TREATMENT OF SEXUAL OFFENDERS AND ITS EFFECTS

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I. INTRODUCTION

In the early 1980s research began to reveal high rates of sexual offending in various English-speaking countries (Baker & Duncan, 1985; Finkelhor, 1984; Russell, 1984). Unfortunately, the response by both the media and politicians to these revelations took the form of harsh punishments for the offenders (Freeman-Longo & Blanchard, 1998; Sampson, 1994). This approach was consistent with the sentiment of the time that rehabilitation efforts were wasted on criminals (Martinson, 1974). However, subsequent research has shown that harsh responses to crime (such as longer sentences and more severe sanctions) actually increase, rather than reduce, re-offence rates (Andrews, 2003; McGuire, 2002). Furthermore, there is now convincing evidence that treatment for all types of criminals can effectively reduce recidivism (Andrews, Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990; Redondo, Sanchez-Meca, & Garrido, 2002). For sexual offenders the evidence is mounting that treatment can be effective (Marshall & McGuire, 2003). This paper will outline the governing principles of sexual offender treatment, the necessary issues that must be addressed in such treatment, how the treatment should best be applied, and the benefits of such treatment.

II. PROVISION OF TREATMENT

Allocation to Treatment

Many treatment programmes for sexual offenders place all of these clients in the same group, where they receive the same treatment components over the same period of time (Marques, Day, Nelson, & Miner, 1989; Schweitzer & Dwyer, 2003). Since sexual offenders display heterogeneity across every aspect of their history, personal characteristics, and sexual interests that have been evaluated (see Marshall, Anderson, & Fernandez, [1999] for a summary of this literature), it makes no sense to treat them all the same. In order to better allocate sexual offenders to treatment programmes that best meet their needs, some pre-treatment assessments are necessary.

While many programmes prior to treatment, engage in extensive assessments (Barbaree & Seto, 1997; Mussack & Carich, 2001) or in an elaborate case-formulation for each offender (Drake & Ward, 2003) it is not clear that such comprehensive pre-treatment evaluations are either necessary or sufficient (see Marshall, Marshall, Serran, & Fernandez [2006] for a discussion of this issue). In fact the distinction between assessment and treatment is artificial; these two processes are best seen as progressing together as mutually complimentary aspects of a process that will hopefully lead to effective changes in the clients. Instead of conducting comprehensive pre-treatment assessments, an evaluation using risk assessment instruments should provide sufficient information to effectively allocate sexual offenders to programmes best suited to their needs.

Andrews and Bonta (1998) have delineated what they refer to as "governing principles of offender treatment". These governing principles were derived from extensive meta-analyses of studies that demonstrated effective treatment of non-sex offenders. Three principles were generated from these meta-analyses: risk, needs, and responsivity. Available resources (i.e., treatment and community supervision) should be allocated according to each sexual offender's risk to re-offend where risk levels are determined by actuarial risk assessment instruments.

Actuarial risk instruments have been based on long-term follow-up studies of hundreds of sexual offenders where a variety of features of the offenders were examined to see which ones predicted subsequent re-offending (see Doren [2006] for a description). The features identified in the early versions of these instruments (e.g., the SORAG [Quinsey, Harris, Rice, & Cormier, 1998], the STATIC-99 [Hanson &

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Thornton, 2000], the RRASOR [Hanson, 1997], and the MnSOST-R [Epperson, Kaul, Huot, Hesselton, Alexander, & Goldman, 1999] are, however, mostly static and unchangeable. Nevertheless, scores on these instruments can usefully serve as a basis for allocating sexual offenders to levels of treatment intensity. Sexual offenders identified as high risk by actuarial measures, constitute the greatest threat to the public upon release from custody and, therefore, they require more extensive treatment than do moderate risk or low risk offenders. Accordingly it is best to allocate sexual offenders to treatment in the following way: high risk offenders should be involved in sexual-offender-specific treatment for three sessions per week for nine months; moderate risk sexual offenders should receive three sessions per week for four months; and low risk offenders should be exposed to two sessions per week for three months. If we were to place all these offenders in the same programme, then in order to most effectively treat the high risk clients, we would necessarily over-treat the low risk sexual offenders. Over-treating sexual offenders is likely to make them worse rather than better (Marshall & Yates, 2005), and should therefore be avoided.

The principle of need suggests that we should target in treatment those features of sexual offenders that have been shown to be criminogenic features (i.e., features that predict future risk to re-offend). The features that the early risk assessment instruments (e.g., the SORAG, STATIC-99, RRASOR and MnSOST-R) identified as predictors of re-offending were, as noted, primarily static unchangeable features. Thus these features could not be targeted in treatment. Fortunately, Hanson and Harris (Hanson, 2006; Hanson & Harris, 2000; Harris & Hanson, 2003) have developed an empirically-based scale (the Stable-2000) that measures these features, and, even more fortunately, the features this scale measures are potentially changeable. The Stable-2000 can, therefore, serve to identify the features of each client that should be the focus of treatment. Thus, the combination of the scores on the static actuarial risk instruments and the scores for each item on the Stable-2000, provide the basis for allocating sexual offenders to the required extent of treatment and for identifying what should be targeted in treatment.

The final principle of effective offender treatment derived from the studies analyzed by Andrews and Bonta (1988) is the responsivity principle. This principle essentially states that treatment should be adjusted to meet the learning capacity and style of each client and modified to match the client's cultural background. In addition, therapists should alter their approach to respond to the client's day-to-day fluctuations in mood and cooperation. In other words therapy should be delivered in a manner that allows the flexibility necessary to adjust to each client's unique features. This places a demand on the skills of the therapist and tends to deny the value of over-manualizing treatment.

Recent research has revealed the importance of the therapist's characteristics and style in achieving the goals of sexual offender treatment. For example, Drapeau (2005) found that sexual offenders responded to treatment best when they saw the therapist as someone who cared about them and treated them respectfully. Similarly, Marshall and his colleagues (Marshall, Serran, Moulden, Mulloy, Fernandez, Mann, & Thornton, 2002; Marshall, Serran, Fernandez, Mulloy, Mann, & Thornton, 2003) demonstrated that an empathic and warm therapist, who was also rewarding and directive, generated the greatest positive changes in sexual offenders. Marshall et al. also showed that a harsh confrontational style by the therapist led to a worsening of sexual offenders' problems while firm, but supportive, challenges produced clear benefits from treatment. These data on the role of the therapist in sexual offender treatment fits with the responsivity principle and with the need for flexibility in treatment that has been demonstrated in the general psychotherapeutic literature (Marshall, Fernandez, Serran, Mulloy, Thornton, Mann, & Anderson, 2003).

III. TARGETS OF TREATMENT

Table 1 lists the targets for treatment with sexual offenders. These targets have been derived from extensive research that has identified the problems sexual offenders have that distinguish them from others. These targets have also been identified in studies of stable dynamic risks among sexual offenders derived from the work of Hanson and Harris (Hanson & Harris, 2000; Harris & Hanson, 2003). The offence-specific targets in the table are those that are the focus of our treatment programmes (Marshall, Marshall, Serran, & Fernandez, 2006). In the prisons where we work the offence-related targets are addressed in separate programmes run by experts in each area. During the sexual offender specific programme, the therapist helps each offender integrate what he has learned in these offence-related programmes. In other settings, where these additional programmes are not provided, these offence-related targets would have to be incorporated into the sexual offender programme thereby extending the length of the programmes that was suggested earlier.

Table 1: The Targets for Treatment with Sexual Offenders

Offence–Specific Treatment Targets

1. Life-line
2. Self-esteem
3. Acceptance of responsibility
    - Denial/Minimization
    - Cognitive distortions
    - Victim harm
    - Empathy
4. Coping skills/Style
5. Intimacy/Attachments
6. Fantasies/Preferences
7. Offense pathways
8. Self-management/Good life
9. Warning signs
    - Self
    - Others
10. Support group
    - Professionals
    - Others

Offence-Related Treatment Targets

1. Substance use/abuse
2. Anger management
3. Family violence
4. Parenting
5. Other psychological disorders
6. Cognitive skills
7. Spiritual issues

For the full details of the way in which each target of treatment is addressed, the reader is referred to Marshall, Marshall, Serran and Fernandez (2006), and Marshall, Anderson and Fernandez (1999). Brief descriptions will be provided here.

1. Lifeline

Each offender is asked, at the end of his first treatment session, to begin writing out his autobiography between the next few sessions. This lifeline is to cover his childhood, adolescence, early, mid, and late adulthood (where relevant) and is to include relationships (with parents and peers, and romantic attachments), health, education, work and hobbies, as well as significant positive and negative experiences. The lifeline is intended to help the therapist to better understand the client and to assist both the therapist and client in identifying factors that may have led the client to offend. A thorough autobiography can reveal aspects of the client's behaviour and attitudes that need to be changed if he is to function effectively, and it can also contribute to identifying his offence pathway.

2. Self-esteem

Self-esteem is enhanced both because low self-esteem has been shown to predict recidivism in sexual offenders (Thornton, Beech, & Marshall, 2004) and because low self-esteem limits effective involvement in treatment (Marshall, Anderson, & Champagne, 1997). Clients are encouraged to increase the range of their social interactions, to pay attention to, and increase, their mildly pleasurable experiences, and to focus on their positive attributes. We have outlined the details of this approach and provided evidence on its effectiveness in enhancing the self-esteem of sexual offenders (Marshall, Champagne, Sturgeon, & Bryce, 1997).

3. Acceptance of Responsibility

Developing an acceptance of responsibility for all of their actions (including their offending) is a process that begins early in treatment and continues throughout the programme. Most programmes for sexual offenders attempt to elicit full responsibility within the first several treatment sessions. These programmes do not move on to the remaining targets of treatment until the client admits to all aspects of his offence as documented in the official police (or victim) report. Unfortunately, this approach can increase resistance in sexual offenders and encourage them to simply learn to say what they believe the therapist wants to hear rather than presenting themselves truthfully.

Cognitive distortions refer to perceptions and attitudes that serve to justify offending and reduce the offender's acceptance of responsibility. Sexual offenders distort their perceptions in a self-serving way in order to reduce feelings of shame about their offensive acts. These distortions emerge over the course of treatment; they can be challenged more firmly and directly as the client develops trust in the therapist. Similarly, although we raise the issue of victim harm within the first three to four sessions, the development of a full appreciation of this harm, and the associated empathy for victims of sexual abuse continues throughout treatment. Again denial of harm is a distortion that both allows offending to continue and reduces the shame the offender feels about his crimes.

Helping clients accept responsibility, overcome their distortions, and recognize the harm they have done, all require therapeutic skills. A therapist who is warm and empathic, who treats the clients with respect, and who encourages their progress, will soon win their trust and, as a consequence will more readily get the clients to accept full responsibility for their actions.

We have described in detail how we achieve these goals and we have provided evidence on the effectiveness of our procedures (Marshall, 1994; Marshall, O'Sullivan, & Fernandez, 1996).

4. Coping Skills/Styles

Inadequate attempts to cope with life's problems typically leads to a disturbed mood state (e.g., depression, anxiety, or anger), and among sexual offenders, mood disturbances trigger attempts to offend (Hanson & Harris, 2000). Not only do sexual offenders have a poor coping style (Marshall, Cripps, Anderson, & Cortoni, 1999; Marshall, Serran, & Cortoni, 2000), they also lack the skills necessary to cope with specific problems (Cortoni & Marshall, 2001; Miner, Day, & Nafpaktitis, 1989). Since poor coping inevitably leads to emotional distress, it is not surprising to find that sexual offenders also have poor emotional regulation skills (Ward & Hudson, 2000). It is, therefore, important to train sexual offenders to develop more effective coping skills and to approach problems with an adequate coping style. Research (Serran & Marshall, 2006) has shown that sexual offenders have deficits in the skills necessary for effective coping, that they adopt a poor approach (or style) toward problems, and that they respond to life's difficulties with acute mood states (e.g., anger, depression, or a sense of hopelessness).

We have outlined procedures for enhancing coping skills, for developing a more effective coping style, and for regulating mood (Serran, Firestone, Marshall, & Moulden, in press). Serran et al. (in press) also provided evidence on the effectiveness of these procedures.

5. Intimacy and Attachments

Marshall (1980) outlined a theory suggesting that sexual offenders attempt, in their offences, to achieve the intimacy they lack in the rest of their lives. Marshall's paper generated a burst of research activity that has focused on examining intimacy deficits and poor adult attachments in sexual offenders. This research has convincingly demonstrated serious deficits in these skills among sexual offenders (see Marshall, Anderson, & Fernandez [1999] for a summary of this evidence). If sexual offenders are to replace their deviant sexual interests with more appropriate sexual interests (i.e., sex with consenting adults), then obviously they must develop the skills and attitudes necessary to fulfil these changed desires.

We have developed a comprehensive approach to enhancing intimacy skills that includes exploring the clients' prior relationships, discussing what intimacy is and its benefits, training in communication skills, and understanding the broad range of human sexual expression, as well as considering the nature of jealousy and loneliness (Marshall, Bryce, Hudson, Ward, & Moth, 1996). Marshall et al.'s (1996) study also reported evidence indicating the effectiveness of this approach in increasing intimacy and in reducing emotional loneliness.

6. Fantasies and Preferences

No doubt all sexual offenders have at least occasional sexual fantasies about their deviant acts; however, only a limited number display sexual arousal to deviant themes at assessments of sexual interests (Marshall & Fernandez, 2003). More to the point, even fewer complain about persistent deviant sexual thoughts. This latter few, however, need treatment to eliminate these persistent fantasies.

We (Marshall, O'Brien, & Marshall, in press) have described a variety of behavioural procedures that aim at reducing deviant thoughts and enhancing appropriate sexual interests. While these procedures are usually effective when applied appropriately, sometimes they do not achieve the desired goals. In those cases where behavioural procedures fail, we employ either a Selective Serotonin Reuptake Inhibitor (SSRI) or one of the anti-androgens. We use an SSRI (usually sertraline) for those offenders who display compulsive sexual activities (Marshall & Marshall, press), and we reserve the anti-androgens (usually luperon) for the highly dangerous or sadistic sexual offender. Kafka (1994) and Bradford (2000) have described the evidence on the use of pharmacological agents in the treatment of sexual offenders, and we (Marshall, O'Brien, & Marshall, in press) have summarized the evidence on the effectiveness of the behavioural procedures.

7. Offence Pathways

The therapist helps the client develop an outline of the factors that led him to offend. The client's life-line is valuable in identifying chronic problems (e.g., low self-worth, antagonistic relationships, abuse of alcohol or other drugs, anger) throughout the client's life that might have created a state in him that led him to offend. We refer to these as background factors. These background factors generate a state (e.g., a feeling of hopelessness, a feeling of entitlement, a sense of being used by others) that leads the client to either create an opportunity to offend or take advantage of an unexpected opportunity. These states, and the background factors that generate them, as well as the client's strategies to access a victim, all form what we call the client's "offence pathway". Sometimes there are several offence pathways for each client (see Laws & Ward, 2006) but for the purposes of treatment one illustrative and typical pathway will usually do to reveal the issues to the client. Those offence pathways can serve to identify further treatment needs as well as situations and people to avoid in the future. These problematic situations and people are what treatment providers call "high risk events".

8. Self-Management Goals

Using the "good lives model" (see Ward & Marshall [2004] for a description of its application to sexual offenders) as a guide, the therapist and the client work collaboratively to produce a set of goals for a better life. These goals should be realistically matched to the client's interests and abilities, and should be exclusive of opportunities to offend. Included in the development of the client's "good lives" goals should be a realistic set of plans for release from prison. He needs to begin the process of finding a job and accommodation, and he needs to plan for the development of meaningful relationships. In this segment of treatment, the offender is also required to identify signs that would alert him and his support group to the possibility that he may be moving toward a heightened risk to re-offend. This should allow the client to abort this movement toward offending at an early stage. Finally, the client identifies people who can provide him with support upon release from the programme. Two groups are typically formed: a group of professionals (e.g., parole supervisor, community treatment provider or clinician he can access, minister of religion), and a group of non-professionals (e.g., his family, friends, and workmates). These two groups are meant to assist the client with his reintegration back into the community, help him avoid risks, and assist him in implementing his "good lives" plans.

This, then, ends the summary of the treatment programme.

IV. TREATMENT EVALUATIONS

There has been some disagreement in the literature regarding the effectiveness of sexual offender treatment with some claiming that it is ineffective (Quinsey, Harris, Rice, & Lalumière, 1993) while others point to evidence suggesting it can be effective (Marshall, 1993; Marshall & Pithers, 1994). The basis for this disagreement, however, is not about the published evidence but rather whether or not this evidence provides a basis for confidently asserting that treatment is effective. For example, Rice and Harris (2003) claim that the only satisfactory basis for unequivocally concluding that treatment for sexual offenders either does or does not work, are outcome studies employing the Random Control Trial (RCT). This type of study requires that sexual offenders who volunteer for treatment be randomly assigned to either a treatment group

or a non-treatment comparison group. All subjects would be followed for several years after release to determine differential recidivism rates.

Several authors have pointed to serious ethical, practical and technical problems with the RCT designed study (see Hollin, in press; Marshall, 2006; Seligman, 1996). For example, is it ethical to deliberately withhold treatment from a group of sexual offenders then release them into the community for several years to see how many innocent people they assault? Some would argue it is not. From a practical point of view, withholding treatment from some sexual offenders would, in most jurisdictions, lead to the creation of differences between them and treated offenders that might confound the comparison between them. For example, in the Canadian system, the National Parole Board will not release untreated sexual offenders until near the end of their sentence whereas treated offenders get released much earlier. Finally, from a technical perspective, the artificiality of the RCT design (e.g., highly manualized approach that rigorously monitors the therapist adherence to the manual) makes it irrelevant to the issue of how effective treatment is when it is conducted in an appropriate clinical manner. All these effects of the RCT design are likely to reduce the effects of treatment (Marshall, 2006).

As a result of these problems, other authors (e.g., Hanson, Gordon, Harris, Marques, Murphy, Quinsey, & Seto 2002) have suggested employing what they call "an incidental design". In this type of evaluation study, the treated group is matched with a group of untreated sexual offenders from the same setting. While this "incidental design" has some appealing aspects, the comparison group is likely to have some features (e.g., later release from prison, housing in a non-programme institution, less supervision after release) that may increase the risk to re-offend thereby artificially inflating treatment effects. Nevertheless, the incidental design is typically seen as the only alternative available to evaluate treatment.

One other position, however, has been proposed (Barbaree, Langton, & Peacock, 2004; Marshall, 2006). It has been suggested that actual observed recidivism rates in the treated group could be statistically compared to the expected rate of recidivism based on actuarial risk instruments. Since actuarial risk assessment instruments are based on large scale studies of released sexual offenders, and since they are accepted by courts as a basis for establishing future risk, the estimates of risk provided by these instruments should provide a satisfactory comparison with actual re-offences to estimate treatment effects. Indeed such an approach appears to circumvent the problems inherent in both the RCT and incidental designs described above. As we will see, two large scale outcome studies (Barbaree, et al., 2004; Marshall, Marshall, Serran, & Fernandez, 2006) employed this actuarial-based approach.

In addition to the problems of the design of an outcome study, it is necessary to have a reasonably large group of treated offenders released into the community for at least four years (Barbaree, 1997). This is because the base-rate recidivism (i.e., the recidivism rate observed in untreated sexual offenders) is quite low; according to several studies the average re-offence rate among sexual offenders is in the range 16% - 20% (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2004; Hanson et al., 2002). This low rate results from collapsing across all risk categories; the highest risk sexual offenders can be expected to have re-offence rates well above 30%, while the lowest risk offenders can be expected to recidivate at less than 6% - 8%.

Hanson et al. (2002) gathered information on a variety of treatment outcome studies with sexual offenders. They identified 43 studies that had a comparison group of untreated sexual offenders and used official re-offence information as the basis for determining long-term recidivism. Employing a meta-analysis to collapse all these studies into one evaluation resulted in over 4,000 subjects in each of the treated and untreated groups. Hanson et al. found that those programmes that utilized a cognitive/behavioural approach and/or employed relapse prevention strategies had the greatest effects. These programmes reduced the sexual recidivism from 17.3% in the comparison group to 9.9% in the treated group. In addition, it was observed that non-sexual re-offending was also reduced in the treated group (32.3%) compared to the untreated group (51.3%). Recently Lösel and Schmucker (2005) completed a similar meta-analysis but with over 80 studies including several from Europe that were not included in Hanson et al.'s study. Lösel and Schmucker found even more compelling evidence of the effectiveness of sexual offender treatment. The treated group in Lösel and Schmucker's study has a recidivism rate 11.1% compared to a rate of 17.5% in the untreated subjects. These two meta-analyses included some studies that were not effective and some that employed the RCT design. In fact, the four RCT designed studies in Hanson et al.'s study, were all

ineffective, just as was predicted in the discussion above.

Correctional Service of Canada (CSC) has been operating sexual offender treatment in prisons across Canada since 1973. It is not possible within CSC to conduct RCT studies and, in most areas of the country, such a large proportion of the available sexual offenders enter treatment that it is rarely possible to identify a matched comparison group of untreated offenders thereby ruling out the possibility of employing Hanson et al.'s "incidental design". It is important to note that CSC treatment providers have, to a large extent, led the field in developing sexual offender programmes. CSC researchers generate a significant number of studies, and treatment providers in CSC continually incorporate new evidence into their programmes. Thus CSC programmes are at the forefront of treatment for sexual offenders so we can expect them to be among the most effective in the world. For these reasons, appraisal of CSC-based programmes will be considered separately.

V. CSC PROGRAMMES

Four CSC prison-based treatment programmes have been evaluated. The Clearwater programme in Saskatchewan, which targets sexual offenders at the higher end of the risk scale, was evaluated by Nicholaichuk, Gordon, Gu and Wong (2000). They followed 579 sexual offenders (296 were treated, 283 were not) for six years. Of the treated group 14.5% sexually re-offended whereas 33.2% of the matched untreated subjects committed another sexual offence. Looman, Abracen and Nicholaichuk (2000) completed a similar study of the treatment programme at the Regional Treatment Centre (RTC) in Ontario. This RTC programme is specifically designed for the most problematic and dangerous sexual offenders including sexual sadists, so we can expect the re-offence rates to be high. Looman et al. followed 89 treated subjects and 89 matched untreated subjects for 9.9 years. This study also showed significantly lower re-offence rates in the treated group (23.6%) than in the matched untreated group (51.7%).

Since these studies were published, it has been increasingly difficult to identify a matched untreated group of sexual offenders within CSC prisons. In Ontario, in particular, over 90% of sexual offenders in the region's prisons receive treatment. In these circumstances there is no alternative but to use, as a comparison, the expected recidivism. This expected rate is based on determining the risk to re-offend by scoring for each treated client, on actuarial measures, the risk group to which he belongs. An overall estimate of the average actuarially-determined risk of the group, can then serve as an expected recidivism rate against which to compare the actual recidivism rate of the treated group. Both Barbaree et al. (2004) and Marshall, Marshall, Serran and Fernandez (2006) used this strategy to evaluate their Ontario-based programmes.

Barbaree et al. (2004) followed for five years a group of 468 sexual offenders treated at the Warkworth Penitentiary, a medium security federal prison. The expected recidivism rate of Barbaree et al.'s treated subjects was 18% (based on STATIC-99 scores), but only 11.3% actually re-offended. Marshall et al. (2006) reported the findings of their study of the treatment programme they operate in Bath Institution (a medium security federal prison). They followed 534 treated sexual offenders for 5.4 years after their release from prison. The expected recidivism rate was 16.8% (based on STATIC-99 scores), but only 3.2% actually re-offended.

These four CSC programmes demonstrated statistically significant reductions in recidivism among the treated sexual offenders. Not only are these results statistically meaningful, they are also meaningful in terms of reducing the number of innocent victims who might otherwise have been harmed by these offenders. In addition, any reduction in recidivism saves money. Both Marshall (1992) and Prentky and Burgess (1990) showed that by preventing even 1% or 2% of re-offences, a saving is made sufficient to cover the costs of running the programme. All the results described above reveal far greater reductions in recidivism rates than simply 1% or 2%. Indeed, it can be demonstrated that each of the CSC programmes saves Canadian taxpayers as much as one million Canadian dollars per 100 sexual offenders treated (see Marshall, Marshall, Serran, & Fernandez [2006] for an illustration of a cost-benefit analysis).

VI. CONCLUSIONS

This paper has described an approach to the treatment of sexual offenders, and provided details of the application of this treatment and of the role of the therapist in achieving the goals of treatment. The effectiveness of treatment was then evaluated. It was concluded that treatment can be effective and, that when it is effective, it is cost-effective. Most importantly, effectively treating sexual offenders saves from harm innocent people who might otherwise have been abused.

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