presence of multiple diagnoses, as opposed to one diagnosis in isolation, may be related to increased risk of recidivism. Data collected by our team underscore this point. Abracen and Looman (2006), for example, examined a sample of 188 clients seen at the RTCSOTP who scored 5 or above on the Static-99 (corresponding to a moderate-high risk of sexual or violent recidivism). We observed that over 20% of the sample met diagnostic criteria for both a personality disorder and a paraphilia (20.6%). Those with both a personality disorder and a paraphilia reoffended at significantly greater rates than the remainder of the sample; however, neither a diagnosis of a personality disorder alone nor a paraphilia without a pre-existing personality disorder was related to significantly elevated rates of recidivism. Diagnostic information related to other psychiatric conditions were not collected for the purpose of this study. A more recent investigation by our team (Wilson et al., 2010) also observed that a diagnosis of a paraphilia alone did not add to prediction over and above the use of an actuarial instrument designed to assess risk of sexual offense recidivism.

Looman and Abracen (2013) examined the extent to which data concerning psychiatric history added to the prediction of recidivism. Using 244 released offenders and the history of psychiatric assessment or treatment noted earlier, Looman and Abracen (2013) found that whether or not the offender had a history of psychiatric involvement significantly added to the prediction of sexual recidivism obtained by the use of actuarial risk assessment measures (i.e., the Static-99R). We have also demonstrated that there are very high rates of mental illness among offenders living in the community (Abracen et al., 2012, 2014). For example, Abracen et al. (2014) investigated a group of 136 consecutive admissions to a community correctional center (CCC) in the Greater Toronto Area. All offenders who spent at least one night in the facility in fiscal 2007–08 (i.e., April 1, 2007–March 31, 2008) were included in the dataset. A conservative strategy was used to assess diagnostic information in that only information regarding the 5-year period prior to arriving at the CCC and up to the point of data collection was used for the purpose of coding psychiatric history. Only information contained in reports by registered mental health professionals was used for the purpose of coding psychiatric data. In spite of this conservative strategy, approximately 20% of the CCC population evidenced a history of psychotic behavior within 5 years of arriving at the CCC. Approximately 20% of the sample also had been diagnosed with attention deficit hyperactivity disorder (ADHD). Over

55% of the sample evidenced a diagnosis of one or more personality disorders, although this estimate was certainly an underestimate of the true rate of personality disorder among the population, as many of the clients had not been assessed by a mental health professional. In addition, the contract psychiatrist who works at the CCC has noted to one author (Jeff Abracen [J.A.]) that he rarely included diagnoses of antisocial personality disorder (APD) in his reports, as the vast majority of the clients he assesses would meet diagnostic criteria for APD. When the association between specific diagnoses and recidivism was examined, both borderline personality disorder and ADHD were found to be significantly associated with recidivism. Clients who were diagnosed with a paraphilia, on the other hand, were significantly less likely to recidivate. Although it is unclear why this is the case, it is possible that treatment may have contributed to this finding, as the vast majority of these paraphilic clients attended psychological counseling sessions.

In a more recent study involving these 136 offenders housed in the CCC (Abracen et al., 2015), those offenders who were only assessed for psychological treatment or who received no treatment were compared with those who received a moderate dosage of treatment (less than 20 individual therapy sessions) or who received a high dosage of treatment (20 or more individual therapy sessions). Results indicated that the moderate dosage of treatment was associated with approximately eight times less likelihood of recidivism and that a high dosage of treatment was associated being 11 times less likely to recidivate. As the first author (J.A.) oversaw all individual treatment, all therapy was delivered in accordance with the RNR-I principles described earlier.

These findings are consistent with other results emerging in the literature. For example, Hodgins et al. (1998) argued that the available evidence suggests the prevalence of violent behavior is higher among persons suffering from major mental disorders than among non-disordered community controls. although they caution that many of the studies reviewed are based on self-report data. However, they offered a suggestion which we believe is increasingly supported by the literature; that major mental illness, in combination with substance abuse disorders, may be strongly related to violent crime. Dunsieth et al. (2004) reported very high levels of psychiatric disturbance in a group of 113 men convicted of sexual offenses. For example, 85% of those included in the study had a substance use disorder, 58% had a mood disorder, and 35% a bipolar disorder. Of relevance, these authors noted very high rates of co-morbidity among this group. Similar findings with reference to co-morbidity were observed by Carlstedt et al. (2009). Unfortunately, these authors did not discuss the association between these conditions and recidivism. Långström et al. (2004), however, demonstrated in a group of sexual offenders that alcohol use disorder, drug use disorder, personality disorder, and psychosis all increased the risk of sexual offense recidivism. These authors suggest, based on the longitudinal assessment of a large cohort of offenders in Sweden, that psychiatric morbidity be considered a risk factor for continued criminal offending.

When one looks at the forensic literature more generally, there is also abundant evidence that mental health issues appear to be related to criminal behavior. Although we agree with Andrews and Bonta (1998, 2003) that earlier research did not support a strong association between mental illness and recidivism, a number of factors appear to be related to a change

regarding this state of affairs. The first issue is that with the closing of many psychiatric wards, individuals with serious mental illness who might not otherwise have come to the attention of the criminal justice system have been diverted to the courts. As noted by Lamb et al. (2004) "the greatly increased presence of severely mentally ill persons in the criminal justice system is an urgent problem" (p. 108). Lamb et al. (2004) note the recent nature of this change, indicating that large numbers of mentally ill persons entering American jails and prisons only began appearing in the 1970s. Other researchers have echoed these concerns (e.g., Lamberti & Weisman, 2004; Adams & Farrandino, 2008; Markowitz, 2011) and noted that major mental illness appears to be associated with an increased risk of incarceration at present. Butler et al. (2006) compared a consecutive sample of reception prisoners ($n$ = 916) with data obtained from an Australian national survey of mental health ($n$ = 8,168) with reference to the prevalence of mental illness. The composite International Diagnostic Interview and a number of other screening measures were employed in this study. Logistic regression analysis controlling for age, sex, and education revealed a prevalence rate of 80% in the prison sample and 31% in the community. Substantially more psychiatric morbidity was detected among prisoners than in the community sample, particularly for symptoms of psychosis and substance abuse disorders.

Several meta-analytic studies have now been published which demonstrate that mental illness may either be directly related to recidivism or indirectly related to recidivism by way of the impact that such conditions have on the ability to complete treatment. Douglas et al. (2009) have published a comprehensive meta-analysis in relation to the association between psychosis and criminal behavior. Douglas et al. (2009) demonstrated that psychosis was significantly associated with recidivism. Among the more interesting data reported by these researchers were such findings as the fact that psychosis was associated with a 49–68% increase in the odds of violence.

Arguably the most important meta-analysis conducted in relation to the association between mental illness and recidivism was completed by Olver et al. (2011). These authors demonstrated that offenders with more serious mental illness (e.g., psychosis, borderline personality disorder) were less likely to complete treatment programs. Those who did not complete treatment were, in turn, significantly more likely to recidivate. That is, the findings clearly indicate an indirect association between serious mental illness and recidivism via the impact that mental illness has on the ability to complete programs.

It should also be noted that several empirically supported measures of dynamic risk assessment, all of which include psychiatric features, have now been demonstrated to significantly add to the prediction of recidivism (Howard & Dixon, 2013; Wilson et al., 2013). For example, Wilson, Desmarais et al. (2013) demonstrated the utility of both the Historical-Clinical-Risk Managment-20 (HCR-20) and the Short-Term Assessment of Risk and Treatability (START) measures in the prediction of recidivism. The HCR-20 includes such features as "major mental illness" and "active symptoms of major mental illness." The START includes such items as "mental state" and "medication adherence." It should also be noted that both of these measures include items related to social support, another feature that these measures have in common with the RNR-I.

Langton (2007) and Looman et al. (2005c) have suggested that mental illness should be considered a criminogenic risk factor. Further treatment specifically geared to such populations would be in keeping with the responsivity principle as outlined by Andrews and Bonta (1998, 2010). This may be particularly salient for co-morbid conditions involving the combination of substance abuse and other Axis I disorders. With reference to responsivity factors specifically, we believe that offenders who present with serious mental illness require treatment interventions that cater to their needs. The complex nature of presenting problems that we are currently seeing in high-risk populations requires specialized knowledge both in the area of forensic treatment specifically and that of mental health interventions more generally. Further, given the limited resources available, these services must be made available in a cost-effective manner. Particularly when such groups are released to the community, they present with numerous difficulties that must be addressed in a systematic manner. Chapter 15 is dedicated to the management of high-risk offenders when they are released to community settings. There, we describe a comprehensive management plan that relies heavily on the use of resources that are typically available in community forensic centers. We will argue that it is not simply the availability of resources that is needed to address this growing problem area, but also effective communication on an ongoing basis between specialists with different areas of expertise.

Within the RNR-I we argued that mental illness may have both direct and indirect effects in association with recidivism. Chronic mental illness may have a direct impact on recidivism and is consequently included as a static risk factor. With reference to indirect effects associated with mental illness, complex trauma has been associated with a myriad mental health conditions. Research linking complex trauma with violent behavior suggests that it may well be that a history of abuse is associated with violence and that mental illness is simply one route by which abuse is associated with violence. Furthermore, as noted earlier, those clients with serious mental illness are less likely to complete treatment, which increases their risk of recidivism.

## Summary

As we have seen in the preceding chapter, high-risk sexual offenders often present with a complex array of significant emotional difficulties. There is clear evidence that sexual offenders as a group have disordered attachment, which contributes to their offending by leading to difficulties in intimate relationships and the confusion of sex with intimacy. Evidence is emerging that high-risk sexual offenders are likely to suffer from complex trauma, based on their histories of abuse. This further contributes to attachment difficulties and personality disorders, as well as contributing to substance abuse difficulties, which are a primary risk factor for sexual offending. In addition, complex PTSD is related to significant mental health difficulties, the third area of focus in the current chapter. While initially thought not to be a significant criminogenic factor (Andrews & Bonta, 2003), mental disorders are increasingly identified as criminogenic needs in both general prison populations and sexual offenders. For high-risk, high-need sexual offenders, addressing mental disorder as a part of a

comprehensive treatment approach is crucial.

# 8
# The Good Lives Model and Sexual Offending

Although we have touched upon issues associated with the Good Lives Model (GLM) in previous chapters, we believe that a more involved discussion comparing this model to both the Risk–Need–Responsivity (RNR) and Integrated Risk–Need–Responsivity (RNR-I) models is necessary. Although the focus of this text is on issues relevant to those actually tasked with working with groups of high-risk offenders, a discussion of these various approaches is of practical significance from our perspective. For example, a variety of assessment strategies will be employed depending on the model selected. In Chapter 9 we provide details about the assessment measures we used. It is impossible to understand why we have chosen to use these measures without some discussion regarding such matters. For example, we do not employ a GLM-based assessment, nor do we limit ourselves to instruments that solely investigate one or more of the "Big 8" risk factors identified by Andrews and Bonta (2003, 2010). The rationale for these decisions follows from our perspective regarding the factors that need to be assessed. Further, we believe that the RNR-I should act as a guide to treatment. The reasons why we have not adopted the GLM, which has certainly received a fair amount of attention in the clinical literature, also need to be discussed in more detail than we have done before now.

## The RNR approach

The RNR approach and the theoretical model on which it is based have resulted in measurable gains in terms of the reliable assessment of offenders, as well as significant reductions in rates of recidivism among offenders treated in programs that have followed these principles (Andrews & Bonta, 2010; Polaschek & Devon, 2011). Hanson et al. (2009) have shown that these principles are reliably associated with reductions in rates of recidivism among sex offenders. Hanson et al. (2009) demonstrated that those programs that adhere to a greater number of RNR-based principles are associated with greater reductions in recidivism. These conclusions apply equally well in treatment aimed at the reduction of violent (Dowden & Andrews, 2000) or general recidivism (Andrews et al., 1990). The definitions of risk, need, and responsivity were provided in Chapter 1 and will not be repeated here. What should be emphasized is that this model has resulted in several decades of research that has revolutionalized the practice of assessment and treatment of offender populations. The principles of risk, need, and responsivity are clear, concise, and empirically verifiable. Furthermore, the model is based on the principles of cognitive-behavioral therapy (CBT) and social learning theory. As decades of research now demonstrate, the CBT approach has received a great deal of support in the empirical literature when applied to forensic populations. It is not that other theoretical models (e.g., psychodynamic or holistic therapies) are of no relevance, only that they have not received as much (or any) empirical support when applied to forensic populations.

Proponents of the GLM have argued alternately that their approach is compatible with the RNR perspective (Ward & Maruna, 2007) or that it represents an alternative to the RNR model. For example, when Ward and Stewart (2003b) discuss the "risk–need model" and the fact that this model views individuals as "disembodied bearers of risk rather than as integrated agents" (p. 354), it hardly seems as if they are advocating the use of this approach. In addition, these authors are silent regarding the underlying (and potentially divergent) assumptions associated with these two respective models. It is to these topics that we now turn our attention.

## The Good Lives Model

Ward and his colleagues (Ward & Steward, 2003b; Laws & Ward, 2011) have argued that the primary focus of RNR-based approaches to treatment has been on the reduction of various deficits present in the individual. Further, they have noted that the RNR model pays insufficient attention to the person and the idiosyncratic goals that he or she may wish to address. Ward and Stewart (2003b) propose that the GLM promotes the enhancement of strengths, skills, and abilities rather than the suppression of negative behavior. In short, they advocate for the development of a "good life."

These authors (Ward & Stewart, 2003b; Ward & Marshall, 2004; Laws & Ward, 2011; Yates & Willis, 2011) claim that, rather than addressing criminogenic needs, the focus of treatment should be the enhancement of offenders' abilities to obtain so-called "primary human goods." These "goods," as described by Ward and Maruna (2007), have their origins in human nature and have evolved in order to help people establish strong social networks, survive, and reproduce.

Yates and Willis (2011) describe 11 primary human goods:

1. Life (including healthy living and optimal physical functioning, sexual satisfaction)
2. Knowledge
3. Excellence in work
4. Excellence in play
5. Excellence in agency (i.e., autonomy and self-directedness)
6. Inner peace (i.e., freedom from emotional turmoil)
7. Relatedness (including intimate, romantic, and family relationships)
8. Community
9. Spirituality
10. Happiness
11. Creativity.

For each of these primary goods, the authors identify secondary goods. These secondary goods provide the means by which the individual chooses to strive towards the various primary

goods. Either appropriate or inappropriate secondary goods may be chosen by the individual. For example, the goal of relatedness may be achieved either by appropriate means (e.g., seeking a consenting adult relationship) or inappropriately (by seeking a sexual relationship with a child).

From the GLM perspective, criminogenic needs are internal or external obstacles that frustrate and block the acquisition of primary human goods (Ward & Marshall, 2004). When individuals become frustrated in their ability to choose pro-social primary goods, they may opt for antisocial or otherwise problematic means of trying of achieve these goals, according to the GLM.

More recently, Laws and Ward (2011) have discussed the idea that offenders who desist from crime tend to adopt a personal identity inconsistent with offending. Rather than target individual risk factors, which they argue is the focus of the risk–need model, advocates of GLM argue that change results from the "holistic reconstruction of the self" (Laws & Ward, 2011, p. 189). The role of human agency is strongly reinforced by proponents of the GLM. In the most recent comprehensive statement about the model, Laws and Ward (2011; see also Ward & Laws, 2010) incorporate theory related to the GLM, desistance research, and positive psychology. Ward and Laws (2010) identify 12 influences that contribute to the desistance of offenders. These influences include aging, marriage, work and job stability, juvenile detention, prison, education, spirituality, and fear of serious assault or death. Further, the GLM takes an agency-centered approach to rehabilitation. That is, the model is concerned with the ability of individuals to select goals, formulate plans, and act freely to implement these plans.

Proponents of the GLM suggest that a focus on the promotion of goods is likely to automatically eliminate or modify risk factors (Ward & Laws, 2011). This assumption of the model is critical and we discuss it in more detail later on. This proposition (that risk factors will somehow take care of themselves when one promotes human goods) is certainly in keeping with the principles of humanistic psychology. However, this perspective may contradict cognitive-behavioral principles, where the focus is on directly addressing problematic thoughts or behaviors.

## *An analysis of the GLM desistance perspective*

Laws & Ward (2011) indicate that the GLM has empirical support. Unfortunately, they do not offer any citations in support of this claim. Although some of the principles of positive psychology have received support in the clinical literature more generally, this cannot and should not be taken as evidence that these approaches would work with offender populations. We have previously reviewed some of the research (Looman & Abracen, 2013a,b) that has demonstrated that issues such as self-esteem, self-worth, or vague feelings of personal distress are not associated with any treatment effect. Yet these appear to be exactly what proponents of the GLM suggest should be among the most significant targets of treatment.

Ward and his colleagues have offered several case studies to illustrate the efficacy of the GLM. However, these vignettes tell us little about whether GLM-based strategies are of any greater utility than other approaches at managing offender behavior. Ward & Maruna (2007)

forcefully argue that the GLM is compatible with RNR-based strategies. Unfortunately, we are not aware of any large-scale studies that compare and contrast these two approaches in terms of the direct impact that each might have on recidivism.

In fact, Willis & Ward (2013) recently made the assertion that research supporting the RNR perspective can be taken as support for GLM-based approaches. In our view, this is a very misleading assertion. As we noted earlier, the GLM and RNR perspectives appear to be based on differing assumptions and the goals of therapy appear to be at odds. The typical goal in CBT-based treatment, for example, is not the holistic reconstruction of the self. Rather, the more prosaic goals are stated to be progress in relation to a specified set of clearly defined treatment objectives. For example, progress in the area of communication skills as measured by pre–post changes on particular instruments (all of which have sound psychometric properties) is taken as evidence in favor of treatment efficacy. How does one measure the holistic reconstruction of the self within such a framework? Happiness has received much attention in philosophic circles over a number of centuries; however, it seems fair to say that there is likely no one definition of happiness. Perhaps all that matters from a GLM perspective is that our clients say that they are "happier" at the end of treatment than they were at the beginning. Fair enough, but this perspective is hardly in keeping with cognitive-behavioral traditions generally or the RNR perspective specifically. As we have noted repeatedly, the RNR specifies eight primary treatment targets, all of which are clearly defined and which have been supported in the empirical literature. We are, for example, not familiar with any meta-analytic data suggesting that the pursuit of happiness in and of itself is related to significantly decreased risk of recidivism among high-risk groups of offenders.

Willis and Ward (2013) suggest that such case studies as provided by Whitehead et al. (2007) offer support for their model. The case described by Whitehead et al. (2007) involved Mr. C, who was described as being a gang member with a long criminal history of violence, including sexual violence. Mr. C was provided with treatment according to a GLM perspective after RNR-based treatment failed to result in significant changes. Mr. C's outcome 14 months after release was discussed. He had enrolled in university but dropped out due to "transportation difficulties." The authors are to be credited with discussing two post-treatment incidents of violence. The second of these two incidents occurred after his partner was offended and insulted. Mr. C's reaction included "smashing" the victim (p. 593). Although a number of possible interpretations are possible regarding whether treatment was effective with Mr. C, a cynic might argue that, rather than the GLM being shown to be effective, Mr. C continued to engage in multiple incidents of violence within a rather short period following treatment. Whether or not he was more happy or felt an increased sense of self-efficacy may well have been less relevant, at least from a traditional forensic standpoint.

Two studies addressing the effectiveness of GLM approaches in contrast to "treatment as usual" approaches have been conducted to date. In the first of these, Harkins et al. (2012) compared 76 men who participated in a community-based sexual offender treatment program based on the principles of GLM with 701 who participated in a relapse prevention (RP) RNR-based program. It was found that the attrition rates did not differ significantly between the GLM- and RP-based programs. With reference to change on a variety of psychometric

instruments, no differences were detected between groups.

With reference to clients' ratings regarding the extent to which they understood factors related to their offending behavior, 80% of the RP group rated their understanding as improved compared with 46% of the GLM participants. On the other hand, GLM participants were far more likely to indicate that they had a better understanding of themselves when compared with participants in the RP-based program (61% vs. 20%, respectively). Of course, rated changes on psychological variables may or may not translate into reductions with reference to recidivism.

In the second study, Barnett et al. (2013) investigated whether changes to the GLM program based on the findings of Harkins et al. (2012) resulted in improved outcomes. These authors examined two samples of offenders who participated in community-based sex offender treatment programs. In total, the sample included 321 men participating in an RP-based program and 202 in a GLM-based program. Overall, results indicated that there was no significant difference between the two groups in the amount of change achieved on the measures administered.

## GLM vs. RNR

As mentioned earlier, although never explicitly stated, it appears that proponents of the GLM (e.g., Ward & Stewart, 2003b) are advocating for a humanistic approach to treatment (e.g., Rogers, 1951). In our view, this is a potentially critical difference between the RNR and GLM approaches. Throughout this text, we have pointed to both traditional outcome studies and meta-analytic reviews that demonstrate that contemporary cognitive-behavioral approaches to treatment are associated with significant reductions in recidivism among offender populations. The Rogerian/humanistic perspective, in contrast, is associated with a non-directive, unconditionally accepting approach to therapy where the emphasis is placed on the nature of the therapeutic contact rather than on specific techniques to be used with particular clients. Both Andrews & Bonta (2010) and our team at the Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP; see Abracen & Looman, 2004; Abracen et al., 2008; Looman & Abracen, 2013a,b for reviews, as well as Looman, 2006) have demonstrated that structured approaches to treatment, which are cognitive-behavioral in nature and which focus on a specified list of factors empirically linked with recidivism, are associated with significant reductions in recidivism.

When one looks at the list of goods described by proponents of the GLM, although laudatory in theory, in practice they represent either a re-statement of the criminogenic needs addressed by Andrews and Bonta (2010) or vaguely defined philosophic pursuits that may not be subject to empirical enquiry. That is, such concepts as happiness may not easily lend themselves to definitions that can be accepted by all members of a group of clients, nor can they be easily quantified for research purposes. Perhaps this is why the research that has been done to date has asked participants of GLM-based programs if they are happy without providing much guidance as to how these terms are defined. From a humanistic perspective, such matters may

not be essential.

The humanistic orientation may not be as easily integrated with cognitive-behavioral traditions as proponents of the GLM would have clinicians believe. In fact, whether intended by the authors or not, by emphasizing such concepts as the pursuit of human agency, proponents of the GLM may be advocating for treatment that bears a closer resemblance to psychodynamic approaches than to cognitive-behavioral traditions. That is, clients choose to pursue goals that have personal meaning, and therapists are given great leeway with reference to how they choose to help clients achieve these goals. Of course, it is possible that therapists will choose to address such issues as the acquisition of knowledge (one of the primary goods) using a cognitive-behavioral perspective. Alternatively, however, we see no reason why a clinician who is not well versed in the forensic treatment literature would choose to adopt insight-oriented techniques that have more in common with dynamic perspectives than with cognitive-behavioral traditions. Although dynamic approaches may be of use with reference to other treatment conditions, there is little in the way of empirical research demonstrating that these approaches are effective when working with correctional populations.

When one discusses concepts such as the value of education and work., it is our view that such criminogenic needs are less likely to be confused with the goals of dynamic-oriented approaches. Although proponents of the GLM argue that they are simply offering guidelines that clinicians can apply in any way they think reasonable, we believe that a model that offers specific direction regarding which factors need to be addressed in treatment is preferable. Further, such factors must be empirically supported and the model should be demonstrated to be effective. We believe that the RNR-I offers one such approach.

Although there are a number of goods that are, in our view, vaguely defined in practice or more aspirational in nature (e.g., the pursuit of happiness), there are other goods listed that merely re-state various criminogenic needs listed by Andrews & Bonta (1998, 2010). For example, the primary good of “excellence in play and work” has its counterpart in the RNR principle of “employment/schooling” as well as “problematic use of leisure time.” Although it is our view that the primary good of “inner peace” is vaguely defined and does not easily lend itself to the concrete, structured, and directive approaches advocated by Andrews and Bonta, it is possible that this primary good is inversely related to the RNR criminogenic needs of antisocial attitudes and antisocial personality pattern.

The need to re-state some of the criminogenic needs with reference to approach goals and with reference to the language of positive psychology is a contribution; however, it is simply a reminder of what good clinicians should be doing. The RNR approach has always been dedicated to skills acquisition. Both the RNR and GLM approaches stress the need for the clients with whom we work to acquire new pro-social skills. Unfortunately, the GLM approach does not appear to take an empirically guided approach to theory in that a number of Primary Goods have little or no empirical support in the forensic literature. In addition, both approaches fail to incorporate mounting evidence regarding the role that complex trauma and serious mental illness present with reference to groups of high-risk, high-need offenders and neither of these models provides concrete guidance regarding how a comprehensive set of

clearly defined factors related to recidivism might be incorporated into an integrated system of treatment programs. We believe that RNR-I represents one such contemporary approach to the management of high-risk, high-need offenders.

# 9
# Therapeutic Orientation and Relevance to Assessment

The approach adopted by our team with reference to initial assessment and consent more specifically is in keeping with the tenets of motivational interviewing and harm reduction strategies more generally. We have already discussed why such approaches are in keeping with the tenets of motivational interviewing. With reference to harm reduction (Marlatt et al., 2012 ), these techniques have proven very useful in the treatment of substance abuse disorders and high-risk offenders (Laws, 2003 ). Harm reduction techniques, and older variations of this approach such as relapse prevention, emphasize minimizing the harm that clients do to themselves or others. These techniques have as a core assumption that the client's perspective is quite valuable and should be respected. Harm reduction techniques also accept the fact that complete abstinence from problematic behaviors may not be possible, at least in the short term. In the case of the clients we see, this may involve ongoing problems with deviant arousal or aggressive behavior. Harm reduction techniques do not reinforce such behaviors, but rather assume that such behaviors can occur even in motivated clients. Efforts are made to reduce the frequency of such behaviors or eliminate them altogether. In presenting the philosophy of the treatment staff to clients, we hope to encourage them to share more information in therapy. Marshall et al. ( 2008 ) have shown the utility of such an approach in the use of their preparatory program for sexual offenders. A variety of research studies also attest to the utility of relapse prevention and harm reduction strategies as applied to high-risk groups of offenders. Many of the findings cited at the beginning of this book regarding treatment with high-risk groups of offenders have adopted the principles of relapse prevention and harm reduction. As noted, meta-analytic reviews of such research have found that such contemporary approaches to treatment result in lower rates of recidivism than observed with comparison groups. Moreover, meta-analytic reviews that investigated "get tough" programs have concluded that such approaches either have no effect on recidivism or, in fact, result in elevated rates of recidivism (Andrews & Bonta, 2010 ). It is our perspective that such get-tough programs typically run counter to the principles listed above and may not have a therapeutic component at all given the focus of these approaches.

The question of how to undertake a comprehensive assessment of such groups of clients is one to which no definitive answer will likely ever be provided. That being said, we will describe in some detail the approach to assessment that we have found to be useful as well as the theoretical underpinnings to this model.

## Actuarial risk assessment

Given that, from our perspective, an accurate estimate of risk is essential to a comprehensive assessment, we strongly advocate the use of actuarially based assessment instruments. Hanson and his colleagues (Hanson & Morton-Bourgon, 2009 ; Mann et al., 2010 ) have persuasively

argued that the most accurate risk assessment instruments are actuarial in nature and outperform assessments based on clinical judgment, with clinically adjusted actuarially based risk assessments being intermediate between the two other approaches. As noted by Hanson et al. in the reviews cited, there is a great deal of overlap between the predictive accuracy of actuarial instruments specifically designed to measure risk of sexual offense recidivism. We have found the Static-99/99R to be a useful measure in general when specific estimates of sexual offense recidivism are required (Looman & Abracen, 2010 ). Hanson and Morton-Bourgon ( 2009 ) demonstrated that there are many studies showing the utility of this measure. In addition, recent scoring criteria introduced for the Static-99/99R have specifically adjusted for age and are in keeping with recent developments in this area (Phenix et al., 2009). These new estimates for the Static-99R produce much lower estimates of risk for older offenders.

We have found that the Risk Appraisal Guide-Sex Offender Version (SORAG; Quinsey et al., 1998) is the most accurate at placing the high-risk groups that we have worked with into broad bins based on risk of violent (including sexual) recidivism (Looman & Abracen 2010 ). Unfortunately, the SORAG does not provide an estimate of risk for sexual offense recidivism specifically. As such, the measure represents an overestimation of risk for this type of recidivism. Where a certain threshold of risk for sexual offense recidivism is required for placement in a program (e.g., where commitment criteria in certain US states require that an offender be more likely than not to commit a sexual offense if not confined involuntarily to a treatment facility), measures such as the SORAG should be used very cautiously. This is especially important given the tendency for such measures to be significant overestimates of risk among older offenders. In keeping with the results of Howard Barbaree's and Calvin Langton's excellent research related to age and relative risk of recidivism (e.g., Barbaree et al., 2003, 2007, 2009; Prentky et al., 2006 ), Looman (2006) demonstrated that, for higher-risk bins on the SORAG, the predicted rate of recidivism exaggerates the observed rate of recidivism such that the 95% confidence intervals do not overlap. Such data indicate that, at least among treated clients, the SORAG significantly exaggerates the actual risk of recidivism.

Our team begins with a risk assessment grounded in the approach advocated by Hare for use with the Psychopathy Checklist-Revised (PCL-R). We have found the interview guide associated with the PCL-R to be a very logically organized approach, though, as we will demonstrate, such materials are not sufficient for a comprehensive assessment of high-risk sexual offenders. The PCL-R interview guide requires that clients be asked about a large number of domains. Topics covered in the interview guide include information regarding formative years, schooling, relationship with parents, family and siblings, work and financial history, psychiatric and medical history, including history of having abused substances and history of difficulties with the law, starting from an early age and as an adult. Information regarding a variety of dimensions related to the personality traits associated with psychopathy is also included. Questions regarding manipulative behavior and lying, lack of responsibility, poorly integrated sex life, and difficulties in the comprehension and expression of emotionally based material are also included in the manual. Although the Level of Supervision Inventory-Revised (LSI-R; see Andrews & Bonta, 1998, 2003) is an excellent measure for use in the assessment of risk for general and violent recidivism, we have found some of the questions

included in the manual less relevant to groups of clients who have been incarcerated for many years, although the most recent revision of the LSI-R (LS/CMI; Andrews et al., 2011 ) has included material more relevant to incarcerated samples. For those working with clients in the community, we see no reason why the interview schedule associated with the LSI-R cannot be used with equal efficacy.

Nonetheless, neither the PCL-R nor the LSI-R interview are sufficient for a comprehensive assessment of high-risk sexual offenders. We believe that it is essential that comprehensive information be obtained regarding a number of domains. Aside from the psychometric instruments listed in the following section and questions included in the interview schedules listed earlier, we believe that detailed information related to history of inappropriate sexual behavior and any relationship between such a history and abuse (be it physical, emotional, or sexual) and/or problematic intimate relationships is essential. As noted by a variety of authors (e.g., Dhwan, & Marshall, 1996 ; Dwyer et al., 1988 ; Hanson, & Slater, 1988 ; Langevin et al., 1989 ; Peugh & Belenko, 2001 ), and discussed in the Chapter 7, sexual offenders are more likely to have been victims of sexual abuse than other groups. Given the relatively high incidence of abuse in the histories of such clients, it is important to accurately assess such histories and examine the association between such a history and difficulties later in life. Knight and Sims-Knight ( 2004 ) have also demonstrated, using structural equation modeling, that a history of either physical/verbal abuse and/or sexual abuse is related to antisocial behaviors or, indirectly, to deviant sexual fantasies in a sample of 275 male sexual offenders. This is not to say that being a victim of abuse is causally related to the commission of sexual offending, but rather that the association between sexual offending and having a very traumatic upbringing is sufficiently common that such issues simply cannot be ignored in an initial assessment.

As discussed in Chapter 7, recent research suggests that a history of mental illness/disorder is criminogenic. In addition, in recent years the prevalence of such disorders has been increasing in prison populations. We believe the increasing prevalence of mental health disorders in the criminal justice system necessitates a comprehensive screening for such conditions. At the Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP) we have used the Millon Multi-Axial Inventory (MCMI-III; Millon, 2002). This scale assesses for the presence of personality disorders, but also contains scales related to other specific diagnoses listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), such as anxiety, somatoform, mood and substance abuse disorders. In addition, it assesses for the presence of post-traumatic stress disorder (PTSD) and the possibility of more severe disorders such as thought and delusional disorders. Elevated scores on a particular scale do not necessarily indicate the presence of a particular diagnosis; however, such information is very useful in terms of alerting the clinician to the possible need for a more comprehensive assessment of this particular area. Further, the MCMI has received considerable empirical support in the literature. There are a variety of other measures that have been used with forensic populations and which are also of value (e.g., the Personality Assessment Inventory [PAI]; Morey, 1991 ).

# Psychometric assessment battery

Appendix 2 contains a comprehensive list of the measures that are administered at the RTCSOTP with exception to the Static-99R, the STABLE-2007 and the SORAG, discussed in the previous section. The specific measures we use were chosen to assess the specific treatment targets addressed in the sex offender treatment program, and to assess change related to those targets.

In order to assess attitudes tolerant of sex offending, we administer Bumby's Child Molester and Rape Cognitive Distortions Scales (Bumby, 1996 ). These two scales measure elements of cognitive distortions related to child and adult victims, respectively. We agree with Marshall et al. ( 2009 ), who noted that the term cognitive distortions has been used so widely with reference to sexual offenders that it has almost ceased to have much meaning at all. There is nonetheless a need to tap into the level of distortions displayed by the clients with whom we work, as the majority of sexual offenders evidence at least minimal distortions that help rationalize their offending or help to minimize the blame that the client may feel with reference to his actions. Marshall et al. ( 2009 ) argued that the Bumby scales seem to capture a number of important aspects of cognitive distortions related to sexual offenders.

To assess negative emotionality we administer the Buss–Durkee Hostility Inventory (BDHI; Buss & Durkee, 1956). The BDHI is a 66-item true–false self-report questionnaire that was developed with a non-forensic sample and designed to measure seven subtypes of hostility (assault, indirect hostility, irritability, negativism, resentment, suspicion, and verbal hostility). Summing the hostility scale scores provides a total hostility score that can range from 0 to 66, with higher scores reflecting greater hostility.

To assess inappropriate coping with difficult situations, we use the Coping in Stressful Situations Scale (CISS; Endler & Parker, 1999 ) and the Coping Using Sex Inventory (CUSI; Cortoni & Marshall, 2001 ). The CISS is a 48-item measure of coping styles which assesses the use of three kinds of coping styles: task-oriented, emotion-focused, and avoidance-focused coping. Avoidance-focused coping is broken into two components: distraction and social diversion. Individuals who score high on task-oriented coping use behavioral or cognitive problem-solving techniques when confronted with stress. Emotion-focused copers respond to stressful situations with emotional outbursts, self-preoccupation, or fantasy. Avoidance copers rely on social supports or distract themselves with other activities. Endler and Parker ( 1999 ) noted that the CISS is both valid and highly reliable.

The other measure of coping style, the CUSI, is concerned with how a person generally responds to stressful events with sexual activities. It is currently the only measure of such coping and has exhibited good internal consistency (α 0.85 to 0.86) in three independent samples (Cortoni & Marshall, 2001 ; Marshall et al., 2003 ). The measure employs a Likert-type scale with responses from "not at all" to "very much" (scored 1–5). The sub-scales include items such as: "Fantasize about having sex with a consenting adult" (consent-oriented), "Use violent pornography" (rape-oriented) and "Masturbate while fantasizing about a child" (molestation-oriented). Scores are in the following ranges: for overall sexual-oriented coping,

16–80; for consent-oriented sexual coping, 5–25; for rape-oriented sexual coping, 6–30; and for molestation-oriented sexual coping, 4–20. Factor analysis also confirmed that the CUSI contains the three theoretically derived sexual coping sub-scales: consent-oriented, rape-oriented and molestation-oriented.

As an assessment of intimacy difficulties we use the UCLA Loneliness Scale (Russell et al., 1980 ) and the Miller Social Intimacy Scale (SIS; Miller & Lefcourt, 1982 ). The SIS is a measure of intimacy which has been administered to sexual offenders (e.g., Seidman et al., 1994 ; Marshall et al., 1997 ). This measure has been shown to be related to in-treatment changes in behavior for sexual offenders (Marshall et al., 1996 ). The SIS is a 17-item questionnaire which asks respondents to rate the frequency and intensity with which they engage in activities that reflect intimacy with their current or most prolonged partner. Miller and Lefcourt ( 1982 ) list a mean of 152.5 (standard deviation = 10.9) for married men.

Regarding social skills deficits we administer the Adult Self-Expression Scale (Gay et al., 1975 ), which is a 48-item measure of assertiveness; each item is described as behavior in a situation. Responses indicating frequency of behavior fall into categories scored from 0 (never) to 4 (almost always). Seven kinds of behaviors are assessed: expressing personal opinions, refusing unreasonable requests, initiating conversations, expressing positive feelings, standing up for legitimate rights, expressing negative feelings, and asking favors in six interpersonal situations. Scores are combined into two broader subscales: positive assertion and negative assertion.

As an assessment of the offender's awareness of risk factors, we administer the High Risk Situation Test (Marques et al., 1991 ), which was developed for use in the California Sex Offender Treatment and Evaluation Project (SOTEP). It consists of 58 items, rated on a five-point Likert scale regarding the extent to which the situation would lead to elevated risk. Examples of the types of items include: "If I were angry or frustrated"; "If I were bored"; "If I were to think about a past sexual offense." We also employ the Relapse Prevention Knowledge Test (Abracen et al., unpublished ), which was developed by our team and has not yet been subjected to empirical validation. Although we are currently in the process of conducting some outcome research related to this measure, we have continued to use this unvalidated measure for several reasons. First, we were unable to find an instrument that, from our perspective at least, tapped into the various elements of relapse prevention with which we were concerned in treatment, and some of the existing measures were too complex for use with our population. However, we required an instrument that quickly and easily assessed the extent to which our clients understand the concepts that we were trying to teach, and assess changes (gains) in this knowledge with treatment.

We also use the Multiphasic Sex Inventory (MSI; Nichols & Molinder, 2000) as a measure of a number of treatment targets, including acceptance of responsibility and the use of cognitive distortions (e.g., the cognitive distortions and immaturity scale; justifications) and sexual preoccupations (sexual obsessions scale). The MSI is a 300-item inventory designed to measure various aspects of behavior frequently seen in convicted sexual offenders. The MSI is composed of a variety of scales, including the sexual obsessions scale, which assesses the

extent to which offender is preoccupied by thoughts of sex; the cognitive distortions and immaturity scale, which assesses the extent to which sexual offenders engage in offense-specific distorted thinking; the justifications scale, which assesses the extent to which offenders justify and minimize their offending behavior; and the child molester, rapist and exhibitionism scales, each of which samples behaviors and cognitions typical of that offense type. In the past few years we have begun to use the revised version of this scale, the MSI-II (Nichols & Molinder, 2000), which has an expanded number of scales but measures the same basic constructs as the MSI.

Another measure employed at the RTCSOTP assessing areas of concern is the Michigan Alcohol Screening Test (MAST; Selzer, 1971). The MAST consists of 24 yes/no questions pertaining to lifetime use of alcohol. Each item is scored 0 or 1, with scores of 10 or more indicating evidence of having had a severe drinking problem at some point in one's life. The MAST has been found to have higher concurrent validity when compared with other alcoholism measures with reference to lifetime history of alcohol dependence (Watson et al., 1995 ). Elevated MAST scores have also been found to be associated with recidivism among various groups of sexual offenders (Firestone et al., 1998, 1999), including our own sample (Looman & Abracen, 2011 ). Although the original MAST includes 25 items, one item that was not assigned any score in the original MAST was deleted ("Do you ever try to limit your drinking to certain times of the day or to certain places?"). Total scores of 4 or above represent at least moderate difficulties with reference to alcohol abuse. Given that this is a measure of lifetime alcohol abuse, we only administer it at pre-treatment.

The Drug Abuse Screening Test (DAST; Skinner, 1982 ) is similar in design to the MAST. It consists of 20 yes/no questions, each scored 0 or 1. Scores of 11or more indicate substantial problems with drug abuse. Langevin & Lang ( 1990 ), using factor analysis in a large sample of male sexual offenders ($N$ = 461), demonstrated that both the MAST and the DAST could be treated as single factor tests. Alpha reliabilities for the MAST and the DAST were found to be 0.89 and 0.90, respectively. Again, given the historical nature of the measure, it is only administered at pre-treatment.

The Relationship Styles Questionnaire (RSQ; Griffin & Bartholomew, 1994 ) is a measure of four adult attachment patterns: secure, preoccupied, fearful, and dismissing. Individuals rate the extent to which each statement best describes their characteristic style in close relationships according to a five-point scale. The original RSQ consists of 30 items. However, for the purposes of our assessment battery, a shortened version of the RSQ was used. Only those items related to the four attachment patterns described were included.

Research on our population has indicated significant changes in the desired direction on the majority of these measures from pre- to post-treatment. Table 9.1 displays the results of a paired-samples $t$-test analysis involving the various measures.

**Table 9.1** Pre–post changes on psychometric measures

| ***Test name*** | ***Pre-treatment*** | ***Pre-treatment*** | ***t*** |
|---|---|---|---|
| Relapse Prevention Knowledge | 13.4 | 16.0 | |

| | | | |
|---|---|---|---|
| | | | 7.42**** |
| Test | | | |
| Child Molester Empathy Measure | | | |
| Child's perspective total | 586.1 | 665.1 | 3.70*** |
| Offender's perspective | 396.6 | 422.1 | 1.93† |
| Rapist Empathy Measure | | | |
| Victim's perspective | 601.2 | 640 | 2.67** |
| Offender's perspective | 406.3 | 408.8 | 0.2 |
| High Risk Situations Test | 84.4 | 103.1 | 5.8**** |
| Coping Using Sex Inventory | | | |
| Consenting score | 12.6 | 12.5 | 0.2 |
| Rape score | 7.2 | 6.5 | 1.64 |
| Child score | 6.0 | 5.9 | 0.27 |
| Total Score | 27.8 | 25.6 | 2.02* |
| UCLA Loneliness | 45 | 43 | 1.86† |
| CISS | | | |
| Task | 54.7 | 59.8 | 2.67** |
| Emotion | 44.7 | 42.6 | 1.28 |
| ASES | | | |
| Positive assertion | 51.9 | 56.3 | 4.06*** |
| Negative assertion | 55.6 | 60.6 | 4.07*** |
| BDHI – total hostility | 28.8 | 27.9 | 0.99 |
| Bumby | | | |
| Child Molester Cognitive Distortion | 55.4 | 48.6 | 5.06**** |
| Rapist Cognitive Distortion | 56.3 | 48.9 | 5.85**** |
| Multiphasic Sex Inventory | | | |
| Sexual obsessions | 3.2 | 2.9 | 1.28 |
| Social sexual desirability | 23.3 | 22.6 | 1.62t |
| Cognitive distortions/immaturity | 6.1 | 5.7 | 1.81† |
| Justifications | 3.2 | 2.4 | 3.18*** |
| Treatment index | 3.8 | 3.9 | 0.53 |

[*]-$p < 0.05$; [**]-$p < 0.01$; [***]-$p < 0.001$; [****]-$p < 0.0001$; [†]-$p < 0.10$.

CISS, Coping in Stressful Situations Scale; ASES, Adult Self-Expression Scale; BDHI, Buss–Durkee Hostility Inventory.

In addition, we have completed analyses suggesting that changes on these measures are associated with recidivism post-release. Looman et al. ( 2005a ) found that after accounting for the SORAG score in the prediction, pre-treatment scores on the High Risk Situation Test, the MAST, the Adult Self-Expression Scale negative assertion scale, and the MSI sexual obsessions scale were significant predictors. At post-treatment the BDHI total score, the Child Molester Cognitive Distortions score, and the MSI social sexual desirability scale were significant predictors.

Thus, these measures can detect change with treatment, and there is some preliminary evidence that these changes are associated with recidivism following treatment.

# 10
# Self-Management Component

As described earlier in the book, the Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP) consists of two primary streams of treatment, as well as individual and milieu therapy. This chapter describes the self-management component, while the following chapter will provide a description of the social skills component and individual therapy. Many of the issues discussed during the self-management component are addressed in other chapters in this volume, but the current chapter provides a brief overview of the major topics addressed.

The self-management component consists of a series of modules intended, first, to introduce offenders to the treatment program and enhance motivation; and, secondly, to provide them with the skills needed to assist them in identifying when they are becoming at greater risk of reoffending and intervene to prevent future reoffending. The modules that make up the self-management component are as follows:

1. Introductory module
2. Disclosures
3. Attitudes
4. Cognitive distortions
5. Distortions that affect empathy
6. Emotions management
7. offense cycles
8. Offence cycle presentations
9. Self-management plans

## Introductory module

The purpose of the introductory module is to introduce clients to the group process and to address responsivity issues such as lack of motivation/engagement. In the initial groups of this module, group rules are derived through group discussion, in order to enhance a sense of group responsibility. In addition, the clients are introduced to treatment concepts/jargon (cognitive-behavioral therapy [CBT], offense chain, etc.). For example, the core notion of CBT, that thoughts and behavior are related, can be new to some of our clients.

In the introductory module, clients are also introduced to the process of change. Ideas such as how we begin the change process and the costs and benefits of changing are discussed; for example, the idea of “possible selves” (Markus & Nurius, 1986) is introduced and discussed.

As described by Markus and Nurius (1986), possible selves represent individuals' ideas of what they might become, what they would like to become, and what they are afraid of becoming, and thus provide a conceptual link between cognition and motivation. We ask the clients to develop an idea of who they would like to be once they have made all the changes they need to make, ensuring that they keep the expectations realistic. As part of this, we ask them to identify a role model for themselves, somebody from their life who is not a criminal (e.g., the cousin who has been working as a mechanic, who has a family and a house), which can aid them in formulating their possible self. Also as part of this exercise the clients complete the "old me/new me" assignment (Haaven & Coleman, 2006) homework.

## Autobiography and disclosure

The autobiography outline is handed out during the second introductory session and the clients are told the date on which the first in-group disclosure of offenses will occur, which is also the deadline for the autobiography assignment. For the autobiography, unlike in some other programs, we are not expecting a detailed sexual/personal history – rather, we are looking for no more than 30 pages (a minimum of 10) outlining their personal and social history, including relationships, substance abuse, criminal/antisocial behavior. The focus of the final section is on their sexual offending history. We also ask them to touch on periods of their lives in which they were offense-free, in order to gain an understanding of desistance levers (Laws & Ward, 2011) for the offender. The autobiography serves as the basis for their in-group disclosure and as the beginnings of the development of their offense chain.

In the course of writing the autobiography, they will meet with their therapist at least twice for guidance and to allow the therapist to track progress with the assignment. Keeping responsivity issues in mind, most of our clients are functioning at about a grade 4 level in terms of literacy, and thus it is important to keep expectations regarding the produced work realistic.

Regarding the in-group disclosure of the offenses themselves, we allow one session per client. Each client provides a 30- to 45-minute presentation to the group, followed by a short break. Following the break, we allow another 30–45 minutes for questions from other group members. In terms of the content of the disclosure, we require a brief personal background, an overview of their relationship history, and a brief description of their non-sexual criminal history. The majority of the time should be dedicated to the client's sexual offenses. During the questioning, we expect all group members to participate. The questioning is intended to clarify issues related to the disclosure in order to assist the client to understand his offense process. The questioning is done in a supportive, non-confrontational manner while challenging minimization and denial.

The non-confrontational nature of the questioning is important, as research suggests that therapists who present as warm, empathic, rewarding and directive, but not confrontational are most effective (see Marshall et al., 2011). The goal of these sessions is to increase accountability and openness about the client's offending and sexual deviance (if present).

# Cognitive distortions

The third component of the self-management module is the cognitive distortions component. The focus of these sessions is on becoming aware of distorted thinking, related to both general criminality and sexual offending (antisocial attitudes, offense-supportive thinking), and then developing the ability to intervene in distorted thinking and replace it with pro-social thoughts. Again, the focus is on using the group process and challenging cognitive distortions without being confrontational.

An important concept in relation to cognitive distortions is the idea of cognitive distortions as excuse-making (Maruna & Mann, 2006; Mann & Ware, 2012). As pointed out by Mann and colleagues, there is a normal human tendency toward excuse-making, i.e. the cognitive "process of shifting causal attributions for negative personal outcomes from sources that are relatively more central to the person's sense of self to sources that are relatively less central" (Mann & Maruna, 2006, p. 156). They point out that "When challenged about having done something wrong, all of us reasonably account for our own actions as being influenced by multiple, external and internal factors. Yet, we pathologize [offenders] for doing the same thing" (p. 158). Mann et al. note that excuse-making is a highly adaptive mechanism for coping with stress, relieving anxiety and maintaining self-esteem, and that those who assume full responsibility for their failings put themselves at risk of suffering depression.

Thus, when addressing cognitive distortions, it is important to distinguish between those distortions that are simple human excuse-making and those that are offense-related. For example, "I did it because I was drunk" may be excuse-making, while "10-year-old girls are sexual beings" is offense-related. Addressing the latter distortion in treatment is more important than addressing the former.

A recent survey of sex offender treatment programs in North America (McGrath et al., 2009) found that approximately 90% of programs have a victim empathy/awareness component. This continues despite research indicating that a lack of victim empathy is not related to recidivism (Hanson & Bussière, 1998; Hanson & Morton, 2004; Mann et al., 2010). In addition, as summarized by Mann and Barnett (2013), there is no evidence that sexual offenders differ from non-sex offenders in terms of their ability to empathize. Rather, it appears that sexual offenders may suffer from a lack of empathy for their victim *at the time of offending*. Thus, in the RTCSOTP, rather than a general victim empathy component, we address cognitive distortions that impede empathy as part of the cognitive distortions component, and view these distortions as another form of offense-supportive thinking.

# Emotions management

The next module of the self-management component is the emotions management module. This module of the program addresses coping with difficult emotional states, such as loneliness, jealousy, depression etc. using cognitive strategies such as self-talk, and challenging distortions; behavioral strategies, such as relaxation; and mindfulness strategies such as simple

acceptance of negative emotions.

Part of this module is teaching an awareness of emotions and differentiating emotions from each other through the use of self-monitoring homework. Particular emotions that are addressed in detail are sadness, anxiety, anger, hostility, loneliness, shame/guilt, and self-pity, as these are the common “high risk” emotions. In addition, we also discuss how positive emotions may place someone at risk. These emotions are tied back to the distorted cognitions that were discussed in the previous module, in terms of linking them to an offense chain.

Following the discussion of the identification of emotions, we address strategies for managing emotions, such as the use of assertion, self-talk, relaxation/mediation/mindfulness, and effective communication. These strategies are role-played in the group and clients are encouraged to use them on a day-to-day basis on the unit.

We also hold a discussion of sexual arousal during the emotions management module, and the fact that strategies to manage difficult emotions, such as anger and self-pity, can also be used to manage sexual arousal. Like other emotions, it is not necessary to act on sexual arousal and self-talk can be used to reduce it. Arousal management will be discussed in a later chapter as a topic that is addressed in individual therapy.

## Behavioral progression

The next module of the self-management component is the behavioral progression (or offense chain) module. The goal of this module is for the client to develop a detailed understanding of how they committed their offense(s). There are many different ways of doing a behavioral progression, but we prefer to keep it simple (see Box 10.1 and Table 10.1).

## Box 10.1 Behavioral progression example: “My fourth wife”

My fourth wife and I had recently been divorced and I started living on my own again. I was pissed off and feeling lonely. I eventually met Wanda and started up a relationship with her. She was already pregnant with her ex-boyfriend's child. She moved in with me, because she had nowhere else to stay. I wasn't thrilled with the situation, but at least I wasn't alone. She might be someone else's throwaway, but at least I felt like somebody wanted me. A little while later I got laid off. It seems like I always get treated like shit. I started spending a lot of time around the house. At that point Wanda's 13-year-old daughter Betty, who had been living with her grandparents, moved in with us. I really had no choice in the matter. I'd rather live alone with Wanda, but where else would Betty go? A short time later Betty told me her uncle had sexually abused her. When I heard this I told Wanda and her parents, but they didn't do anything about it. This left me thinking that they didn't care if she had sex or not. I also started looking at Betty a bit differently now that I knew she was sexually experienced. One day I saw Betty walking from her bedroom to the bathroom nude. What a great body she had! I told Wanda about it, thinking that she would stop her daughter from doing that sort of thing but she did nothing. I guess her mom doesn't care what Betty does. A while later I was drying off after my own shower and Betty walked in on me. She was completely nude! I told her to leave but the incident got me thinking; maybe she is coming on to me. Why else would she walk in like that? I was really turned on thinking about her that way. One night Wanda and I had an argument, and I left and I ended up at the bar. I was thinking about everything I had done for the bitch, and she still treats me like dirt. Man I was pissed off. I decided to get drunk. When I got home it was late. Wanda was already in bed, but Betty was lying on the floor in front of the TV. Again I noticed her hot little body, and got turned on. I lay down beside her. I was thinking again about Wanda, and how she doesn't seem to appreciate anything I do for her. Finally I said to myself, “Screw it, I deserve to feel good” and that's when I had sex with Betty.

**Table 10.1** Behavioral progression based on example in Box 10.1

| *Event* | *Thought* | *Feeling* | *Behavior* |
|---|---|---|---|
| 1. Divorce from fourth wife | ? | Pissed off<br>Lonely | ? |
| 2. Started a new relationship | Wasn't thrilled<br>Someone else's throwaway | ? | Moved in together |
| 3. Got laid off | I always get treated poorly | ? | Hangs around the house |
| 4. Betty moves into the house | I have no choice<br>I would rather that Betty didn't move in | Angry<br>Frustrated | ? |
| 5. Betty says she was abused by her uncle | She is experienced<br>They don't care if she has sex or not | Curious<br>Confused<br>Frustrated | ? |
| 6. Betty walks nude | What a great body<br>Mom doesn't care<br>She's coming on to me | Aroused | Tells her mother<br>Tells her to leave the room |
| 7. Argument with girlfriend | She's a "bitch"<br>I have done so much<br>I'll get drunk | Anger<br>Frustration<br>Lonely | Goes to the bar and gets drunk |
| 8. Goes home and lies down next to Betty | Thinking about girlfriend/how she doesn't appreciate him | Aroused<br>Frustrated<br>Angry<br>Anxious | Sexual assault |

This assignment requires the client to develop a series of thoughts, feelings and behaviors which culminate in a sexual offense, building on what they have discovered about themselves through the preceding treatment activities. We asked them to identify 7–10 such sequences and if they have multiple offenses we ask them to chose a "typical" offense.

In order to assist the clients in understanding the nature of the assignment, we work through, in group, the example in Box 10.1. The resulting behavioral progression is displayed in Table 10.1. In completing their behavioral progression, we also ask the clients to identify any other factors that might contribute to their sexual offending. For example, many of our clients' backgrounds are characterized by emotional, physical, and/or sexual abuse; many have long-standing substance abuse problems (particularly alcohol); and they have a history of relationship problems. These are often factors that are always present in their lives, affecting the manner in which they respond to situations but may not be specifically related to sexual offending.

Like other major assignments, behavioral progression is presented to the group for the clients to give and receive constructive feedback, as well as to learn from each other.

## Self-management

The final module of the self-management component is what we term the self-management module. It is in this module that clients develop a self-management plan, which puts together everything they have learned during the program. In this plan they remind themselves of their goals and reasons for change which they identified early in the program; they identify their main risk factors and coping strategies; they identify their strategies for appropriate use of leisure time; and their main sources of support, among other important factors related to preventing reoffense. Again, this plan is presented in the group for the purpose of obtaining feedback.

# 11
# Social Skills and Individual Therapy

The Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP) functions as a closed program with no more than 10 persons attending a treatment group. It should be noted that for 2 years in the late 1990s we tried starting with 12 offenders in each group, but attrition rates increased during that period due to increases in disruptive behavior. The groups were more difficult to manage and there was more conflict among group members. Our recommendation is that when dealing with high-risk, generally antisocial sexual offenders, group sizes should be no greater than 10.

Treatment generally consists of both individual and group components. Where it is deemed appropriate, clients may first attend individual therapy only until such time as they are ready to participate in the full program. For example, clients with significant histories of mental health difficulties sometimes benefit from a period of adjustment where issues are discussed in individual therapy prior to being discussed in a group format. The concerns that such clients express regarding the reaction of others to their histories or the sometimes unpredictable nature of their behavior may make individual therapy the only viable option, at least at first. For example, clients who have a history of psychosis and who may have some residual signs of the disorder, even if they are being successfully treated with anti-psychotic medication, may require a period of individual therapy. That being said, our goal is to have clients attend group at the earliest opportunity.

## Individual vs. group therapy

In keeping with the work of Yalom (1995), we believe that the group format allows for certain opportunities that individual therapy alone cannot provide. When one member of the group engages in a distorted justification in order to rationalize his behavior, we believe that a counter-argument provided by another member may prove to be more powerful than the same comment made by a therapist. Self-disclosures that sometimes accompany such counter-arguments simply add depth to the perspective of the person challenging the justification. For example, if a client states that, had he not been drinking, the sexual offense would never have occurred, we have had other clients state that this is what they have previously said to themselves as a way of avoiding the other issues that contributed to their offending (e.g., ongoing issues related to anger directed at women). Further, the fact that it may be more difficult to give up drinking in the first place if other issues are unresolved typically is brought up by other group members. By discussing the struggles that other group members have had, clients come to see that the difficulties that they are experiencing are not unique to themselves.

It is interesting to note that some clients, in spite of our best efforts, are never able to participate in the full treatment program. In the vast majority of cases, this relates to the very

complicated psychiatric history with which they present. Every effort is made to go over the material typically covered in group with these clients. Nevertheless, these clients receive many fewer hours of therapy than those attending the full treatment program. In two studies by our group (Di Fazio et al., 2001; Looman et al., 2014), we found that there were no significant differences in terms of sexual offense recidivism between those attending the individual-only program and those attending the full treatment program (which consists of both individual and group therapy). In the earlier of the two studies, data were available on 143 clients who received the full treatment program vs. 62 clients who attended the individual-only program. Follow-up was approximately 5 years for those attending the full program vs. *c.* 7 years for those attending the individual therapy only program. With reference to the full program, 14.7% were convicted of a new sexual offense compared with 19.4% in the individual-only program. These findings are somewhat counter-intuitive in that those clients in individual therapy received significantly fewer treatment hours and yet recidivated at similar rates to those in the full treatment program. Although there are a variety of possible explanations for these findings, the explanation that made most sense to us is that these clients presented with primarily mental health-related deficits (and associated social skills and intimacy deficits). The more recent study by our team confirmed the fact that the majority of clients in individual therapy had significant psychiatric histories and/or a history of cognitive impairment. Treatment that addressed these needs may have resulted in sufficient improvements for their risk of recidivism to be reduced. Clearly more research is needed in this area, but these data do raise an intriguing possibility. That is, for severely mentally disordered sex offenders who do not present with many traditional criminogenic needs, individual therapy that focuses on issues related to general psychological functioning may be sufficient to meet their treatment needs. Perhaps this explanation also accounts for the findings of Craissati and McClurg (1997), who observed that, for certain outcomes, those treated in individual or group therapy improved to a similar degree. Unfortunately, given the limited number of studies in this area, our perspective has to be viewed as tentative at present. A recent study by our team (Abracen et al., 2015) also demonstrated that, among a high-risk sample of offenders living in a community setting, the more individual therapy sessions that clients attended, the better the outcome in terms of rates of recidivism. We had previously demonstrated that this sample of offenders presented with very high rates of mental illness (Abracen et al., 2014). The sample consisted of both sexual offenders and offenders with no prior history of sexual offending. Relative to those who were only assessed or who had no treatment, those offenders who received more individual therapy sessions (i.e., > 20 sessions) were approximately 12 times less likely to recidiviate.

It should be emphasized, however, that even though there was an emphasis on helping these clients cope with issues related to general psychological functioning (including the skills necessary to achieve and maintain intimate relationships), abbreviated discussions related to more traditional treatment targets were also a focus of treatment. For example, discussions concerning the identification of factors related to the commission of a sexual offense or a series of offenses were invariably incorporated into treatment sessions. In addition, the identification and management of high-risk situations (i.e., situations that, if encountered, would present the client with an elevated risk of recidivism) were topics also incorporated into these sessions. However, even these so-called traditionally forensic discussions were

related to mental health issues in many cases. For example, it is quite common for clients in individual therapy alone to note that isolating themselves was related to the development of deviant fantasies and negative emotionality (anger, loneliness) which contributed to the commission of a sexual offense.

## Social skills deficits

Marshall et al. (2006) and Mann et al. (2010) have both outlined a small number of social skills deficits that appear to be related to sexual offending. In general these writers have noted that many social skills deficits have not been found to be directly associated with recidivism. However, both Marshall et al. (2006) and Mann et al. (2010) note that intimacy deficits in sexual offenders have received sufficient support in the literature to reasonably be considered a dynamic risk factor related to recidivism. Marshall et al. (2006) have also plausibly argued that loneliness and attachment difficulties are potentially important risk factors for sexual offenders. Obviously, there are a number of social skills that are related to these dynamic issues, at least indirectly.

Although the available evidence is not conclusive, we believe that concurrent psychiatric disorders (and, in particular, substance abuse in combination with Axis I or serious Axis II disorders) can reasonably be added to the list of likely dynamic risk factors. It should be emphasized that this latter point is not simply of theoretical relevance. Our program operates on the assumption that such concurrent disorders need to be addressed in treatment. Although the evidence in support of specific social skills deficits and their relation to recidivism is inconsistent, we believe that the need to address the complex social skills deficits typically seen in clients with concurrent disorders is critical in addressing the mental health needs seen with our population. For example, Mann et al. (2010) note that hostility has been associated with recidivism in some research and these authors suggest that it might therefore be a legitimate target of therapy. We have incorporated into our program sessions addressing hostile attitudes generally (see Chapter 10) but in the social skills component this is addressed in a more behavioral fashion. Many of the clients with whom we interact do indeed engage in hostile communication but, to some degree, this relates to their difficulties in differentiating among passive, assertive, and aggressive communication styles generally. Further, difficulties that they frequently experience with reference to intimate relationships may relate in part to their inability to differentiate between these patterns of communication.

We believe that a variety of social skills deficits may be indirectly related to recidivism as well, via their impact on known risk factors (e.g., intimacy deficits). For example, clients who are unable to engage in empathy or who fail to differentiate among passive, aggressive, and assertive communication styles would likely have difficulties establishing and maintaining an intimate relationship. Helping such clients resolve issues of jealousy might also be plausibly related to a reduction of risk, even though we are not familiar with any research directly linking jealousy with an increased risk of recidivism. The link between jealousy and anger/hostility is, however, not hard to make. Further, difficulties with emotions management may be related to other known risk factors for offending. We have frequently encountered

clients who stated that they used street drugs as a way of coping with depression or anxiety issues. This drug use is related to their establishing links with criminal associates. Both the drug use and criminal associates are known risk factors for recidivism, yet it is difficult to address such issues without also addressing the mental health needs and associated social skills deficits of this population. Of course, these issues become more germane only if it can be shown that the majority of the clients we treat have serious (and typically concurrent) mental health disorders and that these disorders are associated with social skills deficits. We believe that the available evidence currently supports such a perspective. That said, we have engaged in social skills treatment long before the more recent evidence related to mental health difficulties and recidivism appeared in the literature. Needless to say we are relieved that recent research has begun to bear out the assumptions on which we have operated for many years.

It should be emphasized that a variety of techniques have been developed in the cognitive-behavioral tradition that have proven to be effective in the acquisition of social skills. Many of those techniques have been adapted for use with our clients. Further, rather than simply focusing on extinguishing inappropriate behaviors, (e.g., anger, hostility) we believe that there is a need to provide clients with a general set of social skills that they can use to improve their lives (e.g., assertive communication skills, appropriate problem-solving). Such an approach is consistent with the Good Lives Model suggested by Ward and Maruna (2007). Our model (i.e., Integrated Risk–Need–Responsivity [RNR-I] Model), which we view as a simple elaboration of the approach advocated by Andrews and Bonta (2010), is in keeping with the tenets of cognitive-behavioral therapy, which has proven to be very effective with correctional populations. Role-plays, modeling techniques, and discussions in individual therapy can all be used to adapt these techniques to the specific needs of individual offenders. Treatment progresses through an orderly series of goals and skill development exercises and addresses a variety of social skills deficits that are related to dynamic risk factors. The dynamic risk factors identified in the literature (e.g., anger management, development of intimate relationships) are a focus of the social skills component of treatment.

Rather than simply trying to eliminate inappropriate behavior, the RTCSOTP teaches important skills that clients can use in numerous ways to achieve happier, more pro-social lives. We leave it up to the client to use these same skills in a variety of different domains (e.g., work, intimate relationships). Further, clients are provided with opportunities to practice these new found skills both in formal treatment and on their living units with staff who spend part of each shift on the unit interacting informally with those participating in treatment.

There are a variety of aspects to the social skills component that is offered as part of the full treatment program at the RTCSOTP. Although aspects of the social skills manual have evolved over time, the overall content has remained relatively stable. Advances in the research and treatment literature have led us to evolve the way in which treatment is offered. Although from a methodological standpoint it could certainly be argued that the program material should remain static, we believe that this is an untenable position for a variety of reasons. Given the low base rate of sexual offense recidivism (for a discussion, see Barbaree, 1997), it is necessary to treat a large number of clients and to follow these clients for many years if one

wishes to have a reasonable expectation of finding statistically significant differences between treatment and comparison groups. Given the relatively small numbers of clients who are treated at any one time at the RTCSOTP and the need to follow such groups for many years (in practice we have followed clients for a minimum of approximately 5 years, on average), it would simply be impractical to keep the program static for a decade or more in order to determine whether one version of the program is successful. An argument could be made that it would also be unethical to maintain program content despite changes in the literature. For example, research indicating that confrontational approaches are counter-productive (Marshall et al., 2011) was considered in modifying program structure in the mid-1990s. Had we adopted a confrontational approach, as was popular at the time, this would probably have come at the cost of treatment effectiveness.

Further, even if such a procedure were adopted in theory, in practice our program evolves with each group of clients who attend. We believe that the program must meet the needs of the individual clients attending a specific group. Although a manual is used and treatment progresses through an orderly series of stages, the discussions related to each topic change with each group. Program material is intentionally designed to allow for such discussions. We believe that it is an error to place so much information in any one session that little time for group discussion related to the topic is allowed. For example, in the social skills module on empathy, two full sessions are dedicated to role-plays. Each client is given a chance to be involved in a role play related to empathy and time is allowed for feedback from other group members. Group members are encouraged to give positive and constructive feedback. It is difficult to dictate that only 10–15 minutes should be allowed for discussion of each role-play. This is particularly true for high-risk groups presenting with concurrent disorders. Although it may seem an unlikely constellation of characteristics, we certainly have had numerous clients attend treatment who present both as antisocial in orientation and as having difficulties with anxiety and depression. If therapists adopt the position that at least some of the clients attending treatment suffer from complex trauma-related disorders, this presentation seems less unusual and may help therapists empathize with such groups. Such clients present with unique responsivity issues that may take time to address either in individual or group therapy.

The point that needs to be emphasized is that many clients in such groups will not necessarily take enthusiastically to such exercises and need to discuss the reservations that they may have prior to participating in such role-plays. We believe that such resistance is natural and probably an honest reflection of the contradictions that such clients typically present with. These clients may simultaneously understand that they do have many difficulties in communicating with others (e.g., they may be tired of only being comfortable being angry with others) but feel that role-plays are an artificial and meaningless enterprise. Clients are reassured that such feelings are normal and that engaging in certain types of unfamiliar patterns of communication will likely feel foreign at first. When real-life situations occur on the living unit, clients are encouraged to practice these same behaviors outside of the group setting. Further, given the presence of staff on the unit when clients are not in group, these same clients have an opportunity to watch staff modeling appropriate behavior.

Readers interested in the full treatment program manual can contact the authors for this

information. We will not review the details of each session in the social skills manual in the following pages. Rather, we will discuss the topics that are covered as well as the order of presentation of these materials. Details regarding several sessions will be provided in order to help inform readers on how the material is typically presented. We are in agreement with Marshall and his colleagues (e.g., Marshall & Marshall, 2007) that when overly prescriptive manuals are used, it is difficult to meet the treatment needs of offenders attending the program. That said, we believe that there is a need for some structure to the group and that therapists should be provided with information related to what topics should be covered in group and the order in which this information should be presented.

# Social skills component

## *Introductory sessions*

Treatment begins with a variety of sessions where clients are introduced to the treatment process and basic group rules (e.g., confidentiality) are discussed. A variety of discussions related to why clients have chosen to attend treatment begins the process. Clients are encouraged to be honest in terms of their motivations to attend. For example, we would never chastise a client for saying that he has agreed to attend the treatment program because he hopes to get an early release. From our perspective, this is a reasonable rationale for attending treatment as the institutional environment is very difficult to cope with, particularly for clients with significant mental health histories. It is interesting in this regard that some of our clients present with hyper-masculine orientations and would probably deny any significant mental health histories. It is not uncommon, however, even in such cases, to find that aside from a personality disorder (e.g., antisocial personality disorder) and a substance abuse disorder (in many cases, the abuse of more than one substance) these same clients have exhibited signs of other serious mental health-related concerns. For example, it is our impression that many of these same clients have engaged in some type of self-harming behavior. That is, the bravado sometimes seen in these clients masks severe difficulties in a number of aspects of their lives. Marshall et al. (2006) made similar observations regarding some clients who appear to present with very high levels of self-esteem. Conversations with staff who worked with these clients suggested that such bravado masks a number of significant difficulties. Clients are encouraged to discuss the sometimes contradictory nature of their motivations to participate in treatment, noting simultaneously that they are attending treatment because they want an early release and that they have one or more personal issues they might like to address.

The early social skills sessions focus on group process and help to encourage clients to begin trusting others. For example, clients are encouraged to provide answers to some of the following questions. What is your level of trust within the group on a scale of 1 to 10? What has stopped you in the past from trusting others? What role does your level of trust play in your ability to communicate? What factors either hinder or encourage the process of change? Clients are provided with several homework assignments which further help them to establish their goals for treatment. As an example, we have included one such assignment, “Goals for

professional growth and development," in Appendix 3. In addition, there are "values identification" exercises, which help clients to identify those things they value in their lives and which, in turn, assists them in goal-setting (a future component).

## *Communication skills*

Following the introductory groups, information regarding communication skills is provided. These sessions are general in nature, as specific modules related to assertiveness, anger management, and relationships come later. These sessions provide basic information on listening skills as well as the impact of non-verbal aspects of communication. Rather than having the information presented in a purely didactic fashion, where possible, humor is used to help convey the essential information. For example, in one session, half of the group is asked to leave the treatment room with one facilitator and the other half remains in the treatment room with a second facilitator. The clients outside the room are asked to pick a group member inside the room to relate a story or anecdote to. The clients inside the room are instructed not to listen to the person who is trying to relate a story to them. They can turn away, they can fidget, interrupt or use any other distracting behaviors that occur to them. After 5 minutes with each pair of clients, the exercise is stopped. Both participants are then asked about their reactions to the exercise. Clients are also presented with handouts regarding various aspects of communication (e.g., non-verbal aspects of communication, use of self-disclosures, and pace and volume of communication, barriers to communication).

Discussions of barriers to communication and giving and receiving feedback are also included in this module, as these are important aspects of group participation as well as developing supportive relationships. The communication skills module is presented early in the program in part to help prepare clients for the upcoming offense disclosure component of the self-management component. It is hoped that clients will benefit from role-plays and discussion oriented towards effective communication in order, in part, to make later aspects of the program easier.

## *Goal-setting*

The goal-setting module is a relatively recent addition to the RTCSOTP. This module was added due to the observation that the majority of our clientele have never set appropriate goals for themselves, and are unfamiliar with the process of identifying the steps needed to engage in appropriate goal-setting. It is believed that setting appropriate pro-social goals helps clients to monitor their progress in life towards concrete achievements. Goal attainment provides clients with a sense of accomplishment and enhances motivation to maintain gains and pursue further positive change. Sessions are oriented toward assisting clients in identifying and setting realistic pro-social goals and teaching the steps required to set goals and monitor progress toward them.

## *Problem-solving*

With reference to problem-solving, research reviewed earlier suggests that sexual offenders

are more likely than other groups to engage in emotionally based problem-solving strategies (e.g., Marshall et al., 2000; Cortoni & Marshall, 2001). These strategies are less likely to result in a satisfactory resolution of the issue that the client is trying to resolve. For example, by focusing on their difficulties, clients with an emotionally based coping strategy tend to react by feeling anxious, depressed, or angry. In the problem-solving module offered in the RTCSOTP, information related to five basic steps that can be used to more effectively engage in problem-solving behavior are provided, namely

- the identification of the problem
- setting goals
- generating alternatives
- decision–making
- assessing the results of the decision.

Clients are provided with several scenarios where they get an opportunity to practice these skills. In addition, there are typically real-world opportunities to practice these skills while attending the program. For example, it is quite common that clients attending the RTCSOTP receive unwelcome news regarding their release plans. Two typical scenarios that clients attending the RTCSOTP may have to confront include being told that they will not be allowed to move to a lower security environment following the completion of treatment, and being informed that they will be required to complete their entire sentence within an institutional setting rather than being granted a conditional release to the community. Clients may initially respond by becoming angry and they may say that there is no point in completing the treatment program given the bad news they have received. By working through the five steps of problem-solving, clients may come to see that quitting treatment is not a good long-term solution to the difficulties that they are experiencing.

## *Empathy*

During the empathy module of the social skills component, clients are assisted in first understanding the definition of empathy and differentiating empathy from sympathy. It is important to note here that this does not refer to victim empathy; rather the empathy addressed in this component is a more general empathy that allows for effective communication.

Thus, the ways in which empathy may be expressed during communication are discussed. For example, clients are asked about the verbal and non-verbal aspects of empathy. Many of the clients attending the RTCSOTP have difficulties in both recognizing and expressing emotions and therefore several sessions of the empathy module are dedicated to these topics. The assumption made by treatment staff is that if clients can neither recognize nor express emotions, it will be difficult or impossible for them to engage in empathic behavior. A variety of group exercises and discussions as well as a series of homework assignments help clients become more familiar with recognizing and expressing emotions. Some of the exercises that we have found to be helpful include asking clients to identify the emotions in a series of statements that

are read by staff (e.g., “I love him a lot, but sometimes he drives me up a wall”). Clients are also asked to bring in pictures of themselves, and other group members are asked what emotion the client is showing in the picture. The client whose picture is being shown is then asked to provide information regarding what emotion(s) he was experiencing when the picture was taken. Handouts of facial expressions and the corresponding emotion are also given to clients. It is important to note that the discussion of emotions in this component is brief and related to the identification of emotional responses in communication. There is a more in-depth emotions management module of the self-management component which addresses the identification and management of difficult emotions to supplement this. These issues are also addressed in depth in individual sessions as required.

## *Assertiveness*

The next section of the manual addresses issues associated with assertiveness. The most important aspect of this module is helping clients differentiate between three response styles: passive, aggressive, and assertive communication. It has been our experience that many clients attending the RTCSOTP experience difficulties differentiating between these response patterns. Clients are provided with the opportunity to practice various patterns of communication via role-plays and are also given homework assignments where they are provided with a series of statements and asked to rate whether the statement is passive, assertive, or aggressive in nature.

Discussions related to these topics may reveal the assumptions that some clients hold. For example, it is not uncommon for clients who typically behave aggressively in interpersonal situations to view assertive people as weak. On the other hand, those who are more comfortable being passive in their approach may be uncomfortable with assertive communication, thinking that assertive individuals are too pushy. These assumptions need to be discussed for there to be much hope of clients making any long-term changes in their patterns of communication.

Clinicians also need to be attentive to non-verbal aspects of communication. It has been our experience that those clients who typically behave aggressively tend to try to use non-verbal aspects of communication to intimidate the listener. These issues should be discussed as well so that clients understand that it is not simply what they are saying that has an impact on the listener, but also how they are saying it. The fact that both the person talking and the listener have rights and responsibilities in any conversation needs to be stressed. That is, the person talking has a right to express his opinion but also has a responsibility to present his perspective in a manner that is respectful to the listener. The listener, on the other hand, has the right to be treated with respect but the responsibility to be attentive to what the person talking is saying. When the listener is unsure about what is being communicated, he therefore also has the responsibility to ask questions to clarify what is being said.

## *Anger management*

A module that directly addresses anger management follows the module related to

assertiveness. While, as noted earlier, there is a complete emotions management module in the self-management component of the program, it was decided that, given the level of difficulty our clientele have with anger, it would be appropriate to address this particular issue separately in each of the components, to take advantage of repetition and over-learning. Additionally, in the self-management component, anger is only one of several emotions discussed, whereas in the social skills component, anger is the focus of discussion.

Clients first begin by answering questions in group related to what is anger and how anger can be differentiated from aggression. It is hoped that clients come to understand that anger is an emotion but that aggression is an action or behavior. The physical symptoms of anger are also discussed. Clients are provided with an anger log where they begin to understand the connection between what they are thinking about a situation, the feelings that are related to these thoughts, and the behavior that follows from these thoughts and feelings. As clients become more familiar with the connection between their thoughts, feelings, and resulting behavior, they come to understand that they can influence both how they feel about a situation and how they will react in similar circumstances in the future. Many of the clients attending high-intensity treatment programs have come to believe that they have little control over their anger and aggression. They may also blame the other person for "causing" them to become angry, stating that the other person "should have known better."

By understanding the connection between thoughts, feelings, and behavior, clients become better able to recognize their anger and intervene prior to their level of anger becoming too difficult to manage. It should be emphasized that clients are not held responsible for feelings of anger; rather it is what they do with these feelings once they experience anger that is important. This statement may seem blatantly obvious to any reader with a background in cognitive-behavioral interventions. However, we believe that it is worth mentioning as both of the authors have seen forensic reports (from a variety of correctional jurisdictions, it should be noted) where clients are returned to secure custody because they were experiencing anger even if they had not acted on this anger. One of the authors (Jeff Abracen [J.A.]) became aware of a situation the day before this paragraph was written where an offender with a history of violence became angry that a visit to his girlfriend might be denied. The visit was being threatened as the client had expressed some frustration about another case management team decision. This anger was seen as evidence in favor of the potential denial of the trip. In reality, the client had not engaged in violent behavior in many years and, in spite of having ongoing anger management issues, had never given any indication that he would act out violently, even if angry. In fact, quite the opposite was true. The client had been exposed to frustrating situations both at work (as he had been living in the community for many years at this point) and in relation to correctional decisions made about his release. He had, for many years, managed to work through his anger and not become physically aggressive. Further, he had made exceptional gains in being able to express his feelings and understand the connections between his thoughts, feelings, and behavior. His girlfriend expressed no reservations about his visit in private conversations with correctional staff.

Clinicians need to be aware that anger is a universal emotion and clients, especially those with many years of pro-social behavior in the community, need to be given credit for their more

recent behaviors. The fact that a client with a history of violence experiences anger is not sufficient rationale to deny him basic freedoms. The context of the anger and his recent history need to be taken into account before any release decisions (or other correctional management decisions) are made. Needless to say, there may be situations when a client with a history of recent violence expresses anger and a more conservative course of action (e.g., in reference to release decisions) is required. The fact that a client is expressing anger in and of itself, however, does not imply that he will act violently. This is particularly true for those clients with no recent history of violence and who are better able to engage in active listening. By asking questions as to why particular decisions are being made, and learning to understand that the perspective of others may legitimately be different than their own, such clients are generally better able to process their anger in a pro-social manner. Helping clients work through such anger-related issues allows for a greater sense of self-confidence in their ability to manage similar situations in the future in a pro-social manner.

## *Intimacy and relationships*

The modules listed above all precede the largest module of the social skills component, concerning issues related to the establishment and maintenance of intimate relationships. In fact, in one version of the RTCSOTP manual, 16 of the 40 sessions related to social skills were dedicated to issues related to relationship skills. Although the social skills component allows for sessions with no pre-determined topic (e.g., to deal with issues that the group must process before moving on to other matters such as recent violence between group members), it is fair to say that the focus of the social skills manual rests largely on relationship skills, problem solving and emotions management.

The relationships module covers a wide range of topics, beginning with introductory sessions, and followed by information related to disclosing one's history of offending to a potential partner, dealing with loneliness and rejection, negotiating sexuality within the context of a relationship, maintaining relationships, and issues associated with parenting. Although many of these topics are familiar to clinicians working in the area of sex and marital therapy, especially those with a cognitive-behavioral orientation, there are aspects to working with high-risk, high-needs groups of offenders that make some of these discussions quite different than in more conventional settings. For example, negotiating consent for sexual behavior is in some ways quite different for a client with a long history of sexual offending. Clients are encouraged to discuss their history of offending prior to becoming sexually involved with a potential partner. However, questions such as what environment such a discussion should take place in and when such a conversation should occur are topics that may be more salient for forensic populations than other groups. To give one obvious example, clients are strongly discouraged from saying that they have been convicted of multiple sexual offenses against adult women on a first date while in a locked room in a secluded location. Although this may seem obvious to most, certain clients, intentionally or otherwise, might not follow such common-sense approaches unless the issue is specifically addressed in treatment. This latter statement is based on comments made by clients and treated by either of the authors. Clients are also encouraged to rehearse what they are going to say and to provide some of the contextual information that may

help the listener understand that the client was experiencing a wide range of other difficulties at the time the offense was committed (e.g., abusing drugs and alcohol, unemployed, spending time with criminal associates).

In spite of all of their best efforts, clients may still be rejected by potential partners after disclosing their history of offending. They must be prepared for such rejection. Clients should be able to use their empathy and anger management skills when dealing with rejection. Even if the potential partner is still interested in pursuing a relationship, however, clients must be aware that there will likely be an extended period where they will have to build trust with the partner, who may be leery of being intimately involved with someone who has committed a sexual offense. Given how difficult this topic can be for many clients, we strongly recommend that this issue is raised both in institutional treatment programs and once again when the client is released to the community. Although clients may have few opportunities to form a relationship while incarcerated, we believe that the process of helping them to think about how they will manage such situations in the future is important and may increase the likelihood that they will implement such techniques when released.

The reader should keep in mind that for many clients seen in our treatment programs, the notion of disclosing any personal information to a potential sexual partner is essentially a foreign idea. Clients need to be able to address any resistance they may have to such an idea, which, when initially presented, may seem quite foolish to them. If clients are given an opportunity to explore how their approach to sexual encounters/relationships has worked for them in the past, they may become more receptive to some of the ideas being shared in the group-based setting. For example, such discussions may result in the conclusion that there are people who could be willing to form a relationship with the client but whom the client should avoid. For example, potential partners who are involved in criminal activities or who are actively engaged in substance abuse should probably be avoided. As some clients attending our programs confuse intimacy with sexual behavior, they may operate on the assumption that the more sexual partners they have, the more likely they are to be satisfied or to find intimacy. In order to change such fundamental assumptions, many conversations with the client will probably be required. Further, we have found that, to be most useful, such conversations should take place at various points and during several different treatment programs. Simply put, clients need time to reflect upon information like this.

The sessions regarding disclosing one’s history of offending are followed by discussions related to the initiation of intimate relationships. These conversations involve helping clients determine what is important to them in a relationship, whether these expectations are reasonable, and the value of compromise in relationships. Clients may also be asked about how their ideal partner compares to partners they have been with in the past. It is quite common for clients to arrive at the conclusion that these previous partners are very different from the type of person they would ideally like to become involved with. On the other hand, sometimes clients will say that they are with their ideal partner at the moment and fail to recognize inconsistencies between this person and their perceived ideal. In such situations, the therapist and the client can discuss these issues, preferably in a non-threatening and non-judgmental manner. In the end, it is important for therapists to recognize that it is the client and

not the therapist who chooses the client's partner. We cannot impose our values on the client in making these choices. The job of the therapist is to help the client understand the potential consequences of being with a partner who presents the client with potentially high-risk situations (e.g., having alcohol or drugs lying around the house in the case of a client with a history of polysubstance abuse).

We have found, particularly in community settings, that although clients may initially be reluctant to end a relationship with such partners, with time many come to the realization that such relationships are very problematic. For example, clients may not be terribly concerned about alcohol lying around the house, claiming that they have not had a drinking problem in some time, but they find it very difficult to manage the emotional volatility with which their partner presents. We have also found that comments made by other group members can have a profound impact on the behavior of clients involved in such problematic relationships. This is particularly true in groups that possess more cohesion and where group members are therefore motivated to offer constructive feedback to other participants. Clients will also need to assess what qualities they are able to bring to a relationship.

Some may expect more from a partner than they themselves are willing or able to give. In such situations, clients will need to evaluate what compromises they are willing to make in terms of who their ideal partner might be. Humour can be quite beneficial in discussing such issues, especially when the clinician has a rapport with the client and whatever is said is conveyed in a manner that is respectful. We have also found that such discussions may be more productive when addressed in both individual and group therapy, especially with clients suffering from long psychiatric histories who may be very sensitive to perceived negative feedback in a public forum. Some clients may, in fact, feel that they have nothing at all to offer in a relationship and such issues, particularly in cases where clients have substantial psychiatric difficulties, may require more clinical attention than can be provided in a group session.

Suggestions regarding support groups or organizations that may offer assistance can be helpful for these clients in forming friendships and sometimes intimate relationships with others who have struggled with similar issues. In addition, community-based volunteer organizations that are specifically designed to help offender groups can have a profoundly positive impact on such clients when released. In this respect, we discuss the research related to circles of support and accountability (e.g., Wilson & Prinzo, 2001; Wilson et al., 2002) in Chapter 15 on community management of high-risk offender groups. This community-based support system for high-risk, high-need clients, formed with the assistance of faith-based volunteer groups, has been found to have a significant impact on helping such groups of clients reintegrate successfully into the community. Clinicians working with such groups can have significant input in helping such organizations to achieve positive outcomes.

The reader should keep in mind that discussions that relate to sexual behavior are important to the client not only to ensure consent but also to help the client improve other aspects of his sexual life. Conversations with clients should reinforce the fact that by talking about sexual matters, they not only ensure that they have consent but also that they can maximize safety for both themselves and their partner and hopefully have better sexual experiences. In other words,

communicating about sexuality should not simply be viewed in a negative light (e.g., so as to ensure that the client avoids committing another assault unintentionally) but also as an opportunity to explore sexuality with a partner. By discussing what both partners enjoy or would like to try sexually, clients may be able to experience more positive sexual relationships, which may further help to establish a deeper level of intimacy. All too often, issues regarding sexuality with clients attending sex offender treatment are presented in terms of activities to be avoided or discussions that should occur if only to avoid committing other sexual offenses. Although these topics are clearly relevant, we believe that clients are more likely to try to engage in these prescribed activities if they believe that such activities not only will help them to avoid being charged again but also may improve the quality of their sex lives.

It is naïve to think that sexual offenders will not be concerned with sexuality following treatment or that a complete lack of sexual desire or behavior is the best possible outcome and therefore conversations regarding improving one's sexual life should be avoided. The question is not whether clients will choose to engage in sexual behavior (most will), but rather whether they are choosing appropriate partners and engaging in responsible sexual behavior. In Chapter 13, dealing with inappropriate arousal, a number of concrete examples are discussed (e.g., regarding masturbation practices and the use of fantasies). Hopefully it will become apparent from such examples that whether a client masturbates (to give but one example) is not the relevant issue. The questions that are more relevant include how often the client is masturbating, his motivations (e.g., to cope with negative feelings), and what fantasies are being employed. As recently as the day before this section was written one of us (J.A.) read a report that implied that the fact that a client had masturbated (without any contextual information) was a lapse or slip. From our perspective the fact that a client engaged in this activity is not at all problematic. Whether he had used an inappropriate fantasy to become aroused, and how many times he had masturbated during the day, however, are more relevant details. Of course, clients will likely be unwilling to discuss such issues unless they feel that the therapist is supportive and not trying to use this information in a negative manner (e.g., to incarcerate or otherwise detain the client). It is our perspective that inappropriate fantasies can be managed, except in exceptional circumstances, even in community environments. If clients understand that this is the orientation of the clinical team, they may be more willing to discuss such matters.

As loneliness, negative emotionality, and emotionally based coping strategies more generally are thought to be potential risk factors for many sexual offenders, issues with loneliness, rejection, and jealousy are specifically addressed in group sessions related to relationships. With reference to loneliness, discussion focuses on the difference between loneliness and being alone. Conversations concerning how clients have coped with loneliness in the past also become a focus of discussion in these groups. It is not uncommon to hear clients say that they picked up a sex worker, engaged in excessive masturbation, used alcohol/drugs, or engaged in some type of self-harm as methods of coping with loneliness. In contrast, by engaging in activities that are both pleasurable and prosocial (e.g., exercising, volunteering) they may help themselves feel better about their situation and feel less bored or anxious. Further, some of these activities may put them in situations where they are more likely to meet other like-minded

persons (e.g., if they join the local YMCA to exercise). Modifying personality traits that may make them less appealing to others (e.g., always being angry, overly critical) may also assist clients to achieve the frequently stated goal of being less lonely. Negative self-talk that may contribute to feelings of loneliness should also be challenged. Clients sometimes discount the role of friends or families in their lives, and the value that such groups can present to them should be discussed. Engaging in positive self-talk can also improve clients' sense of self-efficacy in terms of their perceived ability to talk to others and form new relationships.

Aside from sessions being devoted to loneliness group discussions are also included regarding rejection and jealousy. Given that many of the clients we treat have come from very dysfunctional backgrounds, they may experience exaggerated reactions to perceived rejection. Such reactions may be related to ongoing attachment difficulties and can sometimes lead to antisocial behavior. With reference to rejection, clients are encouraged to understand the role that their very difficult backgrounds may play in their response to perceived rejection. Understanding that they can choose to respond in a new fashion and the role of their thoughts in perpetuating such reactions can be important in helping them to respond more appropriately. For example, some clients typically respond with anger when a relationship ends, blaming their partner for the break-up. They lack awareness or fail to acknowledge that the break-up has triggered fears about being lonely again or that it brings up feelings of rejection by significant others in the past (e.g., by parents or caretakers). For some, especially clients with a hyper-masculine orientation, it is easier to express anger, an emotion with which they are more comfortable. If clients have learned in earlier sessions to both identify and express a wider range of emotions, it may be easier for them to deal with feelings of rejection and jealousy. We have found that anger allows clients to justify blaming the end of a relationship solely on the other person. However, if clients are able to identify the positive feelings they might have experienced in the relationship, this might improve the chances that they can objectively assess how they contributed to the end of a relationship as well (e.g., expressing suspicion every time a partner went out on his or her own with friends).

Ward et al. (1995) suggested that sexual offenders may enter a "cognitively deconstructed" state related to a narrowing of their focus to the point where sexual aggression may seem the only possible reaction to a particular situation. Such states are associated with very superficial and concrete thinking, whereby the person begins to focus solely on the behaviors they want to engage in and little else. By expanding the range of feelings that clients experience in reaction to perceived rejection and by helping clients understand their possible role in the end of a relationship, therapists can help clients cope with such cognitively deconstructed states. Further, if clients are able to identify very strong positive feelings towards the person, even if they simultaneously experience anger that the relationship ended, they may be more willing to consider the fact that they actually do not want to harm the person and consider the long-term consequences of the behavior both for themselves and the other person. In other words, they might be able to engage in thinking that is not part of a cognitive-deconstructed cycle of thinking that can lead to one or more types of sexual offenses.

For many of the clients seen at the RTCSOTP, the information presented in the social skills groups will be insufficient for their needs. Individual therapy is typically used to allow clients

to process some of this material in greater detail than can be accomplished in group. Clients may, for example, be very reluctant to discuss what sexual activities they enjoy or be unwilling to compromise about sexual activities with partners. Further, any difficulties that they have experienced with reference to sexual functioning may be topics they are uncomfortable discussing in a group setting. When discussing very sensitive issues such as these, the significant psychiatric histories of the clients seen in our programs can inhibit their ability to make meaningful progress without additional discussion in an individual context. To give a few examples of issues that may impede progress in this area we will briefly discuss two examples from opposite ends of the clinical spectrum.

### *Tom – clinical anxiety*

We have seen clients with significant levels of clinical anxiety. The case of Tom is not atypical of several clients with whom we have worked. We have removed any identifying information from the discussion but have included some detail regarding general psychiatric and psychological information of relevance. Tom presented with generalized anxiety regarding a wide range of issues. Among the issues that Tom was anxious about were concerns over even initiating conversations with adults that may result in dating, much less specific discussions about what sexual activities he wished to engage in. Given Tom's fears related to sexual functioning, should he have been able to form an intimate relationship with another person, he might have avoided all sexual behavior in spite of his feelings that he very much wanted to have sex with the other person. Given Tom's attachment insecurity, he even wondered if there was any point in trying to establish an intimate relationship, as he presented as skeptical that anyone would choose to be with him romantically. In keeping with his overall perspective, he worked in a convenience store where there was always a barrier between himself and others. He had few social interactions except at work. Tom presented as having legitimate issues with reference to clinical anxiety, sexual dysfunction, and attachment difficulties. It is sometimes even difficult to know where to begin with clients such as Tom.

Individual therapy is critical in helping both clients and therapists parse such complex issues. In reality, in such situations two separate sets of issues need to be addressed for clients to make progress. The first relates to therapist characteristics (discussed earlier in this chapter). It is critical that therapists establish a safe, non-evaluative environment where clients are able to discuss such issues. Therapist openness and empathy are critical in this regard. However, specific information related to the management of attachment difficulties, sexual dysfunctions, and their treatment and management of general mental health conditions is also essential to help such clients. It is our perspective that although therapist characteristics are absolutely necessary to successful treatment of such groups, they are not sufficient in and of themselves. In cases such as Tom's, knowledge about the management of anxiety-based disorders and sexual dysfunctions is also of importance. For example, therapists should have knowledge of cognitive therapy principles in order to assist such clients to cope with their overall feelings of anxiety. Knowledge of the principles and practice of sex therapy would also be very helpful in helping this client address issues associated with sexual dysfunction. For readers unfamiliar with such sex therapy techniques, an excellent book, which many clients are able to read as

well, is Bernie Zilbergeld's *The New Male Sexuality* (Zilbergeld, 1999). This text, which can still be found in some bookstores, can help clients make gains with reference to communication about sexuality in general and about the management of sexual dysfunctions in particular.

### *Presence of psychopathy*

As noted earlier, discussions related to the management of sexual behavior can be quite varied. One potentially mediating factor to consider is the presence of psychopathy. Psychopathic clients may present with a dismissing style of attachment, claiming that they have no need for relationships. Further, they may present as uninterested in discussing matters of sexuality with potential partners. It has been our experience that such clients are very likely to confuse sexuality with intimacy and are inclined to note (perhaps bragging) that they can find someone to have sex with whenever they like. Such clients may argue that conversations about sexual matters are of little value to them. They have little difficulty initiating relationships, even with complete strangers, given their propensity towards glibness and superficial charm. Further, given very low levels of anxiety, they may be unconcerned about engaging in unsafe sexual behavior or contracting a sexually transmitted disease. Such clients may present as unconcerned about either their own or others' physical safety.

Clearly the manner in which a therapist would interact with such a client needs to be very different than with Tom (see previous section). In the case of clients presenting with such high levels of psychopathy, helping them to understand that their callous attitudes may have been related to being charged with a sexual assault is a reasonable place to start. Such clients might have been unaware or unconcerned with a person's non-verbal behavior (expressions of fear or trying to push the client away). If they were armed, the fact that they were carrying a weapon (whether or not it was intentionally used to help subdue a victim) will need to be discussed. Some clients, for example, may state (and appear to be genuine) that, as they never actually brandished a weapon, the fact that they were armed should have had no bearing on whether a person complied with their sexual wishes. Such clients have argued that the person they were with knew that they tended to carry weapons.

Helping such clients to understand that they need to be concerned about how other people might react to such situations (e.g., being alone in a room with someone they don't know well and then putting a knife or gun on a table while trying to "negotiate" consent) is essential if they are to remain offense-free. The possibility that the client lied about whether the victim knew he was armed is not the relevant issue to discuss from our perspective. Although therapists may be tempted to confront such clients with contradictory file information, we feel this is not the most productive approach. Clients need to understand that other people cannot be treated callously if they wish to remain offense-free in the future. This typically results in conversations about the fact that if they wish to not be charged with a sexual offense in the future they may have to refrain from other criminal behavior where they might treat others callously, since it is difficult in practice to treat one group of persons callously and other potential victims with dignity and respect. For example, both of the authors have treated high-risk clients who have said, apparently with some degree of honesty, that they would rather not commit another sex offense. They may not say that they are likely to remain offence free

however. They may focus on more narcissistic issues, noting how such crimes simply don't pay or that they are concerned about their safety inside the institution if it were discovered they were a sex offender. These clients may also state that they might become involved in other criminal behavior in the future (e.g., continuing to sell drugs). Rather than becoming angry with clients who make such statements, we treat such comments as an opportunity to engage in potentially productive discussions. From our perspective, the most productive approach is one where therapists share their own view and help clients assess the logic of their own approach to arrive at conclusions for themselves. Neenan and Dryden (2001) have, for example, provided a series of excellent examples of how this might be accomplished using cognitive-behavioral principles. That being said, Neenan and Dryden (2001) note that with some clients a more didactic approach may be necessary as well.

The discussion of examples such as these would suggest the need for an integrated system of treatment when working with groups of high-risk, high-need clients. One of the shortcomings to many programs that we are familiar with is that they do not provide an integrated model of treatment simultaneously focusing on a variety of both sex offender-specific and more general criminogenic treatment targets. It is very difficult in practice to address cognitive distortions, for example, without also addressing other treatment concerns. Later in the book (Chapter 14) we will discuss how issues associated with substance abuse can be combined with more traditional elements of sex offender treatment programs. The point of this exercise is not simply to suggest that substance abuse treatment and sexual offender treatment programs need to be combined. Marshall and his colleagues have demonstrated that programs that predominantly focus on sex offender-specific targets (see Marshall et al., 2006) are valuable in reducing the risk of recidivism among low to moderate risk groups of sex offenders. Further, comprehensive reviews have demonstrated the efficacy of cognitive-behavioral approaches to treatment with both sexual offenders (e.g., Hanson et al., 2002) and general offender populations (for a discussion, see Andrews and Bonta, 2003). However, for groups consisting almost exclusively of higher-risk, higher-need offenders, more comprehensive cognitive-behavioral approaches may be required. These approaches need to focus on a wide variety of treatment issues. The discussion in forthcoming chapters will hopefully demonstrate how such goals can be achieved. To date, we are unaware of any comprehensive treatment approaches being described in the literature that focus on the needs of high-risk, high-need sexual offender populations which have also produced long-term outcome data in support of their program. It was with this in mind that we decided to write this book.

The information contained in the social skills component of the manual serves as a necessary foundation to the other topics that are covered in both group and individual therapy. Given the criminal and psychiatric histories of clients attending our programs, we believe it is beneficial for all clients to participate in such discussions. In the chapters that follow, discussions related to more idiosyncratic treatment targets will focus on substance abuse, its link to intimacy deficits, and negative emotionality.

# 12
# Alcohol Abuse, Drug Abuse, and Sexual Offending

The purpose of this chapter is two-fold. First, we will review some of the research related to alcohol and drug abuse and sexual offending. We have recently completed a more comprehensive review of the literature (Ferguson et al., 2014) and readers interested in a more detailed discussion of the empirical literature can also make reference to that manuscript or to Kraanen & Emmelkamp's (2011) recent review. In each of these reviews, the relevance of alcohol abuse to sexual offending has been stressed. For those wishing to read reviews that have provided an alternative view on the association between alcohol and sexual offending, Testa (2002) has provided a discussion of the literature more generally. As we have previously noted (Abracen et al., 2008), however, the review by Testa (2002) did not focus on forensic populations and some of the relevant forensic research was therefore not incorporated into that paper. Also, more research has been published in the area since the writing of Testa's (2002) review. Boles and Miotto's (2003) review of the substance abuse literature more generally, and not specifically related to sexual offending, has suggested that substance abuse may be causally related to violence more generally. Marshall (1996) should be credited for initially suggesting that more research, using psychometric instruments with reasonable levels of reliability and validity, should be used in research related to alcohol abuse and sexual offending. Although there has been some progress in this regard, more research that uses both appropriate instrumentation and relevant comparison samples is clearly needed.

Unlike in our previous review articles (Abracen & Looman, 2004; Abracen et al., 2008, 2014) where the focus was on the empirical literature, the second purpose of the present chapter is to discuss concrete strategies that might be used with sexual offenders who present with substance abuse issues. We focus on clinical matters related to this topic for a variety of reasons. Perhaps the most significant reason for including a chapter on alcohol and drug abuse and sexual offending is that it clearly illustrates one of the central tenets of the Integrated Risk–Need–Responsivity Model (RNR-I). That is, to improve the quality of treatment offered to sexual offenders and other groups of high-risk offender populations, we need to specifically include discussions related to the way in which various risk factors act synergistically to increase the likelihood of offending. Alcohol abuse does not act in isolation to increase a person's risk of offending. For example, as we will demonstrate in the following, alcohol abuse is related to negative emotionality, itself a risk factor for recidivism among sexual offenders. In addition, alcohol and drug abuse contributes to difficulties in managing intimate relationships and one's ability to stay employed. These two issues are widely considered to be criminogenic for both sexual and violent non-sexual offenders. Further, for clients with serious mental illness substance abuse may be a sign of decompensation, which should signal that a variety of mental health interventions may be necessary. It is our view that contemporary treatment programs need to become more comprehensive in the coverage of relevant criminogenic needs. Although likely unintended, one consequence of the RNR model appears

to have been that specific programs were developed to address individual risk factors associated with offending. We believe that this silo approach to treatment delivery has prevented further advances in the field.

When one looks at the treatment literature related to sexual offenders, those programs that have addressed a wider range of clinical issues that have been empirically linked with recidivism have produced some of the most impressive outcome data. These programs include those by Dr. Marshall and his group at Bath Institution (see Marshall et al., 2006) as well as Terry Nicholaichuk, Steve Wong and Mark Olver and their group in the Prairie Region of the Correctional Service of Canada (e.g., Olver et al., 2009; Olver & Wong, 2013). Duwe and Goldman (2009) have also produced data from Minnesota that discusses how issues associated with alcohol abuse might be incorporated into contemporary sex offender treatment programs.

## A review of the empirical literature regarding substance abuse and recidivism among sex offenders

As noted in previous chapters, a variety of issues have been found to contribute to recidivism among sex offenders. Substance abuse, and in particular alcohol abuse, has been frequently linked with sexual offending in the literature. Alcohol abuse has been found to more than double the risk of recidivism among sex offenders (Långström et al., 2004). Abbey (2002) and Abbey et al. (2004) also noted that alcohol use by the offender or the victim, or both, increases the likelihood of sexual assault by male acquaintances.

In keeping with these findings, Mumford et al. (2011) investigated drinking patterns and self-reported history of sexual assault among a sample of 650 American men visiting Tijuana, Mexico from San Diego, California. It was observed that respondents with a history of coercing sex drank more in Tijuana and were more likely to binge drink. Further, Hamdi & Knight (2012) noted that alcohol use was associated with increased rates of aggression in both rapists and child molesters.

In a large-scale study of female college students in the United States, Ullman et al. (1999) observed that alcohol may have both direct and indirect effects on the outcome of sexual assaults. Kingston et al. (2008) noted that alcohol abuse was associated with recidivism among their sample of sexual offenders against children. The relative importance of alcohol abuse versus drug abuse in relation to sexual offenders has been of some interest to us for the last two decades, with a number of our studies having focused on this topic. If we are to incorporate issues surrounding substance abuse into our treatment programs, it seems reasonable to know if all forms of substance abuse are equally important for various groups of high-risk offenders. We have now completed five investigations related to substance abuse patterns with the Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP), which have yielded results that strongly implicate alcohol abuse in the development of sexual offending (Abracen et al., 2000, 2006, 2008; Looman, & Abracen, 2011; Looman et al., 2004a). In all but the data reported by Abracen et al. (2008) and Looman & Abracen (2011), separate groups of violent non-sexual offender comparison subjects were

used to compare groups on the Michigan Alcohol Screening Test (MAST), the Drug Abuse Screening Test (DAST) and a variety of other instruments depending on the investigation.

In the first study conducted by our team (Abracen et al., 2000) a very interesting pattern of results was observed. As only one other well controlled study had been produced at the time (Langevin & Lang, 1990), we made few hypotheses other than that we believed that sexual offenders attending the RTCSOTP would show high rates of alcohol abuse as evidenced by the MAST. What we found surprised us. We observed very high scores for both rapists and child molesters on the MAST (mean scores for these groups were 9.29 and 7.09, respectively). Such scores indicate clinically significant lifetime histories of alcohol abuse. The rate of alcohol abuse for the violent non-sexual offender group was 3.67, which corresponded to the "mild" range of symptoms. We had admittedly used a very conservative method of both scoring and interpreting the MAST in that all items were scored 0 or 1 rather than using Selzer's (1971) original scoring of the measure. The original scoring for the MAST involved items being scored from zero to five points. Had we used the original scoring method, frankly the vast majority of all groups of offenders we assessed would have demonstrated substantial histories of alcohol abuse. This would have potentially obscured important differences between subgroups of offenders. Needless to say, the differences between sex offenders and violent non-sexual offenders was statistically significant on the MAST.

We were quite surprised, however, when the DAST scores were investigated. The DAST, a measure of lifetime history of drug abuse, produced the exact opposite pattern of results as that obtained with the MAST. That is, the violent non-sexual offenders evidenced significantly higher scores on this measure than either group of sex offenders (mean scores on the DAST were 5.54 for the rapists, 4.27 for the child molesters, and 8.04 for violent non-sexual offenders). The majority of both child molesters and rapists fell into the "mild" category on the DAST, whereas the majority of violent non-sexual offenders fell into the "moderate" range on the DAST. In two subsequent studies (Abracen et al., 2006; Looman et al., 2004a), we replicated the findings with reference to the MAST using different groups of violent non-sex offender comparison subjects.

It should be noted that we went to great efforts to ensure that none of the violent non-sexual offenders had any history of sexual offending. The vast majority of the violent non-sexual offenders included in these studies had attended a program for persistently violent offenders. Although these clients were required to have a minimum of three violent non-sexual offenses on their record, many had far more. Our colleague, Roberto Di Fazio, who ran the violence prevention program, screened all of these clients to ensure that no sexual offending was included in their histories by means of a careful review of all available file information (including police reports and other official documentation) regarding both past and present offending.

We have also found that alcohol abuse moderates the ability of the Hare Psychopathy Checklist-Revised (PCL-) to predict recidivism among the group of sexual offenders we have treated at the RTCSOTP (Abracen et al., 2008). As noted in Chapter 3, the PCL-R is one of the better actuarial instruments used in the prediction of sexual offending. However, among sexual

offenders with a substantial history of alcohol abuse (as measured by the MAST), those with high PCL-R scores did not recidivate at higher rates than those with lower scores on the PCL-R. In short, a history of alcohol abuse alone appears to predict recidivism among the RTCSOTP population. In keeping with these data, we have also observed that both the MAST and the and the Sex Offender version of the Violence Risk Appraisal Guide (SORAG; an actuarial instrument designed to predict risk of sexual or violent recidivism) independently added to the prediction of serious (i.e., violent or sexual) recidivism among the RTCSOTP population (Looman & Abracen, 2011). Looman & Abracen (2011) observed that the DAST did not significantly add to the prediction of recidivism after having statistically controlled for the SORAG.

## The RNR-I, alcohol abuse, and sexual offending: theoretical considerations

The results of our research and that of others have concluded that alcohol abuse and, to a lesser extent, drug abuse represent risk factors for sexual offending. Alcohol abuse in particular appears to be of relevance in understanding the genesis of sexual offending. The question that we have wrestled with over recent years is why this may be the case. Rather than simply being an academic exercise, however, we believe that this undertaking is of direct relevance to clinicians. That is, if we understand more fully why alcohol abuse may be related to sexual offending, we may be able to further improve the treatment that we offer to our clients.

One of the earliest studies that caught our attention in this regard was a very well controlled investigation by McGue et al. (1999). They observed that alcohol abuse, as opposed to drug abuse, appears to be associated with negative emotionality. Drug abuse, in contrast, was more closely associated with disinhibited behavior. As noted by these authors, however, this pattern only becomes apparent when one controls for the other type of substance abuse. That is, studies that only investigate alcohol and/or drug abuse and do not control for the other type of substance abuse will likely find that both are associated with negative emotionality and disinhibited behavior.

In discussing the RNR-I (see Chapter 5) we noted that Marshall (e.g., Marshall, 1989, 1993; Marshall et al., 2006) theorized that insecure patterns of attachment and associated intimacy deficits may be related to the development of sexual offending. Marshall has observed that negative emotionality (e.g., loneliness) is one of consequences associated with such patterns of insecure attachment. As we suggested in earlier reviews (e.g., Abracen & Looman, 2004; Abracen et al., 2008), negative emotionality may be an important link between two well documented risk factors for sexual offending, namely alcohol abuse and intimacy deficits. In fact, there is reason to believe that these two risk factors work reciprocally to increase risk.

Self-regulation theories related to alcohol abuse stress the importance of negative emotionality and that alcohol abuse may be a means of coping with insecurity, or avoiding negative situations (Hull & Sloane, 2004). With reference to sexual offenders both Marshall et al. (2000) as well as our group (Looman et al., 2004a) have demonstrated that sexual offenders

have greater difficulties in the area of negative emotionality than do comparison groups as measured by the Coping in Stressful Situations Scale.

Looman (1999) also demonstrated that negative emotionality may be associated with deviant fantasies in sexual offenders. Specifically, it is possible that one of the strategies emloyed by sexual offenders to cope with negative emotionality is the use of deviant fantasies, which may serve a soothing or calming function. Alcohol abuse does not cause these individuals to employ deviant fantasies as a coping strategy; rather, for persons who already present with difficulties in the area of inappropriate fantasies and negative emotionality, alcohol abuse may serve to increase these problems.

More recent findings by Witkiewitz and Villarroel (2009) have highlighted the link between negative affect and alcohol abuse. One of the main findings by Witkiewitz and Villarroel (2009) was that negative affect and alcohol lapses are dynamically linked in the first year following alcohol treatment. These authors have suggested that specifically targeting the link between negative affect and alcohol abuse could significantly contribute positively to outcomes. These data are in keeping with the results of Berking et al. (2011), who observed that deficits in emotion regulation skills predicted alcohol use during and after cognitive-behavioral therapy for alcohol dependence.

Maniglio (2013), in a review of four meta-analyses conducted on the association between having been a victim of child sexual abuse and the etiology of anxiety disorders (consisting of over three million subjects), found a significant association between child sexual abuse victimization and anxiety disorders, especially post-traumatic stress disorder. The association between sexual abuse and the development of anxiety disorders applied regardless of the severity of the abuse. Given the association between negative emotionality (e.g., anxiety) and the development and maintenance of alcohol abuse, such data would suggest that traumatic history is indirectly associated with an increased risk of alcohol and/or drug abuse.

In keeping with the research discussed here, Davis et al. (2012) conclude that independent lines of research have identified substance abuse as both an outcome of child sexual abuse and a risk factor for sexual offending. They further note the possibility that substance abuse may mediate the relationship between sexual abuse and later commission of a sexual offense.

In another relevant study, Eames et al. (2014) observed that stress moderates the effect of childhood trauma and adversity on recent drinking in treatment-seeking alcohol-dependent men. These authors found that scores on a measure related to trauma history were associated with drinking history for the 6 months prior to treatment. These authors also observed that drinking severity was related to scores on a measure that assessed chronic stress only for those clients who reported higher levels of childhood trauma. Perhaps more so than any other study to date, this research highlights the complex interactions among childhood adversity, chronic stress, and alcohol use.

From our perspective, it is not surprising that the research supporting a causal link between past trauma more generally and sexual offending specifically is mixed (see Chapter 7 for additional information). It is certainly the case that sexual offenders we have treated at the

RTCSOTP have very high rates of abuse in their early histories. However, alcohol abuse represents just one of any number of sequalae of abuse that may be related to committing a sexual offense. As suggested by the RNR-I, to understand sexual offending requires an understanding of much more than a history of trauma and the consequences of such trauma (though these are clearly important mediating variables in our view). Issues related to offending in general, including criminal attitudes and personality (not to mention the remaining Big 8 risk factors identified by Andrews and Bonta, 2010) need to be considered as well.

In summary, the available research suggests that a history of trauma is associated with a number of factors, all of which may be associated with sexual offending. In particular, a history of abuse or neglect is clearly associated with the development of issues associated with negative emotionality and substance abuse. These factors may act reciprocally to increase the risk of sexual offending. Whether these factors act as mediating variables or can be demonstrated to be causally linked to sexual offending remains to be determined at present. More research is clearly needed regarding the association between trauma, alcohol abuse, negative emotionality, and sexual offending. That being said, in our view, the fact that we need to help clients understand the relationship between these factors is irrefutable. Such discussions lend themselves to individual and group-based approaches that cannot easily be incorporated into overly prescriptive manuals.

# 13
# Deviant Sexual Arousal

The assessment and treatment of deviant sexual preferences are fundamental aspects of sexual offender treatment. Deviant sexual arousal has been shown to be related to sexual recidivism, with a sexual preference for children as assessed by phallometric testing having an effect size of $d = 0.32$ in a recent meta-analysis (Mann et al., 2009). In addition, although there is a lack of research demonstrating a long-term effect of treatment addressing deviant arousal, given the relationship between recidivism and deviant arousal, it seems that addressing such arousal in treatment in some manner is advisable.

## Sexual preference hypothesis

The reason why determining the sexual interests of a sexual offender is important is self-evident: given that sexual offenses are sexual in nature, some sort of sexual motivation is assumed to be involved in the offense. This is what is known as the sexual preference hypothesis (Lalumière & Quinsey, 1994). This hypothesis states, quite simply, that people will engage in sexual behaviors for which they have a preference. There are two "forms" of the sexual preference hypothesis (Lalumière & Quinsey, 1994) – the strong form, which states that sexual offenders will prefer the deviant sexual activity over the appropriate; and the weak form, which states that sexual offenders find the deviant activity more arousing than non-sexual offenders do, although it may not be an absolute preference. There is an alternative explanation for both of these hypotheses, however, and that is that the sex offending is driven by non-sexual motivations such as anger, an overall antisocial orientation, or even a simple misreading of cues.

Research suggests that a deviant sexual preference is predictive of risk of further sexual offending, particularly in men who offend against children (Hanson & Morton-Bourgon, 2004). While Hanson and Morton-Bourgon's meta-analysis did not find a relationship between a sexual interest in the use of violence and having a later conviction for sexual or violent offenses, a more recent meta-analysis (Mann et al., 2010), with the addition of more recent research, found a small effect for arousal to rape and reoffense. However, it is important to note that the majority of sexual offenders do not have deviant arousal on phallometric testing, nor do they meet the criteria for a paraphilia (Akerman & Beech, 2012).

## Phallometric testing

An important question in this regard is, how do we know what a person's sexual preferences are? The best way to determine someone's sexual preference is to measure it in some fashion. We can ask a person what arouses them, but people are not always honest about such private matters. We can examine their behavior to see what that tells us about their attraction; however,

people do not always act in a manner consistent with their preferences. Probably the best way to determine what men are attracted to is to measure their sexual responding directly, and the best way to do this – at least currently – is through a process called phallometric testing or penile plethysmography (PPG).

Phallometric testing is a process whereby the client's sexual responses are directly measured while they are being exposed to some form of sexual stimuli (e.g., pictures, audiotaped stories). Phallometry was introduced for the assessment of sexual offenders by Kurt Freund (1957), who designed a device that measured volume changes in the penis in response to various sexual stimuli. Freund's volumetric device consisted of a glass tube that was placed over the subject's penis. At the base of the tube was an inflatable cuff, which provided an air-tight seal. When the subject is exposed to sexual stimuli, changes in his arousal are measured in terms of volume of air displacement within the glass tube (Freund, 1965). However, the device as designed by Freund was cumbersome and difficult to use, which led to the development of other methods, especially the mercury-in-rubber strain gauge.

The mercury-in-rubber strain gauge is a small mercury-filled rubber tube which is placed around the penis and changes to the circumference of the penis are measured through changes in electrical resistance as the ring stretches. These gauges were first developed for medical use in measurement of changes in tissue volume occurring in response to venous occlusion (Gamble et al., 1993). This gauge was adapted for purposes of assessing arousal in sex offenders by Bancroft et al. (1966).

While the volumetric device designed by Freund is cumbersome, it has the advantage of capturing small changes in the penis in the early stages of arousal, which are not detected by the strain gauge. Kuban et al. (1999) compared sexual arousal as measured by a volumetric device with arousal measured by a circumferential device and found that for arousal greather than about 10% full erection, there was little difference in the measurement. However, below 10% full erection the volumetric device was more sensitive, as it captures changes in the length of the penis, as well as the circumference.

## *Stimulus sets*

Stimulus sets used in phallometric testing vary widely according to the setting in which the testing is done (Marshall & Fernandez, 2000). Typically, however, they comprise either slides or audiotaped stories that describe sexual activity, while some laboratories use a combination of slides and audio stimuli. Some settings have used videotapes, but this is a less popular stimulus modality.

Slide stimuli are used as an assessment of age and gender preference. Typically, these consist of slides of nude children and adults of both sexes and varying ages. The offender's arousal is monitored via the PPG as these slides are projected on a screen. Research indicates that such assessments can reliably discriminate child molesters with victims younger than 13 from rapists (Baxter et al., 1984; Looman & Marshall, 2000). Interestingly, men with pubescent victims have not been found to differ from adult rapists in such assessment (Baxter et al., 1984).

Ethical concerns have been raised regarding the use of child pornography in the assessment of sexual offenders, as most of the stimuli of children are produced using child pornography seized by police. Thus, the use of slide stimuli in PPG assessment has decreased substantially. Efforts have been made to develop alternatives using modern technology. For example, the Not Real People stimulus set (http://www.pacific-assmt.com/products/nrp-not-real-people-visual-stimulus-set) consists of computer-generated images of adults and children, which could be used in PPG assessment. Rouleau et al. (2014) have also developed three-dimensional, computer-generated stimuli, which have been demonstrated to reliably differentiate child molesters from non-offender volunteers.

Audiotape assessments of sexual interest in children have also been found to reliably identify child molesters (e.g., Quinsey & Chaplin, 1988; Looman & Marshall, 2000). These stimuli typically consist of audiotaped stories depicting sexual interactions between an adult male and prepubescent children of both genders. For comparison, there are also depictions of sexual activity between an adult male and another adult, also of both genders.

The research concerning stimuli designed to detect arousal to rape has been less consistent in the findings. The stimuli used typically depict sexual activity between an adult male and an adult female, varying in terms of the amount of violence used in the depiction, ranging from the woman initiating the sexual encounter to the man brutally raping the woman using excessive violence to gain compliance. Some stimulus sets also include stimuli that describe a non-sexual assault, in order to assess for arousal to violence itself.

As noted earlier, the research findings regarding the ability to discriminate rapists from other groups has not produced consistent results. For example, Baxter et al. (1986) found that rapists and non-rapists (university students) did not differ significantly in terms of their responses to rape depictions, and that rapists responded significantly more to consenting stimuli than to rape stimuli. However, Quinsey et al. (1984), using a different stimulus set, found that rapists were more aroused by rape than by consenting sex, and that comparison subjects were more aroused by consenting depictions than were the rapists.

Harris et al. (1992) explained this difference in findings in terms of the differences in the stimuli sets used by the two research groups, hypothesizing that since the Quinsey et al. stimulus set has more graphically violent depictions than that used by Barbaree et al., the former set is better able to discriminate rapists from non-rapists. Lalumière and Quinsey (1994) conducted a meta-analysis of studies regarding the sexual arousal patterns of rapists and concluded that in those studies that used more effective stimuli (i.e., more brutal, graphic stimuli; more stimuli per category), rapists responded more to rape stimuli than to consenting stimuli. However, in reviewing the literature, Looman (2000) noted that the debate concerning whether or not rapists as a group display deviant sexual preferences appears to be a function not of the study setting or the stimulus sets used, but a combination of these variables. No study had employed more than one stimulus set when testing subjects within a single setting.

Looman (2000) reported on a group of high-risk sexual offenders assessed using both the Barbaree and Oak Ridge stimulus sets and found that rapists did have higher rape indices using the Oak Ridge stimulus set. However, the average rape index for both stimulus sets indicated a

preference for consensual sex as opposed to rape. In a second study, Looman and Marshall (2005) reported data from a different set of 78 high-risk rapists assessed with both the Barbaree and Oak Ridge stimulus sets. In this sample, the different stimulus sets did not result in group differences on the rape indices. Additionally, Looman and Marshall compared the rapists from their sample with non-sexual offenders from studies in the published literature. The rapists in the Looman and Marshall sample were found to have more deviant arousal patterns than the non-sexual offenders, although overall their deviance indices indicated a preference for consensual depictions (Looman, 2006). However, when rapists were classified, based on their rape indices, as being definitely deviant (clear sexual preference for rape), definitely not deviant (clear preference for consenting sex), or ambiguous (non-discriminating), agreement in the classification between stimulus sets was no better than chance.

Looman and Marshall (2005) and Looman (2006) interpreted this result to indicate that the stimulus sets are not assessing the same construct. Because the content of the stimulus sets is quite different, this interpretation is plausible. It may be that the stimulus sets are detecting deviant arousal in different types of offenders. Looman (2006) suggested that the stimulus sets that contain more graphic and brutal stimuli may be assessing a particular aspect of deviant sexual arousal, and that the Barbaree set may be assessing something else, which is not tapped by the latter sets. Looman and Marshall (2005) suggested that a study examining arousal patterns of different rapist types to the two stimulus sets may shed light on this issue.

Looman et al. (2008) conducted such a study. For this study we used the Massachusetts Treatment Center Rapist typology (MTC-R3; Knight & Prentky, 1990) to classify rapists according to offense characteristics. The MTC:R3 identifies five subtypes of rapists: opportunistic; pervasively angry; sadistic; sexual non-sadistic; and vindictive (Knight & Prentky, 1990). When Looman et al. (2008) compared these different subtypes in terms of their responses to the two different stimulus sets, the same pattern of results was found regardless of stimulus set used. Opportunistic rapists tended to have appropriate profiles, with greater responses to the consenting stimuli than to the rape stimuli, while the sadists tended to have an overall preference for the rape stimuli. The other groups did not differentiate between rape and consensual stimuli in terms of their responding.

## *Summary*

Thus, research has demonstrated that, for child molesters at least, phallometric assessment of sexual deviance reliably discriminates men who have sexually abused children from non-sex offenders. The research concerning phallometric assessment with rapists is less clear – the results suggest that opportunistic rapists, a group that makes up the majority of rapists in most samples, are unlikely to display deviant sexual preferences. However, other types of rapists are likely to demonstrate deviant responding in testing.

It is important to point out that when conducting phallometric testing, it is important to use stimulus sets that have been empirically validated. A number of jurisdictions have used locally developed and poorly standardized sets (Marshall & Fernandez, 2000), which leads to poor reliability from a forensic psychological standpoint.

# Phallometric testing at the RTCSOTP

In the early 1990s, the Correctional Service of Canada in the Ontario region underwent a review of sexual offender assessment and treatment services (Quinsey, 1990, 1992). Part of this review was the formation of a working committee of practitioners, who developed a standardized set of stimuli for the phallometric laboratories in the Ontario region. The following is a descriptive list of the standardized stimuli available at the Regional Treatment Centre (Ontario).

### *1. Age Gender Preference Profile*

The purpose of the Age Gender Preference Profile is to determine the client's gender preference and within that gender to determine if there is a sexual preference for prepubescent or pubescent stimuli compared with age-appropriate material. This stimulus set has been shown to reliably distinguish child molesters from adult rapists (Looman & Marshall, 2001).

The stimulus set contains three "warm-up" slides – one nude adult female, one neutral, and one nude adult male. The purpose of warm-up stimuli is to allow the client to adapt to the testing situation (as some clients may be anxious about the testing procedures), as well as allowing the technician to calibrate the plethysmograph, as the client's baseline can shift during the initial phases of the test. Responses to warm-ups are not to be interpreted.

The Age Gender stimulus set contains 24 slides. All slides depict either partially or totally nude models. There are nine slides of each gender: three adults (Tanner stage 5), three pubescent (Tanner stage 3) and three prepubescent (Tanner stage 1). In addition, there are three neutral slides with scenic views and/or pictures of urban development.

### *2. Female Violence Profile (Quinsey et al., 1984)*

The Female Violence Profile is a test that was constructed to identify arousal to sexual or non-sexual violence. This test consists of 16 audio vignettes that describe sexual encounters between adult males and adult females, taken from a larger stimulus set used by Quinsey et al. (1984). Of the 16 stimuli, two are warm-ups, one each of a consenting and rape stimulus. The remainder of the stimulus set consists of four consensual sex, four rape and four non-sexual violence stimuli. In addition there are four neutral stimuli to provide a comparison. All stimuli are narrated in a male voice.

### *3. Female Sexual Violence Profile (Barbaree version)*

The Barbaree Female Sexual Violence Profile (Baxter et al., 1986) consists of eight audio vignettes that describe consenting and non-consenting sexual encounters between an adult male and an adult female. Of the eight stimuli, two are warm-ups, one consenting sexual encounter and one non-consenting. Each stimulus in the set is 2 minutes and they describe encounters that are similar in content but that vary in terms of the extent to which the female is consenting, ranging from a scenario in which the woman initiates the sexual activity and is an eager participant to one in which the woman actively resists and is badly beaten.

### *4. Child Violence Profile*

The Child Violence Profile (Quinsey & Chaplin, 1988) consists of 25 audio vignettes that vary in duration up to 2 minutes in length. Three of the stimuli are warm-ups consisting of two neutral scenes and one adult female consenting sexual encounter. The remaining 22 stimuli are evenly divided between female and male scenarios, with the stimuli further divided into six presentation types. Of the various presentation types there are two stimuli within each type of scene. These presentation types are adult consent, passive prepubescent child, coercion prepubescent child, sexual violence prepubescent child, non-sexual violence prepubescent child, and neutral prepubescent child, with all stimuli narrated in a male voice.

## *Phallometric assessment in the RTCSOP*

Every offender who entered the RTCSOP received a phallometric assessment as part of the pre-treatment assessment. Typically, the assessment content was based on their offenses – that is, if their offense history included sexual offenses against children, they would be assessed using the age/gender assessment and the child sexual violence assessment. If their offense history involved rape of adult females, they would be tested using both adult sexual violence assessments. If they had a mixed victim pattern, they would be assessed using all four stimulus sets.

In terms of interpretation of the results, there are basically three things to consider. First, to what extent does the client respond overall? Typically, for clinical interpretation, a minimum response of 10–15% full erection (Kuban et al., 1999) is considered necessary and responses below this threshold were considered uninterpretable.

Second, we examine the deviance indices produced by the clients responding to the assessment. Deviance indices are a numerical summary of the results of the test, produced by, in its simplest form, averaging the peak responses to the various stimulus categories and dividing the average of the deviant by the average of the appropriate (see, however, Harris et al., 1992 for a discussion of issues related to summarizing phallometric results). For example, if the client's average response to child stimuli is 40% full erection, and his average response to adult stimuli is 30% full erection, the deviance index would be 40/30 = 1.333. In terms of interpretation of such deviance indices, an index of 0.80 and lower is generally considered to indicate appropriate responding, an index above 1.20 is consider deviant and between 0.80 and 1.20 is consider to be non-discriminating. Thus, an index of 1.333 would be considered deviant.

Finally, we examine the overall profile (i.e., responses to individual stimuli) in order to determine the nature of the client's arousal pattern. Using the example from the preceding paragraph, while the client's average arousal to child stimuli was 40%, it may be that his average is highly affected by his responding to slides of 10-year-old females, to which he achieved 80% of a full erection, while he achieved 25% to the 8-year old and 15% to the 6-year-old. Thus, his highest attraction is to 10-year-old girls, while he finds younger female children less attractive. Verifying this can be done through further testing and discussion in individual therapy (see the following section).

## *Use of phallometric testing in treatment*

As noted earlier, every offender who enters treatment in the RTCSOTP completed a phallometric assessment. A number of men who were so tested produced a deviant profile, as described earlier. The response to such a result has typically taken the form of a multi-step approach.

1. Discussion with client
2. Control-no control trial
3. Development of fantasy scripts
4. Training
5. Post-treatment assessment
6. Future directions

### *Step 1: Discussion with client*

This step consists of a review of the results of testing with the client, a discussion regarding what they mean and how the client interprets/accounts for them. Typically, a period of fantasy/arousal monitoring occurs during which the client monitors his sexual thoughts and arousal, paying particular attention to what evokes fantasies, the nature/content of fantasies, and the frequency with which they occur.

If the client reports deviant sexual fantasies, the psychologist will discuss with the client his ability to modify/intervene with these. If the client reports he is unable to change or prevent his deviant fantasies ("They just happen, I can't stop it"), the psychologist will instruct him in strategies for doing so. For example, simple distraction techniques are suggested (e.g., if the stimulus is a television show, turn off the television) as well as thought-stopping (Wolpe, 1969). The next level of intervention suggested includes covert sensitization strategies (Dougher et al., 1987) in which the client is instructed to focus on the negative consequences of sexual offending for both the victim and the offender (e.g., trauma and/or confusion regarding sexuality for the victim; incarceration and shaming for the offender). While ideally thoughts about the consequences for the victim would be sufficient to prevent offending/intervene with fantasies, in high-risk offenders this is not typically the case.

The therapist will also discuss masturbatory reconditioning strategies, including thematic shift (Marquis, 1970), a behavior modification strategy in which the offender fantasizes using deviant sexual fantasies until aroused and then switches to an appropriate fantasy (if necessary, using a script) prior to ejaculation. In this manner, the appropriate fantasy is reinforced by the ejaculation and, over time, the offender is to move the point of the switch earlier into the masturbation episode so that over time he is only using appropriate fantasy material.

A similar process is called fantasy alternation (Laws, 1985), which involves having the client engage in masturbation sequences in a laboratory setting. Blocks of trials with a deviant theme are alternated with blocks of trials with a non-deviant theme. Fantasy content within each

episode is not altered. Typically, this is done twice a week in the phallometric laboratory. Between sessions the client is encouraged only to masturbate using appropriate fantasy. It is hypothesized (Foote & Laws, 1983) that the therapeutic effect results as the client begins to realize that he can in fact become aroused to non-deviant stimuli, experiences a period of confusion during which he re-examines his self-attributions about being sexually deviant, and begins to lose his deviant arousal.

Directed masturbation (e.g., Jackson, 1969) is also used in efforts to modify arousal. In this procedure, the client is instructed to masturbate only to appropriate fantasies, if necessary using prepared scripts and visual aids. The assumption is that by masturbating only to appropriate stimuli, the strength of the client's arousal to this sort of fantasy will be reinforced and thereby increase.

### *Step 2: Control–no control session*

The purpose of a control–no control session is to determine, while monitoring the offender's arousal via the PPG, his ability to voluntarily suppress his arousal. In the control–no control session, the client is exposed to each of the stimuli twice, once with instructions to respond naturally and the other time with instructions to attempt suppression. Both deviant and non-deviant stimuli of the client's preferred gender are used. As before, the results of the session are discussed with the client in order to gain an understanding of the difficulties he had with the task.

### *Step 3: Development of fantasy scripts*

If the results of the control–no control session indicate that the client has difficulty voluntarily suppressing his arousal, the next step is to begin arousal management training. The first phase of this is the development of fantasy scripts for use in the trainings. In individual sessions, the therapist will obtain detailed information about the stimuli that evoke deviant arousal for the client and work with the client on developing various arousing, appropriate (i.e., age-appropriate, consensual) and deviant fantasy scenarios. These scenarios are then audiotaped for use during arousal management training sessions with the PPG being used to monitor success. In order to confirm that these fantasy scripts are in fact arousing and to provide a baseline of arousal, another control–no control session is completed using them.

### *Step 4: Arousal management training*

The next step in addressing deviant sexual arousal is to conduct the actual arousal management training, which is conducted in the phallometric laboratory using the PPG to monitor progress. As mentioned previously, the fantasies developed in Step 3 are recorded and played back to the offender during the session. With the deviant scenarios, when the client reaches 20% full erection the therapist will prompt him to use the strategies discussed in earlier sessions to bring his arousal under control and suppress it. This prompting by the therapist is typically required, at least in the initial sessions, as men rarely have sufficient awareness of their responding in the early stages of arousal. By prompting the client, this helps him to develop this awareness.

In addition to the arousal management sessions, the client is encouraged to continue using the fantasy modification procedures described in step 1.

### *Step 5: Post-treatment testing*

This step consists of an administration of the original phallometric assessment to determine the extent to which arousal has changed with the intervention.

### *Step 6: Next steps*

If the arousal management training as described above is unsuccessful in allowing the client to exert voluntary control over his arousal one of two "next steps" is taken.

For those offenders who express motivation and are willing, a course of aversive conditioning using a foul odor may be tried (e.g., Witt et al., 1996). These approaches involve pairing arousal to deviant stimuli with a noxious odor in an attempt to diminish the arousal to these fantasies.

The second approach, and the preferred one, is a referral to psychiatrist for medication to assist in arousal control. The reason this is preferred is that, for men who have difficulty exerting voluntary control over their arousal, it is likely that the reason for this difficulty is that the arousal represents a fixed preference, which is resistant to modification.

Numerous studies have been conducted regarding the effectiveness of medications in the reduction of deviant sexual arousal (Rice & Harris, 2011; Assumpção et al., 2014). The results and quality of such studies are mixed (Rice & Harris, 2011), but it does appear that the use of pharmacology, in conjunction with psychological treatment, may have an effect in reducing recidivism.

Bradford (2000) offered a suggested algorithm for intervening with a sexual offender's deviant sexual arousal/fantasies. He recommended that pharmacological treatment start with selective serotonin reuptake inhibitors (SSRIs) and, if that is not effective, the physician would supplement the SSRI with an oral anti-androgen. If this is not effective, the next phase would be a intramuscular anti-androgen. Currently intramuscular leuprolide acetate (Lupron) is the preferred drug (Assumpção et al., 2014) due to a less significant side-effect profile.

## Conclusion

This chapter has described the assessment and treatment of deviant sexual preferences used in the RTCSOP. The process begins with a comprehensive assessment and leads into a staged approach to addressing deviant arousal, when detected. To date we have not evaluated this component of the program. However, there is some indication from the literature that some of the methods described here may be effective in the management of deviant arousal.

# 14
# The Integrated Risk–Need–Responsivity Model (RNR-I) *Practical Applications for Assessment and Treatment of Sexual Offenders with Substance or Alcohol Abuse Disorders*

As we have argued throughout, from a risk management perspective treatment is most effective for higher-risk clients. This follows from the risk–need–responsivity (RNR) perspective (e.g., Andrews & Bonta, 1998, 2010) as well as recent research suggesting that the treatment of lower-risk clients will produce fewer returns with reference to the resources expended (Mailloux et al., 2003; Olver & Wong, 2011).

We have also argued that changes as a result of treatment appear to be meaningfully related to a reduced risk of recidivism. In this regard, the results of a recent study by Olver & Wong (2011) are informative in that they indicate that the ability of the Static-99 to predict recidivism appeared to decrease with increases in treatment progress. Perhaps the most parsimonious way of interpreting these results is that treatment progress adds meaningful information related to actual risk of recidivism and that such changes are not reflected in measures of static risk. Such data as these and data collected by our team (e.g., Looman et al., 2005b) suggest that changes as a result of treatment add useful and informative information regarding whether risk has decreased. Static risk assessment measures, by definition, cannot account for meaningful changes made by clients in treatment programs. These data are certainly in keeping with the results of meta-analytic investigations (e.g., Hanson et al., 2002; for a more recent discussion, see also Olver & Wong, 2013) that have demonstrated significant reductions in recidivism among treated sex offenders.

Whether risk has been meaningfully reduced as a result of treatment, however, can be assessed most easily when clients have participated in comprehensive treatment programs. Such programs allow facilitators to observe changes with reference to a wide variety of treatment targets. For example, both the Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP) and the program with which Olver and Wong are associated at the RPC Prairies Sex Offender Treatment Program represent comprehensive treatment programs where staff address a wide variety of treatment targets. Both of our programs have demonstrated that therapist ratings of change are associated with recidivism; that is, those clients who are rated as having made improvements recidivate at lower rates. Of course, such ratings are made by well trained clinicians who are aware of the clients' actuarial assessment data. Duwe & Goldman (2009) have also noted that addressing a variety of treatment targets in sex offender treatment programs appears to be associated with reductions in recidivism. Duwe & Goldman, for example, stress the need to incorporate alcohol abuse treatment targets into traditional sex offender treatment programs.

Although we do not view the following suggestions as being in any way radical, it is our experience that expanding the range of treatment targets typically included in sex offender treatment programs even further is recommended (e.g., by addressing issues associated with trauma and serious mental illness). That said, it is our view that any targets identified must be empirically supported. Poorly defined or vague targets – e.g., the pursuit of "happiness," as advocated by proponents of the Good Lives Model – should be avoided. It is our perspective that all of the elements included in the RNR-I have received empirical support and are therefore legitimate targets for any comprehensive treatment program.

We hope that the following discussion will serve to highlight the fact that clinical matters do not work in isolation. One typically cannot simply address "sex offender-specific" targets without also addressing a variety of other factors known to be criminogenic. Programs that attempt to do this, for example, by using very prescriptive manuals related to a few sex offender-specific targets, are likely to achieve less than hoped-for outcomes. Having addressed a variety of treatment targets in a comprehensive program, staff will also be able to make more informed statements regarding risk as noted earlier. As a general rule, however, risk ratings post-treatment should result in, at most, a one-category reduction in the estimate of risk based on actuarial assessment at pre-treatment. When assessing either static or dynamic risk, actuarial instruments are to be preferred over clinical judgment.

In terms of the treatment of alcohol and drug abuse problems, the process must begin with a comprehensive assessment. This assessment should not be focused solely on substance abuse however. The RNR-I provides a list of areas that should be assessed in any comprehensive assessment. As part of this assessment a number of both actuarial and psychometric assessment instruments should be employed. We have described the psychometric battery employed at the RTC in Chapter 9 and those details will not be repeated here. These instruments allow us to assess the client's overall level of risk, issues associated with intimacy and relationships, lifetime history of alcohol and drug abuse, and use of emotionally based coping strategies, among other issues. As suggested by Tharp et al. (2013) in their review of 191 empirical investigations related to sexual violence, as part of a project conducted by the Centers for Disease Control and Prevention in the US, there were multiple interactions identified among risk factors for sexual offending. These authors note that it is likely that risk factors combine in multiple ways to increase the likelihood of sexual violence. In order to understand how a variety of risk factors are associated with sexual offending for a particular client, we first need to understand the level of difficulty clients are experiencing in a variety of domains.

The clinical interview, which is employed in conjunction with the psychometric instruments administered, generally follows the structure of the Psychopathy Checklist-Revised (PCL-R) interview schedule. However, information related to when clients started to abuse alcohol and drugs and whether these patterns of abuse changed over the years is typically added to the interview schedule. For example, we typically ask not only about periods where clients have increased their use of drugs, but also periods where they have made active efforts to stop abusing alcohol or drugs. Questions regarding whether alcohol or drug abuse coincided with any history of trauma that they may have experienced are also asked. Whether clients tried to moderate their use of alcohol or drugs when in a relationship that they considered meaningful

is also of interest to us. Many clients report that when they were involved in a "good" relationship, where there was a sense of intimacy and connectedness, they frequently tried to control their use of alcohol and-or drugs. In many cases this coincided with one of the few periods where they were able to maintain some degree of stable employment and possibly reconnect with family members. It is very useful to be aware of such factors when discussing the consequences of substance abuse later on in therapy.

We also want clients to share their views on whether alcohol or drug use has had a negative impact on their lives. For example, many clients we have seen argue that cocaine (or some other drug) may have caused difficulties in their lives but neither tetrahydrocannabinol (THC)-based products nor alcohol were disruptive. Such issues need to be discussed in some detail. Clients may assume, for example, that as they were not using THC-based products when they committed their most recent sexual offense it has not been associated with any disruptive events in their lives. However, the fact that such drugs were associated with a variety of other criminal behavior or disruptions in terms of work or relationships may be ignored.

One factor that many of the clients we treat have in common has to do with negative emotionality. There are multiple causes of negative emotionality from our perspective and these issues are not mutually exclusive. As noted in our initial discussion regarding the RNR-I (Chapter 5), many of the clients we treat have had a history of physical, emotional or sexual abuse and present with difficulties consistent with a definition of complex trauma as defined by Courtois & Ford (2009). Complex trauma has been associated with a variety of mental health issues, including both Axis I and Axis II disorders. Many of these conditions (e.g., alcohol abuse, depression) are either closely associated with or defined by negative emotionality. Negative emotionality, especially if associated with insecure patterns of attachment, may be linked with both alcohol or drug abuse and relationship difficulties.

Given the complex relationship among negative emotionality, relationship difficulties, and alcohol abuse, it is probably reasonable to begin by helping clients who have alcohol or drug abuse problems understand the important role that negative emotionality has played with reference to their substance abusing behavior.

We have found that the materials presented in the social skills component of the RTCSOTP are useful in this regard. These sessions provide clients with lists of emotions, as well as the opportunity to role-play situations where they might use emotional terms. For example, in one exercise, clients are asked to bring in pictures of themselves and other group members are asked to provide feedback regarding what that client who brought in the photo may have been feeling. The client who brought in the picture then describes what he was actually feeling in that situation. There are also numerous discussions regarding non-verbal aspects of emotional communication, including facial expressions and body language more generally. Further, sessions regarding anger management are included in the social skills component of the manual. In the most general sense, emotions management requires at least two general sets of skills: the ability to identify a range of emotions and the willingness to express these feelings should such a vocabulary exist (see Jackson et al., 2009). Both group and individual therapy are used to help our clients with both of these general tasks. Many of our clients come to

therapy believing that emotional communication, with the possible exception of anger, is unnecessary or irrelevant. Therapists working with such clients must understand that clients will need ongoing encouragement with reference to acquiring the relevant skills necessary to communicate more effectively in the emotional realm. For clients presenting with hyper-masculine views, motivational interviewing techniques may be of value in helping them appreciate the impact that a lack of emotional communication may have had on their lives. As well, gently challenging some of the cognitive distortions that have supported hyper-masculine views may be required.

Although the social skills component provides clients with useful information, this material is, of necessity, quite general in nature. Individual therapy provides clients with an opportunity to expand upon these ideas. In order to contextualize this material, the autobiography completed by all clients in individual therapy is of critical importance.

In the autobiography (see Chapter 10), clients answer a list of questions in order to document the events in their lives (as well as the thoughts and feelings associated with those events) that were associated with an offense or, more likely in the case of the RTC clients, a series of offenses. This exercise allows clients, in many cases for the first time, to see the connection between what has happened in their lives, starting from the time when they were very young. It also allows clients to see how a variety of risk factors work together to increase risk. It is not uncommon for clients to pay attention to the fact that, in some cases for the first time, their difficulties with rule-breaking or substance abuse began within a year or two of some traumatic event. In other cases, the clients we have seen have lived in such chaotic environments (whether or not there was a history of abuse) that they simply began acting out at the first opportunity that presented itself. As one recent client of the first author (J.A.) noted, he simply acted in the way he had observed others acting.

It is interesting to note that this same client claimed he had promised himself that he would never act in the same way his father had towards other family members (in this case, the client was talking about having witnessed physical violence). Yet this client began to abuse both alcohol and drugs, became involved in a criminal lifestyle, and eventually was convicted of a variety of offenses of a violent nature within relationships. After a number of discussions regarding his life history, this client realized that he never learned either the process of identifying any emotions (other than anger) or the utility in expressing emotions even if had possessed an emotional vocabulary. As he became more comfortable with the use of emotional communication, he noted that he found it easier to navigate relationships and felt less desire to use alcohol or drugs. At the time of writing, the client has not lapsed with alcohol or drug use in over a year. Although this may seem a relatively short period of time, the client noted that he had never been free of alcohol or drugs for this period of time since adolescence.

It should be noted that the last lapse experienced by this client happened approximately 2 years prior to this and was associated with his belief that a parent was terminally ill and that he would not be able to see this individual prior to their death. When asked about this lapse, the client mentioned nothing about his feelings towards his parent, and only noted that he was angry that the Service (i.e., Correctional Service of Canada) would not allow him to visit this

family member in another city. The client appeared much better able to cope with these events when he began to discuss the fact that he was very conflicted emotionally about this parent with whom he felt some sense of connection and yet whom he witnessed engage in a great deal of violence towards other family members. The client had also experienced physical abuse by this same parent on numerous occasions.

We have found that individual therapy can be very effective in helping clients address substance abuse in the context of more general mental health concerns. Given the very difficult circumstances faced by many of the clients we have treated, substance abuse is merely one facet of a very disorganized lifestyle characterized by ongoing involvement with both the health care system and criminal justice professionals (including both the police and correctional institutions). Clients need encouragement to address some of their longstanding issues without relying on the use of alcohol and drugs. Making such changes in their lives and assuming responsibility for their actions require ongoing reinforcement from all persons working with these individuals. As Bedics et al. (2012) have noted in the management of borderline personality disorder, both affirmation and control of the therapeutic relationship are necessary in order to achieve positive results with very difficult client groups.

Although alcohol and drug use are strictly prohibited within institutional settings, the fact remains that alcohol (e.g., “brew”) and drugs are widely available in institutional contexts. In fact, within both institutional and community environments, the use of drugs may add to risk over and above the action of the drug itself given the debt incurred by clients. As a result of accumulated debts, clients may begin to legitimately fear for their physical safety. Such fears may be particularly acute for clients with serious mental illness who have an impaired ability to navigate even fairly innocuous social contexts.

Individual therapy may make it somewhat easier for clients with serious mental illness to disclose alcohol or drug use. If a positive therapeutic context is established, clients may worry less about being told that they have in some way “failed” as a result of having a lapse with drug use. Clients may also be able to discuss in detail the reasons that they choose to use alcohol or drugs. It may take some effort to focus the discussion regarding the factors associated with a lapse with clients suffering from serious mental illness. Also, many clients with mental illness are fairly anxious about social situations and individual therapy may make a difficult situation (i.e., discussing a lapse) somewhat less stressful. For such clients, individual therapy (alone or in combination with group work) is recommended.

It should also be stressed that it is not uncommon for a lapse with alcohol or drug use to be related to issues with medication compliance. A number of clients with whom we have worked appear to have used alcohol or drugs as a way of managing issues associated with complex mental health issues. These same clients, once stabilized on psychotropic medications, may believe that these medications are no longer necessary. Ongoing interventions may be necessary to help clients understand that the psychotropic medications they are taking are essential in helping them mange their mental health concerns. Helping clients understand how they may have used alcohol and drugs as a form of symptom management can be an integral part of therapy.

As many of the clients we have worked with have been alienated from family or other positive social supports, an important part of the work we do is helping clients re-establish contact with positive social supports and understand the role that negative social contacts have in perpetuating any problems they have with substance abuse specifically, and criminal behavior more generally. Clients may need encouragement to re-establish contact with positive social supports, should they exist at all. In some cases, the clients with whom we work have had few if any positive social supports. In such cases, these clients require encouragement in terms of navigating the difficulties associated with establishing such supports. For example, it is fairly typical that clients report some positive social influences in their family as well as a number of negative influences. In such circumstances, discussions regarding how to re-establish contact with some but not other family members may be necessary.

## Summary and conclusions

As Bright & Martire (2013) have argued, coerced treatment of substance-using offenders may not be particularly effective. Rather than using confrontational approaches with offenders, a collaborative perspective is to be recommended. Motivational interviewing techniques may be particularly effective in this regard. Many clients we work with need assistance to understand the role that alcohol and drugs have played in their lives, with many minimizing or denying the importance of substance abuse. That said, it needs to be emphasized that alcohol and drug abuse must be understood in the context of a particular client's history. It is our view that in the past some programs have inadvertently helped clients compartmentalize issues associated with substance abuse by asking them to attend psycho-educational groups that have focused solely on this domain.

# 15
# A Model for Community Management

We have argued for the principle of integrated care earlier in this book. Issues associated with the therapeutic alliance, history of complex trauma and serious mental illness need to be incorporated into contemporary treatment programs. To date, these issues have either received too little attention (e.g., in relation to the therapeutic alliance) or have been falsely relegated to the non-criminogenic waste bin category within the forensic literature. The fact that, from our perspective at least, contemporary evidence suggests that the Risk–Need–Responsivity (RNR) Model needs to be adapted to include the principle of integrated care is no more evident than with reference to the community management of high-risk/high-need offender groups. These groups no longer simply present with traditional criminogenic needs as described by Andrews and Bonta (2003, 2010) and as a high risk of recidivism based on actuarial assessment. Such clients are much more likely to present with complex trauma or, at a minimum, co-morbid psychiatric conditions which require multidisciplinary assessment and treatment. Further, at least in the Canadian context where both authors are employed, there is increasing use of long-term supervision orders (LTSOs) which require the long-term management of offenders in the community after the custodial part of the offender's sentence is completed. Although LTSO conditions can vary in duration for a period of up to 10 years, the most frequently encountered LTSO conditions involve many years of community supervision. As we will discuss, LTSO offenders and similar groups of high-risk clients present with a daunting list of treatment needs, especially when their psychiatric histories are considered.

The principle of integrated care allows for the inclusion of serious co-morbid psychiatric conditions within the domain of criminogenic needs. Further, given that such co-morbid conditions can now be legitimately viewed as the focus of forensic clinical attention, methods appropriate to the management of such complex presentations become appropriate. It is this more comprehensive approach to treatment that is at the core of the principle of integrated care.

As noted, attention must be given to the more traditional criminogenic needs identified by Andrews and Bonta (e.g., criminal thinking and associates and substance abuse). However, issues associated with life skills management, the therapeutic alliance, and intimacy deficits/complex trauma may also become the focus of clinical attention. When dealing with groups of high-risk sexual offenders, issues such as these simply cannot be minimized or ignored.

For example, although the empirical literature has clearly demonstrated that those offenders who are able to gain employment are more likely to succeed in the community (Andrews & Bonta, 2010), it may be very difficult for groups of high-risk, high-need offenders to find such employment. Many of these clients have managed to obtain only sporadic employment in the past. Motivational interviewing techniques may be very useful in helping such clients believe

that they can even find work. In addition, information related to how to manage a job interview and what to include on an application form for work need to be considered. Other issues that need to be considered include how to maintain compliance with medication regimes, and how to manage the development and maintenance of intimate relationships. Each of these areas will be considered in more detail below. The point to keep in mind, however, is that these topics might not be considered relevant without consideration of the principle of integrated care.

Further, it is our belief that such issues are directly relevant to forensic practice. As we shall detail in the following, such tasks present with special challenges when dealing with forensic populations. To name but two examples of such matters, our clients typically ask us how they should prepare a résumé when they have been incarcerated for many years. Also, what do our clients say when asked about their criminal histories either on an application form or during a job interview? These are not simple questions to answer and require persons with experience in such matters to help clients effectively navigate such obstacles. There is also much that can be done at an institutional level to facilitate contacts with potential employers who are willing to hire the mentally handicapped or psychiatrically challenged whom we frequently encounter in community-based forensic settings. Lastly, with clients with long histories of violent behavior, it is not always an easy matter to help them cope with the inevitable frustrations that come with employment. Finding a job may be difficult for these clients – not reacting with anger or overt violence may be even harder for some. The principle of integrated care goes beyond simply referring such clients to a career counselor. Treatment involves helping such clients cope with such difficulties on an ongoing basis. Ideally, treatment is provided by persons with various specialized skills, and frequent communication between team members occurs. Further, with the consent of the client, there may be a need for team members to communicate either with the families of those in our care or employers wondering about the best way to structure work for such clients.

High-risk, high-need offender populations may present with significant difficulties in the area of negative emotionality (see Chapter 12 regarding substance abuse for a discussion). These difficulties may be associated with both the presence of personality disorders and substance abuse. One cannot simply ignore the problems associated with negative emotionality. Yet, negative emotionality is not considered a criminogenic need according to Andrews and Bonta's model. However, given that negative emotionality is central to a variety of psychiatric conditions (e.g., personality disorders) related to the development and maintenance of alcohol abuse and relevant to the management of intimate relationships, such needs simply must be addressed. The research by our team and others showing that emotionally based coping strategies are common among sexual offenders highlights the importance of focusing on such issues.

However, we believe that when addressing such topics as negative emotionality, the focus must still be related to addressing criminogenic needs. Rather than abandoning the RNR model, we are arguing that the model needs to be expanded. To take negative emotionality as an example, we believe that this topic should be addressed as it relates to the development of intimacy or ongoing difficulties with alcohol abuse.

Given the range of issues that such populations face the assessment and treatment of negative emotionality must be viewed as one module in a multi-systemic approach to treatment. Other treatment targets (e.g., criminal associates, criminal thinking styles) cannot be ignored simply because negative emotionality is viewed as a treatment concern. Therapists must be constantly vigilant about the fact that the goal of treatment is reduced rates of recidivism. The treatment targets identified in the model that we advocate relate to both living more effectively and reduced rates of recidivism. However, in the end, the latter become the primary area of concern from a forensic perspective. This overriding concern is used as a basis for treatment delivery. It shapes how much attention is directed to any one module. Negative emotionality becomes a treatment target primarily due to the fact that, if not addressed, the client may be at risk of returning to old counterproductive behavior patterns (e.g., sabotaging relationships, use of alcohol to cope with anxiety or depression).

We believe that proponents of the Good Lives Model have lost sight of this basic tenet of forensic treatment, albeit with the admirable goals of helping offenders live more productively and with a focus on achieving human goods. Programs that have adopted the principle of integrated care should be subjected to outcome research that demonstrates the efficacy of such approaches. We believe that the evaluations of both the Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP) and the community-based sex offender treatment program operated in Central District (Ontario) demonstrate the efficacy of these approaches.

We have already discussed the data with reference to the RTCSOTP and will shortly discuss the community-based sex offender programs with which the first author (Jeff Abracen [J.A.]) has been involved. These programs address the treatment targets noted earlier. Rather than offering a manualized approach to treatment, these programs offer some flexibility as to how and when topics are addressed. There is no denying, however, that the list of potential treatment targets is finite and that, in general, there are a certain set of treatment targets that all clients attending our programs are asked to address. Treatment is geared to the needs of the majority of clients with whom we work. If discussions related to special topics are required (e.g., as in the case of psychotic offenders) these conversations are more typically addressed in individual therapy. These discussions may also be addressed in group if clients are able to manage such conversations.

We do not advocate for the discussion of human goods as defined by Ward and Maruna (2007). For example, we advocate for the need to address issues associated with negative emotionality due to the association between anger and violent recidivism in the case of the offenders with whom we work (to give but one example), not because we believe these offenders have a need for affiliation which can only be met through the management of such emotions. This may seem to be a trivial distinction, but in practice we believe that the difference in emphasis is anything but trivial. The link (direct or indirect) between anger and violent offending can be assessed empirically. Further, whether a particular approach to anger management is effective can be assessed in a variety of ways (e.g., pre–post psychometric testing). On the other hand, how does one measure whether a client is meeting his affiliation needs (or some other human good as described by Ward & Maruna, 2007)? The concept of human needs lacks operationally

defined criteria at present and likely represents such a large target as to be very difficult in practice to assess effectively.

Our programs are geared towards offering time-limited treatment with reference the topics identified in the Integrated RNR (RNR-I) Model. As noted with reference to the discussion of the RTCSOTP treatment manual, there are many modules that need to be addressed. Given the numbers of offenders we are required to treat, therapists must be vigilant about ensuring that all relevant targets are addressed. It may not be possible or even advisable that therapists address all treatment targets to the point that clients no longer feel that that they have any concerns. We need to provide the clients we see with a well balanced foundation on which they can build. Clients will need to be able to practice the skills they learn in therapy in real-world settings. Although as therapists we can provide these clients with feedback based on their initial attempts at coping more effectively, we will likely not be able to watch them improve with reference to all the skills that we help to foster in these clients. Perhaps by letting clients know early in the process that we have a number of treatment targets to cover and that they will have to manage on their own after a period of time, we are encouraging a sense of personal responsibility. The motivational interviewing techniques employed by staff may further help clients believe that they can actually achieve some of these desired changes.

Some readers might argue the treatment targets identified by the principle of integrated care have not received sufficient empirical scrutiny, especially in community settings. Given that we have not focused in any detail on community-based offenders to this point let us review some of the relevant research. Following this discussion we will present a detailed model for the community management of high-risk, high-need sexual offenders.

## Community-based research with high-risk offender populations

Our team has completed a number of studies related to outcome among groups of high-risk offenders treated in the community settings. Axford & Abracen (2011) examined the majority of LTSO-designated offenders living in community correctional centers (CCCs) in Canada in 2008. CCCs are community-based facilities that are operated by Correctional Service of Canada (CSC) and are designed to house offenders on some form of conditional release. These facilities are designed for offenders who present with a high risk of recidivism if not provided with such accommodations. In practice, many of the offenders who reside in such facilities also present with significant treatment needs. Offenders required to live at a CCC are typically given a bed based on a condition established by the Parole Board of Canada (PBC), whose mandate is to manage the release of offenders under federal jurisdiction. However, offenders may also voluntarily reside at such facilities if the assigned parole officer believes that it is in their best interest.

Axford & Abracen (2011) examined a group of 56 LTSO sexual offenders who were compared with two groups of offenders living in CCCs who were released at their statutory release date (SRD), which represents the two-thirds mark in the offender’s sentence. Offenders are

typically released at their SRD unless they are deemed at such high risk of committing a violent offense that they are maintained in an institutional environment until the very end of their sentence. One SRD group consisted of offenders with a history (either past or current) of committing a sexual offense ($n$ = 58) and the other SRD group consisted of a group of offenders with no history (past or present) of having committed a sexual offense ($n$ = 280). The last group, which amounted to a comparison sample, consisted of a group of non-sexual offenders released on parole and living at CCCs across the country ($n$ = 84). Given that this last group of offenders were released comparatively early in their sentence, it was assumed that this group represented a lower-risk population.

Not surprisingly, we observed that the LTSO group and both SRD groups represented comparatively high-risk groups when compared with the parole group. What was more interesting, however, was that for a number of mental health indicators, the LTSO group evidenced higher rates of mental illness than any of the other groups included in the sample. For example, 40.5% of the LTSO group had been diagnosed with a current mental disorder in comparison to 9.3% of the SRD sex offender group and 18.4% of the non-sex offender SRD group. As expected, the parole group had the lowest rate of current diagnoses (i.e., 6.6%).

The same pattern of results applied to having been given a condition by the PBC to follow psychiatric counsel. Approximately 37% of the LTSO group received such a condition. The next highest group, the SRD sex offender group, only received a condition to follow psychiatric counsel 10.3% of the time. Interestingly, none of the parolees received a condition to follow psychiatric counsel.

These data reinforce the findings of an earlier study conducted by our team (Abracen et al., 2012) investigating a much larger sample of offenders in Canada who were living in a CSC-sponsored residence upon release to the community. This study compared offenders who were living in residences sponsored by CSC in 1998 and offenders living in these same residences in 2008. The goal of the study was to examine the changing nature of the offender population living in CSC-sponsored residences over this 10-year period. One of the more pronounced findings of this study was the significant change with reference to increases in the rates of mental health difficulties experienced by offenders living in these facilities over the 10-year period of the study. Although not specifically related to sexual offending, these data reinforce findings presented at the beginning of this book, which indicate that forensic services are increasingly dealing with both a criminal and a mentally disordered population, especially when samples of high-risk offenders are considered. Typically such offenders present with co-morbid conditions which, from our perspective, are both directly and indirectly related to recidivism.

Recently we completed a more detailed study of offenders living at the Keele CCC (Abracen et al., 2014). The first author's office is housed in the same building as the Keele CCC. A database was compiled of all admissions to the CCC in fiscal 2007–2008. In all, 136 offenders spent at least one night in the facility in this period. Information on specific mental health diagnoses were collected from both psychological and psychiatric files. This study observed very high rates of mental illness among those offenders living at the facility. For

example, approximately 20% of the sample had experienced psychotic symptoms within the 5-year period prior to being admitted to the facility. Many of these clients suffered from co-morbid psychiatric conditions.

Serious mental illness can be directly related to recidivism for any number of reasons among offenders living in the community. In the most obvious situation, many offenders use drugs as a way of coping with psychiatric disability. When these offenders use drugs while on conditional release, they may be suspended (that is returned to a more secure correctional environment) or, in more extreme cases, receive new charges. Further, due to difficulties associated with their ability to live independently, some mentally disordered offenders may commit crimes as a simple means of survival. These individuals may steal food or engage in other illegal behavior due to the fact that they do not have sufficient funds to buy food or adequate clothing, nor do they have the psychological resources to find and maintain employment. It is likely that prior to the closing of many provincial or state psychiatric facilities in recent decades, many of these persons might have been dealt with through community-based psychiatric services. The reality at present, however, is that these persons are being seen with increasing frequency in the criminal justice system and are being charged with offenses. Their history of serious mental illness is directly related to the commission of these offenses.

In other cases, psychiatric symptoms may be indirectly related to recidivism. For example, individuals with psychotic conditions and pre-existing criminal attitudes may engage in behavior that is clearly illegal but probably related to their psychiatric disorder as well. Such marginal individuals may seek out very inappropriate partners in the community, exacerbating the significant problems that they are already experiencing. These individuals may be marginalized both because of their involvement with the criminal justice system and the stigma surrounding their pre-existing psychiatric condition. Such marginalization may be indirectly related to behavior that may be criminal in nature.

As we noted earlier in the text, Dr. Marshall and his colleagues have suggested that intimacy deficits and associated negative emotionality may be related to sexual offending. In short, to use the language of the RNR paradigm, these characteristics may represent criminogenic needs for this group. In support of Marshall's perspective, Mann et al. (2010) discussed the fact that lack of emotionally adequate relationships with adults and conflicts in intimate relationships both appear to be supported by the available literature as representing meaningful risk factors for sexual offenders. These authors also observed that lack of employment and deviant arousal, among other variables, have been supported in the literature as representing dynamic risk factors for sexual offenders. It is our perspective that such factors cannot be adequately addressed without also providing treatment related to some of the underlying causes of these conditions (e.g., negative emotionality). Admittedly, more research is necessary in this area but we believe that the available research supports this contention.

It is our experience that it is the exception to the rule that a sexual offender with a diagnosis of a paraphilia does not have one or more other diagnostic conditions. We have demonstrated that the vast majority of the offenders attending the RTCSOTP have either alcohol or drug abuse problems (Abracen et al., 2008). In addition, Hare (for a discussion, see Abracen & Looman

2008) has argued that research indicates that the majority of offenders in correctional facilities meet the diagnostic criteria for antisocial personality disorder (APD). Presumably these findings would apply to a group of sexual offenders whose average Psychopathy Checklist-Revised (PCL-R) score borders on the cut-off for psychopathy, as is the case with the RTCSOTP population.

That is, many of the offenders being treated at the RTCSOTP would meet the diagnostic criteria for a substance abuse disorder, a personality disorder, and a paraphilia. Although we do not support the use of the paraphilia not otherwise specified-nonconsent (paraphilia NOS-nonconsent) diagnosis described by Doren (2002), we believe that this diagnosis, which has been commonly used with rapists, would apply to many clients seen in our programs.

These issues are relevant in that they highlight the realities of working with such populations. In practice, many of the high-risk offenders we see present with multiple diagnostic conditions. The case of offenders who are paraphilic (e.g., have been diagnosed with pedophilia) are typical in this regard. To start with, these individuals have a diagnosis of pedophilia and a substance abuse disorder.

The obvious question becomes one of how to manage such populations in the community. The model that we have adopted in the community is multi-faceted and involves close communication between treatment team members. A graduated approach to release is generally taken with such groups. Further, the community work that we do is only possible in the context of a series of treatment programs each of which builds on the information provided in earlier, and more intensive, interventions.

## Process of initial assessment in the community

High-risk sexual offenders are first treated in institutional treatment programs. With reference to the Ontario Region of the CSC, these offenders were typically treated at the RTCSOTP. Following the completion of the RTCSOTP, a comprehensive final report is produced by staff in that department and reviewed for consistency by the second author (Jan Looman). The report is placed on the Offender Management System (OMS), which is a computer system maintained by CSC. Prior to being released to the community, the client is assessed in order to determine whether he meets criteria for residency. Residency is reserved for offenders who are deemed to require additional structure upon their initial release to the community. For offenders requiring residency, efforts are made to find placement in a community where the client has social supports or, where appropriate, treatment programs are available. We believe that offenders who have been incarcerated for many years and who present with a high risk of violent recidivism may be best served by having such a period of residency available.

In the Toronto area where the first author (J.A.) works, the psychology department is located in the same building as one of the community-based residences. In fact, the psychology department is located in the same building as the only CCC in the Toronto area (i.e., the Keele CCC). CCCs are reserved for some of the highest-risk, highest-need offenders released to the community. As opposed to other residences where offenders might live, CCCs are operated by

Corrections Canada and therefore offer a higher level of security and additional resources when compared with other residential placements. In addition, the CCC in Toronto is located in close proximity to a police station, which allows for near immediate response times if and when an incident occurs at the CCC.

When offenders are first released to the Keele CCC in Toronto there is typically a period where they are not allowed to have access to the community without an escort. Given that the psychology department is located in the same building as the CCC, clients who cannot leave the building without an escort can still attend sessions in the psychology department without having to be physically escorted to their appointments.

Until 2012, when a change in policy was instituted, all sexual offenders released to the Toronto area (whether or not they are given a residency condition by the PBC) were referred to the psychology department. A standard referral form includes information as to why the offender was referred (e.g., has a conviction for a sexual offense on his record) and any other relevant information. If the client has been rated as a high risk of recidivism or presents with specific management concerns, this information is typically included on the referral form.

The chief psychologist then reviews the information on file (detailed information is available via the computer-based information system maintained by the CSC) to determine whether the client might benefit from sex offender-specific programming. In virtually all cases, clients deemed to be at high risk of sexual offense recidivism are required to attend sex offender-specific treatment. Not all lower-risk sexual offenders are required to attend sex offender-specific treatment. For example, in some cases, it may be determined that a domestic violence program is more appropriate for a particular client than sex offender-specific treatment. Until 2012 when the programs department assumed responsibility for group-based sexual offender programming in the community, the chief psychologist (J.A.) would refer the client to be assessed by a psychologist. At present, the psychology department assesses/treats many of the high-risk, high-need sexual offenders as well as some of the low-risk sexual offenders who do not meet criteria for treatment by programs staff according to current guidelines. The vast majority of moderate-risk sexual offenders without a history of serious mental illness have been treated by staff in the programs department since 2012. Programs staff are not registered mental health professionals and only complete several weeks of specialized training prior to delivering treatment. When we discuss the outcome research related to community-based sex offender treatment at the Keele CCC in the following, we are referring to treatment delivered by the psychology department where groups are supervised by registered mental health professionals who also are directly involved in treatment delivery.

Where clients are referred to psychology, they typically meet with the assigned psychologist for one to three sessions prior to the psychologist producing a brief risk assessment report, which also includes information regarding the most appropriate type of treatment program. The psychologist assigned to the case will review the client's psychology file (which is only available in paper form) to determine if there are any mental health difficulties noted on the file; for example, whether the client had been assessed by a psychiatrist and, if so, what measures were taken are noted.

Within our department we have taken the view that one should know very little information about the client for the purpose of the first meeting. Although the psychologist will typically know the reason for referral (as well as other information contained on the referral form) and information regarding what crimes (and the dates) the individual has been convicted of, we have generally adopted the view that this is sufficient information for the first interview. It is not that we are not interested in this information (quite the opposite, in fact), but we want to be able to form our own impression of the client. Almost all the files that we receive contain many reports. These reports commonly contain information regarding the assessor's opinion of the client. We believe that the possibility of being biased by these assessments is significant and prefer to form our own impressions of the client. We actually make a point of informing clients that we do not know much about their history on the first meeting and explain our reasons for not reviewing the file in detail prior to this meeting. In most cases, we have found that this strategy typically increases rapport with the client. For clients who have routinely been assessed in the course of interviews that may not last more than 30 minutes, this approach may seem novel and perhaps suggests that the assessor has not come to any foregone conclusions. Aside from discussions regarding our approach to the assessment, every effort is made to ensure that clients understand the information contained on the consent form provided. From our perspective, consent involves quite a bit more than simply having a client look at, and perhaps read, a form before signing a document.

Therapists always make sure to note that clients are not forced to participate in the assessment and that a written report will be produced that provides an updated assessment of risk. We also note that we are interested both in helping place the client in the most appropriate treatment program and helping him address issues related to risk. Clients who ask questions about the nature of risk assessment information contained in our reports are provided with as detailed information as they wish regarding such matters. We are happy to describe which risk assessment measures we use and whether the measure is related more to static or dynamic risk. When clients are interested in hearing detailed information about risk, we also explain that any estimate we provide does not mean they will necessarily commit another violent or sexual offense. In fact, we stress that there is quite a bit they can do that will decrease their actual rate of recidivism. That being said, we also note that clients will never be assessed as being low risk a few months later if they are assessed as being at high risk during the initial assessment.

With reference to higher-risk sexual offenders seen in the community, the assessment typically begins with a discussion of how they have been coping since being released to the community. For clients who have been incarcerated for long periods of time, the initial process of being released can be quite daunting. If there is some issue with which the attending psychologist can be helpful, this may take precedence over the semi-structured interview that we typically administer. The first session may provide the client with an opportunity to discuss any anxieties that he has regarding his release, for example. It should be noted that it is not uncommon that such unstructured interviews frequently provide very useful information to the assessor. For example, the client may mention the fact that he has moved to an area of the city where a number of old pro-criminal associates live and that he has bumped into one of them. He may express his ambivalence about having met this person, noting that they had many good

times together but also that the person would routinely share drugs with him. Discussion of such matters may be critical. If the client ends up sharing drugs with this individual, his stay in the community may be short-lived. Clients may simultaneously miss some aspects of the lifestyle they had prior to incarceration but wish to make significant changes in their lives. It is our belief that, even among offenders who wish to remain offense-free, many who eventually commit new offenses do so because of this type of ambivalence. It is a much smaller minority from our perspective who have little interest in "going straight" and who quickly return to criminal behavior while showing little or no ambivalence about such matters.

The initial assessment interview includes information regarding the client's offense history. Given the number of times that the clients we see have likely been asked about such matters, we are not so much interested in the details of their offending but in whether their perspective has changed regarding the offenses they have committed. Are clients more willing to take responsibility for the offenses they have committed? Are they better able to understand the variety of factors that resulted in one or more sexual or violent offenses? Do they seem genuinely motivated to change even if simultaneously expressing some ambivalence towards remaining offense-free? It is the answers to these questions that are of relevance, not the exact details of each and every offense on their record. That said, if the client does not have detailed clinical reports on file regarding his history, it may be necessary to discuss such matters in much greater detail than noted earlier.

Information regarding the client's personal history is then taken. We typically keep the topics covered in the PCL-R interview in mind when covering these aspects of the client's background. Information regarding substance abuse and mental health, financial responsibility, work history, history of relationships, and educational background are collected. Also, information regarding how well established the pattern of criminal behavior has been in their lives is collected. How old were they when they first began committing crimes? At what age did they first have contact with the criminal justice system? Were family members involved in criminal activity/the use of drugs? What types of crime have they committed over the years?

The client's perspective on their criminal behavior is also clearly relevant. Do they feel that they were responsible for the crimes they have been convicted of? If they do not take responsibility for these crimes, what is the level of minimization/denial that is present. These topics are relevant not only in terms of scoring the PCL-R but also in terms of discovering what topics should be addressed in treatment. The approach taken with a client who is in complete denial will likely be quite different from one taken with a client who takes complete responsibility for his sexual offending.

For sexual offenders, we typically assess issues specific to sexual arousal/behavior in much more detail than required for a standard PCL-R interview. Information about both normal and inappropriate sexual behavior is collected. Aside from information regarding how many partners they have had and whether they have ever cheated on partners, we are interested in patterns of sexual behavior. Is there evidence of deviant arousal? Are they more interested in inappropriate/appropriate stimuli? If the client has experienced problems in the area of deviant arousal, how has he coped with these issues? We believe that clients experiencing

inappropriate arousal can be safely managed in the community. However, clients are informed that we need to know about these issues in order for us to help them cope with such matters.

Both the authors are familiar with cases where clients have been suspended for having expressed issues with inappropriate arousal. We believe that in the vast majority of situations this is, to say the least, counter-productive. By suspending clients who express inappropriate arousal, we are reinforcing secrecy regarding such matters on the part of clients. That is, clients learn that they should not report any instances of having a deviant fantasy as this will immediately result in re-incarceration. This is precisely the lesson that we do not want clients to learn.

For clients experiencing issues with deviant arousal, such thoughts may well result in high-risk behavior if not addressed in therapy. If clients violate the conditions of their release by engaging in overt high-risk behavior we may have little choice but to re-incarcerate them. In the majority of situations, we can help clients avoid these high-risk situations if they believe that it is in their best interest to be honest. When clients appear to be honest with us, the level of tolerance for problematic behaviors is necessarily increased. Clients may, for example, say that they watched some pornography and that they understand that this is problematic. When such information is volunteered we would never advocate for reincarceration. The issue of the factors that were related to their having viewed such materials are discussed and more appropriate ways of coping are reviewed.

Many clients minimize their sexual offending at least to some degree and may be motivated not to tell the truth regarding inappropriate arousal. In order to help address these issues, all clients treated at the RTCSOTP are phallometrically assessed. The results of these assessments are available to psychology staff working in the community. The information collected during phallometric assessment can be used to broach the issue of inappropriate arousal in more detail. The majority of clients phallometrically tested at the RTCSOTP show evidence of at least some inappropriate arousal (Looman & Marshall, 2001, 2005). If discussed in a non-confrontational manner, at least some of the clients we see are willing to acknowledge that at some point in their lives they may have experienced difficulties in this regard. From our perspective it is this admission that is of relevance. If clients acknowledge having had problems in this domain (regardless of whether they are currently trying to cope with issues associated with deviant arousal), we can then proceed to discuss strategies associated with how to cope with such arousal should it occur again in the future. Of course, these strategies would be useful regardless of whether the client is being honest about only having coped with inappropriate arousal in the past.

We also assess the strengths with which the client presents. One of the most important areas to discuss in this regard is social support. Does the client have any positive social supports in his life and how much contact does he have with these individuals? With reference to the Stable-2007 (Fernandez et al., 2012), the manual states that it is important to know the number of both positive and negative social supports. We agree that this is an important topic for discussion. In some cases, particularly when clients are thinking of reconnecting with a family from whom they have been alienated over the years, some members may represent positive supports,

whereas others may be negative supports. If clients are likely to interact with many family members at one time, there may be a need for discussion as to how to minimize the impact of the negative influences. In some cases this may be as simple as visiting the home only when the family members who are a positive influence are present. In other cases it may be more complicated to address such matters. Providing the client with an opportunity to problem-solve such situations may be quite valuable in therapy. In general, problem-solving techniques include generating a list of alternatives, evaluating which alternative is most likely to be effective, trying to implement the alternative that seems best, and evaluating the evidence regarding whether the behavior chosen results in the desired outcome. If the desired outcome does not occur, the client should be encouraged to generate more alternatives and to try out new coping strategies. Given that many of the clients we see may become frustrated with this process, therapists should be aware that they have an important role to play in continuing to help clients "try out" these techniques, even if not all are successful.

As finding work is a critical area to consider when someone is first released, we also ask about what, if any, plans the client has with reference to employment. As we have a number of resources at our disposal to help clients find work, we will inform clients of the resources available either through the CSC or another organization in the community. For clients who are not able to find employment (e.g., as a result of serious psychiatric impairment) we ask about how they are going to manage their time. With such clients this topic is deceptively complex and may become an important topic in therapy. Clients who have not worked in many years may present with very low levels of motivation. At least in part, such low levels of motivation are associated with the belief that there is very little for them to do and that much of what they have tried has resulted in failure. These cognitions need to be addressed in some detail and will probably take quite a number of sessions to resolve. Therapists should be conscious of reinforcing such clients for any positive steps that they take by way of more productive time management and mastery experiences. We have also found that comments from group members can be very positive in this regard. For example, one client who was seen in group was not able to read. He felt that before he applied for employment he would like to learn to read at least minimally. The other group members offered him encouragement in this regard and not only was the client able to read, but this experience encouraged him to become more optimistic about finding employment.

Issues associated with time management and lifestyle balancing more generally are a central tenet of the community-based treatment program which is offered. The program assesses both ongoing deficits with which the client presents as well as strengths which we can build upon.

Whether the client is interested in other pro-social activities and how he has managed (or intends to manage) his time are discussed during the initial assessment phase in the community. For example, for clients with limited social contacts, whether they have any plans to meet others (and how they might go about doing this) is discussed.

In summary, we believe that the process of initial assessment in the community must focus on both the strengths and weaknesses with which the client presents. The goal of the assessment is to understand where the client is at, what he has learned in previous treatment programs and

what deficits persist. Further, any positive changes that have been made by the client need to be recognized and areas where the clinician might help the client make further improvements should be noted.

## A comment about the Good Lives Model, RNR, and community assessment

Although it has been argued by proponents of the Good Lives Model (GLM) that the RNR approach only emphasizes difficulties/deficits with which clients present, it is our belief that the programs we run address both the strengths and the weaknesses exhibited by our clients. It is undoubtedly true that the clients we treat present with clinically significant deficits in a variety of domains. We have an obligation to help clients address these issues in therapy. Further, given the extent of the deficits with which such clients present, we believe it is best to address these deficits in a structured manner. It is for this reason that the manual used at the RTCSOTP was developed in the first place. Given the necessity of group-based approaches when working with offender populations, we believe that it is not heuristic to have each client develop a list of values specific to themselves and then to help clients address issues that may present barriers to achieving these values. This approach, advocated by proponents of the GLM, is not practical in real-world situations when working with high-risk groups. Although individual therapy is offered as part of the RTCSOTP and available in the community-run program offered by the first author (J.A.), group-based approaches tend to be more cost-effective. In an era where well trained staff are difficult to find and time is limited as a result of the number of clients who require treatment, we believe that group-based approaches are essential. For group-based approaches to be most effective with high-risk groups, we believe that a certain amount of structure is absolutely essential. Of course, a certain amount of latitude must also be given to staff to address issues that are relevant but not necessarily included in the treatment program. It is this dialectic (to borrow a phrase used in dialectical behavior therapy) that is part of the art of doing therapy.

The structured approach to treatment that we advocate is in some ways quite different than the GLM. We believe that the GLM may be too abstract for many of the clients we treat. We believe that Andrews and Bonta (2003) are correct when they state that the evidence suggests that such groups respond best to concrete interventions. Further, given the limited time frames that we typically have to work with clients, we find it most efficient to address specific deficits rather than adding another “layer” to the therapeutic process. Asking clients to first identify the values they would like to pursue may seem a lofty and idealistic goal in theory, but in practice is likely to be quite problematic. For psychopathic offenders, in particular, we believe that they would use such exercises as a way of diverting attention away from the matters they most need to address (e.g., cognitive distortions related to offending). The areas we focus on in both the institutional and community-based programs we offer are ones that the vast majority of clients who we see can benefit from. In summary, we do not believe that the GLM presents a realistic strategy to deal with the many deficits presented by the clients we see, either institutionally or in the community.

Further, where possible, we have always strived to reinforce positive steps by way of lifestyle balancing. When clients are able to prepare a résumé, or have a positive job interview, they are reinforced for these positive steps. Also, clients who engage in other positive pursuits (e.g., find pro-social recreation activities) are reinforced for these activities. We believe that, depending on the stage the client is at clinically, it may be more relevant to focus on specific deficits or to focus on and reinforce the client's attempts at pro-social activities.

It may be nice to believe that all clients strive towards mastery goals; however, the reality is that many of the clients we see present with multiple cognitive-behavioral deficits. The severity of such deficits makes it unlikely that these clients will remain offense-free without interventions specifically geared towards them. If these clients learn the appropriate skills they may then apply these skills in any number of ways. It is putting the cart before the horse if we first ask them to identify the values towards which they might want to strive without first supplying them with basic social skills and risk management techniques.

Some of the clients we see believe that incarceration is simply the price of doing business. That is, they believe that their criminal behavior is a career. We hardly believe that focusing on primary/secondary goods is something that would result in a desired outcome with such persons. Andrews and Bonta (2010) make this point quite clearly when they discuss the values that such an individual might aspire to in discussing difficulties with the GLM. For example, a need for affiliation (one value listed by the GLM) might be met by associating with known criminals. In fairness, Ward and his colleagues would likely argue that the values that Andrews and Bonta (2010) suggest represent misguided efforts on the part of the client to work towards more reasonable approximations of the values suggested by the GLM. That being said, in practice, we believe that it would be more reasonable to specifically target the "Big 8" criminogenic needs discussed by Andrews and Bonta than to try to discuss "values" that the client might try to aspire to. This is especially true with clients whose only regret is having been apprehended.

Although we believe that the RNR and the GLM are not nearly as compatible in practice as Ward and his colleagues would suggest, we also believe that the RNR approach is not entirely adequate. As noted throughout the text, contemporary forensic clients present with very complex histories of serious mental illness. Andrews and Bonta (2010) may be correct in saying that the treatment of anxiety may not be related to reduced rates of recidivism. However, this is a "straw man" argument from our perspective. Andrews and Bonta (2010), in spite of the many advances they have championed in the field of forensic science, have failed to adequately address the complex clinical presentations that are increasingly being seen by clinicians. The clients we typically treat do not simply present with anxiety. They present with multiple diagnostic conditions that simply must be addressed as a part of a comprehensive therapeutic program. For example, for those clients who require psychiatric medications to remain stabilized, strategies to maintain compliance with their medication regimes must be discussed as part of an integrated approach to treatment. If we do not address these issues, it is likely that nobody else will, a point absent from Andrews and Bonta's (2010) discussion of such matters. Many of the clients that we see will destabilize if not on such medications and the failure to discuss such matters will probably result in increased rates of recidivism. In

addition, the discussion of complex trauma is not addressed by these authors. Rather than presenting with one diagnosis, the research on complex trauma clearly indicates that there are a large number of diagnoses that such individuals may present with. This issue was discussed in detail in an earlier chapter where we demonstrated that many of the persons attending the RTCSOTP present with histories typical of persons who later meet the diagnostic criteria associated with complex traumatic disorders. In fact, many of the approaches we use are surprisingly similar to those adopted for use with individuals suffering from complex trauma (for a detailed discussion, see Levers, 2012). The similarities extend to the initial assessment where detailed psychological/psychiatric assessment measures are administered. The self-destructive histories with which such individuals present cannot be addressed simply by focusing on the values that the client aspires to, or to the "Big 8" in isolation.

The principle of integrated care, which we argue in favor of in this text, is a balanced approach to dealing with clients with whom we are actually asked to work in real-world settings. The many advancements championed by Andrews and Bonta are not ignored, but our approach builds on their perspective and applies their principles to a wider range of clinical targets. Complex psychiatric presentations, attachment difficulties (so far as they are related to known criminogenic risk factors for specific clients), and intimacy deficits all become legitimate goals of forensic treatment if it can be demonstrated that these issues have been criminogenic for the client who we are tasked with treating. Further, comprehensive assessment procedures are necessary to adequately assess the extent of the difficulties with which clients present.

## Integrated care: building on institutionally based treatment programs in community settings

Of course, to offer such comprehensive treatment, we must expand our vision of the therapeutic team and the process of therapy in general. It is to these topics that we now turn our attention. Andrews and Bonta (e.g., 2010) argue that treatment in the community is to be preferred over institutional treatment. Although they note that institutional treatment may be relevant, they believe that treatment should be offered where clients apparently need it most, that is in the community. On the surface this argument has a great deal of common sense reasoning behind it. However, in failing to appreciate the significant deficits with which such clients present, we believe that this approach is no longer sufficient to meet the needs of high-risk groups of offenders.

From our perspective, a system of programs must be developed to cope with the deficits presented by the clients we see. Further, we do not believe that treatment should be offered on a continuous basis, with clients jumping from one program to the next with no break between programs.

Clients need to be given an opportunity to integrate the material in real world settings. This is hardly a simple matter as we, in practice, are asking the clients we see to make significant changes in terms of both the way they think about situations and the way they behave. For

example, many of the clients who we see are hyper-vigilant with reference to perceived threats. One of the reasons they have tended to behave violently is that they misattribute a neutral comment as being aggressive and then proceed to quickly escalate the situation to a level where violence is more likely to occur. Asking such clients to take the time to engage in "active listening" and to check out whether the person to whom they are talking is, in fact, being aggressive is hardly something that comes naturally to them. These clients, when they are being honest with us, typically note that they will then lose the advantage that they have if a fight occurs. From their perspective, it is better to attack before the person they are talking to suspects that violence will occur. This thinking must be challenged and clients must be given an opportunity to learn that such changes in their reactions are likely to result in less, not more, violence.

In the community we stress that violence is a very rare occurrence and the probability that the client is overacting to perceived threats is even greater than in institutional settings. To give a real-world example of what we are discussing, let us consider the example of Bob. Bob had a long history of violent offending. Although he never engaged in sexual offending, he had a number of violent offenses that involved domestic violence or violence directed at a new partner of someone he had previously dated. Some of his behaviors might well have been regarded as sadistic in nature, as the violence went well beyond being instrumentally motivated.

Bob informed the author (in the community) that he had recently almost been involved in a fight at a fast food restaurant. Apparently an adolescent boy had pushed in front of him while Bob was trying to get a napkin. Bob aggressively confronted the youth and was about to "step outside" with him to settle the matter. Fortunately, it occurred to him that such behavior was essentially absurd as he would be putting his freedom in danger over what could only be described as a trivial matter. Bob then reported this matter to the author where the situation was discussed in detail.

Bob had never been provided with treatment to address his aggressive behavior institutionally. We believe that this situation might have been avoided had Bob been provided with the type of treatment program that we have advocated. It is likely that Bob would have been frustrated with the experience described, but we have found that clients who have had such institutionally based programs are less likely to escalate situations as quickly as Bob.

When we have worked with clients who have completed a program like the RTCSOTP institutionally, we are better able to help the individual cope with the everyday frustrations that inevitably occur in the community. The staff in Central District Parole (where J.A. works) are very much aware of the material covered in the RTCSOTP and other programs offered institutionally. We build on this treatment in the community and address issues that still present challenges for the client even after having completed an institutionally based program.

Some research and our own clinical impression support this contention. We have found not only that those who complete the RTCSOTP are less likely to recidivate violently but also that their institutional behavior improves both while attending treatment and subsequent to the program but before being released to the community. We discuss outcome for the community-

based program in the following section to highlight the efficacy of these approaches.

The goal of institutionally based treatment is to provide clients with a foundational set of skills on which they can build in subsequent treatment programs. We believe that virtually all of the high-risk, high-need clients we treat can benefit from the skills taught at the RTCSOTP. Further, we believe that the order in which the material is presented is logical. A clear connection is made in almost all sections of the program that both thoughts and feelings are related to behavior. Clients learn the skills necessary to manage negative emotionality and to challenge dysfunctional thoughts. Clients are also given an opportunity to practice more pro-social ways of behaving throughout treatment.

The RTCSOTP allows for near-constant monitoring of clients when not attending treatment. Such constant monitoring allows us to determine whether clients are simply trying to "go through the motions" of therapy while directly involved in a session or whether they are at least making efforts to try and modify their behavior while not in group. In the community, where we have less ability to monitor behavior on a constant basis, we still try to provide the highest-risk offenders with a setting where their behavior can be monitored at least in the evening (e.g., is the client returning to the residence smelling of alcohol?). Treatment builds on the material covered in the RTCSOTP. Given that the RTCSOTP provides clients with a solid basis for growth, the community based program allows for more flexibility on the part of therapists. Nonetheless, treatment is generally limited to the issues discussed earlier with reference to the integrated model. For example, in cases where clients present with simple anxiety and such difficulties do not appear to be criminogenic for them, this topic will likely not be addressed in any detail in therapy. That said, other more traditional criminogenic needs may not be addressed either. If the clients we see in group do not present with any needs in the area of criminal associates, for example, this topic will not be addressed in the community.

## Central District (Ontario) Sex Offender Maintenance Program: model for program delivery

There are two sex offender-specific programs that have been run by mental health professionals and operated in Central District (Ontario). The first was operated under contract to the Centre for Addiction and Mental Health (CAMH). This program was designed for higher-risk sexual offenders or those who have not had much experience with treatment institutionally. This program has not been offered since 2011–12 when the changes noted above came into place regarding treatment. The second program is operated by staff in the Psychology Department in Central District (Ontario). The program was initially intended for low- or moderate-risk offenders or higher-risk offenders who have successfully completed one or more institutional sex offender treatment programs. For simplicity's sake, we will refer to these two programs as the CAMH and Central District Sex Offender Maintenance (SOMP) programs. Both CAMH and staff in the SOMP program offered individual therapy only or in combination with group-based approaches, depending on the needs of the individual offender. Groups in Central District (Ontario) used an open format with new members being introduced

to individual therapy/group as they are released to the community.

The primary difference between the CAMH program and the Central District Program is that the intent of the CAMH program is to more formally address issues associated with the client's offense cycle and behavioral management plan. It is assumed that clients attending this program either have had no formal sex offender treatment programming or have completed a program but the final report indicated that significant deficits still persisted. Issues associated with social skills deficits and intimacy and relationship issues may be addressed more formally than that provided in the SOMP. Whether clients were seen in individual therapy only, group-based treatment or both, all clients attending CAMH or the SOMP have been included in our outcome datasets.

With reference to the SOMP, clients are seen individually if they present with significant psychiatric histories or it has been decided by treatment staff that they are sufficiently high-risk/high-need that they would not be able to cope with the group-based format. As the group-based SOMP is designed for low- or moderate-risk offenders, high-risk offenders are seen only in individual therapy. Fewer offenders have been sent to CAMH in recent years due to the possibility of near immediate communication between the SOMP staff and those staff working at the Keele CCC (where many of the highest-risk sex offenders in Central District are housed). As noted earlier, the psychology department in Central District (Parole) is located in the same building as the Keele CCC. Given that it is the staff in Central District who operate the SOMP, when issues arise, team meetings require little more effort than having staff from the various units walk down the hall.

With reference to the group-based component of the SOMP, groups always begin with a check-in. The check-in can be very brief in the case of clients who say they are doing well and there is evidence from external sources (e.g., their parole officer, correctional staff at the Keele CCC in the case of offenders living at the CCC). However, check-in can be much more involved in the case of clients who present with multiple difficulties. In the case of higher-risk, higher-need clients there may be multiple issues with which the therapist is confronted. For example, the client may be somewhat unstable from a psychiatric perspective and may have difficulty finding employment, at least in part related to his mental health difficulties. To give an example, one client, who presented with cognitive impairment and psychiatric difficulties, had been applying for employment that was clearly inappropriate given his level of functioning (e.g., being a cashier at a store where fashion items were sold). He had previously been offered work in a sheltered work environment but noted, both in group and individual therapy, that he had an aversion to working with disabled persons. When he mentioned this in group a number of the members were, to say the least, surprised. A variety of group members helped the client process the fact that working as a cashier would likely result in his becoming very frustrated. They rightly noted that he might feel overwhelmed if there were a line-up, even assuming that he was offered such a position. With time the client came to accept that it may have been unrealistic that he would be successful in this position.

Additional topics that are typically raised in group include the fact that it is likely a bad idea to lie about one's criminal history in job interviews. Facilitators occasionally share stories of

clients who have lied about their criminal history and been hired. Unfortunately, some time later, when offered a promotion, managers may insist that the client undergo a criminal record check, at which time they are fired for having lied on the application. This is significant not only because the client will lose his job but because he can no longer use this employer as a reference. For clients who have not worked in many years due to incarceration this becomes a very significant issue. With reference to employment, clients and facilitators also discuss how to address questions regarding one's criminal history. In general we recommend providing basic information about their offending history but not making their criminal history the focus of the interview.

Issues associated with intimacy and relationships are frequently discussed in group. These issues are usually brought up during check-in. Although clients have typically made progress in institutional treatment programs prior to their arrival in the community, there are times when clients, in a quest to find a relationship in a timely manner, make poorly considered decisions. There have been occasions where clients have chosen to enter a relationship with someone who is still struggling with alcohol or drug use for example. Both facilitators and group members try to work collaboratively with the client to assess whether this relationship might present him with both internal and external high-risk situations (e.g., there being alcohol or drugs in the house). Wherever possible we attempt to have clients maintained in the community when such situations are raised. Unfortunately, certain situations simply cannot be tolerated. If a client who has committed sexual offenses against children is found to be in a relationship with someone who has children present in the house and those children were present while the client attended this residence, in almost all cases such situations will result in suspension (i.e., the client will be returned to custody). It should be emphasized, however, that these clients have all been told well in advance that they should never be in a house with young children unless correctional staff have explicitly given them permission to be there.

Discussions regarding how to discuss one's sexual offense history with a prospective partner are also a focus of discussion. We have found that comments from group members who have been in the community for longer periods of time are particularly relevant in this context. For example, clients will frequently discuss first making mention of the fact that they have a criminal history without discussing any details of their offense history. As group members will typically mention, some prospective partners will likely say that they are not interested in being in a relationship with anyone who has a criminal history. Our clients must be prepared for such rejection and group discussions regarding such matters are very effective in this regard. If a prospective partner is willing to learn more about the client regardless of the criminal history then we suggest providing additional information in a safe venue. We also recommend that clients provide some context regarding how their lives were probably very different when they committed these offenses and how they have been trying to change the circumstances of their lives since that time.

## Community-based outcome research in Central District (Ontario) Parole

We have completed several outcome studies related to the programs we have offered in the community. An early study completed by staff in the department (Wilson et al., 2000) included 107 sexual offenders treated by staff in the community (either SOMP staff or staff at CAMH). Overall rates of 21% for general offending, 10.3% for violent offending, and 3.7% for sexual offending were recorded. The mean follow-up time for this sample was 3 years and 7 months. Although no comparison group data were available in this study, the authors noted that the sexual recidivism rates reported were lower than those reported in the early literature on sex offender treatment outcome.

It should also be noted that Circles of Support and Accountability (COSA), a faith-based community group originally founded with the help of local Mennonite church groups, began in Central District (Ontario). These groups have justifiably received increased attention in the clinical literature (see Wilson & Picheca, 2005 for a discussion; also see Duwe, 2012; Elliott & Beech, 2012; Wilson et al., 2005, 2007a,b; Wilson & McWhinnie, 2013) and suggest that such community-based groups offer important adjuncts to more traditional approaches. These groups establish a core member (typically a sexual offender) and community members who provide ongoing support for the client in the community. The core member, however, understands that high-risk behaviour will be reported to correctional staff or the police. Ongoing training is supplied to volunteers by correctional staff in the CSC. In the Toronto area, J.A. currently provides training on an ongoing basis to the COSA volunteers. In the past, Robin Wilson, formerly the Chief Psychologist in Central District (Ontario), provided training to COSA volunteers. Janice Picheca, a member of the psychology department in Central District (Ontario), has maintained a database regarding COSA for approximately 20 years and these data have been the foundation on which all of the COSA research in Ontario has been based.

We have already discussed a recent publication (Abracen et al., 2015) in Chapter 11, the section comparing outcome for individual vs. group therapy. In this paper on individual therapy with clients treated at the Keele CCC in fiscal 2007–2008, it was observed that, after accounting for actuarially assessed risk of recidivism, compared with offenders who were only assessed or received no individual therapy, those receiving some individual therapy were 7.7 times less likely to recidivate, and higher doses of individual therapy were associated with 11.6% less likelihood of recidivism. Both sexual and non-sexual offenders were included in this treated sample.

With reference to sexual offenders, we have produced data on a sample of 88 consecutive admissions to the SOMP program between 2005 and 2009. These data were maintained in a database compiled by Janice Picheca who, as noted earlier, is a member of the psychology department in Central District (Ontario) parole. Follow-up data were available for a mean of 2.1 years on this sample. Recidivism data (based on officially recorded criminal history data) indicated a sexual recidivism rate of zero for this sample. Two individuals in the sample had been charged with a sexual offense during this follow-up period. In one case the charge resulted in a stayed sentence and in the other, the client was acquitted. Although admittedly a relatively short follow-up period, a sexual reconviction rate of zero clearly suggests that groups of sexual offenders can be safely maintained in community settings given appropriate types of treatment. It should be emphasized that these data apply to the program operated by

psychology staff. There are currently no data available regarding outcome for the community-based sex offender treatment program being operated in Central District (Ontario) by the Programs department. It is unclear whether such manualized approaches to treatment result in similar outcomes to those discussed earlier with reference to treatment provided by staff in the psychology department.

# 16
# Summary and Conclusions

Throughout this text we have tried to provide an empirically supported and contemporary approach to the management of high-risk, high-need groups of offenders. We believe that the Integrated Risk–Need–Responsivity (RNR-I) perspective offers such a model. This model was designed to be of practical utility for those tasked with working with such groups of clients. The original Risk–Need–Responsivity (RNR) model described by Andrews and Bonta (2010) represented an important development with reference to the management of offender populations. However, in our view the original RNR model can no longer be considered a contemporary approach to the management of offender populations. A number of important developments in the literature have largely been ignored by RNR or viewed as irrelevant to offending in spite of accumulating research suggesting that such factors need to be included in contemporary models. Notably, evidence from a variety of domains suggesting that such factors as complex trauma and serious mental illness need to be incorporated into any comprehensive treatment model of offender behavior is lacking in the RNR approach.

In one sense the fact that mental illness is not viewed as relevant from the RNR perspective is certainly understandable. When one reads earlier versions of the *Psychology of Criminal Conduct* (Andrews & Bonta, 1989), it becomes apparent that the approach advocated by these authors was, at least in part, a reaction to the medical model that viewed criminal behavior as an outgrowth of one or more psychiatric conditions. Andrews and Bonta were, in our view, correct in suggesting that there are a variety of dynamic risk factors that need to be considered in any comprehensive approach to the management of sexual and violent non-sexual offending. Further, they argued at the time that psychological distress was essentially unrelated to the prediction of recidivism.

This perspective could certainly be supported empirically in the 1970s and early 1980s where many individuals whose criminal behavior was directly related to serious mental illness were typically sent to community-based psychiatric facilities. With the closing of many such psychiatric facilities over the last three decades, many persons who had engaged in criminal behavior, at least in part related to serious mental illness, were placed in more traditional correctional environments (i.e., prison). At present, the criminal justice system is being asked to address the needs of two diverse but overlapping populations. Those of us tasked with working with clients involved in the criminal justice system are being asked to manage groups that may be described as “typical” or, more specifically, individuals whose criminal behavior is largely unrelated to mental illness. That being said, especially when discussing groups of high-risk, high-need offenders, more and more clients are presenting with issues associated with serious mental illness. The available data, which has not been acknowledged by Andrews and Bonta (2010), clearly points to both the direct and indirect influence that serious mental illness and complex trauma have on the genesis of criminal behavior. These clients cannot be understood simply in reference to dynamic factors unrelated to mental illness.

Parole and probation officers, as well as mental health professionals working with contemporary groups of offenders are being asked to understand not only general forensic issues, but also issues associated with serious mental illness. In short, we are being tasked with more difficult work and there is little in the way of guidance in terms of how to address the needs of the clients with whom we are actually working in practice.

Models that have recently been proposed (e.g., the Good Lives Model [GLM]) have not provided concrete information regarding what issues need to be specifically assessed and how to target these issues in treatment. Further, these approaches have not resulted in any long-term outcome data demonstrating lower rates of recidivism. Although proponents of the GLM may well argue that the purpose of assessment is to determine both the primary and secondary goods sought by particular clients, it isn't exactly clear how one can reliably assess "happiness," not to mention other primary goods. The RNR-I includes only items that have been supported by the empirical literature and for which there are psychometric instruments with demonstrated levels of reliability and validity. We have also included data regarding how the clients we have treated over the years have changed with reference to pre–post treatment changes on these measures. As we discussed, the clients we have treated have changed significantly on a variety of measures. In addition, we have now produced a variety of outcome studies demonstrating the efficacy of the RNR-I approach in significantly reducing rates of recidivism with both institutional and community-based groups.

We are not familiar with any texts, other than the work of William Marshall and his colleagues, that clearly describe what is actually done in treatment sessions with groups of sexual offenders and which have produced long-term recidivism data supporting the efficacy of these approaches. Although there is much to recommend the work of Dr. Marshall and his colleagues, the treatment program pioneered by Dr. Marshall at Bath Institution primarily meets the needs of moderate-risk sexual offenders. The program described in this text is designed to meet the needs of sexual offenders requiring high-intensity interventions. Moreover, with only minor variations we believe that this approach can be adopted for use with other groups of high-risk offenders. Clearly such features as sexual deviation and, to a lesser extent, intimacy deficits would not be the focus of such groups, but the core elements would likely be quite similar. One advantage to the RNR-I model is that it demonstrates that groups of sexual and violent, non-sexual offenders have many issues in common. In fact, the data available from our community samples show that the RNR-I is clearly useful in reducing rates of recidivism among both sexual and violent, non-sexual offenders. We have also had numerous conversations with our colleague Dr. Roberto Di Fazio who has several decades of experience running programs for high-risk, violent, non-sexual offenders in the Correctional Service of Canada. We have always marveled at how many issues these groups actually have in common, noting, however, that there were, of course, some differences as well. Especially when comparing groups of sexual offenders against adults to the clients in his group, the similarities are quite striking. Roberto has provided much of the data we have used in the series of substance abuse studies we have conducted and which are reviewed in Chapter 12. The RNR-I accounts for those features that these groups share in common but also those features that differentiate the groups.

In the outcome studies that we are currently conducting, we have now moved to using groups of untreated, violent, non-sexual offenders as comparison subjects for the sexual offenders we have treated. Given the nature of the samples with which we work, the vast majority of the sexual offenders we treat have histories of violent non-sexual offending as well. That should come as no surprise to those tasked with working with groups of high-risk sexual offenders. What is perhaps more surprising is the number of violent, non-sex offenders included in the comparison groups we have started collecting data on who have recidivated sexually. Although we have not finished collecting data with reference to a group of untreated, violent, non-sexual offenders we have been following at the Keele CCC, we have begun to notice that a number of the violent non-sexual offenders included in the sample have recidivated with sexual offenses. Given the RNR-I model, this is perhaps not all that surprising. In many cases these groups have much in common.

Essentially, the RNR-I argues that there are two general pathways to offending among groups of high-risk offenders and that many clients we treat have features common to both pathways. The first pathway is that described by Andrews and Bonta where individuals have longstanding issues with traditional criminogenic needs and without any demonstrable history of trauma or mental illness. In our view, this is a much smaller population than Andrews and Bonta would likely argue exists. The data presented regarding history of physical and sexual abuse among clients attending the RTCSOTP attest to this fact. The second pathway typically involves the presence of criminogenic needs but is coupled with a history of physical, sexual, or emotional abuse and issues associated with co-morbidity for mental illness. Issues associated with mental illness may be either secondary to a history of trauma or present regardless of whether the client has a history of trauma.

In our view, issues associated with substance abuse, marital and family functioning and criminal personality are not somehow independent criminogenic needs; rather they need to be understood within the context of the overall functioning of the client. To argue that mental illness is unrelated to criminal behavior but simultaneously that substance abuse and criminal personality are important criminogenic needs seems a contradiction that rarely gets discussed at a theoretical level. Clearly, substance abuse and psychopathy represent important areas of mental health functioning. We are surprised that there have not been more critiques of Andrews and Bonta, questioning why a history of substance abuse or psychopathy should not be considered evidence of mental illness. More important from our perspective, however, is understanding the series of events, and the thoughts and behaviors associated with those events, that resulted in a client developing a substance abuse problem in the first place. If, as is the case with so many clients with whom we work, a history of mental illness more generally or a history of trauma specifically is related to the development of substance abuse, it seems reasonable that these issues should be addressed in treatment. As we hope we have demonstrated, this is not only a more humane approach to addressing the needs of the clients with whom we work, it also results in lower rates of recidivism.

We agree that we need to use sound psychometric instruments to assess for these and other conditions and that a diagnosis alone may not provide sufficient information for use by a clinician. For example, we have found that the Michigan Alcohol Screening Test (MAST)

provides much more useful information clinically regarding history of alcohol abuse than does a diagnosis of alcohol abuse alone. That said, a history of substance abuse needs to be understood within the larger context of the individual's mental health and social functioning. A contextualized understanding of the client's history is essential in providing the necessary skills that clients will need to move forward with their lives. It is not that we are focusing on deficits, but rather we take the more optimistic perspective that we are simply providing clients with the necessary foundation on which to build a new and hopefully more productive life. The reality of our typical clients' lives is that they have never learned a variety of social skills including the ability to recognize and express emotional material (with possible exception to anger). If we provide our clients with these skills, we hope they will use this new knowledge in productive ways. Both our clinical experience and the outcome data we report attest that this is indeed typically what happens. Our clients aren't "cured" at the end of treatment, nor have they typically formed a new generative identity; the truth is far more prosaic. They simply have the necessary skills on which to build a more productive life, should they wish to do so. Hopefully they have also developed somewhat more insight into the various factors that resulted in their committing a variety of violent offenses.

We believe that there are a number of practical implications of the RNR-I Model. For clients who typically present with traditional RNR-based criminogenic needs and who are low to moderate risk, we suspect that psycho-educational programs may be all that is required. Nevertheless, we believe that there is a necessity for such programs to focus on more than one criminogenic need if we are to maximize the efficacy of these programs. The available literature attests to the utility of such programs. However, for groups of high-risk clients and/or those who present with a history of trauma or serious mental illness, therapeutic programs run by clinicians with relevant training and experience in working with both the mentally ill and forensic populations may be necessary. As Marshall et al. (2011) note, case formulation should be viewed as an "evolving concept that begins with a tentatively held, nomothetically based conceptualization and is continually modified throughout treatment to provide an idiographic intervention" (p. 41). That is, we must begin by identifying an empirically supported list of risk factors for offending, identify a set of measures that accurately assess these domains, and develop a detailed understanding of how these factors have resulted in a client committing one or more offenses. The art of therapy is to provide our clients with the skills necessary to address these problem areas in such a way that shows respect for them as persons and allows them to feel that we are working with them in a collaborative way. Such approaches cannot be viewed as psycho-educational and typically require extensive clinical training.

# Appendix I
# Decision Matrix

**Problem-solving**

| | ***Costs (bad things)*** | ***Benefits (good things)*** |
|---|---|---|
| Stop offending | | |

| | ***Costs (bad things)*** | ***Benefits (good things)*** |
|---|---|---|
| Continue offending | | |

# Appendix II
# List of Pre- and Post-treatment Measures

## Paulhus Deception Scales (PDS; Paulhus, 1998).

The PDS is a measure of an individual's propensity to give socially desirable responses on self-report questionnaires. The scale comprises 40 items scored on a Likert-style scale. The first 20 items comprise the self-deceptive enhancement (SDE) scale, which measures the tendency to give honest but inflated self-descriptions, while the second 20 items form the impression management (IM) scale, which measures the tendency to present oneself in a self-inflating manner (Paulhus, 1988). High scorers on the SDE subscale show a form of self-enhancement best described as rigid overconfidence akin to narcissism. The IM subscale is sensitive to situational self-presentation demands and is an indicator of context differences in pressure toward impression management.

## Multiphasic Sex Inventory (MSI-II) (Nichols & Molinder, 2000).

The MSI-II is designed to measure the sexual characteristics of an adult male alleged to have committed a sex offense or sexual misconduct and can be used both to do a sex deviance evaluation and also to measure treatment progress. It assesses various aspects of sexual behavior and cognition across a variety of scales, including cognitive distortions and immaturity, child molest and rape behaviors. Emotional neediness and behavioral scales assess conduct disorder, sociopathy, aggressive patterns of behavior, family violence, and substance abuse. Added to the core paraphilia scales of child molest, rape, exhibitionism and voyeurism, there are additional paraphilia indices of sexual harassment, net sex, obscene call, pornography, transvestism, fetishism, bondage/discipline, sexual sadism and masochism.

## Bumby RAPE scale (Bumby, 1996).

This scale was developed to assess cognitive distortions in rapists. The RAPE scale is a 36-item self-report questionnaire. Items are scored on a four-point Likert scale ranging from "strongly disagree" to "strongly agree." Individual items are summed to obtain a total score. Higher scores are indicative of a greater number of distortions surrounding rape behavior, including minimization, justification, and rationalization (Bumby, 1996). The RAPE scale is a unidimensional scale which yields a single total score, with higher scores indicating greater justifications, minimizations, rationalizations, and excuses for sexual assault of women. Internal consistency of the RAPE scale is excellent (alpha = 0.96) and test–retest reliability is good ($r$ = 0.86). The scale also has good discriminant and convergent validity (Bumby, 1996).

## Bumby MOLEST scale (Bumby, 1996).

The MOLEST scale is a 38-item self-report questionnaire designed to assess cognitive distortions in child molesters. Questions are scored on a four-point Likert scale ranging from “strongly disagree” to “strongly agree.” Individual items are summed to provide a total score, with higher scores indicating greater minimizations, justifications, and rationalizations for sexual activity with children (Bumby, 1996). The scale has excellent internal consistency (alpha = 0.97) and good test–retest reliability ($r$ = 0.84). The MOLEST scale also demonstrates good convergent and discriminant validity (Bumby, 1996).

## Miller Social Intimacy Scale (MSIS; Miller & Lefcourt, 1982).

The MSIS is a 17-item self-report questionnaire that assesses the maximum level of intimacy currently experienced, in the context of a variety of interpersonal relationships. The scale demonstrates high internal consistency (alpha = 0.86–0.91) and excellent test–retest reliability ($r$ = 0.96; Miller & Lefcourt, 1981). Miller and Lefcourt (1981) also found that the MSIS demonstrated good convergent, discriminant, and construct validity.

## UCLA Loneliness Scale – Revised (Russell et al., 1980).

The UCLA Loneliness Scale – Revised is a 20-item self-report measure of loneliness. Loneliness may be related to a variety of personal characteristics, such as low self-esteem, shyness, and feelings of alienation. The UCLA scale also measures satisfaction with social relationships. The measure has high internal consistency (alpha = 0.94). Both concurrent and discriminant validity of the scale have been demonstrated (Russell et al., 1980).

## Adult Self-Expression Scale (Gay et al., 1975).

A measure of assertiveness across a variety of social situations and a variety of types of assertive behaviors. The social situations include interactions with authority figures, parents, the public, and intimate relations. The types of assertive behaviors tapped include asking favors, refusing unreasonable requests, expressing opinions, expressing annoyance or anger, standing up for one’s rights, and stating positive feelings. Data for this scale are available on college, psychiatric, and criminal populations. In addition, it has demonstrated reliability and validity (Gay et al., 1975; Hollandsworth et al., 1977).

## Buss–Durkee Hostility–Guilt Inventory (Buss & Durkee, 1956).

This self-report scale comprises 75 true/false questions and measures various subclasses of

hostility that are reflected in eight subscales: assault, indirect hostility, irritability, negativism, resentment, suspicion, verbal hostility, and guilt. The scale measures several types of hostility, rather than a global evaluation hostility, which is ambiguous. For example, stating globally that an individual is hostile would apply equally well to someone who physically assaults others as to someone who acts in a manner that is irritable or spiteful. Thus, this scale provides an estimate of hostility in eight more specific domains. Two subscales (resentment and suspicion) reflect an attitudinal component of hostility, while four subscales (assault, indirect hostility, irritability, and verbal hostility) reflect a more action-oriented component of hostility. Factor analyses of the subscales revealed two factors: an emotional hostility component (resentment and suspicion) and a physical hostility component (assault, indirect hostility, irritability and verbal hostility; Buss & Durkee, 1956).

## Coping Using Sex Inventory (CUSI; Cortoni & Marshall, 2001).

The CUSI is a 16-item self-report measure of the subject's tendency to use various sexual behaviors to cope with stress. It describes four types of sexual activities: fantasies, masturbation, pornography use, and actual sexual behavior with a partner. Respondents indicate on a five-point scale how often they engage in each of the activities to cope with stress. Cortoni and Marshall (2001) report an alpha of 0.86 using an overall sample of 195 subjects (sexual, violent, and general offenders). The sexual offenders had higher scores on the CUSI than the other offenders. The two sex offender groups had higher CUSI total scores than the two non-sex offender groups. They also reported more use of consenting and rape sexual behaviors than the two non-sex offender groups. The child molesters reported greater use of child molest-related sexual activity than the other three groups.

## Relapse Prevention Assessment (Abracen et al., 1998).

This is an 25-item multiple choice questionnaire which tests knowledge of relapse prevention concepts developed at the Regional Treatment Centre (Ontario) in order to assess acquisition of material taught during the program. Recently incorporated into the assessment battery, this questionnaire is still under development.

## High-Risk Situations Test (HRST; Marques et al., 1991).

This measure asks clients to rate whether, if faced with a particular situation, their risk of recidivism would be increased. It is hoped that the client's score increases post-treatment. That is, by the end of the treatment program it is hoped that clients recognize a wider range of situations as presenting them with a risk of recidivism. All situations are rated on a Likert scale. Data from 21 child molesters and 31 rapists who have completed the Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP) indicate higher scores at post-treatment. Child molesters scores were 87.9 (SD = 34.6) at pre-treatment and

107.4 (SD = 40.3) at post-treatment. For rapists, scores were 73.5 (SD = 20.5) and 93.2 (SD = 36.1), respectively. For both groups these changes were statistically significant, suggesting a greater awareness of risk factors at the completion of the program.

## Michigan Alcohol Screening Tool (MAST; Selzer, 1971).

The MAST consists of a series of 24 yes/no questions pertaining to lifetime use of alcohol. Each item receives a score of 0 or 1 with scores of 9 and over, indicating evidence of having had a drinking problem at some point in one's life. The MAST is a commonly used measure of alcoholism, with demonstrated reliability and validity.

## Drug Abuse Screening Test (DAST; Skinner, 1982).

The DAST is similar to the MAST in design. It consists of 20 yes/no questions each scored 0 or 1. Scores of 11 or above indicate substantial problems with drug abuse. Langevin & Lang (1990) have demonstrated, using factor analysis in a large sample ($N$ = 461) of male sexual offenders, that both the MAST and the DAST could be treated as single factor tests. Alpha reliabilities for the MAST and the DAST were found to be 0.89 and 0.90, respectively.

# Appendix III
# Goals for Professional Growth and Development

This form is to help you think about various aspects of **yourself**, your relationships with others, and your skills in group situations. It gives you a chance to set your own goals for development. The steps in using it are:

1. Read through the list of activities and decide which ones you are doing all right, which ones you should do more, which ones you should do less. Mark each item.
2. Some goals that are not listed may be more important to you than those listed. Write such goals on the blank lines.

| ***Communication skills*** | ***Doing all right*** | ***Need to do it more*** | ***Need to do it less*** |
|---|---|---|---|
| 1. Telling others what I think | | | |
| 2. Being understood | | | |
| 3. Understanding others | | | |
| 4. Encouraging others | | | |
| 5. Listening attentively | | | |
| 6. Asking for ideas/opinions | | | |

| ***Emotional expressiveness*** | ***Doing all right*** | ***Need to do it more*** | ***Need to do it less*** |
|---|---|---|---|
| 1. Telling others what I feel | | | |
| 2. Hiding my emotions | | | |
| 3. Disagreeing openly | | | |
| 4. Expressing warm feelings | | | |
| 5. Expressing gratitude | | | |
| 6. Expressing anger | | | |

| ***Ability to face and accept emotional situations*** | ***Doing all right*** | ***Need to do it more*** | ***Need to do it less*** |
|---|---|---|---|
| 1. Being able to face conflict, anger | | | |
| 2. Being able to face closeness, affection | | | |
| 3. Being able to face disappointment | | | |
| 4. Being able to stand silence | | | |
| 5. Being able to stand tension | | | |

| ***Social relationships*** | ***Doing all right*** | ***Need to do it more*** | ***Need to do it less*** |
|---|---|---|---|
| 1. Competing to outdo others | | | |
| 2. Acting dominant towards others | | | |
| 3. Trusting others | | | |
| 4. Being helpful | | | |
| 5. Being protective | | | |
| 6. Calling attention to one's self | | | |
| 7. Being able to stand up for myself | | | |

| ***General*** | ***Doing all right*** | ***Need to do it more*** | ***Need to do it less*** |
|---|---|---|---|
| 1. Understanding why I do what I do (*insight*) | | | |
| 2. Encouraging comments on my own behaviour (*feedback*) | | | |
| 3. Accepting help willingly | | | |
| 4. Making my mind up firmly | | | |
| 5. Criticizing myself | | | |
| 6. Going off by myself to read or think | | | |

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# Index

AAI *see* Adult Attachment Interview
actuarial risk assessment
ADHD *see* attention deficit hyperactivity disorder
adolescent offenders
  Psychopathic Checklist: Youth Version (PCL:YV)
  psychopathic traits
Adult Attachment Interview (AAI)
Adult Self-Expression Scale
alcohol abuse
  *see also* Integrated Risk–Need–Responsivity (RNR-I) Model; substance abuse
  anxiety disorders
  negative emotionality
  recidivism rates
  RNR-I model
  stress
  theoretical considerations
anger management
  social skills component, RTCSOTP
antisocial personality disorder (APD)
  defining
  vs. psychopathy
  treatment outcome
anxiety, clinical
anxiety disorders, alcohol abuse
APD *see* antisocial personality disorder

arousal management training, treatment step
  arousal management training
  control-no control trial
  discussion with client
  fantasy scripts
  medications
  multi-step approach
  phallometric testing/assessment in
assertiveness, social skills component, RTCSOTP
attachment theory
  Adult Attachment Interview (AAI)
  attachment types
  Integrated Risk–Need–Responsivity (RNR-I) Model
  promiscuous sexual behavior
  violent behavior
attention deficit hyperactivity disorder (ADHD)
autobiography assignment
  RTCSOTP
  self-management

BDHI *see* Buss–Durkee Hostility Inventory
behavioral progression (or offense chain) module
  RTCSOTP
  self-management
Bumby MOLEST scale
Bumby RAPE scale
Bumby's Child Molester and Rape Cognitive Distortions Scales
Buss–Durkee Hostility Inventory (BDHI), negative emotionality assessment
Buss–Durkee Hostility–Guilt Inventory

California Sex Offender Treatment and Evaluation Project (SOTEP)
Cambridge Study in Delinquent Development, complex post-traumatic stress disorder (PTSD)

CAMH *see* Centre for Addiction and Mental Health
CCCs *see* community correctional centers
Central District (Ontario) Sex Offender Maintenance Program
Central District Sex Offender Maintenance (SOMP) program
Centre for Addiction and Mental Health (CAMH)
Child Molester and Rape Cognitive Distortions Scales
Circles of Support and Accountability (COSA), community management
CISS *see* Coping in Stressful Situations Scale
Clearwater Sex Offender Treatment Program, treatment outcome
clinical anxiety
cognitive distortions module
  RTCSOTP
  self-management
cognitive-behavioral approaches, effectiveness
communications skills, social skills component, RTCSOTP
community correctional centers (CCCs)
  high-risk offender populations
  mental illness

community management
Central District (Ontario) Sex Offender Maintenance Program
Central District Sex Offender Maintenance (SOMP) program
Centre for Addiction and Mental Health (CAMH)
Circles of Support and Accountability (COSA)
community-based research, high-risk offender populations
employment plans
Good Lives Model (GLM)
initial assessment in the community
institutionally based treatment programs
integrated care
Integrated Risk–Need–Responsivity (RNR-I) Model
intimacy and relationships
outcome research
social support
violent behavior
community-based support, intimacy and relationships
co-morbidity
complex post-traumatic stress disorder (PTSD)
management
mental illness
complex post-traumatic stress disorder (PTSD)
Cambridge Study in Delinquent Development
co-morbidity
Integrated Risk–Need–Responsivity (RNR-I) Model
National Survey of Adolescents
prevalence
RTCSOTP
Coping in Stressful Situations Scale (CISS)
Coping Using Sex Inventory (CUSI)

Correctional Service of Canada (CSC)
COSA *see* Circles of Support and Accountability
CSC *see* Correctional Service of Canada
CUSI *see* Coping Using Sex Inventory
DAST *see* Drug Abuse Screening Test
decision matrix
definitions
deviance indices, phallometric testing/assessment
deviant sexual arousal
  phallometric testing/assessment
  sexual preference hypothesis
  suspending clients
disclosing personal information, intimacy and relationships
disclosures module
  RTCSOTP
  self-management
discrepancy creation, motivational interviewing
drug abuse
  *see also* substance abuse
  tetrahydrocannabinol (THC)-based drugs, motivational interviewing
Drug Abuse Screening Test (DAST)
  mental illness
  RTCSOTP
emotions, negative *see* negative emotionality
emotions management module
  RTCSOTP
  self-management
empathy, social skills component, RTCSOTP
employment plans, community management

etiological factors
attachment theory
complex post-traumatic stress disorder (PTSD)
GLM *see* Good Lives Model
goals for professional growth and development
goal-setting, social skills component, RTCSOTP
Good Lives Model (GLM)
community assessment
desistance perspective
vs. risk–need–responsivity (RNR) approach
treatment outcome
group sizes, RTCSOTP
Hare Psychopathy Checklist-Revised (PCL-R) *see* Psychopathy Checklist-Revised
harm reduction techniques
HCR-20 *see* Historical-Clinical-Risk Management-20
high-risk offender populations
community-based research
initial assessment in the community
suspending clients
High-Risk Situations Test (HRST)
Historical-Clinical-Risk Management-20 (HCR-20), recidivism risk/prediction
humanistic orientation, Good Lives Model (GLM) vs. risk–need–responsivity (RNR) approach
individual vs. group therapy, RTCSOTP
initial assessment in the community
inpatient-based program, RTCSOTP
institutionalization
institutionally based treatment programs
integrated care, community management

Integrated Risk–Need–Responsivity (RNR-I) Model
*see also* risk–need–responsivity (RNR) approach
alcohol abuse
assessment
attachment theory
community assessment
complex post-traumatic stress disorder (PTSD)
mental illness
practical implications
theoretical considerations
theories of sexual offending
intimacy and relationships
"cognitively deconstructed" state
community management
community-based support
disclosing personal information
ending relationships
loneliness issues
rejection issues
relationship skills, motivational interviewing
Relationship Styles Questionnaire (RSQ)
sexuality following treatment
social skills component, RTCSOTP
substance abuse
intimacy deficits, motivational interviewing
introductory module
RTCSOTP
self-management
introductory sessions, social skills component, RTCSOTP
Level of Supervision Inventory-Revised (LSI-R)

loneliness issues
intimacy and relationships
UCLA Loneliness Scale
UCLA Loneliness Scale – Revised
long-term supervision orders (LTSOs)
community-based research, high-risk offender populations
LSI-R *see* Level of Supervision Inventory-Revised
LTSOs *see* long-term supervision orders

manipulative behaviors, psychopathy
manualized approaches to therapy
MAST *see* Michigan Alcohol Screening Test
MAU *see* Millhaven Assessment Unit
MCMI-III *see* Millon Multi-Axial Inventory
medications, treatment
mental health professionals involvement
mental illness
attention deficit hyperactivity disorder (ADHD)
community correctional centers (CCCs)
co-morbidity
Drug Abuse Screening Test (DAST)
Historical-Clinical-Risk Management-20 (HCR-20)
Integrated Risk–Need–Responsivity (RNR-I) Model
Michigan Alcohol Screening Test (MAST)
recidivism risk/prediction
Short-Term Assessment of Risk and Treatability (START)
Michigan Alcohol Screening Test (MAST)
mental illness
RTCSOTP
Miller Social Intimacy Scale (MSIS)
Millhaven Assessment Unit (MAU)

Millon Multi-Axial Inventory (MCMI-III), risk appraisal
motivational interviewing
  discrepancy creation
  intimacy deficits
  relationship skills
  “rolling with resistance”
  tetrahydrocannabinol (THC)-based drugs
  therapist knowledge/training
MSI *see* Multiphasic Sex Inventory
MSI-II *see* Multiphasic Sex Inventory
MSIS *see* Miller Social Intimacy Scale
Multiphasic Sex Inventory (MSI)
Multiphasic Sex Inventory (MSI-II)
multi-step approach, addressing deviant arousal

National Survey of Adolescents, complex post-traumatic stress disorder (PTSD)
need areas
negative emotionality
  alcohol abuse
  assessment
  Buss–Durkee Hostility Inventory (BDHI)
non-compliance, RTCSOTP

obsessive-compulsive thoughts and behavior
offense chain (or behavioral progression) assignment, RTCSOTP
outcome, treatment *see* treatment outcome

paraphilia
pathways to offending
Paulhus Deception Scales (PDS)
PCL-R *see* Psychopathy Checklist-Revised
PCL:YV *see* Psychopathic Checklist: Youth Version

penile plethysmography (PPG) *see* phallometric testing/assessment
phallometric testing/assessment
  audiotape assessments
  deviance indices
  rapists
  RTCSOTP
  standardized stimuli
  stimulus sets
  use in treatment
post-traumatic stress disorder *see* complex post-traumatic stress disorder
post-treatment measures
PPG (penile plethysmography) *see* phallometric testing/assessment
pressures, vs. triggers
pre-treatment measures
problem-solving, social skills component, RTCSOTP
promiscuous sexual behavior, attachment theory
psychiatric disorders, recidivism rates

psychometric assessment
Adult Self-Expression Scale
Bumby's Child Molester and Rape Cognitive Distortions Scales
Buss–Durkee Hostility Inventory (BDHI)
California Sex Offender Treatment and Evaluation Project (SOTEP)
Coping in Stressful Situations Scale (CISS)
Coping Using Sex Inventory (CUSI)
Drug Abuse Screening Test (DAST)
High Risk Situation Test
Michigan Alcohol Screening Test (MAST)
Miller Social Intimacy Scale (SIS)
Multiphasic Sex Inventory (MSI)
pre-post changes
Relationship Styles Questionnaire (RSQ)
Sex Offender Treatment and Evaluation Project (SOTEP)
Social Intimacy Scale (SIS)
UCLA Loneliness Scale
psychometric test results evaluation, treatment outcome
Psychopathic Checklist: Youth Version (PCL:YV)
psychopathic traits
adolescent offenders
Psychopathic Checklist: Youth Version (PCL:YV)
psychopathy
vs. antisocial personality disorder (APD)
detached approach
manipulative behaviors
as a responsivity factor
social skills component, RTCSOTP
treatment outcome

Psychopathy Checklist-Revised (PCL-R)
defining
treatment outcome
PTSD *see* complex post-traumatic stress disorder
Rapid Risk Assessment of Sexual Offense Recidivism (RRASOR)
recidivism rates
recidivism research, critical review
recidivism risk/prediction
*see also* risk/risk appraisal
Historical-Clinical-Risk Management-20 (HCR-20)
mental illness
Rapid Risk Assessment of Sexual Offense Recidivism (RRASOR)
sexual preference hypothesis
Short-Term Assessment of Risk and Treatability (START)

Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP)
*see also* treatment outcome
advantages
autobiography assignment
behavioral progression (or offense chain) module
changes
cognitive distortions module
complex post-traumatic stress disorder (PTSD)
disclosures module
Drug Abuse Screening Test (DAST)
emotions management module
goal
group sizes
individual vs. group therapy
inpatient-based program
institutionally based treatment programs
introductory module
Michigan Alcohol Screening Test (MAST)
non-compliance
offense chain (or behavioral progression) assignment
pathways to offending
phallometric testing/assessment
program refinements
recidivism rates
resistance to treatment
self-management component
social skills component
violent behavior
rejection issues, intimacy and relationships
Relapse Prevention Assessment

relationship skills
*see also* intimacy and relationships
motivational interviewing
Relationship Styles Questionnaire (RSQ)
research
community-based research, high-risk offender populations
outcome research, community management
recent research evidence, treatment outcome
recidivism research, critical review
Rice and Harris (2003), critical review of recidivism research
sexual offenders research, treatment outcome
resistance to treatment, RTCSOTP
responsivity factors
Rice and Harris (2003), critical review of recidivism research
Risk Appraisal Guide-Sex Offender Version (SORAG)
risk–need–responsivity (RNR) approach
*see also* Integrated Risk–Need–Responsivity (RNR-I) Model
vs. Good Lives Model (GLM)
risk/risk appraisal
*see also* recidivism risk/prediction
actuarial risk assessment
categorizing clients
definitions
initial assessment in the community
Level of Supervision Inventory-Revised (LSI-R)
Rapid Risk Assessment of Sexual Offense Recidivism (RRASOR)
Risk Appraisal Guide-Sex Offender Version (SORAG)
Static-99/99R
Violence Risk Appraisal Guide (VRAG)
RNR *see* risk–need–responsivity approach

RNR-I model *see* Integrated Risk–Need–Responsivity Model
"rolling with resistance", motivational interviewing
RRASOR *see* Rapid Risk Assessment of Sexual Offense Recidivism
RSQ *see* Relationship Styles Questionnaire
RTCSOTP *see* Regional Treatment Centre High Intensity Sex Offender Treatment Program

self-management
  autobiography
  behavioral progression (or offense chain) module
  cognitive distortions module
  disclosures module
  emotions management module
  introductory module
  RTCSOTP
  self-management module
self-regulation, alcohol abuse
setting, treatment
Sex Offender Treatment and Evaluation Project (SOTEP)
sexual offenders research, treatment outcome
sexual preference hypothesis
sexuality following treatment
Short-Term Assessment of Risk and Treatability (START), recidivism risk/prediction
Social Intimacy Scale (SIS) *see* Miller Social Intimacy Scale (MSIS)

social skills component, RTCSOTP
anger management
assertiveness
clinical anxiety
communications skills
empathy
goal-setting
intimacy and relationships
introductory sessions
problem-solving
psychopathy
social skills deficits
recidivism rates
social support, community management
SOMP *see* Central District Sex Offender Maintenance program
SORAG *see* Risk Appraisal Guide-Sex Offender Version
SOTEP *see* Sex Offender Treatment and Evaluation Project
START *see* Short-Term Assessment of Risk and Treatability
Static-99/99R, risk appraisal
stress, alcohol abuse
substance abuse
*see also* alcohol abuse; Integrated Risk–Need–Responsivity (RNR-I) Model
literature review
recidivism rates
suspending clients
tetrahydrocannabinol (THC)-based drugs, motivational interviewing

therapist characteristics
Good Lives Model (GLM) vs. risk–need–responsivity (RNR) approach
motivational interviewing
therapeutic alliance
therapist flexibility
therapist knowledge/training
anger management
manualized approaches to therapy
mental health professionals involvement
motivational interviewing
therapist ratings evaluation, treatment outcome
training *see* therapist knowledge/training
treatment outcome
antisocial personality disorder (APD)
Clearwater Sex Offender Treatment Program
Good Lives Model (GLM)
outcome research, community management
psychometric test results evaluation
psychopathy
Psychopathy Checklist-Revised (PCL-R)
recent research evidence
recidivism research, critical review
sexual offenders research
therapist ratings evaluation
treatment refusers
Warkworth Sexual Behaviour Clinic (WSBC)
treatment refusers
treatment setting, characteristics
triggers, vs. pressures
UCLA Loneliness Scale

UCLA Loneliness Scale – Revised

Violence Risk Appraisal Guide (VRAG)

violent behavior

attachment theory

community management

RTCSOTP

VRAG *see* Violence Risk Appraisal Guide

Warkworth Sexual Behaviour Clinic (WSBC), treatment outcome

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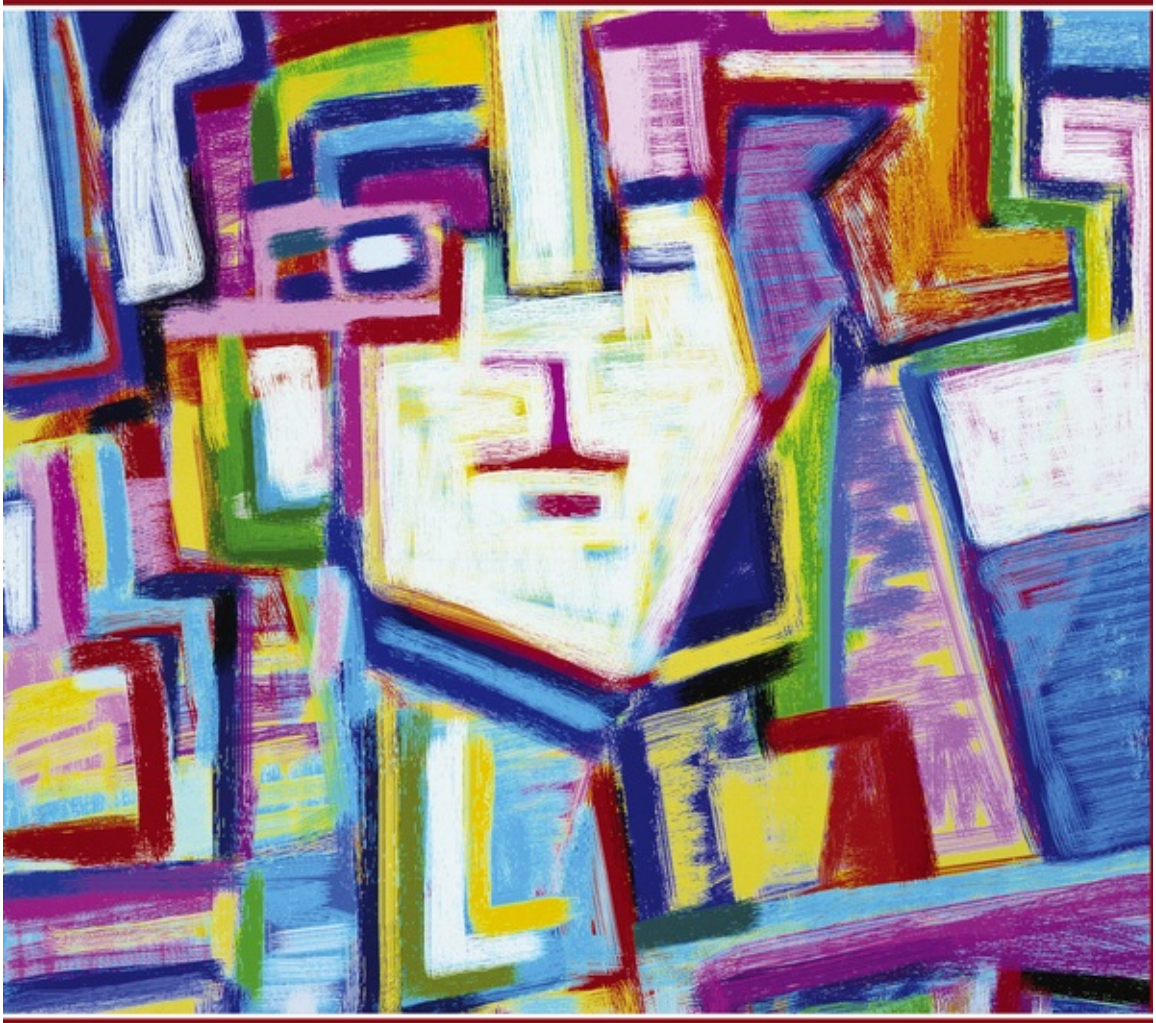

# Treatment of High-Risk Sexual Offenders

## An Integrated Approach

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