COMMUNITY-BASED TREATMENT FOR CHILD SEX OFFENDERS: AN EVALUATION

by

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ABSTRACT

This project was designed to measure and evaluate the effectiveness of the West Midlands Probation Service (WMPS) sex offender treatment programme. The study examines treatment impact on a sample of 126 adult male child sexual abusers (CSAs) who were referred to the programme between January 1995 and January 1997. It was postulated that treated sex offenders would be reconvicted at a significantly lower rate than untreated offenders and that psychometric tests would reveal lower levels of deviance (denial and minimisation, cognitive distortions, poor victim empathy, sexual dysfunction) post treatment than prior to treatment. With an average time at risk of 2.5 years, the reconviction rate for the treated sample was significantly lower, at a third of that of a sample of matched controls. In addition, significant improvements were found for the treatment group in levels of deviance as measured by psychometric tests. Therefore, both hypotheses were accepted. These results are consistent with a number of other treatment evaluations and indicate that treatment can be effective in lowering reconviction rates and in reducing the denial, distortions and deviance associated with sexual offending. However, it is suggested that treatment providers need to target treatment provision more effectively, taking into account the needs of individual offenders and working in tandem with other agencies to ensure maximum protection of children.

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This thesis is dedicated to the memory of

Sue McKewan,

a dear friend and colleague

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Apart from the normal stresses and anxieties involved in post-graduate research, since October 1994, I have found myself thinking and talking about the sexual abuse of children for most of my working (and frequently non-working) hours. Thanks to the wonderful support I have had, particularly from staff at the Sex Offender Unit, this has not been the depressing experience it might have been. Not only was I provided with an outside counselling service, but it was also made clear to me that I could share my thoughts and feelings with people who were dealing with these issues daily in their work with men who sexually abuse children. SOU staff also gave generously of their time and expertise when I was collecting data for this study. Not only did they fully co-operate with the evaluation, but they were particularly keen to find out how they might make their work more effective.

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EXECUTIVE SUMMARY

The aim of this study was to measure the effectiveness of a community-based treatment programme for sex offenders run by the West Midlands Probation Service (WMPS) Sex Offender Unit (SOU). This was set up in 1993 to provide cognitive-behavioural groupwork aimed at reducing recidivism in sex offenders. The vast majority of sex offenders are adult male child sexual abusers (CSAs) and this study focuses on the impact of treatment on a sample of 126 CSAs (all adult males) who were referred to the programme between January 1995 and January 1997.

The principle objectives of the thesis were to ascertain whether treatment can reduce short-term (up to 3 years) recidivism levels and whether it has a positive impact on psychological variables (e.g. cognitive distortions about children, poor victim empathy, lack of accountability) associated with sexual offending. Recidivism in the treatment group was measured using both official (from the Home Office Offender Index) and unofficial (reports made to the SOU by police) data. Official data were available for a matched control group of 47 CSAs. In-treatment progress on psychological variables was measured using a battery of psychometric tests at several points in the programme: 0hrs (pre-treatment), 50hrs (post-assessment), 100hrs (mid-treatment) and 200hrs (post-treatment).

Chapter 1 reviews the sex offender treatment evaluation literature and considers the methodological issues involved in undertaking such projects and Chapter 2 presents a brief description of the SOU programme.

Chapter 3 describes the methodology of the study and the sample of CSAs who are the subjects of the evaluation are described in chapters 4 and 5. Chapter 4 focuses on demographics, offence histories and background information relating to childhood and sexuality and finds that the sample is comparable to those described in other studies

(e.g. Beech, 1997/98; Dobash, Dobash and Waterhouse, 1995; Elliot, Browne and Kilkoyne, 1995). Chapter 5 presents pre-treatment psychometric test results and compares these with those obtained from normative samples. As expected, the CSAs in this study are found to be significantly more deviant than non-offenders and to have unacceptably high levels of denial and minimisation.

Chapter 6 examines in-treatment movement in offence-related denial and admission. The results demonstrate significant improvements suggesting that the SOU programme is effective in reducing levels of offence-related denial and admission. Sex-related denial, deviance and dysfunction is addressed in Chapter 7. It is predicted that CSAs will report higher levels of sexual dysfunction pre-treatment when compared to post treatment and that their level of knowledge relating to sexual anatomy and physiology will have significantly improved. Both hypotheses are supported by the results.

Chapter 8 reviews the literature on pro-offending thinking and reports the results of in-treatment changes. CSAs demonstrate significant and positive change between pre and post treatment and reduction in pro-offending thinking is found to be a function of time spent in treatment. Chapter 9 presents results pertaining to awareness of risk and relapse prevention skills. There is evidence for improvement in both of these areas, although progress is disappointingly slow.

Chapter 10 introduces a clustering method (first described by Beckett, Beech, Fisher and Fordham, 1994) for categorising CSAs according to risk/deviance group (i.e. according to actuarial risk and psychometric deviance). In addition, a simple procedure for classifying offenders into "treated" or "untreated" groups is presented. As expected, having a "treated" profile on leaving the programme is positively and significantly related to time spent in treatment.

Chapter 11 presents a brief review of the literature on group environment and its relationship to effective treatment. SOU group environments are found to be generally very positive (as reported by members and facilitators), with some evidence for links between a positive group climate and treatment success.

Chapter 12 presents recidivism data. Only 4 (3.18%) of the treatment group go on to be reconvicted of a sexual offence within the first 3 years at risk. This compares to a figure of 10.87% (N=5) in the untreated controls. Even when unofficial recidivism is included to make a total of 8 (6.36%) recidivists, the treated sample are found to reoffend at a lower rate than the untreated sample. As expected, there is a positive relationship between recidivism and actuarial risk in both groups. The relationship is stronger in the controls (suggesting a mediating effect of treatment on actuarial risk). There is also a positive relationship between recidivism and psychometric deviance. However, a combination of risk and deviance proves to be a better predictor of reoffence in the treatment group. There is also a non-significant trend towards recidivists making less progress in treatment. In an attempt to identify a good predictive tool, a discriminant function analysis is performed on those static and dynamic variables found to be associated with recidivism in the treatment group and a surprisingly accurate algorithm is derived. However, some caution is recommended in its practical application to offender populations as it needs to be cross-validated.

Chapter 13 discusses the results of the evaluation, methodological issues and the problem of treatment non-completion, makes recommendations for improving treatment provision and presents a model of pathways through treatment. Following this, the implications of recent sex offender policies are discussed and the issue is addressed of whether or not the cost of funding sex offender treatment programmes is justified.

Whilst it is clear that the SOU programme did not benefit all offenders and that some improvements are modest, there is significant progress in a majority of areas targeted by the programme. More importantly, rates of reconviction for sexual offences are significantly lower than those in a matched control group. It is concluded that well targeted treatment (i.e. tailoring interventions to the needs of offenders), particularly when supported by inter-agency co-operation and sex offender registration, can be effective in reducing recidivism and protecting children.

INTRODUCTION

The purpose of this evaluation was to assess the effectiveness of the West Midlands Probation Service (WMPS) Sex Offender Unit (SOU) treatment programme, using psychometric test data and both official and unofficial recidivism figures. On commencement of the evaluation, there was limited evidence for the effectiveness of cognitive-behavioural work with sex offenders (Allam and Browne, 1998). There was also no empirical data to support the link between psychometric test performance (i.e. measures of in-treatment change) and recidivism. However, Hedderman and Sugg (1996), reporting results from the STEP evaluation (Beckett, Beech, Fisher & Fordham, 1994) of community-based treatment programmes, have provided evidence for the effectiveness of cognitive-behavioural treatment programmes for sex offenders in reducing (at least in the short-term) recidivism. They also report STEP findings that low deviance (as measured by psychometric tests) offenders are less likely to reoffend than high deviance offenders. This suggests that knowledge of pre and post deviance can help to predict recidivism and in-treatment movement may be regarded as an indicator of programme effectiveness. A number of prominent researchers in the field of sex offender treatment and evaluation (e.g. Hanson, 1997; Miner, 1997) are now advocating the use of targeted psychometric tests to measure in-treatment change. Until long term recidivism data are available, these tests can be indicators of whether or not treatment has been successful.

OVERVIEW OF AIMS AND HYPOTHESES

This study was designed to examine the effectiveness of the SOU programme in reducing short-term recidivism in child sexual abusers (CSAs). It was also aimed at assessing in-treatment change in those psychological and behavioural (skills-based) variables believed to be associated with sexually abusive behaviour. Both psychometric tests and recidivism data were employed in the evaluation.

General Hypotheses

I. The sample of CSAs who enter treatment will be significantly less likely to be re-convicted for sexual offences than a matched sample of untreated CSAs.

II. The CSAs in the treatment sample will demonstrate significantly less deviance as measured by psychometric tests post-treatment than pre-treatment.

Chapter content is summarised below, along with the main hypotheses where relevant. Chapters 1-3 concern the background to this evaluation study. Chapter 1 largely consists of a published article which discusses the methodological issues concerned with the evaluation of community-based sex offender treatment programmes. Chapter 2 consists of a description of the West Midlands Probation Service (WMPS) Sex Offender Unit (SOU) treatment programme. The background to the development of the programme is presented, along with an outline of how it is run, the models it is based upon and programme content. Chapter 3 presents the methodology of the evaluation and reports frequencies and reasons for premature exit from the programme.

Chapters 4 and 5 describe the sample of 126 CSAs who took part in this study. Chapter 4 focuses on demographic and offence-related data and Chapter 5 presents pre-treatment results on the psychometric tests described in Chapter 3. It is hypothesised that pre-treatment CSAs will present with significantly higher levels of deviance than non-offenders and that they will demonstrate unacceptable levels of denial and accountability.

Chapters 6-9 present in-treatment and post-treatment results on psychometric tests, looking at movement at different stages of treatment (0-50 hours, 50-100 hours and 100-200 hours). Chapter 6 focuses on reductions in offence-related denial and minimisation and hypothesises that the most improvement will take place during the first 50 hours of treatment. Chapter 7 examines self-reported sexual deviance and dysfunction and how this changes over time. This part of the study is exploratory,

since little is known about the effect of treatment on general sexuality. Chapter 8 examines movement in pro-offending thinking (cognitive distortions and victim empathy, for example) and postulates a significant reduction in levels of pro-offending thinking. Chapter 9 looks at awareness of risk and relapse prevention skills, hypothesising that these skills will improve significantly over the course of the treatment programme.

In order to gain an insight into individual profiles and how they change over time, Chapter 10 presents a method for identifying "treated" and "untreated" CSAs and also identifies individuals in terms of both their actuarial risk and psychometric deviance (giving a risk/deviance profile). It is hypothesised that there will be more "treated" individuals post-treatment than pre-treatment and that the longer the time spent in treatment, the more likely someone is to have a "treated" profile. In addition, Chapter 10 considers the psychometric profiles of those who do not complete the treatment programme and compares them with those who do.

A positive group environment has been identified in the literature as a predictor of successful treatment programmes. Chapter 11 looks at overall group environment in SOU groups using a measure designed specifically for this purpose (Moos, 1994). There is also an attempt to identify any links between features of the group environment (such as perceived cohesion and leader support) and treatment outcome.

Recidivism is considered in Chapter 12, where both official and unofficial recidivism statistics are presented. It is hypothesised that treated CSAs will be statistically less likely to be re-convicted for a sexual offence in the short-term than untreated CSAs. It is also expected that data from sources other than conviction data will reveal more recidivism in the treated group than re-conviction data alone. An exploration of data considers the possibility of predictors of short-term recidivism in the treated group of CSAs and examines pre-treatment risk/deviance profiles of those who reoffend.

Finally, Chapter 13 summarises and discusses the results of the evaluation comparing these results with those reported in recent literature. Recommendations for the

treatment of CSAs are made in the light of these results and a model of pathways through treatment is presented. Following a brief discussion about recent policies designed to enhance the effective management of CSAs in the community, this chapter ends with a consideration of whether or not the resources going into treatment programmes for sex offenders are justified.

CHAPTER 1: PROGRAMME EVALUATION

The provision of cognitive-behavioural groupwork with sex offenders has become standard practice in the Probation Service of England and Wales. To-date, the evidence for the effectiveness of this form of treatment is encouraging but limited and there is a clear need for community-based programmes to be fully documented and evaluated.

The article which follows discusses isssues concerned with the evaluation of community-based sex offender treatment programmes. It begins by outlining a rationale for both the treatment of sex offenders and evaluating programmes. Results of the few published evaluations are discussed, along with a consideration of how targeted psychometric tests may be used to measure whether the aims of the programme (in terms of in-treatment change) have been met.

The numerous methodological considerations involved in programme evaluation are discussed and suggestions put forward as to how these may be overcome. A framework for evaluation is presented, which takes into account differences in the size of programmes and the resources available. The article concludes, however, that only by standardising both treatment provision and evaluation will we succeed in determining the effectiveness of community-based treatment programmes for sex offenders.

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Evaluating Community-Based Treatment Programmes for Men who Sexually Abuse Children

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The currently dominant multi-factorial explanations of sex offending have been reflected in the widespread adoption of cognitive-behavioural groupwork methods where treatment foci are those attitudes, beliefs, cognitions and behaviours believed to contribute towards the maintenance of sexually abusive practices. Community-based programmes have mushroomed during this decade, with 97% of regional probation services now having provision for sex offender treatment. However, these relatively recent and dramatic developments of practice have to a large extent occurred outside of a framework of rigorous planning and evaluation. This article begins by outlining a rationale for both the treatment of sex offenders and evaluating programmes. This is followed by a framework for evaluation within which treatment providers can consider the issues involved (including the methodological difficulties) in setting up research designed to evaluate treatment effectiveness. It is suggested that, while small-scale (in-house) research may tell us something about the success or otherwise of individual programmes, it is the larger-scale projects carried out by independent researchers that will inform us as to the impact of cognitive-behavioural group work on recidivism and offence-related psychological variables. Such research has the potential to assist policy-makers and to aid managers and practitioners in the development of effective treatment programmes.

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KEY WORDS: offenders; sexual abuse; community treatment; evaluation

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Why Treat Sex Offenders?

'The probation service in 1995 showed that the total sex offender caseload was 7000'

Sex offenders who seek sexual activity with children make up a relatively small proportion of the probation service caseload in England and Wales. A survey carried out by the probation service in 1995 showed that the total sex offender caseload was 7000. Fifty-eight per cent of these were in custody and the remainder in the community. For many years, intervention with sex offenders was not identified as a priority and there was little specialist training or managerial support. However, within the last 5 years there have been moves nationally to coordinate a more consistent approach to the problem of sexual offending. Some probation services, particularly those operating in large urban areas such as the West Midlands, have established specialist units devoted to work with sex offenders, the majority of whom are adult males who have sexually abused a child (Allam, Middleton and Browne, 1997). More rural areas have opted to train a specialist worker within a generic team as being more suited to their needs and resources. Today almost all regions in England and Wales are providing a specialist therapeutic programme and 97% are using groupwork with offenders based on cognitive restructuring. This dramatic change in probation service policy is not difficult to justify.

Firstly, community surveys and college student samples have shown that childhood sexual victimization is relatively common, with prevalence rates ranging from 6 to 62% for females and 3 to 30% for males (Pilkington and Kremer, 1995). Secondly, offender surveys have found that most sexual abusers of children have a number of victims or repeatedly abuse the same victim (Abel, Becker, Mittleman, Cunningham-Rathner, Rouleau and Murphy, 1987; Kaplan, 1989, 1990) and, when interviewed about their offence histories, report an average of 6 years of undetected offending prior to their arrest (Elliot, Browne and Kilcoyne, 1995). Thirdly, recidivism rates for untreated sexual abusers of children have been reported to be as high as 43% for non-familial molesters of boys, 43% for non-familial molesters of girls and 22% for incest offenders (Marshall and Barbaree, 1990). It is unlikely that recidivism studies overestimate reoffending since prevalence figures show that many sexual offences against children go unreported (Pilkington and Kremer, 1995). Fourthly, the harmful consequences of childhood sexual victimization are well documented (Salter, 1988; Briere, 1992; Kilpatrick, 1992). At least a quarter of child sexual abuse carries a legacy of serious long-term psychological harm for both men and women (Bagley and

'Recidivism rates for untreated sexual abusers of children have been reported to be as high as 43%'

King, 1990) and the prevalence of such abuse is high among those seeking help with psychological problems (Bagley, Rodbery, Wellings, Moosa-Mitha and Young, 1995).

Research on offenders indicates that over 80% of sexual offences against children are perpetrated by men (Finkelhor, 1981; Jehu, 1988; Kennedy and Manwell, 1992). Indeed, seven in 1000 men born in England and Wales during 1953 now have at least one conviction for a sexual offence against a child (Marshall, 1997).

'Seven in 1000 men have at least one conviction for a sexual offence against a child'

Research also suggests that these men may be treatable. Psychopathology is no longer thought to underlie the deviant sexual behaviour of these offenders, and it is widely accepted that a multi-factorial approach towards understanding the sexual abuse of children is appropriate (Finkelhor, 1986; Marshall and Barbaree, 1990). Biological, cultural, structural, social and learning factors (Finkelhor, 1986) are all thought to play a part in the sexual abuse of children. Clinical and anecdotal evidence has long suggested the importance of certain beliefs and attitudes in the commission of sexual offences, but it is only during the last two decades that empirical investigations have focused on analysing those factors which distinguish offenders from non-offenders. There is now a considerable body of evidence pointing towards such factors. For example, men who sexually abuse children have consistently been found to have comparatively low levels of victim empathy and high levels of cognitive distortions regarding women and children (e.g. Howells, 1981; Abel, Becker and Cunningham-Rathner, 1984; Stermac and Segal, 1989; Morrison, Erooga and Beckett, 1994; Marshall, Hudson, Jones and Fernandez, 1995). There is also some evidence for social skills deficits, poor problem-solving ability, emotional loneliness and high levels of deviant arousal and fantasy (e.g. Marshall and Barbaree, 1990).

Given the above, it would seem clear that special provision for working with child sex offenders is essential if children are to be protected from harmful victimization and long-term psychological damage. Resources directed at this client group can therefore be justified if such treatment can be shown to be effective in reducing the risk of reoffending. In the long term, an offender treatment strategy may reduce both the personal cost to victims and the cost to the mental health services in general. In addition, successful intervention with men who sexually abuse children will reduce the numbers of child victims who will go on to become abusers themselves. This cycle of victim to offender may be observed for one in five sexually abused boys who later 'act out' and sexually assault others (Watkins and Bentovim, 1992).

Hence, the implementation of appropriate treatment programmes is imperative if children are to be protected and the cycle of victim to offender is to be broken. The most common approach to the treatment of child sex offenders is based on cognitive-behavioural groupwork (Allam, Middleton and Browne, 1997).

Cognitive-Behavioural Groupwork

'Groupwork addresses the offending behaviour by attempting to modify those attitudes, cognitions and behaviours thought to contribute to its maintenance'

Cognitive-behavioural groupwork addresses the offending behaviour by attempting to modify those attitudes, cognitions and behaviours thought to contribute to its maintenance. Programmes typically aim to: reduce cognitive distortions; increase victim empathy; decrease deviant sexual fantasy (and in some cases arousal); provide training in the social and interpersonal skills needed to develop rewarding relationships with consenting adults; and teach relapse prevention skills. This last aim is increasingly seen as being an essential part of treatment, since the evidence for persistent reoffending suggests that deviant sexual behaviour may have addictive features (Pithers, 1991).

The Importance of Evaluation

The purpose of evaluation is to determine the effectiveness of the treatment programme offered. In this case, success in the long term can be measured by comparing recidivism rates of treated and untreated offenders. In the short term, in-treatment changes in target attitudes, cognitions, competencies and behaviours are increasingly being seen as predictive of success (e.g. Beckett, Beech, Fisher and Fordham, 1994). Once a programme has been thoroughly documented and evaluated, results of the evaluation should be replicable. Thus, if a programme is found to be effective, it can be adopted by other treatment providers. More importantly, if a number of programmes are evaluated and reported, it should be possible to identify those characteristics of programmes related to successful outcomes and those clients most likely to benefit from treatment. This is particularly pertinent in an area of treatment which is in the relatively early stages of being developed. Although there is much agreement in the field regarding those psychological and behavioural variables which distinguish sex offenders from non-offenders, there are still uncertainties regarding optimum content and length of treatment, how it should be developed, which offenders

benefit most and how to assess the risk of reoffending post-treatment.

Programmes typically work with adult men within a broadly cognitive-behavioural framework but vary in terms of resources, length and precise content of treatment, level of worker expertise and type of client referred. Because of these variations, it is not always possible to determine which variables have contributed to the success or failure of a programme. Well-conducted evaluations will not only give important feedback to individual programmes but will also contribute to the development of a model of effective treatment and to our knowledge of who is likely to benefit from this treatment. Evaluation is equally important when applied to the treatment of female sex offenders (Saradjian, 1996), juvenile sex offenders (Calder, 1997) and learning-disabled sex offenders (Day, 1994)—perhaps more so given that we know considerably less about these clients or their treatment (Allam *et al.*, 1997). The following suggestions and comments are equally applicable to the evaluation of treatment of all sex offenders, although assessment tools will vary according to who is being assessed. What follows is a guide to effective evaluation.

'Programmes typically work with adult men within a broadly cognitive-behavioural framework'

From Programme Implementation to Evaluation

Minimum Requirements

Ideally, programmes should be evaluated by an independent researcher. In practice, this is rarely possible. Smaller programmes, in particular, are unlikely to have any outside support or assistance and will be restricted by factors such as time, money and lack of research expertise. However, at the very least, treatment providers should ensure that:

- The philosophy of a programme and its treatment objectives are clearly documented along with a description of the programme which includes details of length and content
- Groupworkers/facilitators are involved in treatment planning and the preparation of the above documents
- Staff are appropriately selected and trained to deliver the programme
- Support in the form of supervision and debriefing is provided for all those involved in programme delivery
- Staff adhere to the planned programme of treatment, i.e. there is no 'programme drift'

'High treatment integrity has been found to characterize the most successful rehabilitation programmes'

'The simplest measures will involve recording treatment dropouts and client/groupworker feedback'

The above constitute the minimum requirements for high 'treatment integrity', which simply means that a programme is implemented as intended (a full description of how this is achieved may be found in Hollin, 1992). High treatment integrity has been found to characterize the most successful rehabilitation programmes (Andrews, Zinger, Hoge, Bonta, Gendreau and Cullen, 1990; Moncher and Prinz, 1991; Lipsey, 1991).

Success does not only depend on the type of programme offered and its delivery. It may be that some clients are more likely to benefit than others or that some will require a longer period of treatment. Treatment providers should monitor referrals—who is being accepted onto the programme? Which category of offender does an individual belong to? Child molesters are frequently categorized into intra- or extrafamilial abusers (e.g. Dobash, Carnie and Waterhouse, 1993). A further division might be gender of victim. In untreated offenders these categories are fairly good predictors of risk of subsequent convictions (e.g. Barker and Morgan, 1993). A pre-treatment risk assessment may also be made using an actuarial model based on previous convictions and offence data, such as that described in Fisher and Thornton (1993). Once offenders have been categorized into offence type and/or risk category, it is possible to compare differential response to treatment. Measures of treatment response can vary widely. However, the simplest measures will involve recording treatment dropouts and client/group-worker feedback. More sophisticated measures are detailed below.

Evaluating Treatment Effectiveness

Once a programme can be considered to be high in treatment integrity, it is possible to undertake a formal assessment of the impact of treatment on clients. In order to determine how effective a treatment programme is, it is necessary to define the criteria for effectiveness. These criteria will depend on both stated objectives of a treatment programme and the kind of data it is realistically possible to obtain. The ultimate goal of sex offender programmes is that of reducing recidivism. Obviously, long-term recidivism data are not available for a number of years—years in which a programme will be changing and evolving in response to new research findings, feedback from workers and clients and alternative measures of treatment impact. Thus, while recidivism data are important, the attainment of short- and medium-term goals might be considered an indicator of treatment success.

This is particularly so of shorter treatment programmes whose objectives might be limited to obtaining measurable attitudinal change in some areas. Quasi-experimental designs measure changes in attitudes and cognitions associated with the maintenance of sexually abusive behaviour as well as looking at treatment integrity (Hollin, 1995). Such information may also establish the existence of links between these in-treatment changes and subsequent recidivism.

The design of an evaluation and its criteria for success will depend on factors such as time, resources and research expertise available. However, the financial and societal benefits of a thorough assessment of the effectiveness of a sex offender treatment programme are potentially far-reaching since the results of a large-scale evaluation will be of statistical significance and will therefore be generalizable to similar sex offender populations. Where outside (or in-house) research skills are not available, managers/practitioners may be able to take some steps towards evaluating treatment. For example, they will generally have access to official reconviction data (e.g. Home Office Offender Index) and are frequently in a position to gain access to unofficial data from Social Services and child protection units (although a clear policy on inter-agency sharing of information is advisable here). In addition, there are some attitudinal measures specifically designed to be used by treatment providers (e.g. the Sex Offence Attitudes Questionnaire; Procter, 1994).

'The design of an evaluation will depend on factors such as time, resources and research expertise available'

Methodological Issues

Whatever the scale of a evaluation project, it is important for treatment providers to be aware of the methodological issues involved in order to inform any decisions regarding evaluating their programmes. The following is an outline of some of these issues (comprehensively reviewed in Furby, Weinrott and Blackshaw, 1989). The intention is to highlight some of the limitations to assessing effectiveness of treatment and to suggest ways of conducting reliable evaluations within these limitations.

Design

Sample selection

Offender characteristics need to be taken into consideration when evaluating a programme, particularly if outcome is to

'Offender characteristics need to be taken into consideration'

be compared with that of untreated offenders or those participating in alternative treatment programmes. Beckett *et al.* (1994) point out that the majority of those in treatment within the probation service are of relatively low risk, as identified by offence-related variables and psychometric test scores. Thus, it cannot be assumed that high-risk offenders would benefit from the same type of treatment. In addition, adequate sample size is imperative if inferences are to be drawn about any particular subgroup of offenders within a sample, for example intra- versus extrafamilial abusers. Research questions should take available sample size into account (allowing for attrition—client dropouts) in order to reduce the probability of error. Samples of less than 10 in each subgroup of sex offenders are unlikely to produce results generalizable to the rest of the sex offender population (i.e. it is possible to say something about how this particular group of individuals has responded to treatment but not about how another set of clients would respond).

Controlled studies

Related to the above is the issue of finding adequate control groups. Quite apart from the inherent ethical problems involved in allocating matched offenders to treatment or non-treatment groups, controlled studies of sex offenders are becoming increasingly difficult to carry out. This is due to the fact that the majority of them either receive community treatment as part of a probation order, or they receive a custodial sentence followed by a condition of treatment on release. Those who go to prison are often considered to be at a high risk of reoffending—many of these receive treatment while serving their sentence. Thus, finding matched controls (i.e. sex offenders who have not participated in any rehabilitation programmes) is virtually impossible unless retrospective data are used. Comparison groups (i.e. individuals participating in the same programme but who have not abused children) are less of a problem, since exhibitionists and men who abuse adult women are frequently treated in the same groups as child molesters.

'Inevitably, some will fail to complete treatment, others may be impossible to trace during the follow-up stage'

Attrition

Inevitably, part of the original sample will disappear at some stage of the evaluation. Some will fail to complete treatment, others may be impossible to trace during the follow-up stage. There is little that can be done about individuals who cannot be traced and it would seem appropriate to exclude them

from the sample and to give the percentage of the original sample that were followed up. Treatment dropouts, refusers and those excluded from treatment part way through the programme are more of a problem. It is known that they have a far higher risk of reoffending (Marques, Day and Nelson, 1993) than those who complete treatment. Quinsey, Harris, Rice and Lalumiere (1993) argue that these offenders should be included in any evaluation of programme effectiveness because a high dropout rate may be indicative of the programme's failure to deliver appropriate treatment. Marshall, Jones, Ward, Johnston and Barbaree (1991) question the logic of including such individuals when measuring outcome since they will not have received the treatment in question. There is merit in both arguments. It is clear that a high dropout rate may mask real improvements in those who have completed the programme, but can we judge treatment to be effective when it is obviously failing to achieve its aims with regard to certain offenders? A partial solution to this problem would be to report on the outcome for those who completed the programme, but to include information about the characteristics and outcomes of dropouts. In this way, programme developers can reconsider referral policy and perhaps identify and modify those aspects of treatment considered inadequate or inappropriate for certain client groups.

'Include information about the characteristics and outcomes of dropouts'

Assessment Tools

Cognitive-behavioural treatment for sex offenders is designed to produce measurable change in attitudes, cognitions and behaviours—specifically those thought to be related to sexual offending. Although there is as yet little empirical evidence to link these variables to recidivism in treated offenders, treatment is based on this assumption and recent evaluative research suggests that a lack of in-treatment changes in, for example, victim empathy and relapse prevention skills is predictive of reoffending. An example of a British study is that of the STEP report (Beckett *et al.*, 1994), which evaluated seven treatment programmes using in-treatment psychometric measures. Two years on, the only clients known to have reoffended were those that Beckett *et al.* had identified as belonging to the highest risk group according to post-treatment questionnaire responses.

The most objective way to look at in-treatment change is to use well-validated psychometric test materials. These may be administered pre- and post-treatment or at several points in the treatment process. There are many tests available and the

'The most objective way to look at in-treatment change is to use well-validated psychometric test materials'

majority of these have been normalized on non-offending British males. In deciding on which measures to employ, the specific aims of intervention must be taken into account. The tests chosen should reflect programme objectives in terms of attitude and cognitions (e.g. beliefs about children's sexuality) and skills/behaviours (e.g. relapse prevention techniques). Significant changes in these areas in the desired direction (as demonstrated by statistical analyses of pre- and post-measures) would suggest a degree of success in fulfilling these objectives. Both Salter (1988) and Beckett *et al.* (1994) give comprehensive lists of available test materials as well as an indication of their usefulness in assessing sex offenders. However, those recommended by the STEP report (Beckett *et al.*, 1994) include some particularly useful measures devised by Beckett (1993) and Beckett and Fisher (1993). They have the advantage of having been normalized on a British population. A full assessment package would include measures of certain personality-type characteristics such as empathic concern, self-esteem and locus of control, as well as attitudes and cognitions associated with offending behaviour such as cognitive distortions about child sexuality, victim empathy, acceptance of responsibility and relapse prevention skills.

Some of the measures recommended (such as the Multiphasic Sex Inventory; Nichols and Molinder, 1984) can only be used by psychologists. Programme evaluators who are not qualified to administer and score all questionnaires can use some published materials but should ensure that these materials do actually measure the variables of interest. It might be useful to refer to those evaluations carried out by other programmes (e.g. Mid Glamorgan Probation Service, 1991; Lucas, Raynor and Vanstone, 1992; Procter, 1993; Beckett *et al.*, 1994) in order to standardize as far as possible the way that in-treatment changes are assessed. Pen and paper tests can be used in conjunction with clinical observations. These may be in the form of qualitative data obtained from group observation and client interviews by the evaluator and/or from therapist assessments of client progress. In addition, important information may be obtained from other professionals, family members, partners and friends of clients with regard to behaviours (e.g. grooming, heavy drinking, unexplained absences) related to that particular client's cycle of offending. Qualitative data are generally more subjective than the quantitative data obtained from test scores and evaluators who intend to use such methods of assessment will need to be particularly careful to fully report methods of data collection, analysis and interpretation.

'Pen and paper tests can be used in conjunction with clinical observations'

Measuring Recidivism

Criteria

When measuring recidivism among child sex offenders, a decision needs to be made regarding the criteria used for including an offence in the outcome data. For example, do we limit inclusion to reconviction for a similar offence, do we extend it to any sex offence, or do we consider all criminal offences? Most studies consider any reconviction for a sexual offence. This seems more appropriate than the other options for two main reasons. The first is that few would consider treatment as a success if an abuser simply changed the pattern of his sexually abusive behaviour. Secondly, treatment of sex offenders is directed at sexually deviant behaviour rather than general criminality. Thus, it would not be fair to judge a programme's effectiveness in terms other than those relating to the focus of treatment.

'Treatment of sex offenders is directed at sexually deviant behaviour rather than general criminality'

The majority of studies base outcome data on conviction rates. However, the under-reporting of sex offences and low rates of conviction mean that these data are likely to underestimate the true extent of reoffending. Obtaining unofficial data from sources such as child protection services, policy records, etc, increases the likelihood of having more realistic estimates of recidivism but still tells us nothing about those crimes which go unreported. Another problem with relying on such data is that they may give us a distorted picture of the offending patterns of the abusers themselves. For example, extrafamilial offenders appear to be far more recidivistic than incest offenders. This is usually explained in terms of high deviancy. However, because extrafamilial offenders tend to have multiple victims, there is a stronger possibility that at least one of their victims will report the offence. Also, intrafamilial abuse frequently leads to family breakdown (Bentovim, 1991), where fathers/stepfathers would have fewer opportunities to abuse within the same family.

Length of follow-up

Another consideration that needs to be taken into account when measuring recidivism is that of the time period investigated. So far, few studies have followed up treated and untreated offenders for long periods. This means that even if treatment is found to be effective in the short term, we do not know whether this effect diminishes over time. It would seem logical that a study measuring recidivism over 20 years, for example, is going to find more reoffending than

one which lasts only 5 years. Marshall and Barbaree (1988) found increasing numbers of reconvictions over time in their follow-up study of both treated and untreated child molesters. They found that for up to 2 years post-treatment, 5.5% of these men had been reconvicted. The corresponding figure for untreated offenders was 12.5%. However, after 4 years, reconvictions had risen to 25% among the treatment group and 64.3% among the control group. This suggests that follow-up periods of less than 2 years may be useful when comparing treated and untreated offenders in the short term but caution should be exercised in making assumptions about the long-term impact of treatment on the basis of such data.

'Follow-up periods of less than 2 years may be useful in the short term but caution should be exercised in making assumptions about the long-term impact of treatment'

Is Cognitive-Behavioural Treatment Effective?

There is some evidence from both sex offender treatment work and general offender rehabilitation programmes that cognitive-behavioural treatment can be effective in reducing recidivism. In 1991, Marshall reviewed several evaluations of cognitive-behavioural treatment and concluded that such programmes can be effective in reducing recidivism in those who sexually abuse children. His conclusion is supported by Thornton (1992), who compared four comprehensive outcome evaluations of cognitive-behavioural programmes with four evaluations of other forms of treatment. In all but one case, cognitive-behavioural treatment was shown to be effective in reducing recidivism in terms of reconviction data. The apparent effect showed improvements in the treated groups of between 36 and 69% when compared to untreated groups. The only cognitive-behavioural programme that was shown to be ineffective (Rice, Harris and Quinsey, 1990) does not appear to have been fully implemented (Marshall, *et al.*, 1991), which means that it lacked the treatment integrity thought to be essential to successful treatment.

Further support for the benefit of cognitive-behavioural intervention with sex offenders who abuse children comes from the first major evaluation study carried out in Britain. The Sex Offender Treatment and Evaluation project (STEP) carried out by Beckett, *et al.* (1994) set out to measure the effectiveness of six community-based programmes being run by the probation service and one private residential programme. A process evaluation which looked at measuring change over a variety of dynamic variables such as

cognitive distortions and victim empathy has produced some encouraging data, with 54% of subjects showing treatment effect as measured by psychological and clinical assessment. Of those offenders classified as low risk, treatment effect was observed in 93% of cases. Recidivism data two years post-treatment appears to confirm the positive impact of treatment on offending behaviour (Beech, 1997).

'54% of subjects showing treatment effect as measured by psychological and clinical assessment'

Meta-analyses (i.e. results of a statistical procedure which combines summary data collected from a group of studies) of rehabilitation programmes for delinquents have demonstrated that some treatments tend to yield better results than others and have identified those factors of programmes which appear to be predictive of success (Andrews, *et al.*, 1990; Lipsey, 1991; Antonowicz and Ross, 1994). These include: focusing on criminogenic needs (i.e. attitudes, cognitions and behaviours thought to directly relate to offending); using styles and modes of treatment that are matched with client need and learning styles; delivering the service to higher-risk cases; high treatment integrity. In addition, Andrews *et al.* (1990) found that community-based programmes tended to be more successful than those run within institutions. Although no meta-analyses have been performed on studies specifically relating to sex offender treatment, the above results are nonetheless encouraging and are consistent with early evaluations of individual sex offender programmes (e.g. Beckett *et al.*, 1994). Firstly, because they indicate that treatment can work. Secondly, because probation service (community-based cognitive-behavioural) programmes fulfil at least some of these criteria for success.

'Community-based programmes tended to be more successful than those run within institutions'

Thus, the tentative conclusion may be drawn that, at least in the short term, cognitive-behavioural treatment may be effective in reducing recidivism in some sex offenders and is almost certainly effective in modifying attitudes and cognitions associated with the sexual abuse of children. This does not preclude the need for further evaluations, since programmes will differ in precise content, length, client base, treatment integrity and worker expertise. However, there is reason to believe that current optimism with regard to the effectiveness of cognitive-behavioural work with sexual abusers of children is justified.

Conclusion

While the debate over whether sex offender treatment can be effective continues, the perceived need for rehabilitative work has led to the development of community-based programmes

'Programmes can have a positive impact on both offending behaviour and the attitudes, beliefs and cognitions of this client group'

throughout Britain. There is increasing evidence that such programmes can have a positive impact on both offending behaviour and the attitudes, beliefs and cognitions of this client group. Both quasi-experimental evaluations designed to assess in-treatment changes and recidivism data based on official and unofficial rates of reoffending will assist in the development of practice. Such studies require that the treatment programmes in question and client sample are adequately described, that treatment integrity is high and that the evaluation itself is methodologically sound. Working within this framework, regardless of how detailed the evaluation, will contribute to knowledge relating to what treatment works and for whom. However, it is larger-scale evaluations that have the potential to influence subsequent policy and practice in organizations such as the probation service. Clearly, major resource implications are involved. However, the cost of not ensuring that treatment is implemented as it should be and that it is fully evaluated will almost certainly be that of more victims and, in the long term, more offenders.

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Since the article above has been published, much progress has been made with respect to the development and evaluation of sex offender treatment programmes - both in the prison and probation service. In order to standardise treatment provision and ensure best practice, the Home Office has set up an initiative whereby well-established offending behaviour programmes are helped to attain accreditation status through consultation with experts in the relevant field. Those "Pathfinder" programmes which are accredited (judged by a panel of independent experts) are then made available for others to use.

There are several stages in the accreditation process. The first stage involves further programme development aided by a literature review citing relevant and recent empirical research. The next stage involves the production of manuals to act as guides for those implementing the programme. Once these materials have been accredited, inspections take place to ensure that the programme is being delivered in the way it should be. Finally, evaluation procedures are put in place in order to ensure constant monitoring and assessment of effectiveness.

The West Midlands Probation Service Sex Offender Unit (SOU) was selected as a Pathfinder programme in 1999 and is due to be accredited in 2000. At the commencement of this study, however, the SOU had only been in existence for a year and was running a cognitive-behavioural programme 200hrs in length. The programme manual was in the process of being written up and was published in 1996 (WMPS Sex Offender Unit, August, 1996).

CHAPTER 2: A SEX OFFENDER TREATMENT PROGRAMME

Much of this chapter has been reproduced from a published article which focused on the potentially differing treatment requirements of sub-groups of offenders. An integral part of the paper was a description of the West Midlands Probation Service (WMPS) Sex Offender Unit (SOU). The entire article, "Different clients, different needs? Practice issues in community-based treatment for sex offenders" (Allam, Middleton & Browne, 1997), may be found in Appendix 1. The description below focuses on practice at the SOU at the time of the present study.

BACKGROUND

In 1993 the West Midlands Probation Service took the decision to create a specialist unit to develop work with sexual offenders. This meant that practice and resources could be standardised across the county, ensuring consistent provision of sentencing recommendation to courts and an equal opportunity for sex offenders to change their behaviour. The largest community-based sex offender unit in England and Wales, it serves the whole of the West Midlands region.

An organisation of experienced staff was established to work exclusively with sex offenders. Although the officers had the same basic skills and philosophy regarding the work, their practice had until that time been governed by the needs and resources of the area team they had been a part of. They now had the opportunity to participate in the development of a comprehensive assessment and therapeutic programme based on cognitive-behavioural groupwork methods. All groupwork staff were involved in devising the programme and writing the manual (WMPS Sex Offender Unit, 1996). The manual details the philosophy and aims of the programme and introduces the

concept of cognitive-behavioural groupwork with sex offenders in the context of relevant research. It provides materials and ideas for each session of a 200 hours programme which consists of an Assessment period of 50 hours followed by six modules of 25 hours each. Advice is also given on groupwork style, preparation of sessions and de-briefing.

At the time of data collection, the SOU comprised: six full-time probation officers; one senior probation officer; one full time social worker seconded from the National Society for the Prevention of Cruelty to Children (NSPCC); one part-time clinical psychologist; three administrators. In addition, co-workers from various agencies (local authority social services, NSPCC, other probation offices and mental health services) were working alongside unit officers in group sessions.

The SOU is not only involved in programme development and implementation. It also has responsibility for the preparation of all pre-sentence reports (PSRs) on sex offenders in the West Midlands who appear before the courts (and who are pleading guilty), it is involved in risk assessments of offenders requesting parole and in writing pre-release (from custody) reports. SOU officers regularly attend case conferences when a unit offender is involved and a representative from the unit attends Public Protection Panel (PPP) meetings to provide information to the police about offenders who are currently attending or who have left the programme. Unit officers also deliver short training programmes designed for professionals and workers from various agencies who have contact with sex offenders.

Attendance on the programme is frequently as a condition of a three-year probation order, with approximately half of group members referred in this way. A probation order is recommended to the courts if the pre-sentence assessment suggests that the risk of dealing with the offender in the community is acceptable and if the offence in question would normally attract a sentence of no more than three years. Additional conditions may be added to probation orders (e.g. residence in an approved probation hostel, prohibition of unsupervised contact with children) to provide further controls in the attempt to reduce risk. If, despite these conditions, the risk remains unacceptable

or denial of the offence is extreme and entrenched, then a custodial sentence linked to extended supervision on licence after release (through the use of section 44, Criminal Justice Act, 1991) is proposed to the court.

Just under half of the offenders referred to the Unit are on licence following release from prison - this includes those on discretionary and those on automatic licence. At the time the present study was being conducted, there was a policy of not accepting onto the programme men who were completely denying their offences.

In addition, the SOU also accepts referrals from child protection case conferences. These "voluntary" clients are often men known to have sexually abused a child (usually within the family) who have not been brought to trial. Alternatively, they are individuals who have previously been convicted or accused of sexually abusing a child and are now living in a new household where children are present. A small minority of group members have been referred in this way.

THE TREATMENT PROGRAMME

The WMPS SOU treatment programme is described below with consideration given to: treatment provision; treatment integrity; group philosophy, staffing and organisation; groupwork style; programme content and aims. The programme has changed in certain respects since the evaluation was carried out. However, the description below was accurate at the time of the study.

Treatment provision

At any one time, the SOU is running 3-4 assessment groups (between 10 and 12 per year) and 10 treatment groups (2 of which are for clients with learning disabilities). The purpose of assessment is primarily to introduce the philosophy of the programme and assess suitability for groupwork. Following assessment, and conditional upon a

degree of progress, offenders are moved into a rolling treatment programme. In each group there is a maximum of 12 offenders (with an average of 10) and the SOU is generally doing groupwork with 120-150 individuals. All group members are adult males aged 21 or over. Groups are mixed, i.e. whilst a majority of group members are child sexual abusers (CSAs), generally there are one or two men in each group who have committed offences against adults. Unit policy and provision for learning disabled offenders, female sex offenders and those with serious mental health problems or personality disorders are discussed in more detail in Appendix 1.

Group philosophy, staffing and organisation

All group members are expected to actively participate and co-operate with the therapy programme and they may be subject to breach proceedings or re-call to prison if they fail to comply with conditions. Prior to joining an assessment group, offenders attend for interview with group leaders and have the opportunity to ask questions about the programme and to learn what is expected of them. Group rules, condition of membership and treatment style are discussed in more detail on the first day of Assessment.

Each group is led by a minimum of 2 groupworkers (usually a man and a woman) and there is generally an additional observer or group consultant. At least one of the groupworkers is a full-time member of the SOU with co-workers from the Unit, from field probation offices, from Social Services or the NSPCC. The majority of group sessions are filmed - mainly for training purposes but also for the protection of offenders and workers. Approximately 5% of these videos are viewed by the senior probation officer and they are used to inform staff supervision. Videos of group sessions are held securely for no more than one year, after which the tapes are wiped. Occasionally professionals working with sex offenders or judges involved in sentencing sex offenders are given permission to observe a group session. After being introduced to the group, they go into another room to view proceedings through a 2-way mirror or on the video monitor.

Before an offender begins assessment, as much information as possible is obtained about his offence(s) and his history of offending. Depositions are sent to the Unit which include victim statements. This ensures that sufficient knowledge of an individual is available. Without such information, it is far more difficult to identify and challenge offender accounts of the abuse (which are likely to include a certain level of denial and minimisation). Whilst a sex offender is in contact with the SOU (and sometimes after leaving the programme), the SOU works alongside other agencies, such as the Police and Social Services, in order to maximise the efficacy of assessment, treatment and risk management

Groupworkers use the SOU Groupwork Manual (WMPS Sex Offender Unit, 1996) as a basis for sessions and aim to meet for at least half an hour's preparation before the group begins. Following the session, workers have a de-brief and complete feedback forms on all group members. These are faxed to offenders' probation officers or social workers and copies kept for their files. Full reports are prepared on each offender and his progress at the end of the assessment period. Less detailed reports are completed at the end of each module and information about progress is provided upon request to relevant professionals and authorities.

Groupwork style

Cognitive-behavioural groupwork with sex offenders aims to eradicate abusive behaviours and to promote pro-social modes of interacting with others. It is not a client-centred therapy, since there is much evidence that sex offenders distort and minimise their abusive behaviours and fantasies. Behavioural change is achieved using a combination of role play, rehearsal and cognitive re-structuring. Members are encouraged to explore and challenge one another's behaviours and distortions as well as their own. Whilst groupworkers lead the group, ensuring that certain material is covered and that the group is orderly, members are encouraged to participate fully and are expected to be the primary source of challenges and questions once the assessment period is over.

Whilst content and materials vary from session to session, the format is basically the same. Members hand in any homework assignments and are given the opportunity to raise significant points - relating to the previous session, the homework or to events which have occurred to them since the last session. They may then do a warm-up or "trust" exercise. These are particularly common in the early stages of Assessment and Treatment. This is followed by work on the relevant module, and finally a wind-down/feedback exercise and explanation of any homework. Offenders take home evaluation sheets where they are asked to comment on the good and bad points of the day's session and to say what they have learnt. These forms are returned the next time they attend.

Programme content and aims

The Sex Offender Groupwork Programme consists of an assessment period of 50hrs and a treatment period of 150hrs. Assessment begins with a block week of 25hrs and is followed by 10 weekly sessions of 2.5hrs. The content and aims of Assessment are summarised in Table 1.

Key models of the process of sexual offending are introduced during the assessment period and used throughout treatment in order to help offenders to understand and articulate how they gave themselves permission to sexually abuse and how they developed an abusive pattern of behaviour. One such model is that of Finkelhor (1984) who developed a model of 4 pre-conditions for sexual abuse. These pre-conditions are: motivation (to abuse); overcoming internal inhibitors; overcoming external inhibitors; overcoming victim resistance. The SOU frequently presents this model as a series of hurdles which the offender has to jump before he can come to the point of abuse. Generally, it will first be introduced with an example of a behaviour which is wrong but not connected to sexual offending, such as shoplifting, speeding or having an affair. Group members are encouraged to work on examples of their own behaviour. In this way they are introduced to the concepts of inhibitors/disinhibitors, cognitive distortions and justifications and required to acknowledge that, in order to

overcome hurdles, they must have had considerable motivation to commit the act. An example of an offender's work on his own pre-conditions is in Appendix 2.1.

Another model used consistently throughout assessment and treatment is the sexual assault cycle (Eldridge, 1992, based on Wolf, 1984), which portrays the offence process as a cycle of distorted thinking, triggers, targeting of the victim, grooming, sexual abuse, post-abuse feelings (e.g. guilt, sexual gratification, elation), reinforcement and a return to fantasy, for example. Every individual's cycle is different and some have short-circuit cycles (which omit one or more elements of the above) once the abuse pattern has been established. An example of the same offender's work on his cycle may be found in Appendix 2.2

Assessment is also the part of the programme in which group members are introduced to group rules and encouraged to voice any questions, doubts or anxieties they might have about the treatment process. It is used as an opportunity to foster a positive group environment and to enhance motivation to change.

Table 1: Assessment content and aims

Content	Aims
Offence Stories	To begin to move offenders away from passive to more active accounts of their offending.
Offence Cycles	To teach the concept of an offence cycle and help offenders relate this to their own offences.
Finkelhor's 4 pre-conditions for offending	To teach offenders Finkelhor's model and relate to their own pre-conditions for offending.

The treatment part of the programme is divided into 6 modules, each of which takes place over 10 weeks, with weekly sessions of 2.5hrs. The modules are: Cycles and Cognitive Distortions; Social Skills, Self-esteem and Assertiveness; Sexuality and Gender Issues; The Role of Fantasy in Offending; Victim Awareness/Empathy; Relapse Prevention. Example sessions (from the Groupwork Manual) may be found in Appendix 2.3. Table 2 below summarises module content and aims.

Table 2: Summary of the SOU module content and aims

Module	Content	Main Aims
Cycles and Cognitive Distortions	Further work on cycles and the link to cognitive distortions (CDs) and pro-offending thinking	To help each man recognise the cognitive distortions he used in order to offend. To ensure that each man can give an account of his offending which does not minimise or distort his sole responsibility for the abuse. For each offender to understand his own cycle and the links between the pre-cursors to the abuse. To begin the process of cognitive restructuring in order to facilitate a move away from offending cycles.
Social Skills, Self-esteem and Assertive-ness	Role-play and groupwork exercises that focus on social skills Linking social skills deficits to offending	To enhance offenders' self-awareness regarding their level of social skills, self-esteem and assertiveness. To help them identify any changes necessary to avoid offending in the future. To help sex offenders to function more effectively within society without relapse into abuse.

Sexuality and Gender Issues	Gender stereotypes Facts and myths about sexuality Sexual vs non-sexual needs	To examine and get across the abusiveness of stereotyping. To provide education on sexuality in order to enable offenders to distinguish facts from misinformation. To help offenders understand the difference between sexual and non-sexual needs and roles.
The Role of Fantasy in Offending	The links between fantasy and abusive behaviour Rehearsal of ways of avoiding abusive fantasy/lapses	To help group to understand how fantasy can lead to abusive behaviour. To help offenders learn how to deal with "unwanted" thoughts of abusive behaviour. To encourage the offender to incorporate plans for dealing with abusive fantasy in his relapse prevention plan.
Victim Awareness /Empathy	Rehearsal of perspective-taking Exploring abuse of power Victim accounts (e.g. videos)	To increase awareness of the consequences of abuse to victims and others. To enhance feelings of empathic concern for victims of sexual abuse. To help offenders understand how remorse (not guilt) can act as an inhibitor to further offending.
Relapse Prevention	Linking previous work to RP Rehearsal of possible high risk situations Developing RP plans and strategies	To reinforce understanding of the cycle and how each stage is linked to the next. To ensure that offenders understand the process of lapse and relapse in their own cases and have learnt to manage potentially risky situations. To develop a personal relapse prevention plan.

Because treatment consists of a rolling programme, offenders may enter at various points. Generally, however, it is possible to introduce them into a group at the beginning of the Cycles and Cognitive Distortions module, the Social Skills, Self-esteem and Assertiveness module or the Sexuality and Gender Issues Module. An offender is never entered into a treatment group which is working on the Victim Awareness /Empathy module within the next few months. This is because it is felt that more preparation is needed before such work can be usefully undertaken. Likewise, the Relapse Prevention module is not undertaken immediately after assessment, since it assumes a minimum level of motivation and insight.

Whilst each module has a particular focus, they are not regarded as discrete and elements of each will be included in most sessions. This degree of flexibility is important when rolling programmes mean that modules may not be presented in the ideal order and when a proportion of the group members may not be expected to complete the programme due to their being on short licenses or funded by Social Services for a limited period of time.

SUMMARY

The SOU treatment programme has benefited from having strong organisational support, a dedicated team of experienced sex offender group workers and the opportunity to work with large numbers of sex offenders. The Unit is able to offer a comprehensive treatment package which is grounded in current theory and research on sex offenders and has been designed by individuals with a great deal of experience of this type of work. Group workers are drawn from a variety of professional backgrounds (although core workers are all probation officers) and inter-agency co-operation in assessment, treatment and risk management is well established. The programme itself fulfils the minimum requirements of treatment integrity (as set out in Chapter 1), ensuring that the intended programme is implemented and may be properly evaluated.

CHAPTER 3: METHODOLOGY

RATIONALE

The fact that sex offender treatment has only recently become standard practice in the Probation Service means that programme evaluation is a relatively new concept. Several probation regions have conducted evaluations of in-treatment change and some have included follow-up re-conviction data (e.g. Procter, 1993; Lucas, Raynor and Vanstone, 1992). Until relatively recently, however, evaluators had little in the way of appropriate materials with which to measure the expected changes in attitudes, cognitions, skills, and behaviours of offenders. The STEP Project (Beckett, Beech, Fisher & Fordham, 1994) was commissioned by the Home Office in order to evaluate the work of several community-based sex offender treatment programmes and one residential programme. In the course of this project, useful measures were identified or developed for use in the assessment of sex offenders and the measurement of change over time. Beckett et al provided a framework within which researchers could work with a degree of confidence that they were measuring what needed to be measured.

To a large extent, the design of this evaluation study owes much to Beckett et al (1994). However, there are four important differences which illustrate the advantages of working with a large programme in a specialist unit. One of the most striking differences between the two evaluations is that Beckett et al used volunteer participants. They report that over 50% of the offenders approached refused to take part in the study. One might conclude that this sample may be somewhat biased. A second difference is that the larger numbers of participants in the present study means that the data are more likely to be normally distributed and statistical significance will be easier to establish. Thirdly, the present study has not simply used pre-post measures (where offenders may have received vastly discrepant hours of treatment), but has involved administering tests to everybody at key points in treatment. This has the added advantages of allowing both some analysis of optimum length of treatment

and analysis of who benefits most from the programme. Finally, the nature of co-operation between the Sex Offender Unit (SOU) and other agencies such as the Police and Social Services, has meant that unofficial recidivism, as well as reconviction, data on the treated sample has been made available. Few studies have had access to unofficial data but those that have (e.g. Marshall and Barbaree, 1981) have uncovered rates of recidivism at over double the reconviction rate. The data obtained in the current evaluation, whilst not encompassing other undetected reoffending, should improve our understanding of the differences between those "treated" offenders who reoffend and those who do not.

DESIGN

The evaluation consists of two parts. The first is a study of in-treatment changes in level of deviance (as measured by psychometric tests). The second is a reconviction study. It conforms to a quasi-experimental design, where a control group was identified for the recidivism study but was not available for the study of in-treatment change. In the study which looks at in-treatment change, the independent variable is length of time in treatment (tests are administered at 0hrs, 50hrs, 100hrs and 200hrs) and the dependent variable is deviance (as measured by psychometric testing). In the recidivism study, the independent variable is group (treatment or control) and the dependent variable is reconvictions for sexual offences. Within both studies, examination of the data involves detailed comparisons of between and within group differences. These are outlined in the methodology sections of relevant chapters.

SAMPLES

The main sample in this study is the treatment sample - those offenders participating in the SOU treatment programme. Control and comparison groups have, however, been used where data were available.

Treatment sample

All 126 Child Sexual Abusers (CSAs) entering treatment between January 1 1995 and January 1 1997 participated in the study. They were all men who had committed contact offences against children or young persons under the age of 18 (this age reflecting a change in definition made in the Criminal Justice Act of 1991). In 4 cases the index offence did not involve sexual contact with a child. Current convictions for 2 of these individuals were for indecent exposure, one was for distributing child pornography, and the other was for the rape of a learning disabled woman. However, they all had previous convictions for sexually abusing a child or children.

Participation in the study, i.e. completing the psychometric tests was presented to offenders as an integral part of the treatment programme. The only exclusions from the study were those known to fulfil the criteria for being learning disabled (i.e. an IQ of 70 or below) because it was felt that the validity and reliability of psychometric test results would be compromised. On occasion, low functioning (IQ of 85 or below) individuals were allocated to treatment groups designed for learning disabled offenders. These too were excluded from the study. However, where a low functioning individual was originally included in the sample (and able to complete the questionnaires satisfactorily) but was later moved into a group for learning disabled offenders, tests results are included up to the point of the move. Detailed information on the characteristics of the treatment group may be found in Chapter 4.

Control and comparison groups

A control group of 47 CSAs was obtained in order to compare recidivism in treated and untreated groups of offenders. This group was identified using the West Midlands Probation Service database (PROMIS), which holds data on all persons convicted of offences within the region in the last 5 years. In June 1996, the database was trawled and the control group was selected using the following criteria: the index offence was a sexual offence against a child; the offender was convicted of the offence; the probation service had recommended a probation order with a condition of attending a

sex offender treatment programme; the recommendation had not been accepted and the offender had received an alternative sentence (generally a short prison sentence); the offender had not attended a treatment programme. Further details of the control group may be found in Chapter 12.

Where normative data were available, they have been used in order to provide a means of comparing the psychometric test scores of the current sample of CSAs with non-offender males. These data come from three sources. The first is Beckett et al (1994), who administered a number of the psychometric tests used in the present study to a normative sample of 84 British males. The second is Nichols and Molinder (1984), who administered parts of the Multiphasic Sex Inventory (MSI) to a group of 54 American males. Finally, Allam's (1994a) Victim Awareness Questionnaire was normalised on a sample of 104 university students. This procedure is described in Appendix 3.7.2.

Non-completers and treatment dropouts

In Chapter 1, it was suggested that all offenders who fail to complete a treatment programme should be regarded as dropouts and thus as treatment failures. However, of the 126 CSAs in the treatment sample, only 39 (31%) completed the whole 200hrs programme. Despite this, the average time spent in treatment was 109.17 hours (sd=71.48). This is significantly longer than the duration of many programmes (such as those described by Beckett et al, 1994). It was decided, then, to divide the group of men who did not complete treatment into categories consisting of those who left for an acceptable reason and those who left for an unacceptable reason. The former group is hereafter referred to as non-completers, the latter as dropouts.

The vast majority of those who left the programme prematurely did so on completion of their order. This was the case for 55.2% (n=48) offenders. The second largest proportion of non-completers left for a reason which would not preclude their rejoining the programme (or another programme) at a later date. These had either

moved away from the area (in several cases because of threats to their lives), were ill and unable to attend or were imprisoned for crimes committed prior to joining the programme (19.4%, n=17). Six individuals (6.9%) were moved to more appropriate treatment provision - either to a group for learning disabled/low functioning offenders or to individual treatment.

A minority of offenders left for more obviously unacceptable reasons. These dropped out of treatment because they were breached (generally for non-co-operation with treatment) or excluded from group. They numbered 11 individuals (12.4%) of the sample. Finally, another 5 (5.8%) individuals "dropped out" of treatment because they reoffended. Table 3.1 summarises the information on non-completers and treatment dropouts.

Table 3.1: Frequencies of treatment non-completers and treatment dropouts (n=87)

Reasons for leaving treatment	Frequency	% non-completers (n=87)	% treatment sample (n=126)
Completed order	48	55.2%	38.1%
Diverted to alternative treatment	6	6.9%	4.8%
Breached or excluded	11	12.7%	8.7%
Re-offended	5	5.8%	4%
Other (illness, move from area, etc.)	17	19.5%	13.5%

Those who left the programme prior to completion did not, therefore, complete psychometric tests at every stage of the treatment process (0hrs, 50hrs, 100hrs and 200hrs). Twenty-seven (21.43%) individuals completed pre-treatment questionnaires only, thirty-six (28.6%) completed tests at the 0hrs and 50hrs stage only, thirty-six

(28.6%) did 0hrs, 50hrs and 100hrs tests and twenty-seven (21.4%)[1] completed questionnaires at each of the four stages. Table 3.2 gives the frequencies of questionnaire completion at each stage, i.e. the number of test results available for analysis at the pre-treatment stage (0hrs), post-assessment (50hrs), mid-treatment (100hrs) and post-treatment (200hrs). Pre/post results (i.e. questionnaires completed at least at 0hrs and 50hrs) were available for ninety-nine (78.57%) of the sample.

Table 3.2: Frequencies of test data obtained at different stages of treatment

Test stage	Frequency of respondents (Total n=126)
Pre-treatment (0hrs)	126 (100%)
Post-assessment (50hrs)	99 (78.57%)
Mid-treatment (100hrs)	63 (50%)
Post-treatment (200hrs)	27 (21.42%)

SOURCES OF DATA AND ASSESSMENT TOOLS

The tools employed in the evaluation (see Table 3.3) measure a number of attitudes, feelings and behaviours, many of which are believed to be related to an individual's propensity to commit sexual offences. Apart from the measure of group environment (Moos, 1984) and the Verbal IQ test (Ammons and Ammons, 1962) the majority of questionnaires were designed specifically for use with sexual offenders.

Personal and demographic information was gleaned from case notes, groupworkers and self-report. As part of the test pack, all offenders attending the SOU were asked to complete a personal information form asking for these details (Appendix 3.1). Much of the information about sexual orientation and relationships was obtained from the Sexual History Section of the Multiphasic Sexual Inventory (Nichols & Molinder, 1984).

[1] The reason only 27 individuals have completed the post-treatment 200hrs tests is that twelve of the 39 men who completed the programme had not done so by the time data collection ceased.

Table 3.3: Assessment tools

Measure	Scale
A) The Multiphasic Sex Inventory (MSI: Nichols and Molinder, 1984)	1) Social/Sexual Desirability (SSD) 2) Sexual Obsessions (SO) 3) Child Molest Lie Scale (CM Lie) 4) Cognitive Distortions and Immaturity (CDI) 5) Justifications (Ju) 6) Treatment Attitudes (TA) 7) Child Molest Sex Deviance Admittance Scale (CM scale) 8) Paraphilias Scales (Para) 9) Sexual Dysfunction Scales (Sex Dysf) 10) Sex Knowledge and Beliefs (SKB) 11) Sexual History a
B) The Kids and Sex Questionnaire (K&S: Beckett and Fisher, 1993)	12) Cognitive Distortions (CD) 13) Emotional Congruence (EC)
C) The Sex Offence Attitudes Questionnaire (SOAQ: Procter, 1994)	14) Denial of: offence and related planning; risk; victim harm; personal responsibility (SOAQT) 15) Denial of risk (SOAQR)

D) Personal Reaction Inventory (PRI: Greenwald and Satow, 1970)	16) Social Desirability
E) Victim Awareness Questionnaire (VA: Allam, 1994a)	17) Victim Awareness (VA)
F) Rape Myth Acceptance Scale (Burt, 1980)	18) Rape Myth Acceptance (RMA)
F) Relapse Prevention Skills Questionnaire (RP: Allam, 1994b)	19) Relapse Prevention Total (RPT) 20) Relapse Prevention Insight (RPI) 21) Relapse Prevention Strategies (RPS)
G) Group Environment Scales (GES: Moos, 1994)	20) Cohesion (Co) 21) Leader Support (LS) 22) Expressiveness (Ex) 23) Independence (Ind) 24) Task Orientation (TO) 25) Self-Discovery (SD) 26) Anger and Aggression (AA) 27) Order and Organisation (OO) 28) Leader Control (LC) 29) Innovation (Inn)
H) Quick Test (QT: Ammons and Ammons, 1962)	30) Verbal IQ test b

a The Sexual History Section of the MSI documents self-report data and is not a scale.

b The Verbal IQ test results serve to identify possible learning disabilities and to describe the sample

Information relating to conviction histories and re-conviction data was obtained from the Home Office Offender Index, a national database containing information on all standard list[2] convictions recorded since 1963. Initial data on controls was obtained from the West Midlands Probation Service offender database.

Published and existing measures

The measures and scales described below have either been published or were made available by the authors.

The Multiphasic Sex Inventory (Nichols and Molinder, 1984)

The Multiphasic Sex Inventory (MSI) is a 300-item questionnaire designed for the assessment of sex offenders. It covers a broad range of psychosexual characteristics and consists of 19 scales and a sexual history section. There are 5 validity scales, 3 scales of sexual deviance, 5 scales relating to atypical sexual behaviours (paraphilias), 4 scales of sexual dysfunction, a sex knowledge scale, and a treatment attitudes scale. Those scales relating to other types of sexual offending (Rape and Exhibitionism) were not included in analyses.

Questions appear in the form of statements which require True/False responses. Where a question is not applicable for CSAs (for example, where the question asks whether a respondent has reached orgasm whilst exposing) the instructions indicate that the individual should leave the box blank. Minor adjustments were made to the format of the questionnaire in order to maximise the accuracy of responding and to clarify questions with e.g. double negatives (see Appendix 3.2.1). The MSI manual and test pack contains scoring grids much like that of the MMPI which are placed over the response grid in order to calculate the score for each scale. Scores are then entered onto a profile sheet which allows interpretation of the scores, placing them into

[2] Standard list offences are all indictable or triable either way offences and include a few of the more serious summary offences. A list of these offences may be found in "The Offenders' Index: codebook" (Research & Statistics Department, Home Office, 1996).

defined ranges. These ranges are based on sample means and standard deviations. A copy of the profile form may be found in Appendix 3.2.2.

Nichols and Molinder report internal consistency for only 3 scales, arguing that items on most scales are not equivalent in item difficulty. They report an average test-re-test reliability (using 32 child sexual abusers) of .89. There have been a number of independent studies which have examined the psychometric properties of the MSI and these have found high internal consistency on a majority of scales as well as good test-re-test reliability (e.g. Simkins, Ward, Bowman & Rinck, 1989; Hanson, Cox, & Woszczyna, 1991; Kalichman, Henderson, Shealy & Dwyer, 1992). Indeed, the studies cited recommend the use of the MSI for both initial assessment and progress monitoring. Table 3.4 lists the MSI scales which form part of the evaluation, along with a brief description of what they measure. MSI results are reported in chapters 5, 6, 7 and 8.

The Kids and Sex Questionnaire (Beckett, 1993)

The Kids and Sex (K&S) Questionnaire asks about feelings and attitudes towards children of 14 years and younger. It contains 2 15-item subscales, Cognitive Distortions (CD) and Emotional Congruence (EC), both of which have high internal consistency (alpha=0.9) and positive correlations with related measures (Beckett, Beech, Fisher and Fordham, 1994). Scale items are reproduced in Appendix 3.3. Respondents indicate the degree to which they agree or disagree with the statements presented on a 4-point scale ranging from "very true" to "very untrue". They also have the option to reply "don't know".

The CD scale assesses the extent to which the respondent perceives children to be sexually sophisticated, interested in sexual contact with adults and unharmed by such contact. High scores suggest high levels of distortions. Example statements are: Children want sexual contact with adults; Children can lead adults on.

Table 3.4: Multiphasic Sex Inventory Scales

Scale	Content
a) **Social/Sexual Desirability (SSD)**	Measures the extent to which an individual is prepared to acknowledge "normal" sex drives and interests. Very low scores suggest faking. Example item: "It does not interest me to learn that a woman may not be wearing any panties".
b) **Sexual Obsessions (SO)**	Measures the extent to which an individual is obsessed with sex. However, it is also a measure of denial, in that very low scores can indicate faking. Example item: "I think about sex 80% of the time".
c) **Child Molest Lie (CM Lie)**	Measures the degree to which an individual is prepared to acknowledge arousal to children. High scorers deny this arousal. Example item: "Sometimes I am sexually attracted to children".
d) **Cognitive Distortions/ Immaturity (CDI)**	Measures cognitive distortions rooted in childhood. High scorers adopt a "victim stance". Example item: "I feel like a victim as a result of the accusations that have been made against me".
e) **Justifications (Ju)**	Measures the rationalisations used to justify the sexually abusive behaviour. High scorers are not accepting accountability for their behaviour. Example item: "My sexual offence occurred because of stresses in my life".

f) Treatment Attitudes (TA)	Measures an individual's acknowledgement of sexual problems and the need for help to control his behaviour. Low scorers are not motivated for treatment. Example item: "I need help because I am not able to control my sexual behaviour".
g) Child Molest Sex Deviance Admittance (CM)	Measures the extent to which an individual admits to fantasy, grooming and offence behaviours. Low scorers are unlikely to be giving truthful responses. Example item: "I have never molested a boy".
h) Paraphilias Scales (Para)	Sub-scales measure an individual's admittance of atypical sexual arousal and activity, such as: fetish interests; voyeurism; obscene phone calling; bondage; sado-masochism. An example item from the Fetish sub-scale is: "I have become sexually stimulated when someone urinates".
i) Sexual Dysfunction Scales (Sex Dysf)	Sub-scales measure the extent to which an individual experiences sexual dysfunction in the areas of: sexual inadequacy; premature ejaculation; physical disabilities; impotence. An example item from the Premature Ejaculation sub-scale is: "I am too easily sexually excited".
j) Sex Knowledge and Beliefs (SKB)	This scale measures an individual's level of knowledge relating to sexual anatomy and physiology. An example item is: "If the penis is large enough, the woman will generally experience orgasm."

The EC scale assesses emotional identification with children and an individual's perceptions of how well he understands and gets on with them. Very high scores indicate a possible emotional dependence on children and are more common in higher risk offenders (Beckett et al, 1994), whereas low scorers show little interest in children and their emotional needs. Example items are: I prefer to spend my time with children; When I feel low children cheer me up. Scoring information may be found together with scale items in Appendix 3.3. and K&S results are reported in chapters 5 and 7.

Rape Myth Acceptance Scale (Burt, 1980)

The Rape Myth Acceptance (RMA) questionnaire consists of 19 items concerning attitudes towards victims (mostly women) of sexual assault. Respondents select one of 7 possible responses on Likert scales which differ slightly according to the question being answered (see Appendix 3.4). The scale has high internal reliability (alpha=.875) and has been found to correlate significantly with: sex role stereotyping; adversarial sexual beliefs; tolerance of interpersonal violence; self-reported likelihood of raping (e.g. Burt, 1980; Burt, 1983; Check & Malamuth, 1985). Example items are: Any female can get raped; Women who get raped while hitchhiking get what they deserve.

Because of suggested links between rape myth acceptance and interpersonal violence and because it is known that many sex offenders have multiple paraphilias (Abel, Mittleman & Becker, 1985; Kaplan, Abel, Cunninham-Rathner & Mittleman, 1990), it was felt appropriate that the CSAs in this study should complete the RMA scale. Whilst recent British normative data is not available, levels of distortions about rape victims (i.e. lack of victim empathy) might be expected to reduce as a result of treatment, since the programme aims to challenge and dispel cultural myths about roles and characteristics of men and women as well as to enhance offenders' abilities to appreciate the perspective of others.

Sexual Offences Attitudes Questionnaire (Procter, 1994)

The Sexual Offences Attitudes Questionnaire (SOAQ) was developed to measure the attitudes that sex offenders have towards their offending. It consists of 30 items with a 5-point Likert response scale ranging from "completely true" to "completely untrue" (Appendix 3.5). All items were derived from actual explanations that sexual offenders had given for offending during interviews and treatment. Face validity of the items was confirmed by probation officers working with sexual offenders and possible response bias was accounted for by phrasing items in both active and passive styles. Embedded in the SOAQ are 5 scales of distorted thinking: Perception of risk (9 items); Victim Empathy (6 items); Planning (7 items); Denial (4 items); Distortions/Justifications (4 items). Examples are given below of items within each subscale:

Perception of risk: I think that I am at risk of committing further offences.
Victim Empathy: I think the harm I caused to my victim will be fairly short-lived.
Planning: This offence was an unfortunate accident.
Denial: I have never committed a sex offence in my life.
Distortions/Justifications: I would not have offended if it had not been for alcohol.

The scores in each scale may be added together to form a total denial/distortions score. The higher the score, the more denying and distorting an offender is. Thus, as a unitary measure, the SOAQ assesses the extent to which a sexual offender justifies, minimises and denies the nature of his offending, harm to victims and the continued risk he might pose. This combination of sub-scales has high internal consistency (alpha=.89). Procter reports that it appears to be a very reliable measure with a split half coefficient (Spearman-Brown) of .92.

For the purposes of this study, the SOAQ total score is considered as a measure of denial (chapters 5 and 6). However, the Perception of Risk scale is also reported separately (chapters 5 and 9), since it is believed to be related to relapse prevention skills.

Personal Reaction Inventory (Greenwald & Satow, 1970)

The Personal Reaction Inventory (PRI) is a short measure of socially desirable responding - the tendency to try to "look good". It consists of twelve items taken from the Crowne and Marlowe (1964) scale with responses changed from the original dichotomous T/F items to a 7-point Likert scale ranging from "very like me" to "very unlike me" (Appendix 3.6).

It has high internal reliability with an alpha of 0.92. Example statements from the revised questionnaire are: No matter who I'm talking to, I'm always a good listener; I am quick to admit making a mistake; I have sometimes taken unfair advantage of another person. This version of the scale is adapted from Greenwald and Satow (1970) and was obtained from the authors of the STEP report (Beckett et al, 1994). PRI scores are reported on in Chapter 5.

Group Environment Scale (Moos, 1994)

The Group Environment Scale (GES) was originally developed in 1981 and is designed to measure the social environment in therapeutic groups. The measure has been extensively researched and Moos (1994) cites much evidence of validity and reliability. The GES consists of 10 subscales, each of which contains 9 items to be answered in a True/False response format. The scales assess three underlying sets of dimensions: Relationships (Cohesion, Leader Support, Expressiveness); Personal Growth/Goal Orientation (Independence, Task Orientation, Self-Discovery, Anger and Aggression); System Maintenance and Change (Order and Organisation, Leader Control, Innovation). The sub-scales are described in detail in Chapter 11.

One point is given for every response which indicates that the dimension in question is present in the group and scores on each dimension can range from 0-9. Thus, a high score indicates agreement that the dimension in question is present in the group. For example, a score of 8 for Group Cohesion would indicate that an individual perceives his/her group as highly cohesive but a score of 3 for Leader Control would indicate

that the group is perceived to be run in a rather loose manner with little emphasis given to rules and leadership. The scale is administered to both group members and group leaders once the group has been running for at least 50 hours.

Quick Test (Ammons and Ammons, 1962)

The Quick Test (QT) is a measure of Verbal IQ which is quickly and easily administered and has the advantage of being appropriate for use with individuals who have reading and writing difficulties. Evidence of the validity and reliability of the QT is presented in the test manual (Ammons and Ammons, 1962).

The subject is asked to point to one of four pictures which best fits a word read from the list by the administrator. When an individual passes or fails six consecutive words, that part of the test is terminated and a score is derived by calculating the number of correct items. There are 3 forms of the test, all of which were administered here. The mean for the 3 scores is calculated and converted to an IQ score by reference to a table on the reverse side of the form.

This test was employed to provide an initial screening for learning disabilities but results were also used in order to calculate average IQ of the sample of CSAs in this study. Results of the Verbal IQ are given in Chapter 4.

New measures

A majority of the measures used in this evaluation were existing measures and in publication or obtainable from authors. However, on commencement of the study, it was felt that there was no suitable relapse prevention questionnaire available and also that there was a need for a measure which looked at victim awareness - the capacity to understand how a child victim might experience sexual abuse and what the consequences of that abuse might be. Questionnaires to measure both of these constructs were devised and administered alongside the other measures.

Victim Awareness Questionnaire (Allam, 1994a)

The Victim Awareness (VA) Questionnaire (Appendix 3.7.1) was developed with the intention of providing a measure which would assess and individual's level of understanding about child victims who are sexually abused. It covers issues that concern: attitudes towards sex with children; how a child might feel during abuse; why a child might not disclose abuse; possible long-term consequences of abuse. Like other measures that attempt to uncover attitudes towards and understanding of victims, the VA questionnaire does not claim to be measuring empathy in the sense of feeling compassion and concern. What it does examine are cognitive aspects of victim awareness - understanding emotional expression, perceiving how another might be thinking and feeling, understanding what constitutes appropriate behaviour towards children. Details of the development and standardisation procedure are given in Appendix 3.7.2.

The VA questionnaire has high internal consistency with an alpha of .89. A Split-half reliability test revealed a correlation of .91 between the two test halves. Test re-test reliability was found to be r = .72. The questionnaire comprises 35 items with a 7-point Likert response format, ranging from "strongly agree" to "strongly disagree". Scores for each question range from 0 (no distortion) to 6 (maximum distortion), with a total possible scale score of 0 - 210. Approximately half of the items are worded in an active format (i.e. as a distortion) and half in a passive format. Example items are: Sometimes children don't tell anybody about their sexual contact with an adult because they enjoy the activity and don't want it to stop; It is never OK for a child to masturbate a man; Children who have sexual contact with an adult are likely to have sexual problems when they grow up; Not all kinds of sexual contact with a man are bad for a 4 year old. Victim Awareness results are reported in chapters 5 and 7.

Relapse Prevention Questionnaire (Allam, 1994b)

The relapse prevention (RP) literature distinguishes between two essential components of relapse prevention. The first component is that of insight into offending behaviour.

Unless CSAs can identify the antecedents to their last offence(s), they may be unable to identify high risk situations in the future. The second component incorporates risk awareness and coping strategies - the ability to identify potentially risky situations and to detail ways of coping with these situations.

Clearly, RP treatment needs to be individualised to the extent that a client becomes aware of his own antecedents and risk situations, as well as developing the strategies that he needs to regulate his own behaviour and to avoid lapses and relapses. The RP questionnaire developed for the purpose of this evaluation (Appendix 3.8.1) takes into account the individual nature of RP. This is why questions frequently require some detail in the responses and why the scoring procedure allows for individual differences.

The scale comprises 26 questions and may be divided into 2 sub-scales each containing 13 items. The first is Insight (RPI) and covers insight into past offending and the second is Strategies (RPS), which looks at awareness of risk and at coping strategies. Internal consistency of the RP questionnaire was good. The combined scales (i.e. total RP score) had an alpha of .93 with a Spearman-Brown split-half reliability of .82. The first 13 questions (Insight scale) had an alpha of .9 with a split-half reliability figure of .86. Questions 14-26 (Strategies scale) also had high internal consistency - again an alpha of .9 with a slightly lower split-half reliability of .83.

Example questions in the RPI scale are: How were you feeling just before the first time you abused? Had anything happened to make you feel this way?; How did you groom your victim? Example questions from the RPS scale are: Describe a particularly high risk situation for you; How would you deal with this situation in order to ensure that you did not re-offend? Each reply scores a maximum of 2 points and a minimum of 0 points. The RP scales are considered both separately and as a whole, since aptitude in both areas is required to prevent relapse. The scoring method is explained more fully in Appendix 3.8.1. Details of questionnaire development and standardisation may be found in Appendix 3.8.2.

PROCEDURE

Before beginning the Assessment part of the treatment programme, groups of a maximum of 8 offenders attended the office for an introductory interview (with SOU probation officers) and to complete the psychometric test pack, which was presented as an integral part of the treatment package. Test administration took place in a large group room with desks. Offenders had been warned beforehand that they would need approximately 3 hours to complete the tests. Tea and coffee facilities were available and respondents were able to take a break when they wanted to. A standard set of instructions was given both verbally and in written form (see Appendix 3.9) before the group were instructed to proceed. It was also pointed out that each man had a code number to be used throughout the study and that it was not necessary to write names on the questionnaires. The group was assured that, apart from test administrators (both female), no other people would have access to the completed questionnaires. The same procedure took place at the 50hrs, 100hrs and 200hrs stage of treatment, although sometimes with individuals rather than groups of offenders.

Whenever possible, offenders with literacy problems were invited to attend the unit on a different occasion to other offenders. Otherwise, 1 test administrator remained with the rest of the group whilst another went to another office, explained the questionnaires and read the questions to the respondent. The offender was reassured that the administrator would not be shocked or embarrassed by any of his replies and that she dealt with this material on a daily basis. In order to ensure the maximum possible reliability and integrity of responses, questions were read in a somewhat monotonic (expressionless) manner.

Verbal IQ tests (Ammons and Ammons, 1962) were administered on the same occasion. Individuals were asked to go into a different room with the author to do a "vocabulary test", which generally took 10-15 minutes to complete. It was explained that the main purpose of the test was to ensure that people were allocated to groups that would be suited to them.

As well as the author, another person needed to be available to assist the test administration when necessary. The SOU put forward an administrative member of staff who also supervised group members during their breaks and lunch hours. She was in no way seen as a probation officer or one of the group workers. The author trained this member of staff by: going through each questionnaire to make sure she understood the instructions and what was expected of respondents; asking a variety of questions in order to reflect the kinds of queries or complaints respondents might have; making sure that she was aware of the importance of checking that all questions had been answered before allowing offenders to leave; ensuring that she understood and was able to deliver a standard set of instructions; training her to administer the tests to people with literacy problems by reading questions aloud (in a monotonic voice). Being accustomed to working with this offender group, the assistant did not require special training in dealing with sex offenders.

Test administration was carried out in the same way (with the exception of the IQ testing and the interview) at 50 hours, 100 hours and 200 hours. At times, individuals had to be tested at another centre or had to come in at a different time from other group members. However, testing was always carried out on group premises. Relapse Prevention (RP) questionnaires were not administered at 0hrs and neither were Group Environment Scales (GES). Details of how these measures were used are given in chapters 9 and 11 respectively.

Both questionnaire scores and offence/demographic data were entered onto a database which was set up in SPSS. No names were used in conjunction with the questionnaires or on the database. Code number/name relationships were in written form only and were kept securely.

TREATMENT OF DATA

Details of data analyses may be found in the relevant results chapters.

CHAPTER 4: SAMPLE CHARACTERISTICS

INTRODUCTION

Whilst it is not unusual for published research to give brief descriptions of sex offender characteristics, there have been few attempts to describe child sexual abuser (CSA) samples in any detail. The purpose of this chapter is to give an in-depth description of the CSAs in this sample. Areas covered include: socio-demographic characteristics; relationship and parental status; sexuality and childhood experiences; offence characteristics; offence histories; actuarial risk.

There is no suggestion in the literature that particular ethnic or socio-economic groups are over-represented in sex offenders and no such factors have emerged as predictors of recidivism (e.g. Hanson and Bussiere, 1998). For example, Abel and Rouleau (1990) found that a sample of 561 sex offenders were representative of the general population, coming from all socio-economic levels and representative of ethnic subgroups. A recent British study carried out by members the Sex Offender Treatment and Evaluation Project (STEP) team (Fisher, Beech and Browne, 1999) found that a group of 140 CSAs were indistinguishable from a sample of non-offender males (n=81) in terms of IQ, educational level achieved and ethnicity (although there was a trend in the direction of fewer black men in the offender sample). There was, however, a significant difference in age, with the non-offender sample being significantly younger.

Where relationships are concerned, Fisher et al (1999) found a non-significant trend for more of the CSAs than the non-offenders to be married or in a long term relationship. They were also significantly more likely to have children. It should be noted, however, that the CSA sample was significantly older (at 43.1 years, sd=10.5) than the non-offender sample (average age of 29.1, sd=7.2) and these variances could be attributable to this large difference in mean age of the two groups.

Much has been written about the sexuality and childhood experiences of CSAs. There is evidence that the riskiest CSAs (as indicated by previous offending and psychometric testing) are less likely to describe themselves as heterosexual than those viewed as less risky (Beckett, Beech, Fisher and Fordham, 1994) and we know that CSAs have frequently had disruptive and unhappy childhoods. For example, reports of childhood sexual abuse in CSAs are more common than in the general population. Prevalence studies of the abuse of male children give figures ranging from 3-33% (Marshall, Anderson and Fernandez, 1999; Salter, 1988). However, rates of childhood sexual abuse in CSAs have been reported as high as 70% (Beech, 1997/98). Prentky, Knight, Sims-Knight, Strauss, Rokous and Cerce (1989) found that the level of disruptive childhood experiences predicted the severity of offending in sexual offenders.

Recent British studies reveal that a majority of CSAs are convicted of indecent assault of a child (Beech, Fisher and Beckett, 1998; McClurg, Craissati and Wiseman, 1994/1995; Beckett et al, 1994). Higher deviance offenders (as measured by psychometric tests) are more likely to have abused boys and to have committed extra-familial offences than lower deviance offenders (Beech, 1997/98). Beech also found that level of deviance was positively correlated to actuarial risk level, with higher deviance offenders obtaining higher scores on an actuarial risk scale (which takes into account previous offending).

Where data are available, the characteristics of the CSAs described below are compared with Regional Trends (HMSO, 1994) and/or with reports of (mainly British) CSA characteristics given in recent research papers.

SAMPLE

The data below describe the 126 child sexual abusers (CSAs) who took part in this study. The control sample (N=47) is described in Chapter 12, which looks at recidivism in the treatment group and in a group of untreated offenders.

Socio-demographic characteristics

Demographic and personal history data were obtained largely from self-report (see Appendix 3.1.) and case files. However, some of the information was gleaned from responses to the Multiphasic Sex Inventory (MSI: Nichols and Molinder, 1984)..

Age and Ethnicity

The average age of this sample was 43.98 (12.6) ranging from 21-76 years. Most were of white British or Irish origins with 7.1% (n=9) being non-white. This is comparable with that of other samples, such as that of Beech (1998), whose CSA sample had an average age of 42.6 (9.8). Of the non-whites, 2 offenders were African-Caribbean and 5 were Asian (all from the Indian sub-continent). These figures indicate that non-whites are under-represented according to Regional Trends (HMSO, 1994), which quotes a figure of 14.6% for the West Midlands.

Educational and Occupational Status

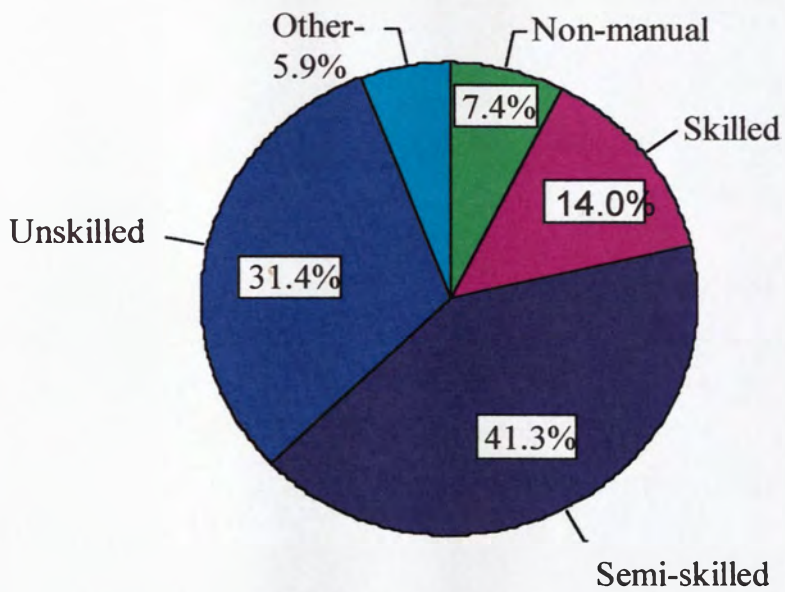
The average Verbal IQ of the sample was 98.07 (13.68) with a range of 73-135. This is slightly lower than that reported by Fisher et al (1999), who report an average Verbal IQ of 100.3 (sd=11.63) in a sample of 140 CSAs. There was a fairly high proportion of offenders with literacy problems. Thirteen and a half percent had reading and writing difficulties and required assistance to complete questionnaires. Self-reported highest educational level achieved ranged from no formal qualifications (53.8%) to professional/degree level (5.1%). The largest minorities had achieved GCSEs or their equivalent (20.5%) or non-professional vocational qualifications (17.1%). For 3.4% of the sample, "A" levels represented the highest level of academic achievement.

Immediately prior to beginning the programme, only 32.5% (n=41) of the sample were in employment, 53.2% (n=67) were unemployed and 14.3% (n=18) were not working due to sickness/disability or because they had retired. The unemployed figure is extremely high but can to a large extent be explained by the fact that 46% of the

sample had only just been released from prison on commencing the programme. Of these, only 13.8% had a job. These figures compare with a regional trend in unemployment of only 6.31%. (HMSO, 1994).

When asked about usual occupation, it emerged that the largest minority (41.3%) were generally involved in semi-skilled/service-industry work. There was also a large minority (31.4%) who tended to work in unskilled manual occupations. Three of the sample had never worked and one was a full time degree student. Just under ten percent of this sample worked in non-manual professions - either with professionals (7.4%) or as professionals, employers or managers (2.5%). Fig. 1 illustrates the breakdown of job categories as they relate to this sample of CSAs.

Fig 1: Usual occupation of CSA treatment group (n=126)



When compared to figures reported in Regional Trends (HMSO, 1994), the SOU sample appears to be more unskilled and less likely to have any qualifications. Regional Trends reports a rate of 21% (compared to just over 7% in this sample) of non manual workers and 28.3% (compared to 53.8% in the SOU sample) of individuals who have no formal qualifications. It should be noted, however, that Regional Trends reports on men and women who are economically active, i.e. in work. Thus, the comparability of the samples is in doubt.

Relationships and Parental Status

On commencing the programme, a majority of the CSAs in this sample did not have a wife or permanent sexual partner. The largest proportion were separated or divorced (42.1%), 19.1% described themselves as single, and 2.3% were widowed. Only 36.5% were married or in a long-standing relationship, compared to a figure of 61.9% before the offence came to light. These figures are somewhat different to those reported by McClurg et al (1994/95) in their evaluation of a treatment programme (38.6% married, 25% were divorced and 36.36% described themselves as single). Also, Fisher et al (1999) report a figure of 62.9% of individuals in a long-term relationship.

A majority (79.4%) of the CSAs in the present sample were parents. This is a slightly higher rate than that reported by Fisher et al (1999), where 58.5% of a sample of 140 CSAs were fathers. A small minority of the parents in the SOU sample (7.9%) did not have any children of their own. At the time of the index offence 53.2% of the offenders were living in a household with children.

Sexuality and childhood experiences

Information about sexuality and childhood experiences was obtained from responses to the MSI and from case notes. Where MSI responses have been reported, these describe the sample prior to treatment.

Validity of responding

Unlike much of the above information, an individual's sexuality (particularly in this context) may be perceived by him as non-neutral. This means that there is some likelihood of validity being compromised by efforts to present as "normal" and this tendency can be seen clearly in the results chapters which follow. Therefore, the following data are an accurate representation of what child molesters were willing to share immediately before commencing the programme of sex offender treatment.

Sexuality

At 0hrs (i.e. immediately before entering the programme), 77% (n=97) of the sample described themselves as strictly heterosexual and 4.8% (n=6) described themselves as strictly homosexual. This leaves 23 clients (18.2%) who did not wish to place themselves in either category. Beckett et al (1994) found that in a sample of convicted CSAs, 73.1% reported being heterosexual, 15.4% homosexual and 11.6% bisexual. Whilst there appear to be a lower proportion of homosexuals in the present sample, some offenders (13.5%, n=17) reported having had sexual experiences with both sexes since the age of 16 and three (17.65%) of this group acknowledged that they were probably homosexual but were afraid to admit it.

A minority (10.3%, n=13) reported never having had a sexual experience with another adult. Only 4 (3.17%) of the sample, however, felt that they had never been in love. At 0hrs 10 (7.94%) offenders admitted to having used prostitutes. Only 3 (2.38%) stated that they had indulged in cross-dressing and one of these appeared to suffer from significant gender dysphoria, wishing he were a woman and feeling like a woman in a man's body.

Childhood experiences

A fairly large proportion (31.7%, n=40) of the sample felt that their parents had not shown them love and affection and some (15.9%, n=20) reported having been punished when caught in sexual activity as children. Although not asked directly about violence in the home, 5.7% (n=7) believed that their fathers had forced themselves on their mothers (i.e. raped them). Also, 9.8% (n=12) reported having family members who had been in trouble over their sexual behaviour. Information about clients' own experiences of childhood sexual abuse was gleaned from case files, group workers and the MSI. The evidence suggests that 43.7% were sexually abused as children. These data are reproduced in Table 4.1.

More than half of those who reported being sexually abused (52.73%, n=29) felt that their own abusive behaviour was a direct result of the sexual abuse inflicted on them.

Table 4.1: Frequencies of childhood experiences in CSAs (N=126) as reported prior to treatment

Childhood event	% "true" responses	% "false" responses
Parents did not demonstrate love and affection	31.7% (n=40)	68.3% (n=86)
Punished when caught in sexual activity	15.9% (n=20)	84.1% (n=106)
Father forced himself on mother	5.7% (n=7)	94.3% (n=119)
Family member in trouble over sex	9.8% (n=12)	90.2% (n=114)
Sexually abused	43.7% (n=55)	56.3% (n=71)

Those men who had been sexually abused as a child, differed from those who had not in a number of respects. Pearson Chi-squared analyses were carried out using the SPSS Crosstabs procedure to explore possible differences relating to offending and sexuality. Table 4.2 sets out the results of the analyses and reveals a range of significant differences between offenders who have been sexually abused as children and those who have not. These differences are in the direction of higher deviance in those who have been sexually abused as children. They are more likely to have abused males, to have had sexual contact with males and females and to be single. There was also a non-significant trend for this sub-sample to have more previous convictions for sexual offences.

Two recent British studies report levels of childhood sexual abuse in the backgrounds of community-based samples of convicted CSAs. McClurg et al (1994/95) found that 52% of their sample complained of having been victims of childhood sexual abuse compared to a figure of 70% in a sample described by Beech (1997/98). McClurg et al also found that CSAs who had been sexually abused children were significantly more likely to have abused boys and to have had a sexual relationship with another man. This is consistent with the present findings.

Table 4.2: A comparison of relationship, sexual and offence variables in CSAs who have been sexually abused as children (n=55) and CSAs who have not (n=71)

Characteristic	% Not sexually abused (n=71)	% Sexually abused (n=55)	Sig. Level (2-tailed)
Currently with a partner	43.67%	27.27%	0.05
Partner at time of offence	69%	52.7%	0.05
Strictly heterosexual	88.7%	61.8%	0.001
Strictly homosexual	1.4%	9.1%	0.05
Sexual contact with both sexes	2.8%	27.27%	0.001
Gender dysphoria	0%	5.45%	0.05
Privately homosexual	8.45%	23.6%	0.05
Pre-sex conviction	33.8%	45.45%	ns
Male victim	16.9%	38.2%	.005

Current offences and victim data

Data concerning index offences were obtained from the Home Office Offender Index and from case notes. They include information about: legal status; type of offence; victim data (age, gender, etc.) and relationship of offender to victim (intra-familial, extra-familial or both).

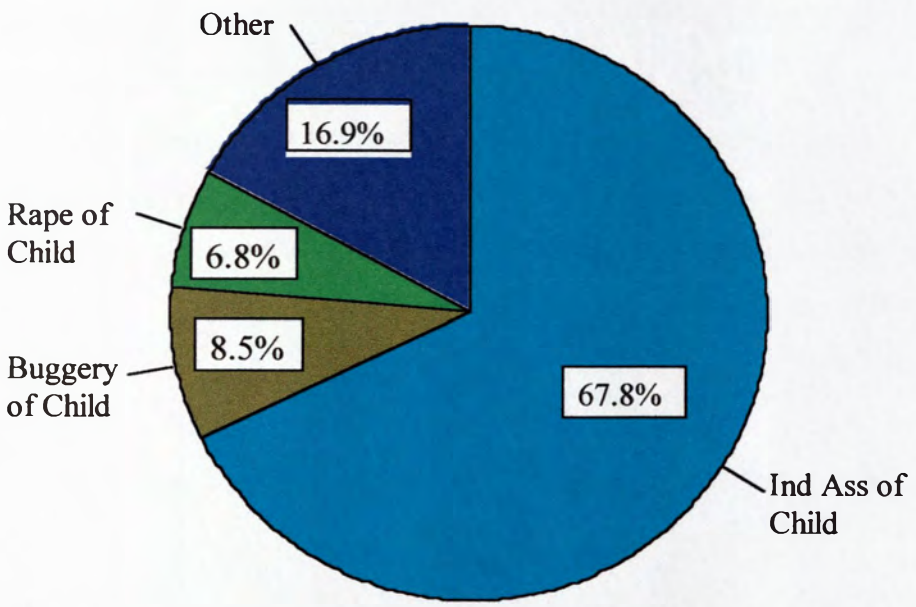
Legal Status and Offence Types

A large majority of the sample (90.5%) were statutory clients, those that were voluntary being either referred by social services (7.1%) or pre-trial (2.4%). A majority (67.8%) of those clients who were not voluntary had been convicted of indecently assaulting a child. Fig. 2 shows the most serious current convictions of the sample and the proportion of different offences in relation to one another. Buggery and Rape of children were the next most common offences at rates of 8.5% and 6.8% respectively. Few people had been convicted of incest, USI (unlawful sexual

intercourse) with a child under 13 years or USI with a child under 16 years (total of 16.9%). Gross Indecency was the main offence for 4.22% (n=5) of the sample, child abduction for 2.5% (n=3) and procuration for 1.7% (n=2). Although abduction and procuration are not strictly contact sexual offence, the individuals involved had all been charged with (but not convicted of) contact offences. A minority of the sample (22.2%, n=26) had been convicted of at least one other sexual offence at the same court appearance. These offences were: Indecent Assault (n=7); Incest (n=1); Gross Indecency (n=8); USI < 16 (n=1); Taking indecent photos (n=6); Abduction of a child (n=1); Indecency between males (n=1); Rape of a child (n=1).

Frequencies of offence type are consistent with those reported by McClurg et al (1994/95) and Beckett et al (1994), with indecent assault being by far the most common index offence.

Fig. 2: Index offences of treatment group (n=114)



Approximately half of the statutory clients (n=114) were on probation (n=56, 49.12%) and the other half were on license following release from prison (n=58, 50.88%). The average probation order was for 33.2 months (6.86). They ranged from 12-36 months with a majority of orders being for 3 years (83.9%). Length of license was generally

much shorter, the average being for 9.2 months (sd=4.42) and ranging from 3 months to a life license (the latter was excluded from analyses).

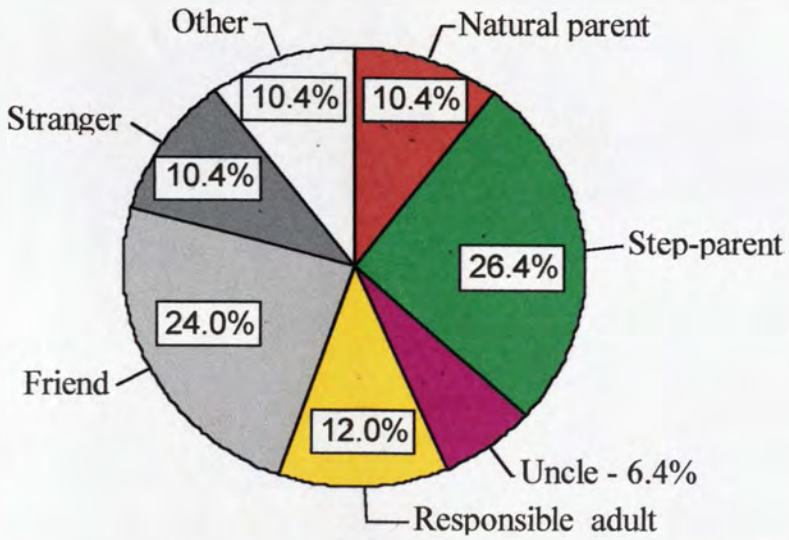
Victim data

With respect to most recent offences, 51.2% of the sample (including those without a conviction) had abused a child within the family. Of these, a majority of 74.2% had sexually assaulted their own children or their step-children. Of the remaining 48.8% of the sample, 47.2% had abused children outside of the family or both inside and outside the family (1.6%). Whilst Beech (1997/98) found that 44.07% of his sample had abused within the family and 42.37% had committed extra-familial offences, he found that a greater proportion than in the SOU sample had been convicted for abusing both children within and outside of the family (13.56%).

Fig. 3 illustrates the relationships between the offenders in this sample and their victims. The largest group abused their step-children (26.4%, n=33). This is followed by those who described themselves as: friends (24%, n=30); responsible adults (e.g. baby-sitter, 15%, n=12); natural fathers (10.4%, n=13); stranger (10.4%, n=13); uncle (6.4%, n=4); grandfather (4%, n=5); cousin (1.6%, n=2); sibling (0.8%, n=1); natural father and uncle - more than 1 victim (0.8%, n=1); uncle and responsible adult - more than 1 victim (0.8%, n=1). For one of the offenders (whose index offence was not for an offence against a child but who had a previous conviction for indecent assault of a child) the relationship between him and his victim was not known.

Present offences do not, however, tell us anything about who an offender has abused in the past and may not give us enough information about to whom he might present a danger in future. In this sample of CSAs, 16.8% (n=21) have a history of committing both intra and extra-familial offences against children. This is comparable to the data reported by Beech (1997/98). If offences involving children or adults are included, the intra/extra crossover rate is even higher at 19.2% (n=24).

Fig. 3: Relationship of treatment group CSAs (n=125) to victims



The majority of victims (most recent offences) are girls (73.8%). However, 22% of victims are boys and a small minority of offences (4%) involved children of both sexes. Again, when previous convictions are taken into account, there is an even larger proportion of offenders who have assaulted both sexes. Beech, Fisher, and Beckett (1998) in their evaluation of prison treatment found that 61.4% of the sample had abused only girls, compared to a figure of 38.6% who had abused boys only or boys and girls. Whilst there are clearly more CSAs in their sample who have assaulted boys, the majority abused girls, as in the SOU sample.

When previous sex offences against children are included, the gender crossover in the SOU sample is 11.2% (n=14). If offences against adults are included, it amounts to 12.9% (n=16). The average age of the youngest victim is 10.08 years (sd=3.55) and the age range of victims is 1-16. Victim ages for 4 (3.2%) of the sample are missing. Table 4.3 illustrates the age categories of victims which apply to the remainder.

The number of victims in the index offence ranges from 1-6. Most CSAs in the sample who were convicted for their offences (n=114) were convicted for abusing 1

child (74.56%, n=85). However, 25.44% (n=29) had more than 1 victim. The mean is 1.5(1.01).

Table 4.3: Age group of youngest victim of CSAs (n=122) in index offence

Age group	% of CSAs with victim in this age group (n=122)
Pre-pubertal	
5 years old or less	11.9% (n=15)
6-10 years old	33.3% (n=42)
Post-pubertal	
11-14 years old	40.5% (n=51)
15-17 years old	11.5% (n=14)

Offence Histories

Offence history data were obtained from the Home Office Offender Index. Additional information was also available from client case notes.

Preconvictions

A fairly large majority(76.21%, n=96) of the sample were known to have a previous conviction of some kind. One fifth (n=22) had been convicted for at least one offence involving violence and twice as many had pre-convictions for sexual offences (40.8%, n=49). The average number of previous sexual offences in this sub-group was 1.96 (sd=2.22) and ranged from 1-15. The mean number of total victims was 4.12 (sd=3.41) for this group and this compares with 1.49 (sd=1.03) for the 71 offenders who did not have a previous conviction for this type of offence. For those with more than 1 conviction for a sexual offence, the time elapsing between convictions is considerable and varies widely, averaging around 9 years. Mean length of time between convictions was 110.56 (sd=83.51) and ranged from 6-312 months. Mean length of time between current and most recent conviction (sexual) was 117.42 (sd=80.11) and also ranged from 6-312 months. The fairly long length of time

between convictions explains why the base rate for sexual reconvictions are rather low. Hanson and Bussiere (1998) report a four year base rate of 13%.

Allegations

One fifth (20.06%) of the CSAs in the treatment group self-reported allegations against them which had not resulted in a conviction for sexual offending. This figure is fairly high but it does include those individuals (n=9) who were referred by Social Services (and did not have a conviction) and those 3 men who were attending group pre-trial.

Risk of reconviction

On the basis of offence history data, members of the treatment group have been categorised into risk (of recidivism) groups using an algorithm developed by Thornton (1997) - the SACJ (Structured Anchored Clinical Judgement) risk assessment scale (Appendix 4). This scale uses offence history data, limited personal history data, and clinical judgement to assess level of risk of re-conviction and is based on a long term re-conviction study. Steps 1 and 2 only (i.e. offence and personal history data) were used to assess this sample of offenders, since Step 3 is not standardised and is more appropriate for those who have undergone a period of treatment.

Risk Categories

Almost half of this sample (n=61) were categorised as medium risk according to the SACJ. Only 14.3% (n=18) were high risk and 37.3% (n=47) were found to be low risk. Since the SACJ uses pre-convictions to allocate sex offenders to one of the risk groups, they clearly differed from one another in terms of number and type of pre-conviction. For example, high risk offenders in this sample had an average of 2.78 (sd=3.39) previous convictions for a sexual offence, medium risk offenders averaged 0.78 (sd=0.95) previous convictions of this nature and low risk offenders had none. The proportion of offenders falling into the three risk categories are presented in Table 4.4., along with the average number of previous sex offences for those in each group.

Table 4.4: Treatment group CSAs by SACJ risk category and average number of previous convictions for sexual offences

Risk Level	Mean and sd of previous convictions for sex offences	% CSAs in group (n=126)
High	2.78 *(3.39)*	14.3% (n=18)
Medium	0.78 *(0.95)*	48.4% (n=61)
Low	0	37.3% (n=47)

However, there are a number of other re-conviction prediction instruments (mostly developed in the USA and Canada) and indicators of risk. In order to see whether other risk indicators identified by the literature (e.g. Hanson & Harris, 1997) were consistent with the groups above, demographic and offence history data were explored in more detail and the groups were compared on a number of variables thought to be associated with risk of re-conviction. These variables were: age at first sexual conviction; relationship to victim; victim gender; total number of known victims; victim age; marital status. One-Way anovas were carried out to compare means of the three groups and where significant differences were discovered, Tukey's-B post hoc comparisons between groups were made. In the case of categorical data the Crosstabs procedure (SPSS, 1992) was used to derive Chi-squared statistics in order to ascertain whether groups differed on the relevant variables.

Age at first sexual conviction (see Table 4.5)

High, medium and low risk groups were compared to see whether they differed in age at the time of their first conviction for a sexual offence. One might expect that the more convictions an individual has, the earlier the first conviction. The mean ages for each group do indicate a difference. For the high risk group the mean was 28.63 (sd=12.55), for the medium risk group it was 36.7 (sd=13.96) and for the low risk group it was 40.23 (sd=11.52). A One-Way anova was carried out in order to

establish whether the null hypotheses of no difference in age between groups could be rejected. It was found that there was a significant difference between the groups (2 tailed, df=2,106, F=4.62, $p<0.05$). A Tukey's-B post hoc analysis of the differences between individual groups indicated that the high risk group was significantly younger at $p<0.05$ than both low and medium risk groups at time of first offence. However, the difference between low and medium risk groups was not significant. The null hypothesis of no difference between groups of age at first conviction for a sexual offence was rejected. Although the difference between medium and low risk groups was not significant, there was a clear trend for the medium risk CSAs to have committed their first sexual offence younger than the low risk offenders.

Table 4.5: Mean age at first sexual conviction and number of known victims according to SACJ risk group

n=126	High risk (n=18)	Medium risk (n=61)	Low risk (n=47)	p value (2-tailed)
Age at 1st sexual conviction	28.63 (12.55)	36.7 (13.96)	40.23 (11.52)	0.05
Average number of victims	5.53 (4.71)	2.57 (1.74)	1.52 (.99)	0.05

Total number of known victims (see Table 4.5)

It would be logical to assume that those individuals with the most pre-convictions for sexual offences (and thus in the higher risk groups) would also have abused more children. The three risk groups were compared in order to see whether the difference observed in number of known victims was significant. Mean number of total known victims for each group was as follows: low risk, 1.52 (sd=0.99); medium risk, 2.57 (sd=1.74); high risk, 5.53 (sd=4.71). A One-Way anova showed that there was a highly significant difference between groups in terms of total number of victims (2

tailed, df=2,109, F=19.22, p<.001) and a Tukey's-B post hoc analysis indicated that there were significant differences (at p<0.05) in victim numbers between all three groups, with the high risk group having the highest number of victims, followed by the medium risk and low risk groups. Thus the null hypothesis of no difference in total victim numbers could be rejected.

Relationship to victim (see Table 4.6)

A number of recidivism studies indicate that intra-familial offenders are less likely than extra-familial offenders to be re-convicted of sexual offences (e.g. Barker and Morgan, 1993) so one would expect the higher risk group to contain more extra-familial offenders. Chi-squared analysis of the index offences suggest that this is the case, with only 27.7% of low risk offenders, compared to 57.4% of the medium risk group and 64.7% of the high risk group having committed offences against somebody outside the family. 1 individual from the low risk and 1 from the medium risk, had abused both within and outside of the family. The differences between the groups were significant at p<.05 (χ_2= 12.0, df=4). When past offences are taken into account, the crossover (intra/extra) rate is far higher, with 47.1% of high risk offenders having abused children both within and outside of the family. This compares to rates of 18.6% in medium risk offenders and 4.3% low risk offenders. The differences here were highly significant (χ_2=16.35, df=2, p<.001). Thus, the higher the risk group, the more likely an individual is to have abused outside the family and both inside and outside the family.

Victim gender (see Table 4.6)

It is known that individuals who abuse boys have higher rates of recidivism (e.g. Barker & Morgan, 1993). Half of the high risk offenders in this sample had a current conviction for sexually abusing boys (44.4%) or boys and girls (5.1%). This is rather higher than the rates for medium risk (26.2% boys and 4.9% both) and low risk (8.5%

boys and 2.1% both) offenders. Chi-squared analysis revealed that the difference between groups was significant at $p<.05$ ($\chi_2=12.2$, df=4). If crossover (boys/girls) rates are obtained from offence history data, not surprisingly, it is the high risk offenders who have the highest incidence of abusing children of both sexes (38.9%). This contrasts with 8.3% of medium risk offenders and only 4.3% of low risk offenders. The difference between groups is significant at $p<.001$ ($\chi_2=16.65$, df=2). Thus, as expected, it appears that the higher risk groups are more likely to have sexually assaulted boys and to have abused children of both genders.

Related to victim gender is the issue of gender preference generally. Since high risk offenders are more likely than medium and high risk offenders to abuse boys and to abuse children of both sexes, we might expect them to be more likely to report being homosexual or bi-sexual. Interestingly, members of the high risk group were no more likely than members of the other groups to describe themselves as strictly homosexual (low risk, 4.3%; medium risk, 4.9%; high risk, 5.6%). However, they were less likely to describe themselves as strictly heterosexual ($\chi_2=11.06$, df=2, $p<.005$). Only 55.6% of high risk offenders in this sample did so, compared with 72.1% of the medium risk and 91.5% of the low risk offenders. This suggests that high risk offenders are the most likely to see themselves as bisexual and medium risk offenders are more likely than low risk offenders to be attracted to both males and females.

Relationship history and parental status (see Table 4.6)

One might expect those who have a strong and enduring attraction to children to have more convictions (i.e. to be in a higher risk group) and to be less likely to be in established adult sexual relationships. This was found to be the case. When asked whether married (or in a long-term relationship), separated, widowed or single, high risk abusers in this sample were more likely to describe themselves as single (33.3%) than medium (19.7%) or low risk(12.8%) offenders. This difference was not significant ($\chi_2=7.17$, df=6) but whether or not an individual had a partner at the time of the offence was highly significant ($\chi_2=10.67$, df=2, $p<.005$). A large majority (78.2%)

of low risk offenders had a partner pre-arrest, compared to 55.7% of medium and 38.9% of high risk group members.

In this sample, those in the low risk group were more likely to be parents (89.4%) than those in the medium (75.4%) and high (66.7%) risk groups. However, this difference was not found to be significant (χ_2=5.22, df=2). In addition, at the time of the offence, more of them (66%) were living with children compared to those in the medium (47.5%) and high (38.9%) risk groups. Again the difference was not significant (χ_2=5.34, df=2). In a larger sample it is possible that the trends observed may prove to be statistically significant differences.

Victim age

Although the average age of youngest current victim (low risk 9.87 (sd=3.75) yrs; medium risk 10.38 (sd=3.51) yrs; high risk 9.65 (sd=3.24) yrs) was not found to be different across groups, significant differences were found across groups in rates of crossover - both pre/post puberty and child/adult. It was expected that higher risk groups would be more likely to abuse both pre and post pubertal children than lower risk groups and that they would also be more likely to have been involved in sex offences involving adults. Chi Squared statistics demonstrate that the three risk groups do differ from one another, although not always as expected.

Half (n=9) of the high risk offenders had abused both pre and post-pubertal children, compared to 24% of the medium risk and 8.7% of the low risk offenders. These differences were highly significant (χ_2=12.89, df=2, p<.001). When crossover child/adult was examined, it was found that none of the low risk offenders had such a history, 19.7% of the medium risk offenders had committed sexual offences involving both adults and children and 11.1% of the high risk offenders. This difference was significant at p<.01 (χ_2=10.4, df=2). Thus, it appears that medium risk offenders are more likely to have a history of sexual offending against both children and adults than both high and low risk offenders.

Table 4.6: Characteristics of treatment group CSAs (n=126) by risk level

Characteristic	High Risk	Medium Risk	Low Risk	p value
Index extra-familial	64.7%	57.4%	27.7%	.05
Intra/extra crossover (including pre-cons)	47.1%	18.6%	2.12%	.001
Index boy victim	49.5%	31.1%	10.6%	.05
Girl/boy crossover (including pre-cons)	38.9%	8.3%	2.12%	.001
Strictly heterosexual	55.6%	72.1%	91.5%	.005
Single	33.3%	19.7%	12.8%	ns
Partner at time of offence	38.9%	55.7%	78.2%	.005
Parent	66.7%	75.4%	89.4%	ns
Living with children at time of offence	38.9%	47.5%	66%	ns
Pre and post pubertal child victims	50%	24%	8.7%	.001
Child and adult victims	11%	19%	0%	.01

DISCUSSION

Whilst comparison data were not available for all of the sample characteristics described above, patterns could clearly be seen - particularly in offence-related data but also in areas pertaining to relationships and sexuality.

Adequate comparison data were not available for all of the socio-demographic categories. Whilst the SOU sample does not differ greatly in IQ from the sample described by Fisher et al (1999), other evidence is inconclusive. The SOU sample present as somewhat under-qualified compared to the normal population and to do less

skilled and less professional/white collar work than Regional Trends (HMSO, 1994) data would suggest. They are certainly more likely to be unemployed, but this could well be a function of the fact that many had just left prison when asked these questions and thus would not have had time to find a job.

A potentially important finding is that non-whites were considerably under-represented in the SOU sample, with only half the rate of that found in the population of the West Midlands. Whilst Fisher et al report non-significant differences in the number of non-whites in their group of 140 CSAs compared to a group of 81 non-offending males, there is a strong trend in the direction of under-representation of black people. This is a topic worthy of further investigation. Possible reasons for this discrepancy could be related to: differences in the sentencing of whites and non-whites; higher levels of denial in the non-white group (which would have precluded their joining the programme); lower levels of reporting/prosecution of CSA cases within certain minority populations.

The average age of the CSAs in this sample was similar to that reported by other sex offender studies (e.g. Fisher et al, 1999; McClurg et al, 1994/95).

Whilst a minority of the SOU sample were in long-term relationships, a majority of them were in such relationships at the time of the offence. This differentiation could account for the differences found between this sample and those reported by Fisher et al (1999) and McClurg et al (1994/95), who report higher levels of CSAs in stable relationships. Another reason for the discrepancy could be the wording of questions (see Appendix 3.1) or simply that the groups are somewhat different from one another. In contrast to the lower levels of CSAs in relationships in this sample, a somewhat higher proportion of them are parents than those in Fisher et al's (1999) sample. The data suggest then, that whilst the CSAs in the SOU sample tended not to be in a stable relationship at the pre-treatment testing stage, a majority of them had experience of such relationships.

Where self-reported sexuality is concerned, over two thirds of the sample described themselves as strictly heterosexual - similar to findings reported by Beckett et al (1994).

The CSAs in this study reported a number of adverse childhood experiences, including being the victims of sexual abuse. The figure of 43.7% in this sample is not unusual for a sex offender sample (e.g. Beech, 1997/98) and the tendency of this sub-group to present as more deviant concurs with data from other studies (e.g. McClurg et al, 199/95).

Consistent with other British studies (McClurg et al, 1994/95; Beckett et al, 1994, a large majority of the SOU sample had been convicted of indecent assault of a child and a majority of victims were girls. Rates of intra/extra-familial and girl/boy crossover are higher when previous convictions are taken into account and consistent with those described by Beckett et al (1994). Although in many ways contrary to expectations, this result could indicate that, 'though clearly abusive, a higher proportion of medium risk offenders than high risk offenders are attracted to adults as well as children. If this is the case, then they have the opportunity for legitimate (and not only abusive) sexual outlet.

Whilst 40.8% of the sample had previous convictions for sexual offences, the space between their convictions averaged 9 years. This may help to explain the low base rates for sexual offending reported in the literature (e.g. Hanson and Bussiere, 1998).

Levels of risk (as calculated using the first two steps of Thornton's 1997 version of the SACJ) of this sample of offenders is proportionate to those registered sex offenders in the West Midlands (Cross, 2000), with a majority of offenders falling into the medium risk category. The SACJ was validated by comparing risk groups on the data reported in the literature to be predictive of sex offender recidivism. Analyses of this sample of 126 child molesters lends support to the validity of the risk (of re-conviction) categories developed by Thornton (1997). Higher risk offenders: have

abused more victims; are more likely to have abused boys and children of both sexes; are more likely to abuse outside of the family and to commit intra and extra-familial offences; are more likely to have abused pre and post pubertal children; are less likely to describe themselves as heterosexual and more likely to be single. Lower risk offenders, however: have abused fewer victims; are usually heterosexual; tend to abuse children within the family; tend to abuse girls; are more likely to be the father of their victim; are less likely to abuse both pre and post pubertal children; are less likely to have also committed sexual offences involving adults; are less likely to be single. These profiles largely conform to those presented elsewhere (e.g. Beckett et al, 1994) and suggest that there are a number of features common to individuals who are the most and least likely to be re-convicted of sexual offences.

CONCLUSION

The data presented here reveal both similarities and differences between the SOU sample of CSAs, the general population and other British CSA samples. However, clear patterns emerged and have been described above. Importantly, trends in the characteristics of higher risk individuals are consistent with the sex offender literature.

Beckett et al (1994), in their evaluation of sex offender treatment programmes, raised concerns about the targeting of sex offender treatment. They found that treatment providers (particularly probation) were working with low risk groups of offenders. The figures above, however, suggest that West Midlands Probation Sex Offender Unit is working with a high proportion of individuals who have a fairly high risk (only 37.3% can be classified as low risk) of being re-convicted without appropriate intervention.

CHAPTER 5: A PRE-TREATMENT PSYCHOMETRIC PROFILE OF CHILD SEXUAL ABUSERS

INTRODUCTION

This chapter describes the psychometric profiles of the sample of 126 child sexual abusers (CSAs) who participated in this study. Following a brief introduction to the characteristics of untreated CSAs, descriptive data from the pre-treatment scores on measures described in Chapter 3 will be presented. This will be followed by a comparison of these data with non-offender data.

Characteristics of untreated child sexual abusers

Untreated CSAs have been found to differ from non-offenders in a number of behavioural, attitudinal, cognitive and skills-based variables (e.g. Beckett, Beech, Fisher and Fordham, 1994). These fall into the broad categories of: denial (of offence-related arousal and behaviours); pro-offending thinking (frequently in the form of cognitive distortions about offending behaviour and about victims); relapse prevention (RP) skills and awareness of risk; sex-related denial and dysfunction (such as sexual obsessions, problems with impotence); socio-affective functioning (intimacy deficits, self-esteem, etc.). Socio-affective functioning is not considered in this study. However, the remaining categories are considered in detail in the following results chapters. Socially desirable responding, whilst rarely examined in the literature, is also of relevance, since it can threaten the validity of assessments.

Beech, Fisher and Beckett (1999) performed a factor analysis on pre-treatment evaluation data from incarcerated child sexual abusers and found that the

evaluation measures they used (many of which have been employed in the present study) tended to fall within three of the above categories - denial/admittance, pro-offending thinking, social competence, suggesting that the distinctions between them are meaningful. Not only are such distinctions a convenient way of reducing data, but they suggest that individuals may have problems in particular areas and not necessarily in others. For example, some CSAs are very open about their offences but have high levels of distortions about victims, whilst others are high in denial but do not attempt to justify their behaviour. Here, social competency has not been considered but and Fisher and Beech (1998), drawing on their work on programme evaluation, have produced a model which incorporates a number of elements - denial, social competencies, offence-specific problems (e.g. lack of victim empathy) and relapse prevention skills. Their model illustrates how the interplay of these factors influences treatment requirements, response to treatment and level of risk.

In this study, Sex-related denial, deviance and dysfunction is included as a category separate from Offence-related denial/admittance and Relapse prevention skills are also considered separately (see chapter 9).

Rationale and hypotheses

Rationale

The purpose of this part of the evaluation study is to explore the data obtained from administration of the psychometric tests described in Chapter 3 pre-treatment (0hrs). Firstly, the mean social desirability score of this sample of CSAs will be compared to that of non-offenders in order to rule out the possibility of a "fake good" stance threatening the validity of other test results.

Means and standard deviations of the scales described in Chapter 3 will be presented and a factor analysis performed in order to confirm the existence of discrete categories of variables. It is expected that the categories of tests described above (Offence-

related denial/admission and Pro-offending thinking) will be supported by a factor analysis. However, the category of Sex-related denial, deviance and dysfunction is not included in the factor analysis. This category deals with issues which tend not to be direct treatment targets and are not discussed at length in the literature on CSAs. Because there is little evidence to suggest that the contents of this category (social/sexual desirability, sexual obsessions, sexual knowledge, paraphilias, sexual dysfunction) are strongly related to one another or to the categories described above, it is not appropriate to see the separate variables as a single factor or to attempt to incorporate them into other factors. Rather, the validity of this category lies in its thematic cohesion. Correlational data will establish the nature of any relationships between variables. The Relapse Prevention Questionnaire was not administered at the pre-treatment stage and is thus not considered here.

Where normative data are available, CSA scores on scales used in the evaluation are compared with those of non-offenders. It is expected that statistically significant differences will be found on a majority of the measures. Where normative data are not available, CSA mean scores will be compared with "cut off" points which separate "functional" from "dysfunctional" ranges in order to assess the extent of the need for change in the sample as a whole.

Hypotheses

1. It is hypothesised that the mean social desirability score of the CSAs participating in this study will not be significantly different from those obtained by non-offender males.
2. It is hypothesised that the sample of CSAs participating in this study will obtain pre-treatment (0hrs) mean scores on evaluation measures which differ significantly from the means obtained by non-offender populations.

Design and Procedure

The design and procedure of the evaluation study are described fully in Chapter 3.

Samples

The 126 child sexual abusers who took part in this study are described fully in Chapters 3 and 4. Normative and comparison data were obtained from three sources: Allam (1994a); Beckett et al (1994); and Nichols and Molinder (1984). The sample from Allam consisted of a group of 104 male university students who were used to normalise the Victim Awareness Questionnaire. This sample is described in Appendix 3.7.2.

Measures

The measures and scales reported here have been described in detail in Chapter 3 and are listed below. The Relapse Prevention Questionnaire was not administered at 0hrs and so has been omitted from this stage of the analysis..

Socially desirable responding

- Personal Reaction Inventory (PRI: Greenwald and Satow, 1970)

Offence-related denial/admission

- Multiphasic Sex Inventory (MSI: Nichols and Molinder, 1984) Child Molest Lie (CM Lie) scale
- MSI Sex Deviance Admittance scale - Child Molest (CM) scale
- Sex Offender Attitudes Questionnaire (SOAQ: Procter, 1994)
- MSI Treatment Attitudes (TA) scale

Sex-related denial, deviance and dysfunction

- MSI Social/Sexual Desirability (SSD) scale
- MSI Sexual Obsessions (SO) scale
- MSI Paraphilias (Para) scales
- MSI Sexual Dysfunction (Dysf) scales
- MSI Sex Knowledge and Beliefs (SKB) scale

Pro-offending thinking

- MSI Cognitive Distortions and Immaturity (CDI) scale
- MSI Justifications (Ju) scale
- Victim Awareness (VA) scale (Allam, 1994a)
- Kids and Sex Cognitive Distortions (CD) scale (Beckett, 1993)
- Kids and Sex Emotional Congruence (EC) scale
- Rape Myth Acceptance (RMA) questionnaire (Burt, 1980)

Treatment of data

Means and standard deviations were obtained for all measures within each category (e.g. pro-offending thinking, denial/admittance). A factor analysis was conducted on

those variables making up the proposed categories of Offence-related denial/admission and Pro-offending thinking. Correlations were then conducted between those variables making up Sex-related denial and dysfunction category

Where normative data were available, independent t-tests were conducted in order to highlight any significant differences between offenders and non-offenders. Otherwise, mean scores were compared with "functional" score ranges or those obtained by treated offenders.

RESULTS

Socially desirable responding

The 126 CSAs in this study obtained a mean PRI score of 57.24(12.32), with scores ranging from 24 (indicating a disregard for social norms and conventions) to 80 (suggesting a "fake good" response set). The 81 non-offender British males reported on in the STEP report (Beckett et al, 1994) obtained a mean PRI score of 57.83(8.41). There was no significant difference in these scores ($p>.05$, 2-tailed, $t=0.21$, $df=205$). Thus, the null hypothesis, predicting no significant difference in socially desirable responding between CSAs and non offenders, cannot be rejected.

Identifying Factors

A Principal Component Factor analysis was conducted on those variables hypothesised to make up the categories of Offence-related denial/admission and Pro-offending thinking. The obliminal method of rotation was employed because it is believed that the proposed categories are not completely unrelated. As expected, two factors emerged, accounting for 63.5% of the variance. Table 5.1 illustrates the relationship of each variable to the two factors.

It may be seen that the relationship between variables and their corresponding factor is very strong ranging from r=.62 to r=.89 (N=126). Whilst a number of variables had moderately strong relationships with both factors (e.g. the Ju scale and the EC scale), their relationship to the predicted factor was far stronger. Thus, as expected, two factors emerged from the factor analysis confirming the validity of the Offence-related denial/admittance and Pro-offending thinking categories.

Table 5.1: Factor analysis pattern matrix showing correlations of scales with offence-related denial/admittance and pro-offending thinking (n=126)

	Factor 1	Factor 2
Child Molest Lie (CM Lie)	***-.86***	-15
Sex Deviance Admittance Child Molest (CM)	***.89***	.24
Sex Offence Attitudes Questionnaire (SOAQ)	***-.81***	.25
Treatment Attitudes (TA)	***.82***	.12
Cognitive Distortions and Immaturity (CDI)	.12	***.78***
Justifications (Ju)	-.32	***.62***
Kids and Sex Cognitive Distortions (CD)	-.13	***.8***
Kids and Sex Emotional Congruence (EC)	.39	***.67***
Victim Awareness (VA)	-.13	***.87***
Rape Myth Acceptance (RMA)	-.2	***.69***

Sex-related denial, deviance and dysfunction

Sex-related denial and dysfunction is a category containing a number of scales which may not necessarily be related. However, there were a number of significant relationships found. Table 5.2 illustrates these relationships.

Social/Sexual Desirability (a measure of the tendency to play down the extent of "normal" sex drives and interests) was significantly and positively related to all other

variables - Sexual Obsessions, Paraphilias, Sex Knowledge and Beliefs - apart from Sexual Dysfunction (with which there was a negative but non-significant relationship). Thus, the more open an individual about "normal" sex drives and interests, the more likely to admit to atypical sexual interests and obsessions and the more likely to have accurate information about sexual anatomy and physiology.

Sexual Obsessions was found to be strongly and positively related to admission of paraphilic interests and also to sexual dysfunction. There was no relationship, however, to degree of knowledge about sexual anatomy and physiology.

There was also a modest but significant positive relationship between admission of paraphilic interests and sexual dysfunction. It was also related to knowledge of sexual anatomy and physiology.

The extent of an individual's knowledge about sexual anatomy and physiology was quite strongly and negatively related to level of sexual dysfunction - the more accurate the information held by an individual, the less likely to suffer from sexual dysfunction.

Table 5.2: Relationships between variables measuring sex-related denial, deviance and dysfunction

n=126	SO	Para	Dysf	SKB[1]
Social/Sexual Desirability	.3**	.43**	-.15 ns	.46**
Sexual Obsessions (SO)	-	.5**	.28**	.02 ns
Paraphilias (Para)	-	-		.18*
Sex Dysfunction (Dysf)	-	-	-	-.36**

* $p<.05$, 2-tailed

** $p<.01$, 2-tailed

[1] MSI Sex Knowledge and Beliefs scale

Pre-treatment deviancy

Means and standard deviations were obtained for each scale. These were then compared with non-offender data where available. Where this wasn't possible, mean scores were assessed as being within "functional" or "dysfunctional" ranges (according to the relevant test manual).

Table 5.3 contains the means and standard deviations for the 126 child sexual abusers in this study on those measures administered at 0hrs. Where available, normative data are given along with the results of independent t-tests conducted to identify significant differences between CSAs and non offenders. For other measures, the score range is given, within which a score is considered to be functional.

Table 5.3: Pre-treatment deviancy - a comparison of child sexual abusers and non-offenders

	CSA mean and sd (N=126)	**Non-offender mean and sd**	**Functional range**	**Value of t**
Offence-related denial/admittance				
Child Molest Lie scale	8.18*(3.54)*	-	0-2[a]	-
Child Molest Scale	11.56*(7.13)*	-	20-39[a]	-
SOAQ	95.4*(21.28)*	-	No data	-
Treatment Attitudes	2.87*(1.91)*	-	3-8[a]	-

Sex-related denial, deviance and dysfunction				
Social/Sexual Desirability	22.02*(7.53)*	30.88*(3.22)*[b]	-	23.32**
Sexual Obsessions	3.22*(3.23)*	-	2-9[a]	-
Paraphilias	2.15*(2.57)*	2.55*(2.19)*[b]	-	1.6 ns
Sexual Dysfunction	4.01*(3.73)*	1.09*(1.41)*[b]	-	11.3**
Sex Knowledge and Beliefs	15.83*(3.21)*	18.93*(2.31)*[b]	-	11.07**
Pro-offending thinking				
Cognitive Distortions and Immaturity	6.56*(3.32)*	-	0-3[a]	-
Justifications	4.56*(3.76)*	-	0-1[a]	-
Victim Awareness	48.74*(29.9)*	42.36*(21.5)*[b]	-	9.38**
Cognitive Distortions	17.75*(11.5)*	13.1*(8.8)*[c]	-	11.92**
Emotional Congruence:				
Fathers (n=100)	16.44*(10.93)*	23.4*(11.4)* n=43[c]	-	10.39**
Non-fathers (n=26)	21.35*(14.04)*	16.1*(9.3)* n=48[c]	-	6.48**
Rape Myth Acceptance	49.96*(19.37)*	No data	-	-

** p<.01, 2-tailed

[a] No normative data available but scores given are in the desired range (Nichols & Molinder, 1984)

[b] University males (N=104) from Allam (1994a)

[c] Non-offender sample of British males (n=81) from (Beckett et al, 1994)

Offence-related denial/admittance

Whilst normative data are not relevant to denial scales, Nichols and Molinder (1984) report "functional" ranges for the Child Molest Lie scale and the Child Molest scale. It may be seen that the average Lie score of 8.18(3.54) is considerably more than 1 standard deviation higher than the acceptable score range of 0-2. In addition, the mean score on the Child Molest scale of 11.6(7.13) is much lower than the acceptable range of 20-39. No comparison data are available for the SOAQ, although the mean score of 95.4(21.28) is comparable with that reported by the STEP evaluation of pre-treated CSAs from community-treatment programmes (mean score = 92.2). The mean score for treatment attitudes (low score representing lack of motivation for treatment) is slightly below the minimum score which would indicate acknowledgement of a problem.

Sex-related denial, deviance and dysfunction

Table 5.3 illustrates a number of significant differences between sex-related denial and dysfunction in the 126 CSAs in this sample and Nichols and Molinder's sample of 56 college males. Pre-treatment CSAs were significantly: less likely to admit to "normal" sex drives and interests; more likely to report sexual dysfunction; less knowledgeable about sexual anatomy and physiology. Whilst the average level of sexual obsessions was higher than that reported in Nichols and Molinder (1984), the authors do not report the standard deviation so a test of significant difference could not be conducted. However, the score obtained by CSAs is in the expected range (indicating that the sample is not sexually obsessed but not faking either). CSAs reported fewer paraphilic interests and activities than non-offenders but the difference was not found to be significant.

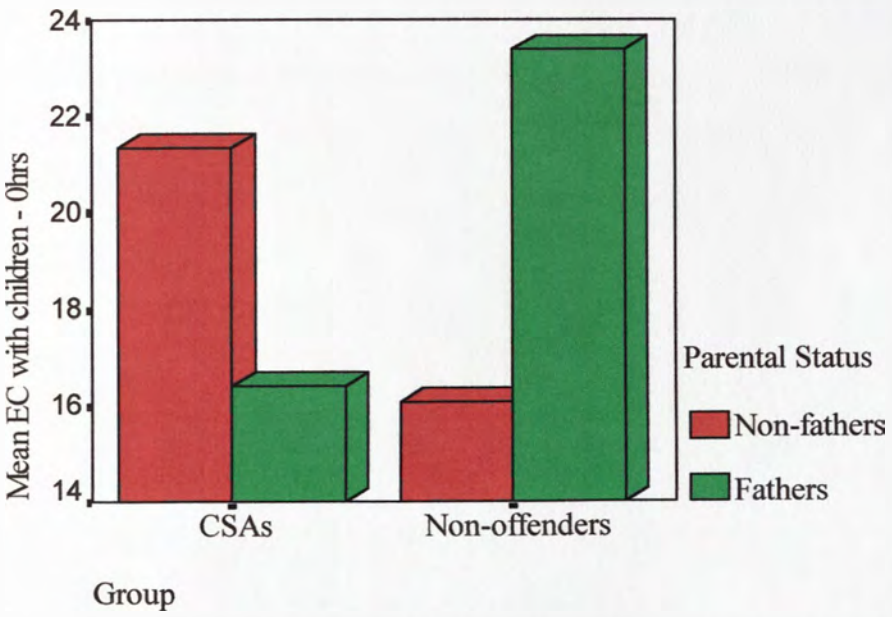
Pro-offending thinking

Measures of pro-offending thinking demonstrate that pre-treatment CSAs have more distortions than non-offenders and tend not to accept full responsibility for their actions. Also, table 5.3 shows that, when compared with non-offenders from Beckett et al's (1994) study, CSAs have significantly higher levels of distortions about child victims of sexual assault and have more global distortions about the sexual sophistication of children.

Emotional congruence with children is higher in non-fathers than fathers in the CSA sample. However, the opposite relationship is true of non-offenders, with fathers tending to identify more with children than men who do not have children. Fig. 4 illustrates this relationship.

Fig. 4: Emotional congruence with children

A comparison of offenders (n=126) and non-offenders (n=81)



No appropriate normative data were available for the Rape Myth Acceptance scale. However, the pre-treatment score of 49.96 is considerably higher than the minimum possible score of 19.

Summary of pre-treatment deviancy results

Pre-treatment deviancy in child sexual abusers has been shown to be significantly higher than that found in non-offenders, as postulated in hypothesis 2. Therefore, hypothesis 2 is accepted.

DISCUSSION

The hypotheses put forward have been supported by the data obtained at the pre-treatment stage. No significant difference was found between offenders and non-offenders in the tendency to give socially desirable responses, thus supporting hypothesis 1. Also, a comparison of CSA psychometric data at 0hrs and normative data, found that CSAs consistently obtained significantly more deviant scores than did non-offenders. These data support hypothesis 2. It was also noted that on measures where normative data were not available, CSAs obtained mean scores outside of functional ranges on every scale.

Factor analysis incorporating variables which were to correspond to the categories of Offence-related Denial/Admittance and to Pro-offending thinking confirmed the existence of these factors.

Implications

The finding that the CSAs in this sample were not responding in a socially desirable manner when compared to non-offenders supports the scant literature on this subject. Stermac and Segal (1989), for example, administered the Marlow-Crowne (1960) scale of social desirability to groups of sex offenders, norms and clinicians. No difference

was found in the tendency to give socially desirable responses between CSAs and non-offender laypersons. Similarly, Beckett et al (1994) administered the Personal Reaction Inventory (PRI: Greenwald & Satow, 1970) to a group of non-offender British males and a group of CSAs and found no significant difference in their tendencies to fake good. This suggests that any comparisons made between offender and non-offender scores on other measures are valid.

The existence of a number of factors relating to sexual offending was confirmed by factor analysis lending support the view that sex offenders have different problems which need to be addressed during treatment. Offence-related Denial/Admittance and Pro-offending thinking were clearly categories in their own right with strong interrelationships between the variables in each category. This lends support to the literature which has identified clusters of related psychological characteristics in CSAs (e.g. Beech et al, 1998). The CSAs in this sample were found to be denying and minimising offence-related thoughts, fantasy and behaviours and those high in denial were not motivated for treatment.

Whilst assumed to be made up of discrete variables, the category of Sex-related denial, deviance and dysfunction was found to be surprisingly coherent, with a number of fairly strong relationships between variables. Some of these relationships were not altogether surprising, such as the correlation of r=.5 between the Sexual Obsessions and Paraphilias scales. However, more puzzling is the finding that Social/Sexual Desirability (the tendency to play down "normal" sex drives and interests) was strongly and positively related to knowledge about sexual anatomy and physiology (i.e. the poorer the sexual knowledge, the higher the denial of sexual interests). Also surprising was the lack of a significant relationship between social/sexually desirable responding and the acknowledgement of sexual dysfunction. Thus, whilst some of these relationships are modest and a few are non-significant, there have emerged some clear and surprising associations between variables in the category of Sex-related denial, deviance and dysfunction. In addition, results show that sexual dysfunction and related problems are typical characteristics of untreated CSAs.

It was found that in all categories, the pre-treatment CSAs in this sample tended to obtain scores outside of normal or functional ranges - indicating problems/deficits in the areas concerned. They minimised their arousal to children and involvement in child sexual abuse, they justified their behaviour and held distortions about their victims and children in general. In addition, they revealed a variety of sexual problems. This is consistent with the literature on child sexual abusers (e.g. Marshall, 2000; Fisher, Beech and Browne, 1999; Beech et al, 1988) and indicates that the Unit is working with a sample of CSAs not untypical of the CSA population. It also suggests that the treatment programme (as described in Chapter 2) is justified in its treatment targets. For example, it is clear that denial is high and motivation is low prior to commencing treatment. The Assessment period aims to reduce denial and minimisation and to create a positive group atmosphere in order that motivation may be enhanced.

CONCLUSION

Pre-treatment results on psychometric tests indicate high levels of deviance in this sample of CSAs. They have a range of problems related to their offending and to their sexuality and are denying and minimising considerably. These results suggest that the treatment programme run by the SOU has appropriate treatment targets.

Also targeted by the programme are socio-affective functioning and self-management. The scope of the current study is limited and does not include measures of these aspects of CSA characteristics. However, a measure of relapse prevention skills (addressed in Chapter 9) does look at insight into offending and strategies for leading an offence-free life.

The psychometric characteristics of CSAs briefly described here, are considered more fully in the results chapters which follow. Progress in treatment is considered in the areas of: Offence-related denial/admittance (Chapter 6); Sex-related denial, deviance and dysfunction (Chapter 7); Pro-offending thinking (Chapter 8); Relapse prevention skills and awareness of risk (Chapter 9).

CHAPTER 6: OFFENCE-RELATED DENIAL/ADMISSION

INTRODUCTION

The factor analysis described in chapter 5 yielded two factors, one of which was named Offence-related denial/admission and the other labelled Pro-offending thinking. Denial, as it is represented in the measures described below, is the tendency to deny or minimise offence behaviours (along with related fantasy and planning) and sexual preoccupations/anxieties. One of several treatment objectives in sex offender programmes is the reduction or elimination of denial and minimisation. It is believed that only when individuals are open about their sexual and psychological problems that treatment can have a significant impact on offending behaviour (e.g. Marshall, 1994). Indeed, Hanson and Harris (1997) found that a significantly higher proportion of sex offender recidivists than non-recidivists had denied and minimised their offending behaviour and the need for treatment.

There is much evidence for the prevalence of denial and minimisation in relation to offending behaviour in the sex offender population (e.g. Beech, Fisher and Beckett, 1998; Fisher and Beech, 1998; Ward, Hudson and Marshall, 1995; Marshall, 1994). The sample considered here is no exception as pre-treatment psychometric test results indicated.

Levels of denial and minimisation

Denial is rarely a simple statement of guilt or innocence. Salter (1988) identifies a range of denial through to admittance in sex offenders. An adaptation of this is summarised below (Table 6.1).

Table 6.1: Types of denial in sex offenders

Type of Denial	Involves
Denial of behaviour: *a*	
physical	Denial of the specified behaviour and thus denial of the need for treatment.
psychological	Less focus on the specific. Rather a denial of being capable of committing a sex offence.
Minimisation of the extent of the behaviour	Offender admits to part of the behaviour and/or some of the offences but not all. This is frequently accompanied by denial or minimisation of fantasy, planning, etc. and denial that there is a serious problem.
Denial of seriousness *b*	Offender admits to the behaviour but denies extent of harm done to victim(s).
Admission with justification *b*	Offender admits to the behaviour but maintains that he was justified in his actions - either that there was nothing wrong with his actions (e.g. the child "consented") or that the victim somehow deserved the abuse.
Denial of responsibility *b*	Offender admits to the behaviour and will acknowledge that it was wrong but externalises the causes. He might, for example, blame drink or drugs, stress, a poor marital relationship or even the victim.
Full admission	Offender is honest about the abuse and accepts full responsibility.

a None of the current sample were completely denying the commission of a sexual offence.

b These levels of denial primarily involve cognitive distortions and are examined in Chapter 8.

It is highly unusual for an untreated child molester to fully admit to his abusive behaviour, to completely accept responsibility for his actions and to be aware of and feel remorse for the consequences to actual and indirect victims of his behaviour. More typically, an offender will expose only a fraction of his abusive behaviour initially. Research into the impact of perceptions of confidentiality on sex offender denial has uncovered huge differences in self report according to whether or not an individual believes that the information will be treated confidentially (e.g. Kaplan, Abel, Cunningham-Rathner and Mittelman, 1990; Abel, Becker, Mittelman, Cunningham-Rathner, Rouleau and Murphy, 1997). Perceived confidentiality has been found to statistically influence offender self-report of: the number of offences committed; number of victims; number of different paraphilias acknowledged. Since most sex offender treatment in Britain takes place within the criminal justice system and under conditions where groupworkers can only offer limited confidentiality, it may be assumed that a majority of offenders are minimising the extent of their offence behaviours considerably - particularly pre-treatment.

However, perceived inability to maintain denial has also been found to increase offender honesty. Salter (1998) cites a study in which 2 equivalent groups of untreated sex offenders were assigned to one of two conditions. The first was a cognitive-behavioural treatment group run by experienced therapists and designed to facilitate openness. The other condition involved the same group experience with the addition of requiring group members to complete a sexual autobiography prior to being examined by polygraph. In the first condition, offenders (n=26) confessed to a total of 54 hands-on assaults at referral - a figure which rose to 900 during treatment. Those allocated to the polygraph group (n=23) admitted to a total of 68 contact offences on referral - a figure which rose to over 4,000 during treatment (and following polygraph). The same pattern was evident when asked about number of victims, with those under the polygraph condition acknowledging approximately 4 times the number of victims in treatment than those who were in the treatment only condition.

Why are child sexual abusers defensive?

There are many reasons why a child sexual abuser might choose to deny or minimise his offending. Perhaps the most obvious is the use of denial as a strategy for mitigating negative legal and/or social sanctions - punishment, separation from family, loss of good name, etc. Even when telling the truth is unlikely to make any difference to the situation of an individual, sex offenders continue to deny and minimise. Salter (1988) points out that, although there is no obvious gain to the offender, it is the norm rather than the exception for CSAs to admit to e.g. abusing over a 6 month period rather than the 2 years his victim reports.

The problems associated with defensiveness and denial are numerous. If somebody is anxious to present well, he will have difficulty in acknowledging that he has a problem. Unless he is open about his behaviour, he cannot admit to being at risk of reoffending. Nor can he be helped to develop effective strategies for relapse. Whilst denial and minimisation may be techniques designed to protect the offender, they ultimately leave him at further risk of reoffending. This is the reason why the reduction of denial and minimisation is an important objective of treatment and an important precursor to genuine positive change (e.g. Marshall, 1994; Maletzky, 1993).

Evidence for the effects of treatment on denial in child sexual abusers

There is much evidence for the positive impact of cognitive-behavioural groupwork on denial and minimisation in relation to offending. Many studies report decreased denial and minimisation post-treatment (e.g. Beech et al, 1998a; Beckett et al, 1994; Marques, Day, Nelson and West, 1994; Marshall, 1994; Procter, 1994). These studies suggest that treatment can achieve the objective of reducing defensiveness and increasing openness in relation to offence behaviours.

Rationale and Hypotheses

Rationale

The purpose of this component of the evaluation study is to discover whether the Sex Offender Unit (SOU) treatment programme is effective in reducing offence-related denial and minimisation.

Levels of denial and minimisation are expected to decrease progressively as a result of treatment. However, it is expected that it is in the first 50hrs that the most movement will be made, since it is during this period that work is most focused on encouraging openness about offending. No predictions are made concerning reductions in denial at other stages and there are no reports in the literature of differential change according to stages of treatment. However, exploratory analyses will investigate the possibility of differential movement.

Where "functional" and "dysfunctional" scores are concerned, there should be fewer CSAs obtaining denial scores within dysfunctional ranges post-treatment than pre-treatment. Frequency data will confirm whether or not this is the case.

Hypotheses

1. It is hypothesised that child sexual abusers will demonstrate significant and positive in-treatment change on measures of denial when pre and post scores are compared
2. It is hypothesised that significant reductions in level of denial will take place during the first 50hrs of treatment.

METHODOLOGY

The methodology of this study is described fully in Chapter 3. However, it has been summarised below.

Design and Procedure

The measures employed to assess levels of Offence-related denial/admittance were administered alongside other evaluation measures at: 0hrs (prior to treatment); 50hrs (post-assessment); 100hrs (mid-treatment); 200hrs (end-treatment). Post-treatment results are obtained by obtaining questionnaire results from the point at which an individual was last tested (i.e. at 50hrs, 100hrs or 200hrs, depending on time spent in treatment).

Samples

The 126 child sexual abusers who took part in this study consisted of all eligible (see chapter 3) CSAs entering the SOU treatment programme within a 24 month period. Demographic data on this sample are described in Chapter 4.

A number of sex offenders in this sample did not complete the treatment programme. Full details of non-completers are given in Chapter 3. However, the figures are summarised here: Before 50hrs test administration, 27 CSAs left the programme. A further 36 dropped out between 50hrs and 100hrs. Between 100hrs and 200hrs only 24 left.

Because of the CSAs leaving the programme, sample numbers become progressively lower at test administrations. Details are as follows. At 0hrs n=127, at 50hrs n=99,

at 100hrs n=63 and at 200hrs (n=27). Whilst 39 (not 27) of the sample actually completed the programme, data collection in the form of test administration ceased before this time.

Measures

The measures and scales used here assess offence-related denial/admission. They are describe in detail in Chapter 3 but are listed and summarised below:

- ***The MSI (Multiphasic Sex Inventory) Child Molest Lie (CM Lie) scale (Nichols and Molinder, 1984)*** measures the tendency of an individual to acknowledge or deny his arousal to children. The higher the score, the less open he is being. Someone who is being honest about their arousal would be expected to score between 0-2 points. The highest possible Lie score is 13. At 0hrs the average CM Lie score was 8.18 (sd=3.54) - a score which falls within the "dishonest" range.

- ***The MSI Sex Deviance Admittance Child Molest (CM) scale*** contains most of the above items but contains other subscales which cover: grooming, sexual assault, aggravated assault, incest behaviours. The higher the score, the more honest an individual. A score of between 20 and 39 is expected to be a fairly truthful representation of sexual outlet. The mean score of this sample of CSAs at 0hrs was 11.56 (sd=7.13) - a score which falls in the "minimisation of sexual outlet" range.

- ***The MSI Treatment Attitudes (TA) scale*** consists of questions relating to motivation for treatment and recognition of a sexual problem. A score of below 3 suggests a lack of motivation and a score of 5-8 would indicate that someone is highly motivated. Pre-treatment this sample of CSAs obtained a mean score of 2.87 (sd=1.91) - in the "may not be motivated" range.

- ***The Sex Offence Attitudes Questionnaire (SOAQ: Procter, 1994)*** is a measure of denial relating to sexual offending - denial of risk, denial of responsibility, denial of planning, denial of harm to the victim and denial of the actual offence. The highest possible score is 150 (indicating complete denial) and the lowest is 30. The mean pre-treatment score for this group was 95.4 (sd=21.28), suggesting fairly high denial.

Treatment of data

Means and standard deviations were obtained for scores on all Offence-related denial/admission scales at each point in treatment - 0hrs, 50hrs, 100hrs and 200hrs.

In order to ascertain whether overall pre/post treatment movement was evident, means and standard deviations of scores D measures were obtained for individuals' final set of tests before leaving the programme[1] - 50hrs, 100hrs or 200hrs. Pre/post treatment scores on the Denial factor were then compared by means of repeated measures Multiple Analyses of Variance (MANOVAs: SPSS, 1992) which looked at within subjects effects. Univariate tests were then examined to identify movement on individual factor measures.

MANOVAs were then conducted on the Denial factor to examine treatment impact between the different stages of treatment - 0-50hrs, 50-100hrs and 100-200hrs. Univariate test results were then examined to identify any in-treatment change in individual scale scores.

Frequencies of "dysfunctional" and "functional" scores were obtained at 0hrs and post-treatment in order to ascertain whether CSAs were more likely to be scoring within a functional range by the time they left treatment than they were pre-treatment.

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[1] Post-treatment results are obtained by using questionnaire results from the last time an individual was tested, i.e. at 50hrs, 100hrs or 200hrs, depending on when they left the programme.

RESULTS

In treatment changes in denial

In-treatment progress in levels of denial was measured by observing and comparing scores at all stages of the programme. This includes examining overall pre/post treatment change, 0-50hrs change, 50-100hrs change and 100hrs -200hrs change.

Overall pre/post change

It was postulated that CSAs would be denying significantly less post treatment. In order to examine pre/post movement a repeated measures MANOVA was conducted on the Denial factor pre and post scores. There was a significant reduction in overall tendency to deny and minimise post treatment ($p<.001$, $f=22.95$, $df=4,95$, 1-tailed). Thus, hypothesis 1 that CSAs would be denying less post treatment may be accepted.

Univariate tests revealed significant movement on all of the 4 measures comprising the Denial factor (see Table 6.2). The mean CM Lie score at 0hrs was 8.02(3.56) compared to 4.98(3.46) post treatment. This difference was highly significant ($p<.001$, $f=77.46$, $df=1,98$, 1-tailed).

A similar pattern was observed with CM scores, CSAs admitting to more child molest behaviours post treatment than pre treatment. The average CM score at 0hrs was 12.29(6.95). This rose to 14.78(7.15) post treatment and the difference was significant at $p<.001$ ($f=20.44$, $df=1,98$, 1-tailed).

Motivation for treatment (signifying acknowledgement of a problem) also significantly improved post-treatment. The mean TA score at 0hrs was 3.0(1.93) compared to a post-treatment mean of 3.61(1.62). This improvement was highly significant ($p<.001$, $f=10.68$, $df=1,98$, 1-tailed).

SOAQ scores were significantly higher (in denial) at 0hrs with a mean of 94.19 (20.68) compared to 78.65 (21.45) on leaving the programme. This movement was found to be highly significant ($p<.001$, $f=42.71$, $df=1,98$, 1-tailed).

These findings confirm that the treatment programme had a significant and positive impact on levels of offence-related denial/admission. Thus, hypothesis 1 is accepted.

Table 6.2: Univariate tests illustrating change in levels of denial pre and post treatment (n=99)

Scale	Pre-treatment mean and sd	Post-treatment mean and sd	p value - 1 tailed
Child Molest Lie scale	8.02 *(3.56)*	4.98 *(3.46)*	.001
Child Molest scale	12.29 *(6.95)*	14.78 *(7.15)*	.001
Treatment Attitudes	3.0 *(1.93)*	3.61 *(1.62)*	.001
SOAQ	94.19 *(20.68)*	78.65 *(21.45)*	.001

Differential impact on denial at different stages of treatment

In order to identify change at different stages of the treatment programme, repeated measures MANOVAs were carried out to compare Denial factor scores between: 0-50hrs, 50-100hrs and 100-200hrs.

0-50hrs

A MANOVA conducted on the Denial factor with 0-50hrs change as the within-subjects factor found a significant overall decrease in the tendency to deny and minimise between 0hrs and 50hrs ($p<.001$, $f=27.82$, $df=4,95$, 1-tailed). Hypothesis 2 may thus be accepted. Univariate tests found significant differences on all measures comprising the Denial factor. Means and standard deviations obtained at 0hrs and

50hrs along with the results of univariate analyses may be seen in Table 6.3.

Table 6.3: 0hrs - 50hrs treatment effect on denial (n=99)

Scale	0hrs mean and sd	50hrs mean and sd	Value of f
Child Molest Lie scale	8.25 *(3.54)*	6.19 *(3.55)*	31.89 ***
Child Molest scale	12.29 *(6.94)*	14.35 *(7.32)*	18.8 ***
Treatment Attitudes	3.0 *(1.93)*	3.62 *(1.74)*	12.82 ***
SOAQ	94.37 *(20.99)*	77.17 *(21.48)*	107.1 ***

*** p<.001, 1-tailed

50-100hrs

Between 50hrs and 100hrs no overall change in denial was revealed (f=1.16, df=4,59, 1-tailed), although there was a significant tendency for CSAs to be more open about child molest behaviours (p<.05, f=4.15, df=1,62, 1-tailed). Means and standard deviations obtained at 50hrs and 100hrs along with the results of univariate analyses may be seen in Table 6.4.

Table 6.4: 50hrs - 100hrs treatment effect on denial (n=63)

Scale	50hrs mean and sd	100hrs mean and sd	Value of f
Child Molest Lie scale	5.39 *(3.37)*	5.03 *(3.3)*	1.18 ns
Child Molest scale	15.71 *(6.54)*	16.7 *(6.36)*	4.15 *
Treatment Attitudes	3.98 *(1.84)*	4.17 *(1.62)*	.98 ns
SOAQ	74.3 *(20.58)*	71.8 *(18.28)*	2.46 ns

* p<.05, 1-tailed

100-200hrs

Similarly, no overall movement in levels of denial was observed between 100hrs and 200hrs (f=1.62, df=4,23, 1-tailed), although significant improvement in levels of denial were observed in SOAQ scores (p<.05, f=3.09, 1,26, 1-tailed). Means and standard deviations obtained at 100hrs and 200hrs along with the results of univariate analyses may be seen in Table 6.5.

Table 6.5: 100hrs - 200hrs treatment effect on denial (n=27)

Scale	100hrs mean and sd	200hrs mean and sd	Value of f
Child Molest Lie scale	4.81 *(3.11)*	4.81 *(2.77)*	.00 ns
Child Molest scale	16.52 *(6.63)*	15.78 *(5.9)* r	.96 ns
Treatment Attitudes	4.07 *(1.59)*	3.59 *(1.62)* r	1.32 ns
SOAQ	70.63 *(16.39)*	67.19 *(15.49)*	3.09 *

* p<.05, 1-tailed

r denotes change in the opposite direction to that predicted

The above analyses demonstrate that level of denial is a function of time spent on the programme. There were significant improvements observed between 0hrs and 50hrs, with levels of denial and minimisation showing a reduction on all measures. Thus, hypothesis 2 may be accepted. There is a (non-significant) trend towards more openness between 50hrs and 100hrs. However, during the second half of the treatment programme, no such trend is evident - indeed on some measures there is a trend towards less openness.

In-treatment change in individuals

In order to examine in-treatment changes in Denial in individuals, frequencies were obtained for pre and post treatment scores falling within "functional" and "dysfunctional" ranges. "Dysfunctional" refers to scores falling outside of acceptable ranges. Table 6.6 illustrates the cut-off points and ranges for denial scales.

Table 6.6: Cut-off points and score ranges identifying "dysfunctional" scores on measures of Denial

Scale	Dysfunctional score ranges
Child Molest Lie scale	5 or higher (i.e. in the "sex deviance interests suppressed" or "dishonest" ranges)
Child Molest scale	19 or lower (i.e. outside of the "probable true outlet" and "highly open" ranges)
Treatment Attitudes	0-3 (i.e. in the "not motivated for treatment" ranges)
SOAQ	73 or higher (i.e. within one standard deviation of the mean 0hrs score)

In order to examine the incidence of CSAs moving from dysfunctional to functional score ranges, score range frequencies were obtained for each scale pre and post treatment. Table 6.7 illustrates the trend towards less denial post-treatment than pre-treatment, with a reduction observed in CM Lie, CM, TA and SOAQ scale dysfunctional scores observed post-treatment.

It was observed that twice as many individuals were obtaining scores within the functional range on the CM Lie scale post treatment, twice as many CSAs were motivated for treatment and almost three times as many offenders had acceptable SOAQ scores post-treatment. However, whilst motivation was generally high (with 83.83% of the sample presenting as motivated post-treatment) less than half of the

treatment group CSAs obtained scores within functional ranges on all other measures of denial.

Table 6.7: A comparison of the proportion of functional scorers in measures of denial pre and post treatment (n=99)

Scale	Pre-treatment	Post-treatment
Child Molest Lie scale *Functional:*	n=21 (21.21%)	N=43 (43.43%)
Child Molest scale *Functional:*	n=18 (18.18%)	N=30 (30.3%)
Treatment Attitudes *Functional:*	n=38 (38.38%)	N=83 (83.83%)
SOAQ *Functional:*	n=15 (15.15%)	N=43 (43.43%)

DISCUSSION

The results obtained from measures of offence-related denial and admission at various stages of the treatment process indicated that there is significant positive treatment impact on levels of denial. Hypothesis 1 predicted that post-treatment scores on the denial factor would show less denial and minimisation than those at 0hrs. This was found to be the case, with significant differences found on all measures of denial. Hypothesis 2 predicted that there would be a significant reduction in denial during the first fifty hours of treatment. This was found to be the case and the hypothesis was accepted.

Implications

Whilst pre-treatment scores on measures of denial could not be compared with non-offenders, mean scores clearly showed high levels of denial of arousal to children and offence-related activities and poor motivations for treatment (see Chapter 5). The high levels of denial reported at 0hrs replicate the findings of many studies (e.g. Beech et al, 1998; Fisher and Beech, 1998; Ward et al, 1995). The effect of treatment in reducing denial also replicate the results of a number of evaluation studies (e.g. Beech et al, 1998; Marques et al, 1994; Marshall, 1994; Procter, 1994). Again, the most movement in levels of denial appeared to take place during the assessment period. Given that the first 50hrs of the programme concentrates on motivating individuals to tell their "stories" and to re-tell them with the help of group challenges and questions, it is perhaps not surprising that this was when the most change took place in terms of admittance.

On examination of the impact of treatment on levels of denial, it should be noted that significant improvements do not necessarily indicate high levels of admittance. Whilst the post-treatment mean score on the CM Lie scale, for example, does suggest a fairly high degree of honesty regarding arousal to children, the post-treatment mean score on the CM score remains in the "expected minimum" range, suggesting that many CSAs are still being less than frank about their sexual outlet.

A particular problem in the interpretation of denial here is the fact that individuals begin the program having genuinely different levels of deviant arousal and having been involved in differing levels of offence behaviours. For this reason, indications of significant change during treatment is likely to be a better indicator of the success of the programme in reducing denial than an examination of frequencies of functional versus dysfunctional scores. This might explain the disappointing results here, with more than 50% of CSAs scoring within dysfunctional ranges on three of the four denial scales post-treatment.

CONCLUSION

This chapter examined the effectiveness of the Sex Offender Unit (SOU) treatment programme in reducing denial in a sample of child sexual abusers. Treatment was found to be effective in reducing denial of offence-related behaviours, thus attaining one of its goals.

Progress occurred during most stages of the treatment programme. However, much improvement was evident in the first 50hrs (the Assessment period) and progress slowed somewhat after this time. It appears that the first 50hrs is a crucial period for motivating individuals and creating an environment in which they feel safe enough to be more open about their offending.

Despite the fact that improvements were evident, a majority of the CSAs in this study continued to score within dysfunctional ranges on 3 of the 4 measures by the time they left treatment. This could be a function of the fact that only 31% of the sample actually completed the programme. However, given that little improvement in levels of denial was observed between 50hrs and 200hrs, this is unlikely to be the case. Indeed, the STEP team in their evaluations of prison and community-based treatment programmes (Beech et al, 1998; Beckett et al, 1994) report similar (or higher) levels of denial to those reported here post treatment. It may be that more focused work on denial needs to occur throughout the programme rather than simply in its initial stages and that this is a problem common to cognitive-behavioural groupwork programmes (at least in Britain) rather than the SOU programme in particular.

CHAPTER 7: SEX-RELATED DENIAL, DEVIANCE AND DYSFUNCTION

INTRODUCTION

The relationship between sex-related denial, deviance and dysfunction to sexual offending is not known. Neither are these areas extensively covered in the sex offending literature. The main objective of treatment programmes for sex offenders is that of reducing recidivism and the main focus of interventions is sexual denial and deviance which is directly related to offending. However, there is increasing evidence that problems relating to adults on a social level, feelings of inadequacy, and poor self-management skills may contribute to offending behaviour (e.g. Marshall and Serran, 2000) and it may be that some of these problems are paralleled in sexual functioning, e.g. feelings of sexual inadequacy may contribute to a person's decision to have sex with a child.

This chapter focuses on several areas of sexuality: social/sexual desirability; sexual obsessions; paraphilias; sexual dysfunction; knowledge about sexual anatomy and physiology.

Social/sexual desirability

The tendency for sex offenders to play down "normal" as well as deviant sexuality is well documented (e.g. Beech, 1997/1998; Beech, Fisher and Beckett, 1998; Nichols and Molinder, 1984; Simkins, Ward, Bowman and Rinck, 1979). Simkins and colleagues discovered that those sex offenders willing to admit to "normal" sex drives

and interests on the Social/Sexual Desirability (SSD) scale of the Multiphasic Sex Inventory (MSI) were denying and minimising their offences less than those who obtained less socially desirable scores. Nichols and Molinder (1984) compared groups of pre and post-treatment CSAs and found that post-treatment scores indicated statistically higher levels of admittance to having "normal" sexual drives and interests. However, two recently conducted British studies - one on a community sample of CSAs and one on a prison sample - revealed no such differences (Beckett et al, 1994; Beech et al, 1998[1]). Thus, it is by no means clear that treatment is effective in reducing social/sexually desirable responding in child sexual abusers.

Sexual obsessions

Sexual obsessions (as measured by the MSI SO scale) have been found to be related to psychopathology (Kalichman, Henderson, Shealy and Dwyer, 1992). However, low scores also indicate faking (Nichols and Molinder, 1984). Only 7.07% (n=7) of the current sample admitted to being sexually obsessed at 0hrs, whilst 38.38% (n=38) were obtaining "fake good" scores. Although the majority of offenders scoring within dysfunctional ranges are faking, it is likely to be the admittedly sexually obsessed group who are going to have the most problems controlling their sexual fantasy and behaviour. Indeed, Beckett et al (1994) found that those clusters of offenders identified as highly deviant had a mean SO score which was approximately 6 times higher than the score of non offenders (Nichols and Molinder, 1984) and low deviance offenders. Likewise, Simkins et al (1989) found that initial MSI SO score in sex offenders was moderately but significantly related to likelihood of recidivism as perceived by clinicians. The effects of treatment on SO scores have rarely been reported but appear negligible (Beech et al, 1998; Beckett et al, 1994). This could, however, be a function of the duality of the measure (i.e. fakers might be expected to

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[1] Whilst significant improvements were found in the group which had undergone longer-term therapy (180 hours), the group men in short-term therapy (80 hours) did not show significant improvements. The current sample has spent an average of approximately 100 hours in treatment and will thus be compared with the short-term therapy group.

fake less and obtain a higher score whereas the sexually obsessed might be expected to become less preoccupied with sex and obtain a lower score following treatment).

Paraphilias

Paraphilic interests and activities (other than those for which an individual has been convicted) have generally been considered in the literature in relation to denial (e.g. Kaplan, Abel & Cunningham-Rathner, 1990; Abel, Becker, Mittelman, Cunningham-Rathner, Rouleau & Murphy, 1987). Indeed, Chapter 5 demonstrates that there is a strong relationship between scores on the MSI Paraphilias (Para) scales and the MSI SSD scale. Like the SO scale, it is probable that high scorers are the most deviant and might be expected to have fewer paraphilic interests post-treatment. However, very low scorers are also likely to be faking and so might be expected to admit to more paraphilias post-treatment.

Sexual dysfunction

Sexual dysfunction is typically a problem for many sex offenders yet rarely discussed within the context of treatment work and is generally not a treatment target. However, there is some evidence that sexual dysfunction is associated with higher deviance. McClurg, Craissati and Wiseman (1994/95) administered the MSI to a group of 44 CSAs and found that pre-treatment scores on the Sex Dysfunction (Dysf) scale were higher than in the normal population and associated with, for example: higher levels of cognitive distortions; more justifications; less likelihood of having had a long-term heterosexual relationship. Simkins et al (1989) found that groupwork failures had endorsed almost twice the number of sexual dysfunction items than successes (although this trend was not significant). Thus, it seems that a reduction in sexual dysfunction, whilst not a stated aim of treatment, is desirable.

Sexual knowledge

Knowledge relating to sexual anatomy and physiology has been found to be typically lacking in sex offenders (McClurg et al, 1994/5; Simkins et al, 1989). Whilst this could be seen as a fairly innocuous failing, there are features of such a lack of knowledge which might well contribute to feelings of inadequacy (e.g. if the penis is big enough a woman will have an orgasm) and distorted beliefs about what constitutes "normal" sexuality (e.g. a man must have an orgasm at least once a day to keep the testicles from over-filling), for example. Simkins et al found that low scores on the SKB scale were strongly associated with perceived risk of recidivism and that the higher the scores, the more likely an individual to benefit from groupwork and to be classified as a success rather than failure. One aim of the treatment programme considered here is to provide accurate information about sexuality and to dispel some of the myths about men, women and sex.

Chapter 5 identified characteristics of this sample when compared to non-offending males suggesting: significantly more denial of sexuality; much higher levels of sexual dysfunction and poorer knowledge of sexual anatomy and physiology. The CSAs, however, did not self-report higher levels of paraphilias and, whilst the mean Sexual Obsessions score was higher than in the normative sample, there was not enough information to determine whether or not this difference was significant.

Rationale and Hypotheses

Rationale

The purpose of this component of the evaluation study is to discover whether the Sex Offender Unit (SOU) treatment programme is effective in reducing sex-related denial. Another aim is to explore the relationship between treatment and changes in levels of self-reported sexual dysfunction and level of knowledge relating to sexual anatomy and physiology.

Few predictions can be made with respect to admittance of sex-related admissions of deviance and dysfunction. Whilst these scales are related to socially desirable responding to an extent (as reported in Chapter 5), it is not possible to say (as it is with offence-related scales) that low scores on e.g. paraphilias scales represents faking or whether they simply represent genuinely low levels of paraphilic interests. In addition, the lack of evidence for significant reductions in social/sexually desirable responding in treated offenders means that no change is hypothesised here.

Self-reported levels of sexual dysfunction, however, are expected be lower post treatment. Not only will the programme deliver accurate information that should dispel the kinds of myths that lead to e.g. perceptions of inadequacy, but it should enable individuals to feel more in control of their lives and feel better about themselves and the possibility of change. This change is expected to be gradual and progressive, however, and no predictions are made about when it might be expected to take place.

The only other prediction which can be made concerns level of knowledge relating to sexual anatomy and physiology. This might be expected to improve during treatment as a result of obtaining more accurate information. Because there is only one session dedicated to this and because this kind of information is likely to be communicated at various stages in a rather piece-meal fashion, all that can be predicted is that post-treatment scores will show a significant improvement over pre-treatment scores on the MSI Sex Knowledge and Beliefs (SKB) scale.

Where "functional" and "dysfunctional" scores are concerned, pre and post treatment data are examined to ascertain whether fewer CSAs post-treatment obtain: scores within dysfunctional (high denial) ranges on the SSD; scores indicating high levels of sexual dysfunction; scores which indicate inadequate knowledge of sexual anatomy and physiology.

Hypotheses

1. Child sexual abusers are hypothesised to report significantly higher levels of sexual dysfunction pre treatment when compared to post treatment.
2. It is hypothesised that scores on the MSI SKB scale will be significantly higher post-treatment when compared to pre-treatment, demonstrating more accurate knowledge of sexual anatomy and physiology.

METHODOLOGY

The methodology of this study is described fully in Chapter 3. However, it has been summarised below.

Design and Procedure

The measures employed to assess levels of sex-related denial, deviance and dysfunction were administered alongside other evaluation measures at: 0hrs (prior to treatment); 50hrs (post-assessment); 100hrs (mid-treatment); 200hrs (end-treatment). Post-treatment results are obtained by obtaining questionnaire results from the point at which an individual was last tested (i.e. at 50hrs, 100hrs or 200hrs, depending on time spent in treatment).

Samples

The 126 child sexual abusers who took part in this study consisted of all eligible (see chapter 3) CSAs entering the SOU treatment programme within a 24 month period. Demographic data on this sample are described in Chapter 4.

A number of sex offenders in this sample did not complete the treatment programme. Full details of non-completers are given in Chapter 3. However, the figures are summarised here: Before 50hrs test administration, 27 CSAs left the programme. A further 36 dropped out between 50hrs and 100hrs. Between 100hrs and 200hrs only 24 left.

Because of the CSAs leaving the programme, sample numbers become progressively lower at test administrations. Details are as follows. At 0hrs n=126, at 50hrs n=99, at 100hrs n=63 and at 200hrs (n=27). Whilst 39 (not 27) of the sample actually completed the programme, data collection in the form of test administration ceased before this time.

Measures

The measures and scales used here assess sex-related denial, deviance and dysfunction. They are described in detail in chapter 3 but are listed and summarised below:

- ***The Multiphasic Sex Inventory (MSI) Social/Sexual Desirability (SSD) scale (Nichols and Molinder, 1984)*** measures the degree to which an individual reports having "normal" sex drives and interests. Low scores indicate socially desirable responding. A score of below 28 indicates some denial of normal sex drives and interests and very low scores (below 20) indicating that the respondent is presenting as asexual.

- ***The MSI Sexual Obsessions (SO) scale*** concerns the tendency to be preoccupied with sexual matters. Very low scores (0-1) indicated socially desirable responding, whereas scores of above 10 indicate that an individual is sexually obsessed.

- ***The MSI Paraphilias (Para) scales*** contain items on: fetish interests; obscene phone calling; voyeurism; bondage; sado-masochism. Whilst useful clinical

information may be obtained from responses here, it is to some extent a measure of denial, having a strong association with the SSD and SO scales. Non-offenders would be expected to endorse 0-4 items on these scales (see Chapter 5).

- ***The MSI Sexual Dysfunction (Dysf) scales*** consist of items relating to: feelings of sexual inadequacy; premature ejaculation; physical disabilities affecting sexual response; impotence. It is not strongly related to socially desirable responding but correlates significantly with the SO and Para scales. However, its strongest association is with knowledge of sexual anatomy and physiology - sexual dysfunction being related to lack of accurate information. Normative data suggests that non-offenders typically obtain a total sex dysfunction score of 0-2 (see Chapter 5).

- ***The MSI Sex Knowledge and Beliefs (SKB) scale*** measures the level of accurate information an individual has about sexual anatomy and physiology. A score of below 17 indicates a lack of accurate information. It was found to be strongly related to SSD scores - the more accurate the information, the less likely an individual was to portray himself as asexual (see Chapter 5).

Treatment of data

Means and standard deviations were obtained for scores on all sex-related denial, deviance and dysfunction scales at each point in treatment - 0hrs, 50hrs, 100hrs and 200hrs.

In order to ascertain whether overall pre/post treatment movement was evident, means and standard deviations of scores on these measures were obtained for individuals' final set of tests before leaving the programme[2] - 50hrs, 100hrs or 200hrs. Pre/post

[2] Post-treatment scores are those obtained at the last testing point before an individual left the programme, i.e. at 50hrs, 100hrs or 200hrs.

treatment scores were then compared by means of dependent t-tests. T-tests were then conducted to examine treatment impact between the different stages of treatment - 0-50hrs, 50-100hrs and 100-200hrs.

Frequencies of "dysfunctional" and "functional" scores were obtained (where appropriate) at 0hrs and post-treatment in order to ascertain whether CSAs were more likely to be scoring within a functional range by the time they left treatment than they were pre-treatment.

RESULTS

In-treatment changes in sex-related denial, deviance and dysfunction

In-treatment changes were investigated on all measures of sex-related denial, deviance and dysfunction. Pre/post treatment comparisons were first made, followed by an exploration of movement between specific points in treatment.

Overall pre/post change

Hypothesis 1 predicted that CSAs would experience significantly less sexual dysfunction post-treatment when compared to pre-treatment. The pre-treatment mean score on the MSI Sex Dysfunction scales was 3.79 (sd=3.33) compared to 2.93 (sd=2.6) post-treatment. This reduction in levels of sexual dysfunction was significant at $p<.001$ ($t=3.51$, $df=98$, 2-tailed). Thus, hypothesis 1 may be accepted.

Hypothesis 2 predicted that post-treatment CSAs would have more accurate information about sexual anatomy and physiology as measured by the SKB. The 0hrs mean of 16.14 (sd=3.2) was lower than the post-treatment mean score of 16.79 (sd=2.3) and this improvement was significant at $p<.01$ ($t=-2.74$, $df=98$, 1-tailed). Hypothesis 3 may therefore be accepted.

It was not expected that SSD scores would improve significantly over treatment. There was a trend towards more openness, with the average 0hrs SSD score at 22.95 (sd=7.15) compared to a mean post-treatment score of 23.73 (sd=6.8). This difference was not significant at $p \leq .05$ (t=-1.56, df=98, 1-tailed) and the null hypothesis could not be rejected.

No predictions were made about pre-post changes in scores on the MSI SO and Para scales. Indeed, whilst there was a slight trend towards lower levels of self-reported sexual obsessions and more paraphilias, neither trend was significant. Results of pre/post treatment movement are presented in Table 7.1.

Table 7.1: Pre-post movement in mean scores on sex-related denial, deviance and dysfunction scales (n=99)

Measure	0hrs mean and sd	50hrs mean and sd	Value of t
MSI Sex Dysfunction (Dysf)	3.8 *(3.34)*	2.93 *(2.6)*	3.51***
MSI Sex Knowledge & Beliefs (SKB)	16.14 *(3.21)*	16.79 *(2.3)*	-2.74**
MSI Social/Sexual Desirability (SSD)	22.95 *(7.15)*	23.73 *(6.8)*	-1.56 ns
MSI Sexual Obsessions (SO)	3.31 *(3.34)*	3.05 *(3.44)*	.76 ns
MSI Paraphilias (Para)	2.12 *(2.64)*	2.16 *(3.26)*	-.13

** p<.01, 1-tailed

*** p<.001, 1-tailed

Differential impact on sex-related denial, deviance and dysfunction at different stages of treatment

In order to identify change at different stages of the treatment programme, dependent t-tests were conducted on mean scores on all measures of sex-related denial and dysfunction between: 0-50hrs, 50-100hrs and 100-200hrs.

0-50hrs

Table 7.2 presents 0hrs and 50hrs scores compared on measures of sex-related denial, deviance and dysfunction. There was a non-significant trend towards less sexual dysfunction and more accurate knowledge of sexual anatomy and physiology but there was significant movement on the SSD scale only ($p<.05$, $t=-1.7$, $df=98$, 1-tailed).

Table 7.2: 0hrs - 50hrs treatment effect on sex-related denial, deviance and dysfunction (n=99)

Measure	0hrs mean and sd	50hrs mean and sd	Value of t
MSI Sex Dysfunction (Dysf)	3.8 *(3.34)*	3.52 *(2.78)*	1.19 ns
MSI Sex Knowledge & Beliefs (SKB)	16.14 *(3.21)*	16.39 *(3.05)*	-1.02 ns
MSI Social/Sexual Desirability (SSD)	22.95 *(7.15)*	23.75 *(7.12)*	-1.7 *
MSI Sexual Obsessions (SO)	3.31 *(3.34)*	3.41 *(3.65)*	-.32 ns
MSI Paraphilias (Para)	2.12 *(2.64)*	2.43 *(2.98)*	-1.04 ns

* $p<.05$, 1-tailed

50-100hrs

Between 50hrs and 100hrs no significant movement in SSD, SO, Para or SKB scores was found, although there was a non-significant trend towards improved knowledge of sexual anatomy and physiology over this period. However, CSAs reported significantly less sexual dysfunction at 100hrs compared to 50hrs ($p<.01$, $t=2.56$, $df=62$, 1-tailed). Table 7.3 illustrates the movement on these measures occurring between 50hrs and 100hrs.

Table 7.3: 50hrs - 100hrs treatment effect on sex-related denial, deviance and dysfunction (n=63)

Measures	50hrs mean and sd	100hrs mean and sd	Value of t
MSI Sex Dysfunction (Dysf)	4.1 *(3.05)*	3.38 *(3.56)*	2.56**
MSI Sex Knowledge & Beliefs (SKB)	16.21 *(3.06)*	16.6 *(3.12)*	-1.51 ns
MSI Social/Sexual Desirability (SSD)	24.13 *(7.14)*	24.16 *(6.76)*	-.06 ns
MSI Sexual Obsessions (SO)	4.14 *(3.77)*	3.9 *(3.8)*	.7 ns
MSI Paraphilias (Para)	2.87 *(3.25)*	2.43 *(3.65)*	1.23 ns

** p<.01, 1-tailed

100-200hrs

No significant movement in levels of sex-related denial, deviance and dysfunction was observed between 100hrs and 200hrs, as demonstrated in Table 7.4. There was, nevertheless, a continued trend towards less reporting of sexual dysfunction and improved knowledge relating to sexual anatomy and physiology.

Table 7.4: 100hrs - 200hrs treatment effect on sex-related denial, deviance and dysfunction (n=27)

Measures	100hrs mean and sd	200hrs mean and sd	Value of t
MSI Sex Dysfunction (Dysf)	3.74 *(3.56)*	3.22 *(3.23)*	1.71 ns
MSI Sex Knowledge & Beliefs (SKB)	16.7 *(3.43)*	17.22 *(2.93)*	-1.36 ns
MSI Social/Sexual Desirability (SSD)	24.19 *(7.07)*	24.04 *(6.81)*	.21 ns
MSI Sexual Obsessions (SO)	3.67 *(3.17)*	2.89 *(2.19)*	1.5 ns
MSI Paraphilias (Para)	2.33 *(2.91)*	2.3 *(3.01)*	.09 ns

The above analyses reveal few significant changes between specific points in treatment on the measures described. However, whilst social/sexually desirable responding showed no significant overall change, it did improve significantly during the first 50 hours of treatment. A significant reduction in levels of sexual dysfunction was seen between 50hrs and 100hrs, with a consistent trend towards less dysfunction throughout treatment. Whilst pre-post scores indicated a significant improvement in level of knowledge about sexual anatomy and physiology, this happened gradually, with no significant changes between certain points in the programme. No significant change or clear trends were observable in SO and Para scores.

In-treatment change in individuals

In order to look at progress in individuals between pre and post treatment, frequencies of "functional" and "dysfunctional" scores on measures of sex-related denial, deviance and dysfunction were obtained for each point in time. "Dysfunctional" refers to scores falling outside of acceptable ranges. Table 7.5 illustrates the cut-off points for SSD and SKB scales. In addition the average non-offender scores and standard deviations (reported by Nichols and Molinder, 1984) have been used to create cut-off points for the Dysf scales.

Table 7.5: Cut-off points and "dysfunctional" score ranges on SSD, Dysf and SKB scales

	Dysfunctional score ranges
Social/Sexual Desirability (SSD)	23 or lower (i.e. in the "asexual" and denial of "normal" sex drives and interests ranges)
Sexual Dysfunction (Dysf)	3 or higher (i.e. in the sexually dysfunctional range)
Sex Knowledge and Beliefs (SKB)	16 or lower (i.e. in the lack of accurate information ranges)

In order to examine the incidence of CSAs moving from dysfunctional to functional score ranges, score range frequencies were obtained for the SSD, Dysf and SKB scales pre and post treatment. It was expected that more CSAs would be acknowledging "normal" sex drives and interests post-treatment, that they would have fewer problems with sexual dysfunction and that more of them would display an accurate knowledge of sexual anatomy and physiology. This was found to be the case. Post-treatment 57.8% (n=57) CSAs were scoring within a functional range compared to 53.5% (n=53) pre-treatment - a small increase in the numbers of functional scores. On the Dysf scales, 47.46% (n=46) of CSAs were scoring in a functional range at 0hrs compared to 56.6% (n=56) post-treatment. Similarly, 59.6% (n=59) CSAs had an adequate knowledge of sexual anatomy and physiology post treatment, compared to only 46.46% (n=46) at the pre-treatment stage. As predicted more individuals were obtaining scores within functional ranges on these measures post-treatment. Table 7.6 presents the frequencies of CSAs scoring within functional ranges at pre and post treatment.

Table 7.6: A comparison of the proportion of functional scorers on measures of sex-related denial, deviance and dysfunction pre and post treatment (n=99)

Scale	% "functional scores at 0hrs	% "functional scores post-treatment
Social/Sexual Desirability (SSD)	53.5% (n=53)	57.8% (n=57)
Sexual Dysfunction (Dysf)	47.46% (n=46)	56.6% (n=56)
Sex Knowledge and Beliefs (SKB)	59.6% (n=59)	46.46% (n=46)

In order to ascertain any movement away from extreme scores in the SO and Para scales, the proportions of offenders obtaining proposed "fake good" scores were identified pre and post treatment. Similarly, the proportions of offenders obtaining highly deviant scores (more than one standard deviation higher than the non-offender mean) on these measures were examined pre and post treatment. Table 7.7 illustrates the results, along with the relevant cut-off points.

Table 7.7: Pre treatment compared to post-treatment "fake good" and "deviant" scores on SO and Para scales (n=99)

Scale	% dysfunctional scores pre-treatment	% dysfunctional scores post-treatment
Sexual Obsessions (SO) Fake good (0-1)	38.38 (n=38)	40.4 (n=40)
Sexual Obsessions (SO) Deviant 10+	7.07 (n=7)	5.05 (n=5)
Paraphilias (Para) Fake good (0)	26.26 (n=26)	38.38 (n=38)
Paraphilias (Para) Deviant (5+)	16.16 (n=16)	13.13 (n=13)

It can be seen that the proportion of individuals apparently faking good on the SO scale has increased slightly but the number of sexually obsessed individuals has decreased a little. The same pattern may be observed on the Para scales. A higher proportion of CSAs were admitting to some paraphilic interests at 0hrs than at post-treatment. However, fewer offenders reported high levels of paraphilic interests post-treatment.

DISCUSSION

Hypothesis 1 predicted that CSAs would report significantly less sexual dysfunction post-treatment. This was found to be the case and the hypothesis was accepted. Hypothesis 2 predicted that knowledge of sexual anatomy and physiology would be significantly better post treatment. This was also found to be true and the hypothesis accepted. No predictions were made about movement in levels of social/sexual desirability, sexual obsessions and paraphilias. Indeed, no pre/post significant movement was observed.

No predictions about when the most change would take place were made. Indeed the only significant change between 2 points in time within the programme was a reduction in sexual dysfunction between 50hrs and 100hrs and a reduction in social/sexually desirable responding during the first 50 hours.

When proportion of CSAs obtaining dysfunctional scores was examined, it was found that there were moderate improvements in levels of dysfunctional scores on: social/sexual desirability; sexual dysfunction; sexual knowledge. However, whilst the numbers of highly deviant scorers on the SO and Para scales reduced slightly post-treatment, the number of apparently fake good scorers increased.

Implications

The reduction in reported levels of sexual dysfunction and improvement in knowledge of sexual anatomy and physiology is encouraging because it suggests that individuals are overcoming problems which might interfere with their adult relationships. However, despite the progress, post-treatment 43.43% of CSAs still suffered considerable sexual dysfunction and 40.4% continued to demonstrate a lack of accurate information about sexual anatomy and physiology. This, of course could be related to the fact that the average time spent on the programme varied widely and to the fact that only 31% of CSAs completed the programme. It may be that, had everyone completed the programme, progress would have been more dramatic. It should also be remembered that testing points did not always coincide with an individual leaving treatment. For example, if an offender left the programme at 180hrs, the last test results available would be those obtained at 100hrs. Clearly, one might have expected some progress to have taken place in the subsequent 80 hours. There was certainly a trend towards improved scores on these scales at each stage of treatment. For example, those who completed the programme had an average SKB score above the cut-off point and were approaching this point on the Dysf scales.

As reported in other studies (e.g. Beckett et al, 1994), little improvement was observed in SSD and SO scores. The post-treatment SSD mean was still in the dysfunctional range (although at 200hrs it was approaching the cut-off point) and even more CSAs presented as "faking good" on the SO scale. The trend in SO scores to fall, may be a result of increased faking but this would not be consistent with indications of lower levels of denial post-treatment found elsewhere (see Chapter 6). It is possible that individuals genuinely experienced lower levels of sexual preoccupation and anxieties as a direct result of treatment having the effect of generally reducing stress and negative affect. This may explain the fact that fewer individuals with highly deviant scores pre-treatment exhibited such deviance post-treatment. Exactly the same pattern was observed on the Para scale, with fewer people reporting paraphilias post-treatment but also fewer people reporting abnormally high levels of paraphilias.

Marshall, Anderson and Fernandez (1999) suggests that sexual deviance could be an epiphenomenon of other social and interpersonal problems and that resolving these problems leads automatically to lower levels of deviance. Whilst this is a rather controversial statement, it does have some empirical support and it is not inconsistent with the results obtained here. Marshall and colleagues found that reductions in level of deviance as measured by phallometric assessments were observed despite the fact that group therapy had not directly addressed deviant sexual preferences. They report similar observations by Abel and Pithers (1995).

With respect to the possible importance of sexual dysfunction, Thornton (1999: personal communication) cited the results of a study suggesting that sexual dissatisfaction was a predictor of recidivism in CSAs. This suggests that the results reported here may be tentatively regarded as positive.

CONCLUSION

This part of the evaluation was largely exploratory, dealing with areas of sexual functioning somewhat neglected by the literature on sex offender treatment and evaluation. It concerned sex-related denial, deviance and dysfunction not directly targeted by most treatment programmes and targeted in a very limited way by the West Midlands Probation Service (WMPS) Sex Offender Unit (SOU) treatment programme. The general impression obtained from these results is a reduction in deviance and dysfunction and a trend towards less denial of "normal" sexual interests, i.e. positive change. Further research into these areas might clarify the role of these elements of sexual functioning in sexual offending. Should definite links be found, it will then be possible to evaluate the usefulness of targeting these areas more directly in treatment compared to the present strategy of focusing on offence-specific sexuality and denial.

CHAPTER 8: PRO-OFFENDING THINKING

INTRODUCTION

This chapter examines the impact of the SOU treatment programme on pro-offending thinking. Pro-offending thinking refers to the various kinds of cognitive distortions commonly held by sex offenders.

Cognitive distortions are self-statements which distort reality in such a way that an individual's anti-social behaviour may appear acceptable or excusable to him/herself[1] and, at times, the outside world. Such cognitions serve a similar function to denial and minimisation, in that they make an individual feel better. It is thought that these distortions both facilitate and encourage offending (Ward, Hudson and Marshall, 1995). In contrast to denial, the focus is not on whether or not the behaviour took place or to what extent the offender is aroused to the abuse, but rather whether it can be justified, was wrong, had harmful consequences, and so on.

Chapter 5 identified 2 clear factors drawn from the measures used in the current evaluation. One of these factors may be described as Pro-offending thinking since the scales are to a greater or lesser extent measuring thinking errors/distortions that are related to offending. Specifically, these scales are indices of distorted thinking and accountability. Pro-offending thinking refers to the holding of attitudes and beliefs which might serve to disinhibit (and later excuse) somebody who is motivated to sexually abuse and accountability refers to the degree to which an individual accepts responsibility for his own behaviour.

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[1] Child sexual abusers will henceforth be referred to using the pronoun "he", since the focus of the evaluation is male sex offenders.

Pro-offending thinking in child sexual abusers

Pro-offending thinking in CSAs is considered in its various forms of: global distortions about children; emotional congruence with children; poor victim empathy; lack of accountability.

Global distortions about the sexuality of children

If an individual believes that children are interested in and unharmed by sexual contact with adults, then having sexual contact with a child need not appear (to that individual) wrong. Such distortions may then serve to disinhibit the abuser. There is much evidence for the existence of global distortions about child sexuality in a section of the child sexual abuser (CSA) population (particularly those CSAs believed to be "fixated"[2] on children) and evidence of differences between levels of distortions in offenders and non-offenders (e.g. Beech, 1997/1998; Beckett, 1994; Beckett, Beech, Fisher and Fordham, 1994; Hanson, Cox, Woszczyna, 1991; Murphy, 1990) and eliminating these distortions is an important feature of sex offender treatment programmes (e.g. Ward, Hudson, Johnston and Marshall, 1997).

Emotional congruence with children

Emotional congruence with children refers to the degree to which an individual identifies with them on an emotional level. If a CSA has high levels of emotional congruence with children, he may see them as equals because he feels that he is on the same wavelength as them, that he has a special understanding of them. This allows him to interpret their behaviour in a way which suits his desires for intimacy with a child. Beckett (1994) was the first to design a measure to identify high

[2] The term "fixated" was coined by Groth and Birmbaum (1978) and Groth, Hobson and Gary (1982) to characterise paedophiles with arrested psychosexual development and a primary sexual interest in children.

emotional congruence (EC) with children and they found high levels of EC were more commonly found in extra-familial abusers and men who had abused the most victims. This fits in with Groth and Birnbaum's (1978) theory of "Fixated" and "Regressed" CSAs. They describe the former as having arrested psychological maturation, as having a preference (sexual and emotional) for children which is rooted in puberty. These individuals are seen as acting out with mental or emotional age peers. The regressed abuser, on the other hand, is thought have a sexual preference for adults but in particular situations, such as stress, and often within a family context comes to view a particular child (or children) as a surrogate adult. In support of this theory, Groth and Birnbaum quote figures which suggest that 88% of fixated abusers in their sample had never been married, compared to only 25% of the regressed CSAs. Similar theories in the literature on CSAs include: Howells (1981) "preferential" and "situational" abusers; Knight and Prentky's (1990) "high fixation" and "low fixation" abusers.

Thus, high EC appears to be a feature of those abusers who feel more comfortable with children than with adults and are less likely to have experience of long term satisfactory relationships with other adults. Beckett and colleagues (1994), however, also found abnormally low levels of EC in a subset of CSAs (mainly incestuous abusers). These individuals had very little identification of children and demonstrated little understanding of their emotional needs. Finkelhor and Lewis (1988) cite findings that a majority of a sample of fathers who had abused their children had either been absent for long periods during the child's infancy and/or had taken little part in the every day care of the child - contact which might be expected to contribute towards the parent-child bonding process. Williams and Finkelhor (1990), in a review of the characteristics of incestuous fathers suggest an impaired capacity for empathy/bonding with their children. It is suggested that low EC, whilst not strictly distorted cognitions is an absence of cognitions which might inhibit somebody from sexually abusing a child. If one doesn't identify with a group, there is less likelihood of behaving towards members of that group with understanding and consideration. It seems, then, that both abnormally high levels of EC and abnormally low levels of EC may contribute to an individual's pro-offending thinking, thus making sexual abuse

more acceptable to him. Fig. 4 (Chapter 5) illustrates the abnormal pattern of EC found in the present group of offenders, with fathers demonstrating abnormally high levels of EC and non-fathers demonstrating abnormally high levels of EC when compared to non-offenders.

Reducing high levels of EC with children and increasing very low levels of EC has not been specifically been cited as a treatment aim in the literature. However, it has been used as an outcome measure in 2 British studies. These studies looked at the effectiveness of prison (Beech et al, 1998) and community-based sex offender treatment (Beckett et al, 1994) found that emotional congruence with children was resistant to change, with no significant pre-post differences either in intra-familial or extra-familial sub-groups of offenders. This suggests that identification with children is a relatively stable characteristic and it again fits in with the idea of fixated and regressed CSAs.

Victim Empathy

The way that individuals attend to, perceive and misperceive children can extend to how they see and how they feel about child victims of sexual abuse and, in the case of CSAs, their own victims. Enhancing victim empathy is a common aim in sex offender treatment programmes because empathy is thought to be an inhibitor of sexually abusive behaviour. Bowers (1999) cite Knopp, Freeman-Longo, and Stevenson's (1992) study which found that 94% of sex offender programmes in the USA included the development of empathy in their list of objectives. It has been found that, whilst there is little or no evidence to suggest general deficits in empathy, untreated CSAs have little or no empathy for their own victims and frequently victims of sexual abuse in general (e.g. Hudson et al, 1993; Marshall et al, 1994; Beech, Fisher and Beckett, 1999; Bowers, 1999). Someone who has little or no victim empathy will often have difficulty appreciating a victim's perspective of abuse - understanding how a victim might feel, the reasons why children might not resist or disclose the abuse, the consequences of sexual abuse to a child, i.e. poor victim awareness. Hanson and Scott

(1995) found perspective-taking deficits (in relation to victims of sexual abuse) in sex offenders were significantly higher than in comparison subjects, although deficits were most severe in those who had not used overt violence and were not intoxicated during the abuse. Clearly, some cognitive understanding of the victim experience is needed before an individual can be expected to feel compassion and (if the victim in question is specific to the abuser) remorse, i.e. empathise with their own victim and with others.

Whilst the literature on CSAs has tended to focus on the attitudes of offenders to children and to their own victims, there is also evidence that they hold stereotypical attitudes towards women and subscribe to the kinds of beliefs that excuse the rape and maltreatment of women (e.g. Brownmiller, 1975). There have also been suggested links between rape myth acceptance and interpersonal violence and it is known that some sex offenders have multiple paraphilias (Abel, Mittleman & Becker, 1985; Kaplan, Abel, Cunninham-Rathner & Mittleman, 1990). It is believed, then, that poor victim empathy may not be confined to children. Indeed, recent research has been cited (Thornton: personal communication) which suggests that not only do some CSAs have high levels of EC with children but that they have low levels of EC with adult women. One of the aims of treatment is to reduce the stereotyping of women by sex offenders and to encourage positive interpersonal relations with adults.

Accountability

Pro-offending thinking can make it easier for somebody who is aroused to children to abuse. Once the abuse has occurred, it may serve to justify behaviour that either the abuser or the outside world sees as wrong. In this way the abuser does not feel that he is entirely responsible for his actions. He can blame his victim for being seductive, provocative or acting older than his/her age or he can justify behaviour which he understands to be wrong by blaming drink, drugs, stress or lack of understanding from his partner, for example. This externalisation of blame for the abuse (also seen in poor victim empathy) is commonly found in untreated sex offenders and treatment programmes aim to eradicate such distortions (e.g. Beech et al, 1998; McClurg,

Craissati and Wiseman, 1994/1995; Elliot, Browne and Kilkoyne, 1995 Marques, Nelson, West and Day, 1994). Some individuals not only lack accountability for actions connected with sexually abusive behaviour, but seem to have difficulty accepting responsibility for anything in their lives (Beech et al, 1999; Graham, 1993). Such people may adopt a "victim stance" which is founded on distortions rooted in childhood. They believe, for example, that life has treated them badly and that they are constantly misrepresented and misunderstood. Such beliefs are entrenched and may impede the capacity for somebody to take responsibility for specific behaviours because this would challenge his whole conceptualisation of himself and the world around him. Unless an abuser accepts responsibility for his actions, there is little likelihood of developing victim empathy. Indeed, the presence of this type of distortion has been found to predict treatment outcome, with initially low levels of distortion predicting positive outcome (e.g. Simkins et al, 1989). There is also evidence for the persistence of this tendency to see oneself as a victim (i.e. having an externalised locus of control), some studies showing little treatment effect in many programmes (e.g. Beech et al, 1999; Beckett, Beech, Fisher and Fordham, 1994; Simkins et al, 1989).

Rationale and hypotheses

Rationale

As reported in Chapter 5, the pre-treatment CSAs in this study demonstrated abnormally high levels of pro-offending thinking. They obtained deviant scores on all measures of pro-offending thinking for which normative data were available. On scales of accountability, they obtained scores in dysfunctional ranges. Clearly then, levels of pro-offending thinking are higher than is acceptable at the 0hrs stage. The purpose of this part of the study is to discover whether the Sex Offender Unit (SOU) treatment programme is effective in reducing pro-offending thinking.

There is evidence that treatment can be effective in reducing cognitive distortions and increasing accountability (e.g. Marshall and Serran, 2000; Marshall, Anderson and

Fernandez, 1999; Beech et al, 1998) and it is expected that a comparison of pre and post treatment scores will confirm positive treatment impact on the Pro-offending thinking factor. Another finding from the treatment literature is not only that treatment can be effective in reducing pro-offending thinking, but that longer programmes appear to be more effective than shorter programmes (e.g. Beech et al, 1998). Thus, it is predicted that improvement in levels of pro-offending thinking and accountability will be seen at various stages of the treatment process with CSAs displaying fewer distortions the longer they spend in treatment.

In-treatment success implies a reduction in deviance. Frequencies of "functional" and "dysfunctional" scores on measures of Pro-offending thinking are obtained prior to and post treatment in order to examine individual progress.

Hypotheses

1. It is hypothesised that child sexual abusers will demonstrate significant and positive in-treatment change on measures of pro-offending thinking when pre and post scores are compared.
2. It is hypothesised that reduction in levels of pro-offending thinking will be a function of time spent in treatment - the longer the period in treatment, the lower the levels of pro-offending thinking.

METHODOLOGY

The methodology of this study is described fully in Chapter 3. However, it has been summarised below.

Design and Procedure

The measures employed to assess levels of Pro-offending thinking were administered alongside other evaluation measures at: 0hrs (prior to treatment); 50hrs (post-assessment); 100hrs (mid-treatment); 200hrs (end-treatment). Post-treatment results are obtained by obtaining questionnaire results from the point at which an individual was last tested (i.e. at 50hrs, 100hrs or 200hrs, depending on time spent in treatment).

Samples

The 126 child sexual abusers who took part in this study consisted of all eligible (see chapter 3) CSAs entering the SOU treatment programme within a 24 month period. Demographic data on this sample are described in Chapter 4.

A number of sex offenders in this sample did not complete the treatment programme. Full details of non-completers are given in Chapter 3. However, the figures are summarised here: Before 50hrs test administration, 27 CSAs left the programme. A further 36 dropped out between 50hrs and 100hrs. Between 100hrs and 200hrs only 24 left. Because of the CSAs leaving the programme, sample numbers become progressively lower at test administrations. Details are as follows. At 0hrs n=127, at 50hrs n=99, at 100hrs n=63 and at 200hrs (n=27). Whilst 39 (not 27) of the sample actually completed the programme, data collection in the form of test administration ceased before this time.

Measures

The measures and scales used here assess pro-offending thinking. They are described in detail in chapter 3. However they are listed along with a summary of their purpose and content below:

- ***The Kids and Sex (K & S) Cognitive Distortions (CD) scale (Beckett and Fisher, 1993)*** assesses the extent to which the respondent perceives children to be sexually sophisticated, interested in sexual contact with adults and unharmed by such contact. At 0hrs the mean CD score of this sample of CSAs was 17.75 (sd=11.15) - within the normal range but higher than the non-offender average of 13.1 (sd=8.8).

- ***The K & S Emotional Congruence with Children (EC) scale*** assesses emotional identification with children and an individual's perceptions of how well he understands and gets on with them. High levels of EC with children denote an emotional dependence on them, a belief in the existence of a "special" relationship and suggest immaturity and difficulties in relating to adults. On the other hand, very low levels of EC with children may indicate lack of interest in or concern for their emotional well being. At 0hrs the mean EC score of this sample did not differ from that of non-offenders. However, when the sample was divided into fathers and non-fathers, it was found that fathers obtained a mean score of 16.44(10.93), which was significantly lower than non-offenders. In contrast, non-fathers obtained a mean of 21.35 (sd=14.04), which was significantly higher than non-offenders.

- ***The Multiphasic Sex Inventory (MSI) Cognitive Distortions and Immaturity (CDI) scale (Nichols & Molinder, 1984)*** measures self-accountability by assessing early childhood cognitive distortions which have remained with the sex offender. It is a characterological scale and, perhaps more than anything, is a measure of the "victim stance" - the tendency to feel that most of society is unjust and uncaring, particularly towards the offender. Somebody with a high CDI score, in all likelihood, feels that he is a victim rather than the criminal. The pre-treatment CSAs in this sample obtained a mean CDI score of 6.56(3.32), which falls outside of the range (0-3) which would indicate a capacity to accept accountability.

- ***The MSI Justifications (Ju) scale*** is another measure of accountability. However, the kinds of distortions assessed here are not characterological - rather they seek to justify the abuse. The excuses used range from blaming drink, stress, or a poor relationship to blaming the victim. At 0hrs this sample of CSAs obtained a mean score of 4.56(3.76), outside of the functional range of 0-1.

- ***Rape Myth Acceptance Scale (Burt, 1980)*** measures the tendency of an individual to subscribe to myths which are tolerant of rape (particularly towards women) and are victim blaming. Whilst no appropriate normative data were available for comparison, the CSAs in this study did present with distortions at 0hrs.

- ***The Victim Awareness (VA) Questionnaire (Allam, 1994a)*** examines the cognitive aspects of victim awareness - understanding emotional expression, perceiving how another might be thinking and feeling, understanding what constitutes appropriate behaviour towards children. The development of this questionnaire is described fully in appendix 3.6.2. The mean pre-treatment score for the CSAs in this sample was 48.74 (sd=29.9), which was significantly higher than that of non-offenders.

Treatment of data

Means and standard deviations were obtained for scores on all Pro-offending thinking measures at each point in treatment - 0hrs, 50hrs, 100hrs and 200hrs.

In order to establish whether there was any overall pre/post treatment movement, means and standard deviations of Pro-offending thinking measures were obtained for individuals' final set of tests before leaving the programme - at either 50hrs, 100hrs or 200hrs. Pre/post treatment scores on the Pro-offending thinking factor were then compared by means of repeated measures Multiple Analyses of Variance (MANOVAS: SPSS, 1992) which looked at within subjects effects. Univariate tests

were then examined to identify movement on individual factor measures.

MANOVAS were then conducted on the Pro-offending thinking factor to examine treatment impact between the different stages of treatment - 0-50hrs, 50-100hrs, and 100-200hrs. Univariate test results were then examined to identify any in-treatment change in individual scale scores.

Finally, frequencies of "dysfunctional" and "functional" scores were obtained for 0hrs and post-treatment in order to ascertain whether CSAs were more likely to be scoring within a functional range by the time they left treatment than they were prior to treatment.

RESULTS

In-treatment changes in pro-offending thinking

In-treatment changes were investigated on all mesures of Pro-offending thinking. Pre/post treatment comparisons were first made, followed by an exploration of movement between specific points in treatment.

Overall pre/post change

It was expected that CSAs would demonstrate significantly lower levels of Pro-offending thinking post-treatment than they were at 0hrs. In order to examine this movement, a repeated measures MANOVA was conducted on the Pro-offending thinking factor pre and post scores. There was a highly significant reduction in overall levels of Pro-offending thinking post -treatment ($p<.001$, $f=19.53$, $df=6,93$, 1-tailed). Thus, hypothesis 1 that CSAs would demonstrate significantly less pro-offending thinking post-treatment is accepted. Univariate tests revealed significant movement on all measures other than that of EC. Table 8.1 illustrates this movement.

Table 8.1: Univariate tests of pre/post change on measures of pro-offending thinking (n=99)

Scale	Pre-treatment mean and sd	Post-treatment mean and sd	Value of f
Cognitive Distortions and Immaturity (CDI)	6.43 (3.28)	5.05 (3.28)	17.79 ***
Justifications (Ju)	4.47 (3.73)	2.88 (3.54)	16.73***
Cognitive Distortions (CD)	17.69 (11.58)	9.41 (9.09)	72.85***
Emotional Congruence (EC)	17.3 (11.87)	14.69 (11.86)	2.7 ns
Victim Awareness (VA)	47.48 (31.33)	26.25 (23.03)	54.35***
Rape Myth Acceptance (RMA)	49.96 (19.37)	41.74 (19.24)	32.09***

*** p<.001, 2-tailed

In order to establish whether or not levels of EC had improved (i.e. were lower in high scorers and higher in low scorers), CSAs who had obtained a 0hrs EC score which was more than 1sd above the mean (n=12) were identified. Also, low scorers (i.e. more than 1 sd above the mean were identified (n=32). Dependent t-tests were conducted on pre/post measures of EC. At 0hrs the mean score for high scorers was 37.5 (sd=7.04). By the time they left the programme, high scorers were obtaining a mean of 26.83 (sd=13.45). This improvement was significant at p<.05 (t=2.61, df=11, 2-tailed). Similarly, a dependent t-test revealed that abnormally low scorers also showed significant improvement during treatment. At 0hrs, the mean EC score in this group was 5.0 (sd=3.52). This rose to 8.25 (sd=8.32) during the course of treatment, a difference which was significant (p<05, t=-.218, df=33, 2-tailed).

Impact of different treatment stages on pro-offending thinking

In order to identify change at different stages of the treatment programme, repeated

measures MANOVAS were carried out to compare Pro-offending thinking factor scores between: 0-50hrs, 50-100hrs and 100-200hrs.

Pre-treatment to post-assessment (0 - 50hrs)

A repeated measures MANOVA conducted on the Pro-offending thinking factor with 0-50hrs change as the within-subjects factor found a significant overall decrease in distortions associated with pro-offending thinking between 0hrs and 50hrs ($p<.001, f=13.5, df=5,94$). The results of univariate tests are presented in table 8.2. It may be seen that significant movement occurred in the expected direction on all measures except the Emotional Congruence scale.

Table 8.2: Univariate tests of 0-50hrs change on measures of pro-offending thinking (n=99)

Scale	Pre-treatment mean and sd	Post-treatment mean and sd	Value of f
Cognitive Distortions and Immaturity (CDI)	6.43 *(3.28)*	5.49 *(3.5)*	11.88***
Justifications (Ju)	4.47 *(3.73)*	3.45 *(3.7)*	8.28**
Cognitive Distortions (CD)	17.69 *(11.58)*	12.59 *(9.61)*	32.7***
Emotional Congruence (EC)	17.3 *(11.87)*	16.72 *(12.74)*	0.3 ns
Victim Awareness (VA)	47.48 *(31.33)*	32.68 *(24.11)*	33.72***
Rape Myth Acceptance (RMA)	49.96 (19.37)	39.01 *(15.82)*	33.52***

** $p<.01$, 2-tailed

*** $p<.001$ 2-tailed

When 0-50hrs EC was considered in high scorers (n=12) and low scorers (n=32),

mean scores indicated that improvements had taken place. High scorers obtained a mean of 37.5 (sd=7.04) at 0hrs and by 50hrs this had fallen to 33.67 (sd=12.61). However, a dependent t-test showed that this improvement was significant (p>.05, t=1.47, df=11,1-tailed). The scores of low scorers also improved, rising from a 0hrs mean of 5.0 (3.52) to 8.16 (sd=7.44). This increase in EC was significant at p<.05 (t=-2.32, df=31, 1-tailed).

Post-assessment to mid-treatment (50 - 100hrs)

A repeated measures MANOVA conducted on the Pro-offending thinking factor with 50-100hrs change as the within-subjects factor found a significant overall change between 50hrs and 100hrs (p<.005, F=3.78, df=5,58, 1-tailed). The results of univariate tests are presented in table 8.3, where it may be seen that a significant reduction in pro-offending thinking was observed in four of the six measures.

Table 8.3: Univariate tests of 50-100hrs change on measures of pro-offending thinking (n=63)

Scale	Pre-treatment mean and sd	Post-treatment mean and sd	Value of f
Cognitive Distortions and Immaturity (CDI)	6.22 *(3.32)*	5.83 *(3.28)*	1.69 ns
Justifications (Ju)	3.46 *(3.58)*	2.94 *(3.51)*	2.84*
Cognitive Distortions (CD)	13.63 *(10.22)*	9.03 *(9.37)*	20.08***
Emotional Congruence (EC)	18.37 *(12.59)*	16.27 *(12.58)*	3.43*
Victim Awareness (VA)	37.67 *(27.64)*	30.7 *(24.09)*	10.06***
Rape Myth Acceptance (RMA)	39.37 *(16.77)*	36.97 *(14.89)*	2.37 ns

* p<.05, 1-tailed

*** p<.001, 1-tailed

When EC scores were examined with respect to high (n=10) and low (n=17) scorers, significant improvements were observed in high scorers. At 50hrs high scorers obtained a mean of 33.2 (sd=13.81) and this had fallen to 26.6 (sd=14.47) by 100hrs. A dependent t-test showed this to be significant at $p<.05$ (t=2.0, df=9, 1-tailed). Low scorers showed very little improvement over this time with a mean EC score of 8.29 (sd=7.99) at 50hrs and a mean of 8.41 (sd=10.31) at 100hrs. A dependent t-test confirmed that this change was not significant ($p>.05$, t=-.05, df=16, 1-tailed).

Mid-treatment to end of treatment (100-200hrs)

A repeated measures MANOVA conducted on the Pro-offending thinking factor with 100-200hrs change as the within-subjects factor did not find a significant overall change between 100hrs and 200hrs (f=2.58, df=5,22). The results of univariate tests are presented in table 8.4. Whilst there was a general trend towards fewer distortions, results were significant on only two of the measures - Cognitive Distortions (about child sexuality) and Victim Awareness.

When EC scores were examined with respect to high (n=5) and low (n=6) scorers, no significant improvements was observed in either. There was a trend towards CSAs with high levels of EC to improve between 100hrs and 200hrs. At 100hrs the mean score was 24.4 (sd=18.64) and this had dropped to 21.2 (sd=17.25) by the end of treatment. This trend was not significant, however ($p>.05$, t=0.35, df=4, 1-tailed). The same pattern was observed in low scorers. This sample were scoring 8.29 (sd=7.88) at 100hrs and 8.37 (sd=3.44) at 200hrs. Again, this improvement was not found to be significant ($p>.05$, t=-.04, df=5, 1-tailed).

Table 8.4: Univariate tests of 100-200hrs change on measures of pro-offending thinking (n=27)

Scale	Pre-treatment mean and sd	Post-treatment mean and sd	Value of f
Cognitive Distortions and Immaturity (CDI)	5.0 *(3.06)*	4.3 *(2.22)*	1.16 ns
Justifications (Ju)	2.26 *(3.54)*	1.37 *(2.65)*	1.49 ns
Cognitive Distortions (CD)	7.52 *(7.21)*	6.63 *(7.44)*	4.96*
Emotional Congruence (EC)	15.44 (12.66)	12.89 *(9.35)*	0.56 ns
Victim Awareness (VA)	28.44 *(20.02)*	17.48 *(15.01)*	13.2***
Rape Myth Acceptance (RMA)	35.05 *(13.59)*	33.83 *(18.73)*	0.19 ns

* P<.05, 2-tailed

*** p<.001, 2-tailed

The above analyses demonstrate that level of improvement in pro-offending thinking is a function of time spent in treatment. There was a trend towards fewer cognitive distortions at each treatment interval. Between 100 and 200hrs this trend was not significant. However, at least between 0hrs and 100hrs, it is clear that reductions in pro-offending thinking are a function of time spent in treatment as postulated in hypothesis 2.

In-treatment change in individuals

In order to look at individual progress between pre and post treatment, frequencies of "functional" and "dysfunctional" scores on measures of Pro-offending thinking were obtained for both points in time. "Dysfunctional" refers to scores falling outside of acceptable ranges. Table 8.5 illustrates the cut-off points and ranges for Pro-offending thinking scales.

Table 8.5: Cut-off points and score ranges identifying "dysfunctional" scores on measures of pro-offending thinking

Scale	Dysfunctional score ranges
Cognitive Distortions and Immaturity (CDI)	4 or higher (i.e. in the cognitive distortions/immaturity or "victim stance" range
Justifications (Ju)	2 or higher (i.e. in the "Justifies sexual deviance" to the severe lack of accountability range
Cognitive Distortions (CD)	21 or higher, which is one standard deviation above the mean
Emotional Congruence (EC)	*Non-fathers*: 26 or higher or lower than 6 *Fathers*: 35 or higher or lower than 12
Victim Awareness (VA)	64 or higher (one standard deviation above the mean)
Rape Myth Acceptance (RMA)	50 or higher (because there are no normative data, this figure is slightly above the 0hrs average)

In order to examine the incidence of "dysfunctional" and "functional" score ranges, score range frequencies were obtained for each scale pre and post treatment. Table 8.6 illustrates the percentages of individuals obtaining "functional" scores at 0hrs and on leaving the programme.

Table 8.6: A comparison of the proportion of CSAs scoring within "functional" ranges pre and post treatment (n=99)

Scale	% functional scores Pre-treatment	% functional scores Post-treatment
Cognitive Distortions and Immaturity (CDI)	n=17 (17.17%)	n=34 (34.3%)
Justifications (Ju)	n=23 (23.5)	n=52 (52.5%)
Cognitive Distortions (CD)	n=65 (65.7%)	n=90 (90.9%)
Emotional Congruence (EC)	n=55 (55.6%)	n=37 (37.4%) r
Victim Awareness (VA)	n=65 (65.66%)	n=88 (88.9%)
Rape Myth Acceptance (RMA)	n=58 (58.9%)	n=75 (75.6%)

r change was not in the expected direction

Table 8.6 shows that individuals demonstrate improvement in all measures within the pro-offending thinking factor (with the exception of EC). A number of the scales show important improvements in the numbers of CSAs scoring in acceptable ranges by the time they leave treatment (the CDI and Ju scales, for example). By the time they leave the programme, a majority of offenders are obtaining scores within functional ranges on scales measuring victim awareness, cognitive distortions about child sexuality and attitudes supportive of rape. Whilst the proportion of individuals obtaining acceptable EC scores fell rather than improved, the majority of dysfunctional scores were in the low EC ranges rather than the high score ranges.

DISCUSSION

Hypothesis 1 predicted that there would be a significant reduction in pro-offending thinking post-treatment. This was found to be the case with CSAs demonstrating: more accountability for their offending; fewer global distortions about child sexuality;

less distorted attitudes towards adult female victims of rape and fewer distortions about child victims of sexual abuse. In addition, those who obtained abnormally high EC scores were found to have lower levels of EC post-treatment, whilst those with abnormally low levels of EC appeared to identify more with children than they had at 0hrs.

It was also postulated, in hypothesis 2, that in-treatment progress in pro-offending thinking and accountability would be a function of time spent in treatment. Indeed, it was discovered that the longer someone spent on the programme, the lower the levels of pro-offending thinking. Although between 100hrs and 200hrs there was no overall significant change, the trend towards fewer cognitive distortions and improved accountability was evident.

Finally, it was expected that fewer individuals would be obtaining "dysfunctional" scores on leaving treatment than pre-treatment. This was found to be the case for each measure of pro-offending thinking and accountability, other than that of EC. Indeed the trend was reversed in low EC scorers, with more individuals having abnormally low EC with children post-treatment than pre-treatment.

Implications

It has been found that levels of Pro-offending thinking fell significantly as a result of treatment. In this study, as in others (e.g. Beech et al, 1998) scores became progressively less deviant over time, suggesting that the longer an individual spends in treatment, the more likely he is to achieve the goal of low levels of pro-offending thinking and high levels of accountability. Treatment had the effect of: reducing global distortions about the sexuality of children; increasing awareness of the experience of child and adult female victims of sexual abuse; increasing accountability - both in general and in relation to offences; reducing the numbers of highly deviant scorers on all measures. This suggests that treatment has done what it set out to do in terms of in-treatment change in pro-offending thinking. If it is accepted that such

distortions provide an individual with less incentive to avoid further offending (as suggested by Murphy, 1990), it is also true that eliminating such distortions paves the way for the development of relapse prevention skills.

Some aspects of pro-offending thinking and accountability, however, were somewhat more resistant to change or changed in directions which were not expected. Although Cognitive Distortions/Immaturity (CDI) scores fell over time (significantly between 0 and 50hrs), the changes in means were modest (as has been found in other studies reported above). Given that CDI is associated with an externalised locus of control and other indicators of more stable deficits as well as high deviance (e.g. Beech et al, 1999), little change in this area is disappointing and may require further investigation. Despite little change in mean scores over time, on leaving the programme over half of the highly deviant scorers were obtaining scores within functional ranges on the CDI scale. This suggests that treatment had a significant impact on a majority of those who most needed to change.

Whilst significantly fewer offenders left treatment with abnormally high EC scores than prior to commencement of the programme (unlike those reported by Beech et al, 1999, and Beckett et al, 1994) significantly more left treatment with abnormally low levels of EC. High levels of EC are associated with higher deviance, so these results are encouraging. However, we know little about how low levels of emotional congruence with children might influence likelihood of abusing a child. Low EC with children tends to be a feature of lower risk (frequently intra-familial) abusers who are thought to have little emotional connection with children and are thus able to objectify them (Beckett et al, 1994). More research in this area might clarify the function of low EC and whether or not it is an important factor in offending behaviour. Interestingly, EC with children is not a direct target in the treatment of CSAs on the SOU programme. However, it is possible that the social skills and gender and sexuality modules have an effect on how CSAs relate to other adults and thus to children.

CONCLUSION

This study examined the effectiveness of the Sex Offender Unit treatment programme in reducing cognitive distortions in a sample of child sexual abusers. Treatment was found to be effective in increasing accountability and in lowering levels of pro-offending thinking, thus attaining its goals. It was also found to be effective in significantly reducing the proportion of highly deviant scorers.

Progress occurred during all stages of the treatment programme. However, much improvement was evident in the first 50hrs (the assessment period) and progress slowed somewhat after this time. It may be that some distortions or ways of seeing the world are more entrenched than others and take longer to eradicate, whilst others are relatively superficial and can be dealt with in a shorter time frame. Further investigation of the more entrenched distortions may help to clarify how they differ from more superficial thinking errors and thus aid the process of working to eradicate them on treatment programmes.

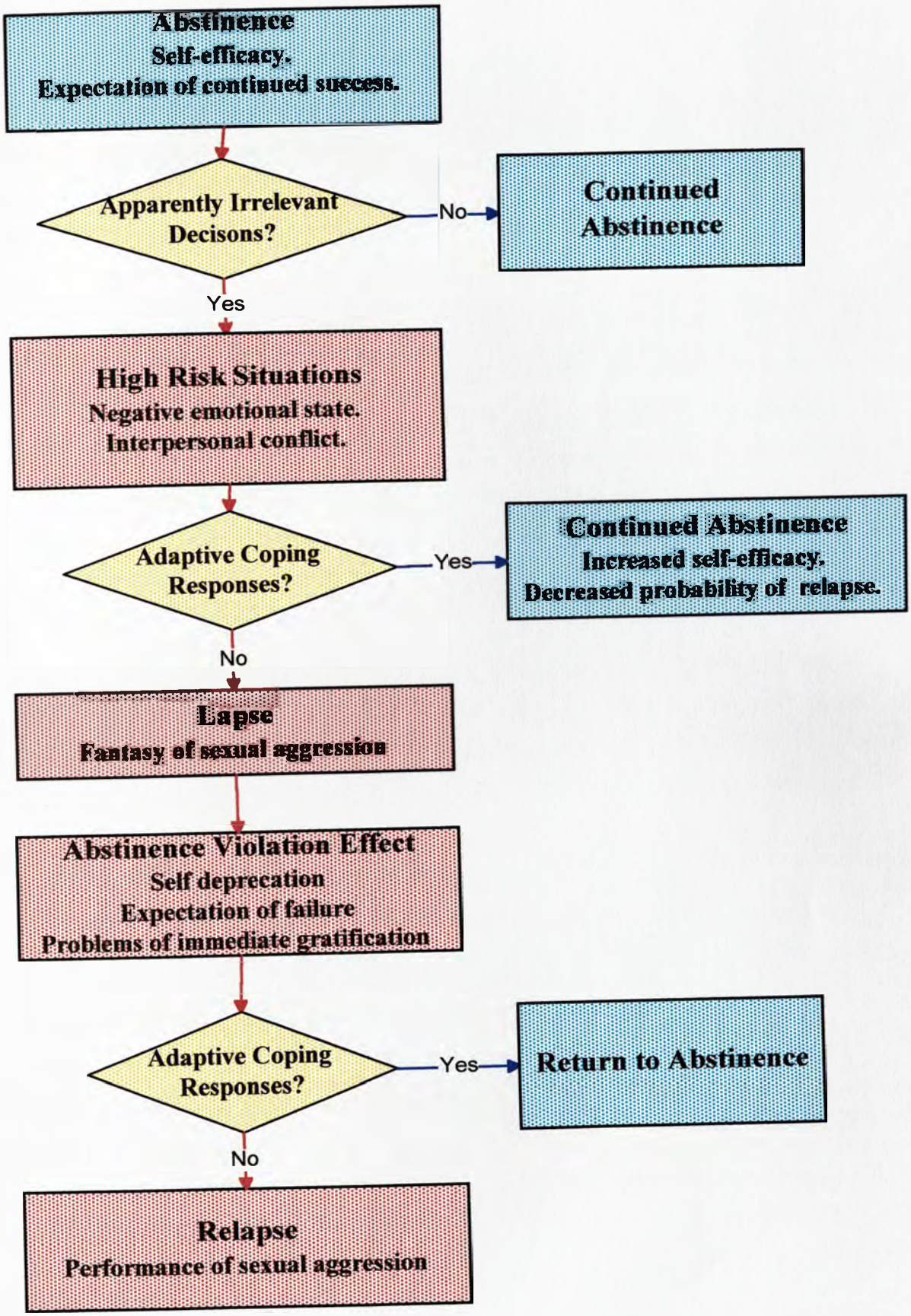
CHAPTER 9: RELAPSE PREVENTION AND RISK AWARENESS

INTRODUCTION

The concept of relapse prevention - the "self-control approach" - was originally developed for addictive disorders. After their 1980 study which found that relapse associated with substance disorders appeared not to discriminate across substances, regardless of supposed level of "addictiveness", Marlatt and Gordon proposed common behavioural and cognitive components associated with relapse unconnected to the "addictive substance" involved. On analysis of initial relapses of alcoholics, smokers, heroin addicts, compulsive gamblers and compulsive eaters that 3 high-risk situations were the primary determinants of over two thirds of the relapses. These situations were: negative emotional states; interpersonal conflict; social pressure. Marlatt (1982) then went on to devise an intervention model - Relapse Prevention (RP) - designed to enhance maintenance of change of compulsive behaviours by providing individuals with methods for: understanding the processes of lapse (i.e. behaviours and thoughts which might precede a relapse) and relapse (actual reoffending); identifying problematic situations; recognising decisions that set up relapse situations; coping effectively with high risk situations. Pithers, Marques, Gibat and Marlatt (1983) modified the RP model for use with sex offenders (see Fig. 5).

Pithers, Buell, Kashima, Cumming and Beal (1987) analysed precursors to the offences of a sample of 136 child sexual abusers and 64 rapists and discovered that there was frequently a common sequence of changes leading to offending. This tended to begin with negative affective states, followed by deviant sexual fantasies, followed by cognitive distortions (rationalisations, for example), passive planning accompanied by masturbatory fantasies, followed by relapse. This lent support to the use of a relapse prevention model with sex offenders and reinforced the idea of sex offending as something which could be controlled rather than "cured".

Figure 5: Cognitive-behavioural model of relapse (From Pithers et al, 1988)



Relapse Prevention in the Treatment of Sex Offenders

Relapse Prevention (RP) work forms an integral part of most cognitive-behavioural sex offender treatment programmes. Since it is based on the idea that the offender is responsible for his own behaviour, specific (tailored to individuals) RP work on the SOU programme tends to be done later on in treatment in order that it is not attempted before an individual has: accepted responsibility for his actions; acknowledged deviant sexual arousal; worked on and eradicated the cognitive distortions he had which helped give him permission to offend; developed some victim empathy; developed problem solving /coping skills. It is felt necessary to do considerable work in these areas before attempting to do detailed RP work with offenders because the model requires that an individual is motivated to change. Motivation to change is not necessarily a feature of CSAs mandated to attend a programme and, whilst disinhibitors such as cognitive distortions about the victim are in place, offenders cannot accept full responsibility for the abusive behaviour and thus their own responsibility for controlling it.

The SOU relapse prevention module generally takes place over 10 weeks (25 hours). Sessions and exercises include: introducing the concepts of lapse and relapse and the decisions involved before either can occur; identifying personal high risk moods and situations; developing behavioural strategies to deal with these risky situations; developing cognitive strategies to deal with high risk situations; developing lifestyle rules in order to maintain change (see Appendix 2.3).

Relapse Prevention Skills as an Indicator of Treatment Success

Marques, Nelson, West, and Day (1994) found the ability of child sexual abusers to apply the relapse prevention model (introduced as part of a treatment programme) was the strongest in-treatment predictor of future success, i.e. highly skilled CSAs were less likely to be reconvicted for sexual offences. This seems to support the utility of the model. Unfortunately, there are few studies which directly relate in-treatment

changes such as this to subsequent reoffending.

Evaluation of in-treatment change using objective measurements is still in its infancy. However, 3 British studies have reported results which include material relevant to relapse prevention. Procter (1993) found that an intensive 2-week sex offender treatment programme (which included RP work) did not result in CSAs changing their perceptions of their own risk - indeed they continued to view themselves as being at low risk of reoffending. Beckett et al (1994), in their evaluation of 7 treatment programmes, also failed to find significant differences in perceived level of risk following treatment. In addition, when they administered a pre-post relapse prevention questionnaire (which covered both issues of awareness and insight as well as strategies for preventing relapse), they found no significant improvement in RP scores. Indeed, very few individuals were able to describe RP strategies and to recognise their risk situations. Beech, Fisher, Beckett and Scott-Fordham (1998), however, do report significant improvement in RP skills in their evaluation of the prison sex offender treatment programme. The evidence for the effectiveness of relapse prevention training is therefore mixed. Clearly, if RP skills are correlated strongly with reoffending, the failure of some programmes to ensure that offenders leave with an adequate grasp of their own relapse prevention plan is very worrying.

An Alternative Model of the Relapse Process

The fact that recent evaluations of several programmes have failed to find significant improvement in RP skills suggests that one of the following is the case: programmes are not conducting RP training effectively; the RP model as it stands is not applicable to all offenders. Whilst it is possible that the RP work done with sex offenders is not of good quality (or is simply lacking), there is evidence that other aspects of sex offender treatment is effective (e.g. Beech, Fisher, Beckett & Scott-Fordham, 1998; Beckett et al, 1994).

In 1995, Ward, Louden, Hudson & Marshall proposed a "Self-Regulation Model of

the Relapse Process" (revised by Ward and Hudson, 1997) - an extensive re-working of the cognitive-behavioural model of the relapse process described above. The model is rather more complex than the traditional RP model, since it proposes 4 pathways to relapse (in contrast to only one), depending on the cognitive and behavioural styles of individual offenders. In this way it can take into account the fact that: some individuals are impulsive and lack inhibitions; some lack coping and problem solving skills (traditional RP model); some have inappropriate coping strategies; some are simply not motivated to change their behaviour. Whilst the model is very new and needs to be tested out in the context of work with sex offenders, it might account for the fact that so many treated offenders leave programmes apparently lacking RP skills.

Rationale and Hypotheses

Rationale

Whilst there is mixed evidence to support the view that relapse prevention skills improve as a result of treatment and whilst a model has been proposed which suggests that the cognitive-behavioural relapse prevention model is inadequate, some improvement in RP skills is expected here. The SOU programme is longer than the majority of those reported in evaluation studies and therefore is likely to spend more time on RP work. In addition, even if the model proposed by Ward et al (1995, 1997) is a more accurate model of relapse, it does assume that a proportion of offenders will follow the path to relapse covered in the traditional model.

It is hypothesised that there will be significant pre/post treatment progress on the measure of perception of risk. Since the most intensive RP work is more likely to take place later on in the treatment programme, it is hypothesised that significant improvements in RP skills will take place between 100 and 200hrs. No predictions, are made about progress at other stages in treatment, although exploratory analyses will examine change at different points in the treatment process.

Hypotheses

1. It is hypothesised that perception of risk will be significantly more realistic post-treatment when compared to pre-treatment, with CSAs better able at post-treatment to identify themselves as being at some risk of reoffending.

2. It is hypothesised that CSAs will have significantly better RP skills (as indicated by the total score on the RP questionnaire) at 200hrs (end of treatment) when compared to the mid-treatment (100hrs) stage.

METHODOLOGY

The methodology of this study is described fully in Chapter 3. However, it has been summarised below.

Design and Procedure

The design and procedure of the evaluation study are fully explained in Chapter 3. However, there is a slight difference in procedure here from that used with other measures. Whilst the perception of risk (Sex Offence Attitudes Questionnaire Risk sub-scale) measure was administered at all stages (0hrs, 50hrs, 100hrs and 200hrs), the Relapse Prevention (RP) questionnaire (see Appendix 3.8) was not administered at 0hrs due to the inaccessibility of its content to pre-treatment sex offenders.

Samples

The 126 child sexual abusers who took part in this study consisted of all eligible (see chapter 3) CSAs entering the SOU treatment programme within a 24 month period. Demographic data on this sample are described in Chapter 4.

A number of sex offenders in this sample did not complete the treatment programme. Full details of non-completers are given in Chapter 3. However, the figures are summarised here: Before 50hrs test administration, 27 CSAs had left the programme. A further 36 dropped out between 50hrs and 100hrs. Between 100hrs and 200hrs only 24 left.

Because of the CSAs leaving the programme, sample numbers become progressively lower at test administrations. Details are as follows: at 50hrs n=99, at 100hrs n=63 and at 200hrs, n=27. Whilst 39 (not 27) of the sample actually completed the programme, data collection in the form of test administration ceased before this time.

Measures

The measures reported here have been describe in chapter 3 and are listed and summarised below:

- ***The Sex Offence Attitudes Questionnaire (SOAQ) Risk Sub-Scale (Procter, 1994)*** measures the tendency of an individual to deny that he is at risk of committing new offences. The higher the score, the more he denies any risk. At 0hrs the mean SOAQR score was 34.54(7.67). The minimum score is 9 and the maximum is 45. This sample of CSAs was therefore very high in denial at the pre-treatment stage.

- ***The Relapse Prevention (RP) Questionnaire (Allam, 1994b)*** contains 2 sub-scales - Insight (RPI) and Strategies (RPS). The RPI sub-scale assesses and individual's insight into his own offending and his understanding of future risk. The RPS scale measures ability to identify appropriate strategies for dealing with potentially risky situations.

Treatment of data

Means and standard deviations for each scale were calculated for each stage of treatment. Following this, dependent t-tests were conducted in order to identify significant changes in perception of risk and in RP skills between test administrations. In the case of the SOAQ Risk scale the following comparisons were made: 0hrs and 50hrs; 50hrs and 100hrs; 100hrs and 200hrs; 0hrs and post-treatment. In the case of the RP questionnaire scales comparisons were made between mean scores at: 50hrs and 100hrs; 100hrs and 200hrs.

Frequency data were collected to ascertain the proportion of individuals who had improved their relapse prevention skills (including perception of risk) during treatment by one standard deviation or more. It should be noted that 0hrs scores are not available for the RP questionnaire and that, since change is being measured, only those who also completed 100hrs tests (n=63) have been included in the frequencies relating to this questionnaire.

RESULTS

Treatment impact on perception of risk

The pre-treatment perception of risk (maximum score of 45, minimum score of 9) score for the 99 CSAs who completed more than one set of assessments was 34.27 (sd= 7.68). Post-treatment the mean was 30.92 (sd=7.4). This difference was highly significant ($p<.001$, $t=4.75$, $df=98$, 1-tailed) and supports hypothesis one which postulated significant improvement in CSAs' perception of their own risk.

Dependent t-tests also revealed significant differences in perception of risk between the various stages of treatment (see Table 9.1). Between 0hrs and 50hrs denial of risk reduced. The 0hrs mean of 34.54 (sd=7.67) compared to a 50hrs mean of 30.76 (sd=8.26) and the difference was found to be significant at $p<.01$($t=5.24$, $df=98$, 2-

tailed). Between 50hrs and 100hrs scores changed little, with a 50hrs mean of 29 (sd=8.03) compared to 29.49 (sd=7.05). No significant differences were found between these scores (t=-.66, df=61, 2-tailed). Average scores at 100hrs and 200hrs were identical at 29.15, with a standard deviation of 6.4 at 100hrs and 5.27 at 200hrs.

Table 9.1: Treatment impact on perception of risk

Stage	Time 1 mean and sd	Time 2 mean and sd	one-tailed p value
0-50hrs (n=99)	34.54 *(7.67)*	30.76 *(8.26)*	.001
50-100hrs (n=63)	29.0 *(8.03)*	29.49 *(7.05)*	ns
100hrs-200hrs (n=27)	29.15 *(6.4)*	29.15 *(5.27)*	ns

Relapse prevention skills

Relapse prevention skills are considered as a whole (using the total score on the RP questionnaire), followed by an examination of sub-scales measuring insight into offending and strategies for preventing relapse.

RP Insight and Strategies Combined (see Table 9.2)

Dependent t-tests revealed that there was a significant improvement in RP skills (maximum score of 50) between 50hrs and 100hrs. The mean score at 50hrs was 19.69 (sd=10.32) and at 100hrs it was 23.46 (sd=9.23). The difference was significant at p<.01 (t=-4.11, df=98, 2-tailed). The same pattern was evident between 100hrs and 200hrs RP scores. The average score at 100hrs was 22.92 (sd=10.23) compared to a mean of 26.24 (sd=11.67) at 200hrs. This difference was also significant (t=-2.05, p<.05, df=26, 1-tailed). Hypothesis 1 postulated that significant progress would take place in RP skills between 100 and 200hrs and the hypothesis may thus be accepted. No predictions about progress between 50hrs and 100hrs were made but there was clearly significant progress and the null hypothesis may be rejected.

Table 9.2: Progress in relapse prevention skills as a function of time in treatment

Scale/Stage	Time 1 mean and sd	Time 2 mean and sd	p value
Total RP score			
50-100hrs (n=63)	19.69 (23.46)	23.46 (9.23)	.01, 2-tailed
100-200hrs (n=27)	22.92 (10.23)	26.24 (11.67)	.05, 1-tailed
RP Insight score			
50-100hrs (n=63)	12.44 (6.24)	14.54 (5.47)	.01, 2-tailed
100-200hrs (n=27)	14.04 (6.02)	16.3.3 (6.45)	ns
RP Strategies score			
50-100hrs (n=63)	7.41 (5.06)	8.75 (5.73)	.05, 2-tailed
100-200hrs (n=27)	8.56 (6.32)	9.64 (6.2)	ns

RP Insight (See Table 9.2)

Dependent t-tests found significant differences between RP Insight (maximum score of 25) scores at different stages of the treatment process. At 50hrs the average score was 12.44 (sd=6.24) and at 100hrs it had risen to 14.54 (sd=5.47). This improvement was significant at $p<.01$ ($t=-3.3$, $df=98$, 2-tailed). A comparison of 100hrs and 200hrs scores revealed non-significant change. When the 100hrs mean score (14.04, sd=6.02) was compared with that obtained at 200hrs (16.3, sd=6.45) the result was not significant at $p<.05$ ($t=-1.99$, $df=26$, 2-tailed). Whilst no predictions were made about movement in RP insight over time, significant progress was made between 50hrs and 100hrs and the null hypothesis may be rejected.

RP Strategies (see Table 9.2)

Dependent t tests to compare scores for RP Strategies (maximum score of 25) at 50hrs and 100hrs found that the mean 100hrs score (8.75, sd=5.73) was significantly

higher than the mean 50hrs score (7.41, sd=5.06). This difference was significant at $p<.05$ ($t=-2.47$, $df=98$, 2-tailed). The average 100hrs score (8.56, sd=6.32), however, was not found to be significantly lower ($t=-1.09$, $df=26$, 1-tailed) than that obtained at 200hrs (9.64, sd=6.2). Whilst no predictions were made about movement in RP strategies over time, significant progress was made between 50hrs and 100hrs and the null hypothesis may be rejected.

Individual movement in perception of risk and relapse prevention skills

Frequency data were obtained at all stages of treatment to determine the proportion of individuals who had improved their scores on perception of risk and RP scales by at least 1 standard deviation. The results are presented in Table 9.3.

Table 9.3: Frequencies of CSAs improving scores by 1 sd on perception of risk and RP measures

	Frequencies of CSAs improving by 1 sd or more			
Scale	**0-50hrs (n=99)**	**50-100hrs (n=63)**	**100-200hrs (n=27)**	**Pre/Post (n=99)**
Perception of Risk (sd=7.67)	14.15% (n=14)	31.75% (n=20)	37.03% (n=10)	26.26% (n=33)
Total RP skills (sd=9.81)	-	14.29% (n=9)	22.22% (n=6)	23.81% (n=15)
RP Insight (sd=5.93)	-	25.4% (n=16)	25.93% 9n=7)	30.16% (n=19)
RP Strategies (sd=5.06)	-	12.7% (n=16)	18.52 (n=5)	17.46 (n=11)

Whilst there was a clear trend towards progress according to amount of time spent in treatment, this was rather modest with overall pre/post treatment movement averaging fewer than 25% of CSAs.

DISCUSSION

Hypothesis 1 stated that CSAs' perception of their risk of reoffending would improve significantly between pre and post-treatment test administrations. This was found to be the case and hypothesis 1 was therefore accepted. Perception of risk improved significantly during the first 50 hours of the programme, but thereafter did not change to a significant degree.

Hypothesis 2 postulated that CSAs would obtain significantly higher (total) scores on the RP questionnaire at 200hrs when compared to 100hrs. RP skills did improve significantly over this time and the hypothesis was accepted. In addition, significant movement was observed between 50hrs and 100hrs.

No predictions were made about improvements which might be observed on the RP questionnaire sub-scales measuring insight into offending and RP strategies. However, significant progress was observed in both areas between 50 and 100hrs. Although there was a trend towards positive movement between 100 and 200hrs, this trend was not found to be significant.

The number of individuals with improved relapse prevention skills increased over time when improvement was measured using a score increase of 1 standard deviation. Also by the time they left treatment, many offenders had measurably improved in all aspects of relapse prevention skills. However, the improvements are rather modest.

Implications

As expected, in-treatment changes took place in offenders' abilities to: perceive their own continued risk of reoffending; understand their offending cycles; detail strategies for avoiding relapse. The results are thus consistent with the findings of Beech et al (1998), who reported significant improvements in RP skills in their evaluation of the

prison sex offender treatment programme. However, despite the statistically significant improvements in scores, it is important to look at the extent of change and level of competence on leaving the programme.

Whilst a majority of the sample showed some improvements in RP skills, by 200hrs the average RP score was only 50% of the possible total, i.e. only half of the questions were answered satisfactorily. Perceived level of risk of reoffending also remained unacceptably low. When one considers that many offenders leave the programme before the 200hrs stage, it may be assumed that a majority are leaving with inadequate RP skills. Overall, improvements are modest compared to improvements in other target areas such as denial (see chapter 6) and pro-offending thinking (see chapter 8). This could suggest that the group leaders are failing to implementing the RP work effectively and/or that offenders do not stay on the programme long enough to do an individualised RP plan. This is not the only evaluation to have found that offenders are leaving treatment programmes with inadequate RP skills. Beckett et al (1994) and Procter (1993) report no significant effects of community-based treatment programmes on RP skills and awareness of risk. It could be that the measures (particularly the RP questionnaire (see Appendix 3.8) does not measure what it is intended to measure. However, it is also possible that the RP model used is simply not appropriate for all offenders.

CONCLUSION

Whilst the predicted statistically significant improvements in RP skills took place (despite the lack of pre-treatment data in the case of RP insight and strategies), it is clear that offenders are leaving the SOU programme with: overly optimistic views of their likelihood of reoffending; inadequate insight into their offending patterns and knowledge of high risk situations; inadequate grasp of the strategies they may need to prevent relapse.

It is not known why treatment is not as effective as it should be with respect to: helping offenders to gain an appreciation of possible future risk; helping them to understand the process of offending and of relapse; helping them to acquire the skills they will need to ensure that they do not reoffend. Possible reasons for this have been outlined above. Given that evaluation findings raise doubts about the adequacy of the traditional RP model, it seems that the concept of RP in sex offender treatment needs to be re-evaluated. Work by Ward and colleagues (1995; 1997) provides a potentially fruitful avenue of investigation and may help to explain why programmes who do well at attaining other treatment targets have so much difficulty with relapse prevention work.

CHAPTER 10: PSYCHOMETRIC DEVIANCY AND RESPONSE TO TREATMENT

INTRODUCTION

Child sexual abusers (CSAs) are not a homogenous group. Many researchers and clinicians have attempted to categorise men who sexually abuse children into meaningful sub-groups. One reason for such categorisation is to assess an individual's risk of reoffending. Clearly some groups will be at more risk of reoffending than others. However, the accurate classification of CSAs can also contribute to the identification of treatment needs and to the evaluation of treatment impact. This chapter considers the utility of classifying CSAs according to both level of actuarial risk and psychometric deviance. It also describes a method for classifying individuals as "treated" or "untreated", allowing for the possibility of assessing individual progress in treatment.

Classifying child sexual abusers

Within current practice in Britain and the USA, one of the most common distinctions between CSAs is intra versus extra-familial abusers. Implicit in this practical distinction is another - that of the "fixated" (or "preferential") versus the "regressed" (or "situational") CSA. There is some evidence that men who actively seek out and have a preference for sexual contact with children are more likely to abuse children outside of the family and that they are at higher risk of reoffending compared to intra-familial offenders (e.g. Groth, Hobson and Gary, 1982; Beckett, Beech, Fisher and Fordham, 1994). However, there is also increasing evidence of substantial cross-over rates, i.e. that a significant minority of abusers commit offences both within and outside of the family (Barker and Morgan, 1993) and the present study has supported this evidence (see Chapter 3).

Assumptions about level of sexual deviance based solely on whether an offender is believed to have committed abuse within or outside of a family setting may not therefore be appropriate. Offender self-report is known to be unreliable (e.g. Abel, Mittelman and Becker, 1985; Salter, 1988; Beckett, 1994; Salter, 1998) and clinical judgement has not been found to be effective in assessing risk (e.g. Hanson and Bussiere, 1998; Salter, 1998). In recent years there has been increasing use of both actuarial and psychometric data to classify child sexual abusers. The actuarial data (e.g. offence history, victim characteristics, marital status) are used within an algorithm to assess risk of reoffending. These algorithms are based on empirical data (Thornton's, 1997, risk algorithm is described in Chapter 4). Some of the offender risk factors common to a number of such algorithms are: number of previous convictions for a sexual offence; male victims; relationship status.

Other methods of assessing deviance in sex offenders include the use of psychometric tests such as those employed in the current evaluation. To the extent that some CSAs will deviate from the norm more dramatically than others, the belief is that high levels of deviation from the norm in terms of e.g. distortions about child sexuality, indicate higher deviance and thus higher risk.

Two studies recently conducted in Britain to evaluate sex offender treatment programmes in the community and within prisons (Beckett et al, 1994; Beech, Fisher and Beckett, 1998), identified clusters of CSAs based on deviance as measured by psychometric tests. To date, not enough time has elapsed to determine the usefulness of such a technique to predicting treatment needs and long term risk of reoffending. However, the few offenders in Beckett et al's 1994 sample who are known to have reoffended had all been assessed as highly deviant using the clustering method. Both studies also identified an association between actuarial risk and psychometric deviance, with offenders in high (actuarial) risk groups tending to have more deviant psychometric profiles.

Measuring individual progress in treatment

Not only do psychometric tests allow practitioners and researchers to assess deviation from the norm, but they may also be used as relatively objective measures of in-treatment progress. This progress is more commonly reported in terms of whole group movement but says little about either individual change or individual profiles pre and post-treatment.

Again, recent research in Britain (Beech et al, 1998) has demonstrated that individual offenders can have "treated" or "untreated" profiles, which are assessed using calculations based on a comparison with normative data. The assumption is that an offender with a "treated" profile is less likely to reoffend than one whose profile deviates considerably from the norm. One of the advantages of this method of assessment is that it can take into account in-treatment change, i.e. an individual's perceived level of risk can be lowered if he has moved from an "untreated" to a "treated" profile.

Rationale and hypotheses

Rationale

The CSAs in this study have already been allocated risk categories according to Thornton's (1997) algorithm (see Chapter 4). However, it is intended that they are clustered according to pre-treatment psychometric profiles (i.e. according to deviance). It is predicted that the findings of Beech (1997/1998) will be replicated and that it will be possible to classify offenders into high and low deviance groups, which differ significantly from one another in levels of deviancy on psychometric tests. It is predicted that offenders with some previous experience of treatment (in prison, for example) are more likely to present as low in deviance. Progress in treatment will then be considered with respect to risk and deviance profiles and the possibility of differential treatment impact will be explored.

No predictions are made about cluster membership and its relationship to non-completion of the treatment programme and to treatment dropout for unacceptable reasons[1]. However, the data will be examined in order to identify any patterns.

In order to provide an assessment of psychometric deviance for each individual in the study, a system of categorising CSAs as "treated" or "untreated" is described. It is believed that having a treated profile will be positively related to time in treatment.

Hypotheses

1. It is hypothesised that a cluster analysis of CSA 0hrs scores on the evaluation measures will identify clusters of CSAs who differ significantly from one another in levels of deviance.
2. It is hypothesised that CSAs who have already done some sex offender treatment are significantly more likely than those who have not to fall into the low deviance clusters.
3. It is hypothesised that having a treated profile will be positively and significantly related to time spent in treatment.

GROUPING OFFENDERS ACCORDING TO RISK/DEVIANCE PROFILES

With the intention of replicating Beckett et al's findings of distinct clusters of deviance (despite the fact that not all measures used were identical), a cluster analysis was performed on pre-treatment data for the 126 CSAs included in this study. Since it was not expected that clusters would be mutually exclusive from one another, an agglomerative hierarchical (or "nesting") clustering method (Ward's method) was selected for the analysis (Aldenderfer and Blashfield, 1990; Kaufman and Rousseeuw,

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[1] This category includes offenders who have breached their probation orders or licenses and/or who have not been co-operative in treatment. It does not include those CSAs who reoffended whilst still in treatment.

1990; Everitt, 1993). Various clustering solutions were arrived at ranging from 2-6 clusters. However, all proved to have little external validity. Whilst the groups certainly differed in test profiles, they did not differ significantly in offence demographics - the data which is most often used in actuarial predictions of risk. In addition, at the time of carrying out the analysis, several offenders had already re-offended and (bearing in mind the small numbers) there was no observable pattern in cluster groups most likely to re-offend. It was decided, therefore, to combine what was known about actuarial risk of re-offending (using the Thornton SACJ, 1997) with psychometric test results (see Chapter 3 for a list of the measures used in this evaluation). A separate cluster analysis was performed on each risk of re-conviction group: high risk (N=18); medium risk (N=61); low risk (N=47). Although several solutions for each cluster analysis were considered (ranging from 2-4 clusters), in every case the 2-cluster solution was the obvious one (on observing resulting dendograms for different solutions), which was ideal given the relatively small numbers in each group. The result of the analyses was that 6 clusters had been identified - 2 in each risk of re-conviction group. Upon examination of the clusters, they were labelled as follows:

Cluster 1: Low Risk/High Deviance (LR/HD: n=22)
Cluster 2: Low Risk/Low Deviance (LR/LD: n=25)
Cluster 3: Medium Risk/High Deviance (MR/HD: n=30)
Cluster 4: Medium Risk/Low Deviance (MR/LD: n=31)
Cluster 5: High Risk/High Deviance (HR/HD: n=9)
Cluster 6: High Risk/Low Deviance (HR/LD: n=9)

Pre-treatment risk/deviance scores: a comparison of clusters

A clear pattern of test scores was apparent (see tables 10.1 to 10.3). All High Deviance groups had more in common with one another (test profiles) than they did with any of the Low Deviance groups (even their own risk group). The same was true

for the Low Deviation groups. In addition, there was a sliding scale within each set of Deviation groups. For example, the High Deviance/High Risk group presented with more deviant test scores than the High Deviance/Medium Risk group, which in turn was more deviant than the High Deviance/Low Risk group.

In order to test hypothesis 1 and determine whether clusters differed from one another on the dependent variables being measured, means and standard deviations were calculated and a multivariate analysis of variance (MANOVA: SPSS, 1992) was conducted in order to identify any overall difference between the groups. A significant difference in psychometric profiles between the 6 groups was identified ($P<.001$, $f=2.36$, $df=5,126$). Hypothesis 1, that the clusters will differ from one another in levels of deviance was accepted. Whilst there was a significant difference between the groups on most scales, post hoc pairwise comparisons were not made since it was felt that the number of comparisons was rather high given the relatively low numbers in some groups. However, univariate test results within the MANOVA are reported below.

Offence-related denial/admittance

Mean scores suggest that the higher deviance groups (regardless of actuarial risk category) are more defensive about their offending behaviour and arousal to children and less likely to admit that they need help. However, of the higher deviance groups, the higher risk groups are most deviant in these areas. Table 10.1 presents means and standard deviations for each cluster.

It was found that groups differed on all measures of offence-related denial/admission, with higher deviance groups denying more than lower deviance groups. Univariate analyses revealed these differences to be significant: self-reported arousal to children ($p<.05$, $f=2.85$, $df=5,126$); admittance of child molest behaviours/fantasy ($p<.01$, $f=4.12$, $df=5,126$); offence-related denial and minimisation ($p<.001$, $f=9.55$, $df=5,126$); treatment attitudes ($p<.05$, $f=3.1$, $df=5,126$).

Table 10.1: Pre-treatment means and standard deviations on measures of offence-related denial/admission by Cluster Membership

Scale	LR/HD (N=22)	LR/LD (N=25)	MR/HD (N=30)	MR/LD (N=31)	HR/HD (N=9)	HR/LD (N=9)
Child Molest Lie	8.59 *(3.13)*	6.64 *(2.96)*	9.5 *(3.47)*	8.52 *(3.42)*	7.22 *(3.99)*	6.56 *(4.61)*
Child Molest	9.68 *(5.53)*	15.68 *(6.66)*	8.83 *(6.48)*	10.84 *(6.53)*	13.44 *(7.38)*	14.33 *(10.42)*
SOAQ	99.5 *(13.54)*	80.56 *(18.01)*	110.83 *(18.68)*	95.5 *(16.9)*	92.11 *(22.9)*	79.89 *(29.14)*
Treatment Attitudes (TA)	2.82 *(1.56)*	3.6 *(3.14)*	2.07 *(1.61)*	2.74 *(2.05)*	2.78 *(2.28)*	4 *(2.55)*

Sex-related denial, deviance and dysfunction

Clusters differed less on measures of sex-related denial, deviance and dysfunction. Whilst there was a trend towards less denial and more dysfunction in the higher deviance groups, this was moderated by risk level to an extent. Table 10.2 presents the means and standard deviations for each cluster on each of the scales.

Univariate tests revealed that the groups differed significantly on the Sexual Obsessions scale ($p<.05$, $f=3.01$, $df=5,126$), with high deviancy and higher risk groups admitting to more sexual preoccupations than the other groups.

Table 10.2: Pre-treatment means and standard deviations on measures of sex - related denial, deviance and dysfunction by cluster membership

Measure	LR/HD (N=22)	LR/LD (N=25)	MR/HD (N=30)	MR/LD (N=31)	HR/HD (N=9)	HR/LD (N=9)
Social/Sexual Desirability (SSD)	19.36 *(8.28)*	22.16 *(7.87)*	22.97 *(6.91)*	22.71 *(8.22)*	24 *(4.3)*	20.56 *(6.54)*
Sexual Obsessions (SO)	2.68 *(2.61)*	3.6 *(3.49)*	4.07 *(3.38)*	1.71 *(1.92)*	5.11 *(4.54)*	4 *(3.91)*
Paraphilias	1.23 *(1.74)*	2.8 *(3.55)*	2.2 *(2.67)*	1.71 *(1.53)*	3.78 *(2.82)*	2.11 *(2.8)*
Sexual Dysfunction	4.41 *(4.51)*	3.88 *(4.07)*	4.73 *(4.23)*	2.32 *(1.85)*	6 *(2.78)*	4.78 *(3.31)*
Sex Knowledge and Beliefs (SKB)	15.82 *(3.28)*	16.84 *(3.36)*	14.43 *(3.15)*	16.61 *(2.64)*	15.11 *(2.98)*	15.67 *(3.74)*

Pro-offending thinking

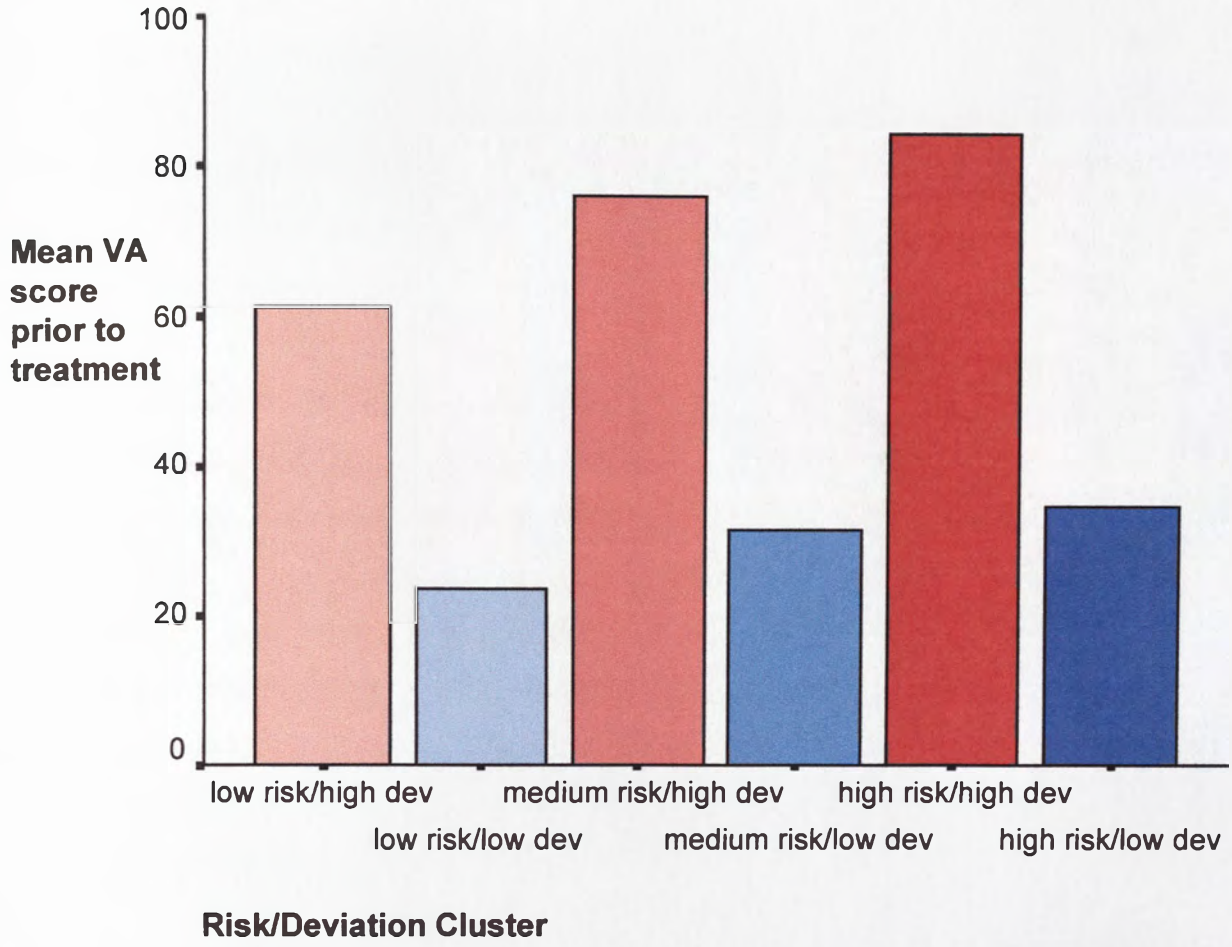
Table 10.3 illustrates some apparently large differences between clusters on pre-treatment mean scores for pro-offending thinking. Mean scores suggest that higher deviation groups (regardless of actuarial level of risk): hold more distortions about their offending behaviour; have higher levels of global distortions about child sexuality; have higher levels of emotional congruence with children; have more immature cognitive distortions; have poorer victim awareness; have higher levels of rape myth acceptance attitudes. However, again, of the higher deviation groups, the higher risk of re-offending groups were more deviant in these areas. Univariate tests revealed that the difference between groups was significant at $p<.001$ for: immature cognitive distortions ($f=6.67$, $df=5,126$); justifications ($f=6.59$, $df=5,126$); victim awareness ($f=27.99$, $df=5,126$); cognitive distortions about child sexuality ($f=13.58$, $df=5,126$); rape myth acceptance attitudes ($f=11.61$, $df=5,126$). The difference

between groups in levels of emotional congruence with children was significant at $p<.005$ ($f=3.73$, $df=5,126$). Fig. 6 demonstrates how these relationships may be observed visually, using the example of the pre-treatment mean scores for Victim Awareness (Allam, 1994a) distortions.

Table 10.3: Pre-treatment means and standard deviations on measures of pro-offending thinking by cluster membership

Scale	LR/HD (N=22)	LR/LD (N=25)	MR/HD (N=30)	MR/LD (N=31)	HR/HD (N=9)	HR/LD (N=9)
Immature Cognitive Distortions	6.09 *(3.08)*	5.64 *(3.4)*	5.8 *(4)*	5.65 *(2.37)*	11 *(2.74)*	4.89 *(2.62)*
Justifications	4.73 *(4.17)*	3.6 *(3.14)*	2.07 *(1.6)*	3.13 *(2.19)*	9.44 *(4.16)*	2.38 *(1.41)*
Victim Awareness	61.38 *(22.76)*	23.5 *(13.2)*	76.35 *(26.31)*	31.67 *(15.66)*	85 *(20.84)*	34.75 *(12.27)*
Cognitive Distortions	20 *(7.28)*	10.8 *(8.03)*	25.9 *(12.09)*	13.94 *(8.24)*	28.78 *(12.29)*	6.44 *(6.84)*
Emotional Congruence	15.09 *(8.41)*	15.2 *(9.84)*	21.77 *(13.28)*	14.81 *(10.65)*	28.67 *(11.68)*	13 *(13.63)*
Rape Myth Acceptance	60.12 *(19.31)*	37.39 *(13.99)*	63.71 *(17.28)*	37.46 *(10.63)*	64.88 *(16.96)*	45.88 *(13.72)*

Fig 6: Pre-treatment victim awareness distortions by cluster membership (n=126)



The effect of previous treatment on deviance level

It was also postulated in hypothesis 2 that within each risk level, a significantly higher proportion of low deviance offenders would have already had some form of sex offender intervention. This was found to be the case. Of the 45 Low Risk CSAs, 6 had participated in a treatment programme - all 6 were in the Low Deviance group. Of the 61 Medium Risk CSAs, 9 had some experience of a programme - 7 of whom were in the Low Deviance group. Of the 18 High Risk offenders, 8 had participated in a prison programme - 6 of whom were in the low deviance group. The differences observed were found to be highly significant ($p<.001$, $\chi_2=22.77$, $df=10$). Hypothesis 2 was therefore accepted.

Response to treatment

Dropouts and treatment non-completers by risk/deviancy profile

The data on progress in treatment and on dropouts were explored in order to identify any links with risk/deviance profiles. First of all the frequencies of individuals leaving the programme prematurely for an unacceptable reason (i.e. treatment dropouts) were obtained for each risk/deviance group. A Pearson Chi-Squared analysis was then performed to identify any significant differences in cluster membership between these dropouts and all other group members (apart from CSAs who recidivated whilst in treatment). No significant difference between the groups was identified ($p>.05$, $\chi_2=4.99$, $df=5$). In order to investigate the possibility of a link between cluster membership and non-completion of programme (for any reason other than recidivism), frequencies were obtained in order to compare the completers and non-completers on cluster membership. A Pearson Chi-Squared analysis did not reveal any significant differences between the two groups ($p>.05$, $\chi_2=7.89$, $df=5$). Frequencies are presented in Tables 10.4 and 10.5.

Table 10.4: Treatment dropouts and non-dropouts by risk/deviance group

Risk/Deviance Group	Treatment dropouts (n=14)a	Non dropouts (n=107)b
Low risk/high deviance (n=22)	14.3% (n=2)	18.7% (n=20)
Low risk/low deviance (n=25)	-	23.4% (n=25)
Medium risk/high deviance (n=30)	35.7% (n=5)	18.7% (n=22)
Medium risk/low deviance (n=31)	35.8(n=5)	25.2% (n=27)
High risk/high deviance (n=9)	7.1% (n=1)	6.5% (n=7)
High risk/low deviance (n=9)	7.1% (n=1)	6.5% (n=7)

a Sample does not include 5 CSAs who dropped out of treatment because they reoffended
b Sample includes all of those who did not drop out of treatment for an unacceptable reason

Table 10.5: Treatment completers and non-completers by risk/deviance group

Risk/Deviance Group	Completed treatment (n=39)	Non-completers (n=82)a
Low risk/high deviance (n=22)	15.4% n=6	18.3% n=15
Low risk/low deviance (n=25)	33.3% n=12	14.6% n=12
Medium risk/high deviance (n=30)	20.5% n=8	23.2% n=19
Medium risk/low deviance (n=31)	23.1% n=9	28% n=23
High risk/high deviance (n=9)	7.7% n=3	60.1% n=5
High risk/low deviance (n=9)	-	9.8% n=8

Whilst the differences in cluster membership between completers and non-completers and dropouts and non-dropouts were not significant, in both cases there was a trend towards those who left the programme prematurely to be in higher risk and higher deviance groups.

Progress in treatment by risk/deviancy profile

To examine the possibility of differential rates of progress in treatment, pre-post change was examined, with movement in one half of a standard deviation on a scale (a total of 15 scale scores are considered) designated as change[2]. Table 10.6 presents the average number of scales where progress was made (progress here is classified as being 1/2sd or more in the desired direction) in each risk/deviance group. It may be observed that the least progress was made by high risk/low deviance offenders and the most by high risk/high deviance CSAs. Whilst the difference in mean change between some of the groups appears fairly substantial, with lower deviance groups tending to show less movement, a One-Way ANOVA did not reveal any significant difference in

[2] Beech, Fisher and Beckett (1998) describe a process for measuring clinically significant change. However, the data needed to do so was not available on several of the scales used in this evaluation.

these mean scores ($p<.05$, $f=2.3$, $df=5,94$). When deviance level alone was correlated with rate of change, the result was not significant at $p<.05$ ($r=.06$, $N=99$, 2-tailed).

Table 10.6: Progress in treatment by risk deviance group (n=99)

Risk/Deviance Group	Mean number of scales where progress of 1/2sd or more was made
Low risk/high deviance	5.45 (7.72)
Low risk/low deviance	4.8 (7.2)
Medium risk/high deviance	5.27 (7.43)
Medium risk/low deviance	5.09 (6.91)
High risk/high deviance	6.03 (8.83)
High risk/low deviance	2.91 (6.09)

"TREATED" VERSUS "NON-TREATED" TEST PROFILES

Average scores across groups say something about the tendency for change to occur overall but say little about the individuals within those groups. In addition, it is not always easy to make sense of a combination of psychometric test scores and to build a picture of an individual's level of deviancy. For this reason, a simple points allocation system has been used to categorise individuals as "treated" or "non-treated", according to the test profile they present with. This system is based on whether for each relevant test (in this case all those included in the cluster analysis plus the Relapse Prevention Questionnaire total score) an individual obtains a score which falls within the normal/functional range. For each score obtained within the normal range, 1 point is allocated. CSAs are considered "treated" if they obtain 11 (from 16 - 68.75%) points and "untreated" if they obtain fewer than 11 points. if an offender goes below the cut-off figure, he is categorised as "untreated". A treated profile suggests relatively low levels of denial and distortions.

Moving from untreated to treated profiles

At pre-treatment only 9 (7.14%) CSAs had a "treated" profile. Most of these (n=6) had some experience of previous treatment (prison programme). By the time they left treatment, 28.28% of clients who had done pre and post-treatment tests (n=99), had a treated profile. By the 50hrs stage, 20.2% of CSAs had a treated profile compared to 33.33% at 100hrs and 40.7% at 200hrs. In addition, total number of hours in treatment was positively and significantly related to the number of scores falling within functional ranges post-treatment ($p<.001$, $r=.3$, $n=126$, 2-tailed). Thus, hypothesis 3, that those who spend longer in treatment are more likely to have a treated profile on leaving the programme has been supported.

It is clear that length of time in treatment is related to whether or not an individual has a treated status on leaving the programme. When frequencies of treated status dropouts (n=14) and non dropouts (n=107) were compared using a Pearson Chi-Squared analysis, it was found that there was a significant difference between the two groups ($p<.05$, $\chi_2=5.28$, $df=1$), with none of the dropouts leaving the programme with a treated profile compared to 28.3% of those who left the programme for an acceptable reason. Similarly, when completers (n=39) and non-completers (n=82) were compared, it was found that treatment completers were significantly more likely to have a treated profile at the end of treatment than those who did not complete the programme. Forty two percent of those who completed the programme left with a treated profile compared to 17.1% of those who did not ($p<.01$, $\chi_2=8.68$, $df=1$).

DISCUSSION

It was hypothesised that high and low deviance clusters of CSAs would be identified within actuarial risk groups. Cluster analyses confirmed the existence of the expected clusters, with a MANOVA indicating that risk/deviance groups differed from one another in their responses to psychometric tests, with a high and low deviance cluster within each risk level (as measured by the SACJ). It was found that irrespective of

actuarial risk level, high deviance offenders had more in common with one another (in terms of their psychometric profiles) than they did with low deviance offenders within their own risk level. It was also predicted that individuals who had already had some experience of treatment would be more likely to present as low in psychometric deviance. Indeed, this was found to be the case.

Risk/deviance profiles were not found to be significantly related to drop-out status, although there was a trend towards higher risk and higher deviance groups dropping out of treatment prematurely. Neither was progress in treatment significantly related to cluster membership.

When treated versus untreated status was considered, as expected, those who spent longer on the programme were more likely to leave treatment with a treated profile. At the pre-treatment stage, only 7.14% of individuals had a treated profile (and 66.7% of these had already participated in a treatment programme) but by the 200hrs stage, 40.7% presented as treated. Also, CSAs who did not complete the programme were less likely to leave with a treated profile than those who attended for the full 200hrs.

Implications

Low numbers in the cluster groups (particularly in the high risk groups) have limited analyses somewhat. However, these results do suggest important differences between clusters and within actuarial risk groups. They suggest that important targets for treatment, such as denial, distortions and victim empathy, vary significantly and that some CSAs traditionally seen as low risk may actually have high levels of deviance. The fact that CSAs who had participated in a programme prior to being referred to the SOU tended to be in the lower deviance groups is encouraging because if recidivism can be linked to level of deviance (this will be considered in Chapter 12), achieving lower deviance would predict lower recidivism rates. Whilst there is an assumption by treatment providers that this is the case, there is still very limited evidence to support the relationship of psychometric deviance to reoffending (Beech, Erikson and

Friendship, 2000; Beech et al, 1998) and more research is needed if the link is to be clearly established.

It was intended that this method of clustering could be used to identify possible group differences which would have implications for treatment. For example, should we be more concerned about a Low Risk/High Deviation offender than a Medium Risk/Low deviation offender? Does one require more intervention than the other? Targeting treatment to where it is most needed is essential, particularly at a time when the Probation Service is under constant pressure to cut costs. More importantly, it is essential that treatment is flexible enough to allow for those who require far longer periods of intervention and support if they are to maintain offence-free lifestyles.

It was found that the identified clusters did not differ significantly from one another in rates of progress in treatment. Neither was treatment drop-out related to cluster group. This suggests that those who are higher in deviance will require far more intervention than those who do not have highly deviant profiles and underlines the need for treatment providers to take this into consideration in treatment plans. The fact that dropping out of treatment for an unacceptable reason was not significantly related to cluster membership indicates that treatment dropout/non-completion is not necessarily an indicator of higher risk/deviance.

Whilst it appears to be the case that cluster membership does not predict dropout/premature exit from the programme, it still the case that the longer an individual spends in treatment, the more likely to leave with a treated profile. This study has found that 40.7% of those who completed the SOU programme had a treated profile on leaving but only 24% of the sample of the total sample of 126 CSAs left with a treated profile[3]. It seems that the SOU programme is very effective in reducing levels of deviance but also that dosage is an important factor.

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[3] It should be noted, however, that these results are based on the last time an offender completed psychometric questionnaires. Most offenders left between testing times, so improvement made since the last test administration will not have been measured.

CONCLUSION

What most people involved with an offender need to know pre-treatment is: what are his treatment needs? Identifying an initial risk/deviance profile has the potential to help to answer this question. It may be obvious that a high risk offender (whatever his apparent level of deviance) will need considerable intervention and monitoring. However, what about a low risk but highly deviant offender? Could he be one of the few low risk individuals who will go on to reoffend?

Once an individual has undergone a treatment programme, the question is: has this offender been successfully treated?. Identifying "treated" and "untreated" profiles (as well as observing progress in terms of proximity to a "treated" profile) may contribute to our knowledge of how far treatment has achieved the goal of making an individual less likely to re-offend.

This chapter, along with preceding chapters has provided evidence that CSAs can make considerable progress (as measured by psychometric deviance) in community-based cognitive-behavioural groupwork for sex offenders. However, progress very much depends on length of time spent in treatment and initial deviance. Whilst a small minority of the sample dropped out of treatment for unacceptable reasons, a majority failed to complete the programme. This is an issue which will need attending to if the rates of treated offenders leaving the programme are to improve.

CHAPTER 11 : GROUP ENVIRONMENT

INTRODUCTION

In this evaluation study, performance (i.e. the effectiveness of the programme) has been measured using a combination of psychometric tests and recidivism data. It would seem obvious that the way in which a group operates influences the outcome and that, like other aspects of treatment integrity (summarised by Allam and Browne, 1998), group process is crucial to success or failure. There is wide agreement that cohesion (an atmosphere of unity, respect and support), leader support and good organisation within a group encourage positive group processes such as: co-operation; disclosure; motivation; commitment to group goals. These processes have been shown to lead to favourable outcomes (e.g. Beech and Fordham, 1997; Clark and Erooga, 1994; Littlepage, Cowart and Kerr, 1989; Marziali, Marmar and Krupnick, 1981). For example, Beech and Fordham (1997) found that a sex offender treatment group which had been identified as successful was more cohesive, encouraged more expression of feelings and had higher perceived levels of leader support and organisation (as measured by the Group Environment Scales, Moos, 1994) than a group which had not demonstrated such success. They also found that there were strong relationships between perceived leader support and sub-scales of the GES measuring: cohesion; task orientation; order and organisation. These relationships are consistent with those identified by Moos (1994).

Group environment as perceived by group members and by group facilitators should be broadly similar, since large differences in e.g. perception of leader support suggests that the learning styles of members are not being taken into account and that the therapeutic process is not based on shared group norms. Whilst it is not uncommon for group facilitators to view groups somewhat more positively than do members (Beech and Fordham, 1997; Beckett, Beech, Fisher and Fordham, 1994; Moos,

1994), large discrepancies could be indicative of problems. Beckett et al demonstrated this in their 1994 evaluation of community-based treatment programmes. Those groups with large discrepancies between facilitator and member scores on group environment scales performed less well on outcome measures than those whose participants and leaders agreed on the largely positive environment of the group.

Rationale and hypotheses

Rationale

The description of the SOU programme in Chapter 2 indicated that the programme meets at least the minimum requirements for treatment integrity. This chapter seeks to establish the nature of the group environment in SOU groups and its relationship to treatment success or failure.

It is expected that this study will replicate Beech and Fordham's (1997) findings and establish the existence of significant relationships between indicators of a positive group environment. It is also expected that both group member and group facilitator scores on group environment scales will demonstrate the existence of a positive group environment. The 2 groups are not expected to have significantly different perceptions of group climate, since the SOU programme is believed to be high in treatment integrity, with aims and expectations of both facilitators and group members made explicit from the outset.

Given that there have been reports linking a positive group environment to performance (successful treatment outcome), it is expected that indicators of a positive group environment will be significantly related to improvement as measured by psychometric tests and time spent in treatment.

Since there is no evidence in the literature to suggest that perceptions of the group environment change significantly over time, no predictions are made here about GES

scores at different stages in the programme. However, the data will be examined to determine the existence or otherwise of differences according to stage in the programme.

Hypotheses

1. It is hypothesised that group members' perceptions of Cohesion and Leader support will be significantly related to other indicators of a positive group environment.
2. It is hypothesised that positive group environment (Cohesion, Leader Support and Order and Organisation scales) will be significantly related to progress in treatment as measured by psychometric tests and length of time in treatment.

METHODOLOGY

The methodology of the evaluation is described fully in chapter 3. However, measurement of the group environment involved some changes in design, procedure and samples.

Design and Procedure

GES forms were completed by offenders and group facilitators at the end of Assessment (50hrs), at 100hrs and 200hrs. In the case of offenders, they were administered alongside the other psychometric tests. Due to delays in obtaining the test manual, it was not possible to administer the GES in the early stages of this project, which means that not all offenders and group facilitators were able to complete the questionnaire at all stages.

Samples

Both offenders and group facilitators completed GES forms. The offenders consisted of a sub-sample (n=68) of the CSAs described in chapter 4. The group facilitators consisted of 11 SOU officers and co-workers.

During the course of the programme, a number of offenders left prematurely (see Chapter 3). Before 50hrs test administration, 27 CSAs left the programme. A further 36 left between 50hrs and 100hrs and another 24 between 100hrs and 200hrs.

Because of the CSAs leaving the programme, sample numbers completing the GES became progressively lower at test administrations. Details are as follows: at 50hrs n=44; at 100hrs n=42; at 200hrs n=27. Test data over 2 administrations is available for 41 individuals. At 50hrs, data are from 11 group facilitators. Because of small numbers at later stages (5 at 100hrs and 3 at 200hrs), only 50hrs data are considered here. No analyses were undertaken to investigate the possibility of a relationship between treatment dropout and group environment due to the same problem of very small data sets.

Measure of Group Environment

The Group Environment Scale (GES) was originally developed in 1981 and is designed to measure the social environment in therapeutic groups. The measure has been extensively researched and Moos (1994) cites much evidence of validity and reliability. The Real (R) Form administered here measures the social climate of an actual group (other forms measure expectations and "ideal" group environments). The GES consists of 10 subscales, each of which contains 9 items to be answered in a True/False response format. The scales assess three underlying sets of dimensions: relationships; personal growth/goal orientation; system maintenance and change. The sub-scales are described in Table 11.1 below (taken from Moos, 1994).

Table 11.1: GES Subscales and Descriptions

Relationship Dimensions	
1. ***Cohesion***	The members' involvement in and commitment to the group and the concern and friendship they show for one another. *Example: There is very little group spirit among members.*
2. ***Leader Support***	The amount of help, concern, and friendship shown to the members. *Example: The leader goes out of his/her way to help members.*
3. ***Expressiveness***	How much freedom of action and expression of feelings are encouraged in the group. *Example: Members will often say the first thing that comes into their minds.*
Personal Growth Dimensions	
4. ***Independence***	How much the group encourages independent action and expression among members. *Example: Most members will "go along with the crowd".*
5. ***Task Orientation***	The emphasis on completing concrete, practical tasks and on decision making and training. *Example: The group rarely has something to show for its efforts.*
6. ***Self-Discovery***	How much the group encourages members' discussions of personal problems. *Example: Members hardly ever discuss their sex lives.*
7. ***Anger and Aggression***	The extent to which there is open expression of anger and disagreement in the group. *Example: Angry feelings are rarely expressed in the group.*

System Maintenance and Change Dimensions

8. ***Order and organisation***	The formality and structure of the group and the explicitness of rules and sanctions. *Example: There is a great deal of confusion in the group at times.*
9. ***Leader Control***	The extent to which the leader directs the group, makes decisions, and enforces rules. *Example: The leader enforces the rules of the group.*
10. ***Innovation***	How much the group promotes diversity and change in its own functions and activities. *Example: New approaches are often tried in the group.*

One point is given for every response which indicates that the dimension in question is present in the group and scores on each dimension can range from 0-9. Thus, a high score indicates agreement that the dimension in question is present in the group. For example, a score of 8 for Group Cohesion would indicate that an individual perceives his/her group as highly cohesive but a score of 3 for Leader Control would indicate that the group is perceived to be run in a rather loose manner with little emphasis given to rules and leadership.

Treatment of data

Firstly, Correlational data were obtained in order to ascertain any significant relationships between initial (50hrs) GES scores. After converting individual scores on the GES into standard scores (see Moos, 1994) mean GES scores at 50hrs were calculated for both offenders and group facilitators and were compared using independent t-tests. From this, it was established whether or not they indicated a positive group environment.

Before comparing offender and group facilitator perceptions of the group environment, A Multivariate Analysis of Variance (MANOVA: SPSS, 1992) was performed on the offenders' 50 hours data in order to identify between group differences attributable to group membership. A MANOVA was then performed in order to compare overall group perceptions (as measured by the GES) of group members and facilitators. Univariate tests were then conducted to compare the two groups on individual scales.

In order to examine the possibility of change in perception of the group environment over time, a MANOVA was conducted on GES scores at 50hrs and those obtained prior to leaving the programme at 100hrs or 200hrs.

Finally, GES scores obtained by offenders on leaving treatment were correlated with outcome measures of treatment progress and treatment success.

RESULTS

Relationships between GES scales

GES scale scores from group members at the 50hrs stage were correlated with one another in order to identify any significant relationships. Pearson correlations (n=55, 2-tailed) are reported below (Table 11.2). As predicted in hypothesis 1, group members' perceptions of the cohesiveness of group and the support given by group leaders was positively and significantly related to other indicators of a positive group environment. Cohesion correlated most highly with Leader Support (r=.67), with Task Orientation (r=.65), with Self-Discovery (r=.49) and Order and Organisation. Leader Support was most strongly related to Cohesion (see above), Task Orientation (r=.67), Independence (r=.6), Order and Organisation (r=.5) and Self-Discovery (r=.43). Hypothesis 1, that Cohesion and Leader Support would be related to indicators of a positive group environment is thus accepted.

Table 11.2: Relationships between CSA scores on GES scales at 50hrs

Scale (N=44)	LS	Ex	I	TO	SD	AA	OO	LC	Inn
Cohesion (Co)	.67**	.31*	.36*	.65**	.49**	-.19	.45**	.01	.23
Leader Support (LS)	-	.22	.6**	.67**	.43**	-.12	.5**	.15	.19
Expressiveness (Ex)	-	-	.06	.42**	.41**	.05	.37*	-.13	.19
Independence (I)	-	-	-	.3*	.29*	-.11	.34*	.17	.26
Task Orientation (TO)	-	-	-	-	.44**	-.09	.56**	.04	.09
Self-Discovery (SD)	-	-	-	-	-	-.06	.26	-.07	.35*
Anger and Aggression (AA)	-	-	-	-	-	-	-.26	.08	.22
Order and Organisation (OO)	-	-	-	-	-	-	-	.34*	.11
Leader Control (LC)	-	-	-	-	-	-	-	-	-.03
Innovation (Inn)	-	-	-	-	-	-	-	-	-

* $p<.05$, 2-tailed ** $p<.01$, 2-tailed

Leader Control was strongly related to Order and Organisation only (r=.34). Innovation and Anger and Aggression scales were not strongly related to many other scales. The only significant relationship with Innovation was Self Discovery (r=.35) and none of the other scales were significantly related to Anger and Aggression.

Group members' perceptions of the group environment

Means and standard deviations of group members' perceptions of the group environment were obtained at 50hrs (n=44) and compared with group norms provided by Moos (1994) [1]. Table 11.3 (below) presents 50hrs descriptive data alongside the results of independent t tests comparing the two groups.

It may be seen that group members' GES scores at 50hrs indicate perceptions of a positive group environment, in which members feel supported by group facilitators and see the group as cohesive. They see the group as organised and as being fairly task oriented and feel that facilitators are very much in control of what takes place in the group. There are a number of significant differences between this data and normative data. The CSAs in this sample, perceived significantly: more leader support; more self-discovery; more order and organisation; more leader control; less expressiveness; less independence; less anger and aggression.

[1] The Moos (1994) norms consist of 2,436 individuals participating in 305 groups. These groups include: task oriented groups (n=101); social-recreational (n=62); psychotherapy and Supervision (n=54); self-help and mutual support (n=88).

Table 11.3: Group members' 50hrs GES scores compared to normative data

Scale	Mean and sd - CSAs (n=44)	Mean and sd - norms (n=2,436)	Value of t
Cohesion	6.8 *(2.56)*	6.61 *(2.21)*	.83 ns
Leader Support	7.57 *(1.62)*	6.69 *(2.14)*	4.19***
Expressiveness	4.93 *(1.56)*	5.51 *(1.36)*	-8.0***
Independence	5.84 *(1.8)*	6.48 *(1.76)*	-3.37***
Task Orientation	6.77 *(2.04)*	6.51 *(1.98)*	1.37 ns
Self-Discovery	6.0 *(2.19)*	5.05 *(2.36)*	4.32***
Anger & Aggression	2.98 *(1.98)*	3.54 *(2.08)*	-2.8**
Order & Organisation	7.52 *(1.61)*	5.74 *(2.26)*	8.48***
Leader Control	7.02 *(1.41)*	4.86 *(2.17)*	10.29***
Innovation	4.66 *(1.83)*	4.38 *(2.16)*	1.33 ns

** p<.01, 2-tailed

*** p<.001, 2-tailed

A comparison of group members' and group facilitators' perceptions of the group environment

Before comparing offender and group facilitator perceptions of the group environment, A MANOVA was performed on the CSA 50 hours data in order to identify within group differences attributable to group membership. No significant overall differences in GES scores was identified between groups (f=1.24, df=9,33, 2-tailed). From this point on, all CSA data were pooled as were data obtained from group facilitators.

A MANOVA was then conducted in order to compare overall perception of group environment by group members and facilitators at 50hrs. It was found that there was a significant difference between the two groups at p<.01 (f=3.35, df=1,55, 2-tailed). No difference had been predicted. Univariate tests indicated that significant difference

between group members and group leaders was limited to 4 of the 10 scales. Table 11.4 displays means and standard deviations of 50hrs scores obtained by group leaders and those obtained by group members. Fig. 7 shows how closely matched perceptions of group environment were in members and facilitators. Differences in mean scores of facilitators and members were found only on scales measuring: Independence; Order and Organisation; Leader Control; Innovation. In all cases, group facilitators perceived higher levels of the group characteristic in question than did group members. However, none of the above scales are considered primary indicators of a positive group environment.

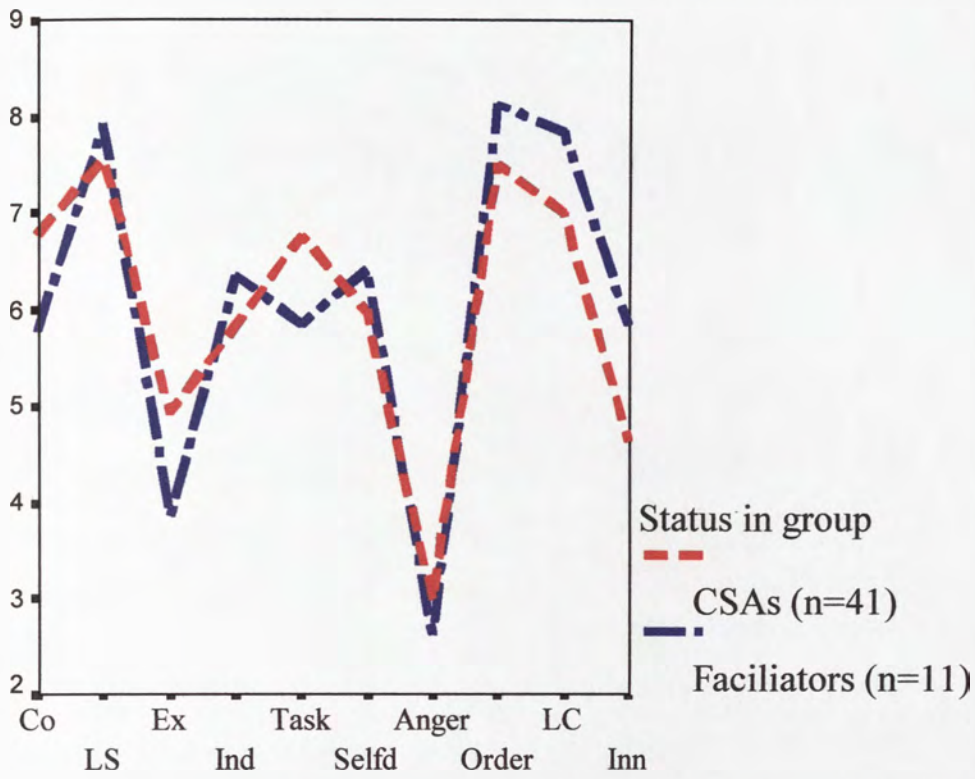
Table 11.4: Univariate tests comparing group members' and group facilitators' perceptions of group environment at 50hrs

Scale	Mean and sd - CSAs (n=44)	Mean and sd - Group facilitators (n=11)	Value of f
Cohesion	6.8 *(2.56)*	7.27 *(1.56)*	.35 ns
Leader Support	7.57 *(1.62)*	7.91 *(.7)*	.46 ns
Expressiveness	4.93 *(1.56)*	4.64 *(2.11)*	.27 ns
Independence	5.84 *(1.8)*	7.18 *(1.17)*	5.46 *
Task Orientation	6.77 *(2.04)*	6.18 *(1.66)*	.79 ns
Self-Discovery	6.0 *(2.19)*	7.09 *(1.58)*	2.4 ns
Anger & Aggression	2.98 *(1.98)*	2.55 *(1.29)*	.47 ns
Order & Organisation	7.52 *(1.61)*	8.55 *(.93)*	4.08 *
Leader Control	7.02 *(1.41)*	8.0 *(.89)*	4.79 *
Innovation	4.66 *(1.88)*	6.54 *(1.81)*	8.99 **

* $p<.05$, 2-tailed

** $p<.01$, 2-tailed

Fig. 7: Group environment at 50hrs - CSAs and facilitators compared



In-treatment change in perceptions of group environment

In order to explore in-treatment change in individuals' perceptions of the group environment, overall group environment at 50hrs was compared with that prior to leaving the programme at 100hrs or 200hrs (n=41). A repeated measures MANOVA was conducted comparing 50hrs and exit scores. No significant difference in perception of group environment was found ($p>.05$, $f=1.27$, $df=1,40$, 2-tailed). However, univariate tests revealed a significant increase in perception of Self-Development ($p<.05$, $f=4.86$, $df=1,40$, 2-tailed) and Innovation ($p<.05$, $f=6.97$, $df=1,40$, 2-tailed) in the group. Univariate test results are presented in Table 11.5.

Table 11.5: Members' perceptions of the group environment at 50hrs and on leaving treatment compared (n=41)

Scale	Group members at 50hrs	Group members on exit	Value of f
Cohesion	6.9 *(2.48)*	7.1 *(2.14)*	.37 ns
Leader Support	7.54 *(1.66)*	7.88 *(1.05)*	2.76 ns
Expressiveness	4.98 *(1.57)*	5.27 *(1.78)*	2.18 ns
Independence	5.83 *(1.8)*	6.29 *(1.55)*	3.45 ns
Task Orientation	6.73 *(2.06)*	7.22 *(1.62)*	3.97 ns
Self-Discovery	5.98 *(2.22)*	6.46 *(2.09)*	4.86 *
Anger & Aggression	2.81 *(1.86)*	2.92 *(2.1)*	.28 ns
Order & Organisation	7.49 *(1.66)*	7.39 *(1.53)*	.19 ns
Leader Control	6.98 *(1.41)*	6.95 *(1.56)*	.02 ns
Innovation	4.59 *(1.84)*	5.32 *(1.78)*	6.97 *

* $p<.05$, 2-tailed

Relationships between GES scales and outcome data

Hypothesis 2 predicted the existence of significant relationships between perception of group environment and outcome data. Cohesion and Leader Support scores at 50hrs (n=44) and prior to exit from the programme (which includes data from 50hrs, 100hrs and 200hrs, n=68) were correlated with psychometric indicators of treatment success/failure. Change in GES scores (n=41) was also correlated with the relevant variables. These were: treated status at end of treatment (treated or untreated); movement in the number of scale scores within acceptable limits; treatment completion; hours in treatment; leaving the programme (acceptable vs unacceptable reason); voluntarily staying on in treatment for 3 months or longer after statutory period has finished. Pearson correlations were conducted and significant relationships are reported below.

At 50hrs, Cohesion was positively related to improvement in the number of scale scores within acceptable limits ($p<.05$, $r=.28$, $n=44$, 1-tailed) . Final Cohesion scores were also related to improvement ($p<.01$, $r=.29$, $n=68$, 1-tailed). There was no strong association with any of the other outcome variables listed above.

At 50hrs Leader Support was positively related to the total number of hours completed ($p<.05$, $r=.33$, $n=44$, 1-tailed) and this was also true of final scores ($p<.05$, $r=.23$, $n=68$, 1-tailed). Final scores were also associated with whether or not an individual completed the programme ($p<.05$, $r=.23$, $n=68$, 1-tailed) and the total number of hours completed ($p<.05$, $r=.23$, $n=68$, 1-tailed). Change in perceived levels of Leader Support was related to the total improvement in number of psychometric test scores within functional limits ($p<.05$, $r=26$, $n=41$, 1-tailed) and to whether or not an individual presented with a "treated" profile at the end of treatment ($p<.05$, $r=.22$, $n=41$, 1-tailed).

Hypothesis 2, that indicators of positive group environment would be significantly related to treatment success, is supported by the data and is thus accepted.

DISCUSSION

Hypothesis 1, that Cohesion and Leader Support would be found to be strongly related to one another and to other indicators of a positive group environment was supported by the data and is consistent with the literature on this subject. Beech and Fordham (1998) report similar findings, as do Moos (1994) and Littlehart et al (1989)..

It was not expected that group members and group facilitators would have significantly different perceptions of the group environment. However, there were differences between the 2 groups on 4 from the 10 scales, with facilitators perceiving higher levels

of: Independence; Order and Organisation; Leader Control; Innovation. None of these scales are seen as a direct measurement of how positive a group is.

Results indicated that group members had positive attitudes towards their groups at 50hrs was accepted (scores on relevant scales compared favourably to those cited in the GES manual (Moos, 1994)). No predictions were made about group environment at 50hrs compared to the last testing point and there was no evidence of overall change.

Finally, it was expected that scores on Cohesion and Leader Support scales would be significantly and positively related to treatment success. There was some evidence for this and hypothesis 2 was accepted..

Implications

In the present sample, the strongest relationships (i.e. between Cohesion, Leader Support, Task Orientation, Order and Organisation) suggest a cluster of indicators of a positive group environment. This, together with the findings that group members in this study were very positive about their groups at both 50hrs and just before leaving the programme, is consistent with the literature on therapeutic environments.

Group facilitators were not found to have more positive views of group than members. Indeed agreement between the two groups was high on most elements of the group. This suggests that there were shared norms and values and that both parties were generally happy with the way that the groups were run. This, together with the fact that no significant differences in GES scores were found between groups is consistent with high levels of treatment integrity. The scales on which leaders and members did differ in perceptions included all sub-scales of the System Maintenance and Change Dimensions. This might reflect the fact that cognitive-behavioural work is not client-centred and is far more directive than many therapies. Group facilitators are quite

likely to view themselves as more in control and as better prepared than group members (as suggested by Moos, 1994) because they are involved directly in the preparation and organisation.

Finally, there was some evidence for a link between positive outcome (such as progress on psychometric tests, and post-treatment profiles. These data support research and meta-analyses which have stressed the importance of the therapeutic alliance between therapist/group leader and client/group member (e.g. Marziali et al, 1981) and have concluded that cognitive-behavioural groupwork (which is characterised by well organised and focused groups) is particularly effective in the treatment of offenders (e.g. Lösel, 1995; Lipsey, 1995; McGuire and Priestley, 1995). The results are comparable with those obtained by Beech and Fordham (1997), who found that a positive group environment predicted successful outcomes on sex offender treatment programmes.

CONCLUSION

Group environment may be an important indicator of whether or not a group is going to fulfil its objectives. Discrepancies between the perceptions of group members and group facilitators could signify problems with treatment integrity - certainly with regards to dealing with learning styles and group member expectations. Also, collecting data on perceptions of group environment has the potential to help identify problems of engagement and motivation in individuals - including group workers. Finally, whilst the evidence from this study is rather modest, there is growing evidence for the relationship between a positive group environment and treatment success. This means that we have another evaluation tool which may be used in the short-term to help to determine treatment success or failure.

CHAPTER 12: EFFECTS OF TREATMENT ON SHORT-TERM RECIDIVISM IN CHILD SEXUAL ABUSERS

INTRODUCTION

The ultimate test of treatment efficacy is whether or not it reduces reoffending.[1] The only way that we can be sure of this is by comparing carefully matched cohorts of treated and untreated offenders. This is becoming increasingly difficult in England and Wales because treatment provision, both in prison and in the community, is now very common. However, there have been a number of evaluation studies which have been able to compare matched samples of treated and untreated sex offenders and many of these have indicated that cognitive-behavioural treatment of sex offenders can be effective in reducing recidivism.

Treatment evaluation

Sex offender treatment and evaluation has come a long way since the pessimistic conclusions of Furby, Weinrott and Blackshaw (1989) that there was no evidence for the effectiveness of clinical intervention. They rightly pointed out the lack of methodological rigour employed in the studies under review, as well as the many different forms of treatment being employed. Today there is far more consistency in treatment and in evaluation methodology. Treatment integrity is considered a minimum requirement for programmes to be successful and routine evaluation of the predominantly cognitive-behavioural groupwork programmes is becoming increasingly

[1] This chapter reports sexual recidivism only. For details of violent and other types of reoffence in both the treatment sample and the controls, see Appendix 5.

common (Allam and Browne, 1998). Whilst the evidence for treatment effectiveness is still quite modest, there does appear to be a growing body of research suggesting that cognitive-behavioural treatment of sex offenders can be effective in reducing recidivism (Dwyer, 1997; Hedderman and Sugg, 1996; Marques, Day, Nelson and West, 1994; Marshall and Pithers, 1994; Marshall, Jones, Ward, Johnston and Barbaree, 1991). Most follow-up studies have looked at relatively short periods at risk (generally under 5 years). However, this still allows for a comparison of untreated and treated offenders, which is all that is required to demonstrate positive treatment impact.

As well as evidence from individual recidivism studies, two recently conducted meta-analyses also provide support for the effectiveness of cognitive-behavioural treatment for sex offenders. Hall (1995) conducted a meta-analysis on a number of treatment programmes for sex offenders and found that there was approximately one third less recidivism (reconvictions) amongst treated offenders (19% compared to 27%). In particular, community-based programmes were found to be the most effective, as were those adopting a cognitive-behavioural approach. Alexander (1999) in her review of the recidivism literature found a combined sexual recidivism (re-arrests) rate of 8.1% in treated CSAs (cognitive-behavioural treatment) compared to a rate of 25.8% in untreated CSAs (not including incest abusers) over a 5 year period at risk. The data are encouraging in that such studies provide evidence that treatment development is moving in the right direction, i.e. the most recently conducted programmes (generally employing cognitive-behavioural group work techniques) have been found to be the most effective (Alexander, 1999).

Base-rates

Meta-analysis is a relatively recent contribution to the study of sex offender recidivism and because data are drawn from many samples, to some extent addresses the problems encountered when well-matched cohorts are not available as controls. Hanson and Bussiere (1998) conducted a meta-analysis of sexual reconviction studies

containing 29,000 sex offenders followed up for an average of 4-5 years. From this they derived a base rate of 12.7% sexual reconvictions for child sexual abusers (CSAs). The number of offenders included in their study is impressive and the base rate is likely to be the most accurate currently available. As such it is widely viewed as a benchmark against which reconviction rates obtained in other studies may be compared.

Whilst the above base rate is widely used for comparison, retrospective data are vulnerable to the variations which occur in both reporting levels of sexual offences against children and in actual conviction levels. Grubin (1999) illustrates this problem. He quotes Home Office statistics comparing the number of convictions/cautions in England and Wales for the 6 most common sexual offences against children in 1985 and 1995. There was a reduction in number of convictions for all types of offence, the reduction ranging from 12% (indecent assault of a girl under 16) to 61% (USI with a girl under 16). Friendship and Thornton (1999) report that the proportion of notifiable sexual offences resulting in a conviction or caution has halved since 1981. A reconviction study conducted during this period and using retrospective data to establish base rates might well draw inaccurate conclusions about the offending behaviour of one or more samples unless this difference in rates of conviction were taken into account. Problems such as these make it difficult to establish a base rate of reoffending against which comparisons may be made.

Whilst reconviction data can be compared across samples and different studies with a degree of confidence if care is taken to ensure that the two or more groups being compared are similar enough for such a comparison to be meaningful, it is known that reconviction data seriously underestimate actual reoffending. Marshall and Barbaree (1988) were able to examine files held by police and child protection agencies and uncovered rates of reoffending which were two and a half times that revealed by reconviction data. Even this may be the tip of the iceberg. Both epidemiological studies of childhood victimisation (e.g. Pilkington and Kremer, 1995) and offender self-report studies (e.g. Elliot, Browne and Kilkoyne, 1995) indicate vast under-reporting of sexual offences. Unofficial data sources, however, are not only difficult to

access, but they are likely to yield varying quantities and quality of data across studies. Therefore, unofficial recidivism data from one study cannot be compared with that of another. What they can do, however, is bring us closer to the truth about actual reoffending in a specific sample, as well as enable us to derive more accurate predictors of reoffence.

Predicting Recidivism

If it were possible to identify those offenders most at risk of reoffending, it would also be possible to target treatment more effectively, i.e. to allocate the most resources to working with those judged to be at the highest risk of reoffending. In recent years, efforts have been made to identify those factors which are predictive of sexual reconvictions (Hanson and Bussiere, 1998; 1996; Prentky, Knight and Lee, 1997; Thornton, 1997; Quinsey, Rice and Harris, 1995) and from research into sex offender recidivism (as measured by reconviction data) there have emerged a number of prediction instruments. These are generally in the form of a simple checklist where offenders score points according to how many of the variables apply to them. Those with the highest number of points are considered to be at the highest risk of reoffending. One example is Hanson's (1997) Rapid Risk Assessment for Sex Offender Recidivism (RRASOR) scale, where risk factors include: previous sex offences; age of offender; victim gender; relationship to victim. Such instruments focus on demographic and offence history data. As well as this being the type of data which is most accessible to researchers, it appears to be far more predictive of recidivism than clinical assessment. Hanson (1996: cited in Salter, 1998) reports correlations with sexual reconviction of .46 for actuarial assessments compared to only .1 for clinical assessments. Common to all risk assessment instruments is the weight given to offence history/offence specifics in the prediction of reconvictions for sexual offences.

One problem of actuarial risk predictors is that they cannot take into account the effects of treatment, which means that an offender can never change his level of risk.

Neither do they allow for a possible interaction of risk (as measured by offence and demographic information) and deviance (as measured by psychometric profiles). Research comparing reconviction data of treated and untreated offenders (see above) suggests that treated offenders are less likely to reoffend and by implication that clinical data can be a useful predictor of recidivism.

Dynamic risk variables

Empirical support for the link between reoffending and dynamic variables related to treatment aims is weak. This could, of course, be due to there being no such relationship. However, the fact that many studies show a positive effect of treatment on recidivism, suggests that treatment targets must be related to reoffending in some way. It is possible that studies finding no relationship between, e.g. victim empathy and reoffending have either not measured the variable in question or are working with outdated or inappropriate tests. Nowadays, there are some very good measures for assessing sex offenders - CSAs in particular and it may well be that in a few years researchers will be able to assess the link between reoffending and some of these variables.

Marques, Nelson, West and Day (1994) found that a strong predictor of recidivism was ability of subjects to apply the relapse prevention module but did not find an association with acceptance of personal responsibility, whereas Dwyer (1997) reports a link between poor self-esteem and reoffending. Hedderman and Sugg report findings from the STEP study (Beckett et al, 1994) that none of those CSAs who were judged to have made significant progress in treatment recidivated within their first 2 years at risk.

A recent development has been that of Thornton's (1997) Structured Anchored Clinical Judgement (SACJ) Risk Assessment Scale (described fully in Chapter 3 and reproduced in Appendix 3). Thornton's scale was developed using data from a 16yr follow-up study of 533 sex offender cohort (80% of whom had sexually abused

children) released from prison in 1979 and yields 3 risk of reconviction categories - Level 1 (low risk), Level 2 (medium risk) and Level 3 (high risk). It consists of a 3 step assessment process, where points are allocated according to the presence or absence of features. Steps 1 and 2 focus on offence histories and demographic data. Step 3, however, relates to clinical assessment. Whilst reconviction data has not been made available to demonstrate the validity of this third step, it has been included to allow for progress in treatment. It is the first prediction instrument to do this, suggesting that an offender's risk level can be reduced by 1 level if he has shown the appropriate in-treatment changes (such as a significant reduction in cognitive distortions, improved victim empathy, motivation to change, adequate relapse prevention skills, etc.). Including such information as a predictor of subsequent recidivism is potentially useful because it does allow treatment-related data to be included in any risk assessment.

Combining actuarial and clinical data to predict recidivism

Given that psychometric testing has been used in many treatment programme evaluations, it is surprising that little has been done to investigate the possibility of an interaction between actuarial risk and deviance as measured by psychometric tests (which may change in response to treatment). However, research conducted by the STEP team has collected information on deviance levels (as measured by psychometric testing) of hundreds of sex offenders, both in prison and in the community (Beckett, Beech, Fisher and Fordham, 1994; Beech, 1997/8). By classifying offenders according to levels of deviance (as well as actuarial risk) they have been able to identify a relationship between actuarial risk and deviance, which suggests that a combination of the two could be a better predictor of reconvictions than one or the other alone.

A recent 6 year follow-up of CSAs in the STEP study (Beech and Erikson, 2000) found that only 10% of men assessed as making progress in treatment compared to 23% of those who had not made progress. In addition, they found that the predictive

value of an actuarial measure of risk was improved by up to 86% by taking into account psychological profiles of the men at the pre-treatment stage.

Rationale and hypotheses

Rationale

The purpose of the present study was primarily to examine the impact of a cognitive-behavioural treatment programme on short-term sexual recidivism. A group of 126 men who had sexually abused children were referred to the West Midlands Probation Sex Offender Unit (SOU) between 1995 and 1997. Sexual reconviction data were compared with those obtained from a group of matched controls who did not receive treatment. Data were then examined further in order to establish links between reconviction and actuarial risk level in both groups and recidivism (official and unofficial) and psychometric deviance in the treatment group. Finally, recidivism data from the treatment group were explored in order to identify any links between reoffending, demographic, offence-related and sexual history variables.

Hypotheses

1. It is hypothesised that treated offenders are significantly less likely to be reconvicted of sexual offences than a group of matched controls.
2. It is hypothesised that there will be a significant and positive relationship between reconviction and actuarial risk (as measured by using step 1 of the SACJ) in both the control and treatment groups.
3. It is hypothesised that recidivism (both official and unofficial) in the treatment group will be positively related to initial high deviance as measured by psychometric tests.
4. It is hypothesised that recidivism in the treatment group will be significantly and negatively related to overall progress in treatment.

METHOD

The methodology described below was designed to assess the impact of participating in the Sex Offender Unit (SOU) therapy programme on short-term recidivism (see Chapter 2 for a description of the programme).

Design and Procedure

The control sample was obtained from the West Midlands Probation Service (WMPS) database, where information is contained on all offenders detained for committing offences in the region. In 1995 adult male CSAs for whom the SOU had recommended treatment over the previous 1.5 yrs were identified. Those who received longer prison sentences were removed from the sample, since they would not be at risk during the time of this study (n=12). Also, 53 of the original sample were removed at a later date because they began attending the SOU following release from prison. This left a total of 47 males who had been convicted of sexual offences against children but who were not mandated to attend a sex offender programme.

Past conviction data and reconviction data on both treatment and control groups were obtained from the Home Office Offender Index, with reconviction data being valid until December, 1998. Some unofficial reoffence data (i.e. not resulting in a conviction during the course of this study) were collected on the treatment group, sources of information being self-report and the Police.

Actuarial risk was calculated using Step 1 of Thornton's (1997) Structured Anchored Clinical Judgement (SACJ) algorithm (Appendix 4). The information required was gleaned from offence history data held on the Home Office Offender Index. Where the treatment group are considered separately, actuarial risk is calculated using both steps 1 and 2 of the SACJ. Level of deviance (as measured by psychometric tests) was calculated (for the treatment group only) using the clustering method described in Chapter 10.

Samples

The treatment sample consisted of 126 adult male child sexual abusers (CSAs) referred to the West Midlands Probation Service Sex Offender Unit (SOU) between January 1995 and January, 1997. All men who began the programme (even if they dropped out) are included in this sample. The control group consisted of 47 adult male CSAs who had not been obliged to attend the SOU programme despite this having been recommended to the courts. Their sentences had ranged from a conditional discharge to imprisonment, with a majority being given a community order with no condition of treatment.

Treatment and control samples were comparable in terms of cohort, location, perceived suitability for treatment. In both groups, a majority had been convicted of indecently assaulting a child - 68.4% of the treatment group and 63.8% of the controls. When actuarial risk was calculated using step 1 of the SACJ (Thornton, 1997), the treatment sample appeared to be somewhat higher risk overall than the control group, as illustrated in Table 12.1 (SACJ risk level using steps 1 and 2 are also presented for the treatment group). However, the Crosstabs (Pearson Chi-Squared) procedure failed to identify significant differences between individuals' levels of risk in the 2 groups (χ^2=1.99, df=2).

Table 12.1: Risk of Reconviction in Treatment and Control Groups

Risk Level	Control Group (SACJ Step 1)	Treatment Group (SACJ Step 1)	Treatment Group (SACJ Steps 1& 2)
I - Low	63.8% (n=30)	51.6% (n=65)	37.3% (n=47)
II - Medium	27.7% (n=13)	35.7% (n=45)	48.4% (n=61)
III - High	8.5% (n=4)	12.7% (n=16)	14.3% (n=18)
Total	100% (n=47)	100% (n=126)	100% (n=126)

There was a fairly large difference in average age of the 2 groups. The mean age of men in the treatment group was 43.11 (sd=12.97), compared to 32.52 (sd=15.41) in the controls. Given that a difference in risk of reconviction had not been identified, it was felt that the age difference would not threaten the validity of the comparison of the two groups. Average time at risk was 25.27 (sd=7.47) months for the treatment group and 26.26 (sd=11.66) months for the controls. This difference was not significant (t=.54, df=61.25, 2-tailed).

Treatment of data

Reconviction rates for sexual recidivism were calculated for treatment and control groups and Chi Squared analyses were conducted to identify any difference in these rates. Lifetable analyses were then performed in order to demonstrate sexual recidivism according to time at risk and survival rates of the treatment and control groups were compared using the Wilcoxon Gehan statistic (SPSS, 1994). Reconviction rates were then examined according to actuarial risk. Risk level was correlated with sexual recidivism in both groups.

Prior to further analyses, unofficial sexual recidivism data for the treatment group was added to official data to produce a more accurate picture of reoffending. Firstly, both risk level (incorporating steps 1 and 2 of the SACJ) and the initial level of deviance (calculated using the cluster procedure described in Chapter 10) in the treatment group were correlated with sexual recidivism. Next, in order to identify any interaction between actuarial risk and deviancy in the commission of new sex offences by treated offenders, a One Way Anova was conducted.

In order to examine possible differences in overall level of movement in treatment (as measured by the psychometric tests described in Chapter 3), an independent t-test was conducted to look at differences in changes in the number of scale scores falling into functional ranges. Next, a MANOVA was performed with recidivist status as the independent variable and change in psychometric test scores as dependent variables.

Finally, analyses were carried out in order to obtain data to use within a discriminant function analysis (SPSS, 1994). Variables found to be significantly related to recidivism were then used to obtain two algorithms (one for the pre treatment stage and one for mid/post treatment) which could discriminate between short-term recidivists and non-recidivists.

RESULTS

Sexual reconviction in treatment and control groups compared

With an average time at risk of approximately 27 months, a total of 4 (3.2%) of the treated CSAs were convicted of further sexual offences - one offence (court appearance) per offender. This compares to a figure of 5 (10.6%) recidivists in the control group, one of whom recidivated twice. A Chi-squared analysis confirmed that the difference in reconviction rates was statistically significant at $p<.05$ ($\chi_2=3.81$, df=2).

Lifetable analyses were conducted in order to demonstrate sexual recidivism according to time at risk. Results are illustrated in Table 12.2. In both groups the majority of reoffending occurred in the first 2 years at risk. However, survival rates (i.e. the proportion of offenders who are not reconvicted) are clearly far better in the treatment group. For example, only 5.5% of those in the sample at risk for 3 years were reconvicted, compared to 21.3% of the controls. When survival rates were compared using the Wilcoxon Gehan statistic, a significant difference was found ($t=3.05$, $p<.05$, 1-tailed). Hypothesis 1, that treated CSAs are less likely to be reconvicted of a sexual offence is therefore accepted.

Table 12.2: Lifetable analyses showing sexual reconviction rates of treated offenders and untreated offenders

Sample	By 1yr at Risk	By 2yrs at Risk	By 3yrs at Risk
Treated (n=126) % recidivists in group at risk	1 (.9%)	4 (5.5%)	4 (5.5%)
Untreated (n=47) % recidivists in group at risk	3 (7.1%)	4 (10.8%)	5 (21.3%)

Pre-treatment risk level and its relationship to recidivism

When reconvicted offenders were grouped according to risk (using step 1 of the SACJ Risk Assessment Scale), the following emerged: none of the low risk offenders in the treatment sample were reconvicted compared to 3.33% (n=1)of the controls; 4.55% (n=2) of the medium risk offenders in the treated sample were reconvicted of a sexual offence compared to 15.39% (n=2) of the untreated offenders; 12.5% (n=2) of the high risk group in the treated sample were reconvicted compared with 50% (n=2) of the controls. There was a significant relationship between risk level and reconviction in both groups. However, whereas the correlation between risk and reconviction in the treatment group was fairly modest (r=.23, p=.01, 2-tailed), it was rather higher in the control group (r=.4, p=.005, 2-tailed). Thus, hypothesis 2, that there would be a stronger relationship between actuarial risk and reconviction in the control group, is accepted.

Treatment group recidivists

Unofficial sexual recidivism data suggested that 8 of the treatment sample had reoffended, although only 4 had been reconvicted. All of the 4 "unofficial" offences (alleged offences were treated as reoffences) came to the notice of the SOU from the Police. In two cases a complaint had been made against the individuals concerned and the remaining 2 men had been charged. The SOU were also aware of all of those reoffences which resulted in a reconviction. In one case, the offender had contacted the Unit after reoffending and the Unit informed the police. None of the recidivists had completed the treatment programme and five had left the programme as a direct result of their reoffending.

When unofficial recidivists and recidivists are pooled, and when steps 1 and 2 of the SACJ were used to assess actuarial risk, recidivism still correlated with risk level. However the relationship was weaker than it was when only reconvicted offenders were included ($r=.18$, $p=<.05$, $df=124$, 2-tailed). Recidivists were more likely to be in a high or medium risk group than non-recidivists.

Recidivism and its relationship to psychometric deviance

Seventy-five percent (n=6) of those who reoffended were within a high deviance group, with 8.7% of the high deviance offenders reoffending compared to 3.13% of the low deviance offenders. This difference was significant at $p<.05$ ($\chi^2=2.72$, $df=1$, 1-tailed). Hypothesis 3, that recidivism will be related to psychometric deviance is thus accepted.

The Relationship Between Recidivism and Risk/Deviance Categories

In order to explore the possibility of an interaction between actuarial risk and deviance (as measured by psychometric testing), both official and unofficial recidivists were

grouped according to initial risk/deviance levels (actuarial risk was calculated using steps 1 and 2 of the SACJ for this stage of analysis). Table 12.3 illustrates the proportions of recidivists in each category, with the data suggesting that both level of risk and level of deviance may be important in predicting recidivism. Few low risk offenders recidivated. However, the only one who did was categorised by psychometric test results as highly deviant. Similarly, the only low deviance offenders who reoffended were both in the high risk group. A Chi-squared analysis was conducted on the data in order to identify any significant relationship between recidivism and risk/deviance. None was found ($p>.05$, $\chi^2=10.53$,df=5, 1-tailed).

Table 12.3: Recidivism in the treated sample (n=125) by risk/deviance level

Low Risk/Low Deviance (n=25, 20% of sample) ***Official Recidivists = 0*** ***Unofficial Recidivists = 0*** 0% of sample, 0% of this group	**Medium Risk/** **Low Deviance** (n=30, 24% of sample) ***Official Recidivists = 0*** ***Unofficial Recidivists = 0*** 0% of sample, 0% of this group	**High Risk/** **Low Deviance** (n=9, 7.2% of sample) ***Official Recidivists = 1*** ***Unofficial Recidivists = 1*** 1.6% of sample, 22.22% of this group
Low Risk/High Deviance (n=22, 17.6% of sample) ***Official Recidivists = 0*** ***Unofficial Recidivists = 1*** 0.8% of sample, 4.6% of this group	**Medium Risk/** **High Deviance** (n=30, 24% of sample) ***Official Recidivists = 2*** ***Unofficial Recidivists = 2*** 3.2% of sample, 13.33% of this group	**High Risk/** **High Deviance** (n=9, 7.2% of sample) ***Official Recidivists = 1*** ***Unofficial Recidivists = 0*** 0.8% of sample, 11.11% of this group

Further analysis revealed, however, that when the risk/deviance categories were converted into dichotomous variables, risk/deviance group was found to discriminate between recidivists and non-recidivists. The first group includes those who are in a high (actuarial) risk group (whatever the deviance level) **or** in the medium risk but high deviance group. The second group consists of those who are either low risk (irrespective of deviance level **or** medium risk but low deviance. A Chi-squared analysis performed on these data indicated a significant difference between the two groups ($p<.005$, $\chi^2=10.54$, df=1, 1-tailed), with recidivists significantly more likely to come from the high risk or medium risk/high deviance groups.

The relationship of recidivism to progress in treatment

When progress in treatment is considered, trends in the predicted direction were identified. When mean improvement (in those who had been tested more than once and had left the programme) was measured using the points system described in Chapter 10, it was found that non-recidivists had moved into a functional range for an average of 1.56 (sd=1.76) scales compared to an average of .75 (sd=1.75) in those who reoffended. This difference was not significant (t=1.3, df=97, 1-tailed), however, and hypothesis 4, that recidivists would show less overall improvement in treatment has not been supported. Therefore, the null hypothesis cannot be rejected.

Associations with short-term recidivism

In order to identify any existing links between other static and dynamic variables and recidivism in the treatment group, independent t-tests were conducted on nominal data and Pearson Chi-squared analyses carried out on categorical data gleaned from files and from responses to the Sexual History section of the Multiphasic Sex Inventory (MSI). Where there were several categories in a variable, they were broken down into dichotomous variables if a significant relationship or a trend was identified. Similarly, where t-tests revealed significant differences between the two groups (in all cases score

data), the data were converted into binary variables. Significant relationships are reported in Table 12.4 below.

Table 12.4: Chi-squared analyses of pre-treatment predictors of recidivism

Variable	χ^2 (n=125, df=1)	p (2-tailed)
High risk or medium risk/high deviance[2]	10.54	.01
MSI Child Molest Lie score of 0-2[3]	9.14	.01
Victim Awareness score of 99+[4]	8.87	.01
MSI Sexual Inadequacies score of 3+[5]	8.02	.01
Was punished as a child when caught in sexual activity[6]	7.45	.01
MSI Premature Ejaculation score of 2+[7]	6.82	.01
Any extra-familial abuse	6.2	.05
Has never lived with a sexual partner[8]	6.16	.05
MSI Sexual Obsessions score of 10+[9]	6.16	.05
Has had a victim under 11yrs of age	5.45	.05
High EC with children - score of 35+ (if a parent) or 26+ (if not a parent)[10]	4.22	.05
Has never had sex with an adult[5]	4.19	.05

[2] Given that 87.5% of recidivists belonged to one of these categories, a chi-squared analysis was conducted on the dichotomous variables: High risk **or** medium risk/high deviance (yes) or low risk or medium risk/low deviance (no).

[3] A score of 0-2 indicates that an individual fully acknowledges his arousal to children.

[4] From Allam (1995a). A score of 99+ represents 3 sd or more above the mean.

[5] A score of 3+ is 1sd or more above the mean.

[6] Item 231 of MSI.

[7] A score of 2+ is 1 sd or more above the mean.

[8] Item 89 of MSI or clinical/file data.

[9] A score of 10 or more indicates that an individual is sexually obsessed.

[10] From Beckett, 1993 (Children and Sex Questionnaire). These scores represent 1 sd or more above the mean.

[5] Item 32 of MSI or clinical/file data.

The strongest association with recidivism was found to be risk/deviance level ($p<.01$, $\chi^2=10.54$, df=1, 2-tailed), with recidivists far more likely than non-recidivists to belong to a high (actuarial) risk group or a medium risk but high deviance group. Other strong relationships concerned sexual problems, acknowledgement of high deviance, high emotional congruence with children, lack of adult partner and high levels of distortions about child victims of sexual abuse.

No significant differences between the two groups were found in: victim gender; parental status; previous convictions (sexual, violent and other); employment status; literacy; disability; ethnicity; being a victim of sexual abuse as a child; a perceived lack of love from parents as a child; a member of the family having been in trouble over their sexual behaviour; using prostitutes; having been in love; gender dysphoria; sexual orientation. Neither were a majority of 0hrs tests scores found to be strongly related to early recidivism, although there were strong trends towards: higher levels of global distortions about child sexuality; lower levels of accountability; more sexual dysfunction; poorer knowledge relating to sexual anatomy and physiology.

Table 12.5 illustrates a further three variables which discriminate between recidivists and non-recidivists post-treatment. It may be seen that final scores on 3 scales were significantly associated with short-term recidivism, the strongest association being with socially desirable responding.

Whilst the number of treatment related variables being significantly related to recidivism is very limited, there are many trends in the data. For example, recidivists were less likely to demonstrate overall progress (and progress on individual measures) during treatment (despite the fact that the average number of hours they completed was no different from that of non-recidivists.

Table 12.5: Chi-squared analyses of post-treatment predictors of recidivism

Variable	χ^2 (n=125, df=1)	Level of significance
Final Social Desirability score of 66+[11]	16.34	.001 2-tailed
Final Rape Myth Attitudes score of 51+[12]	4.24	.05 2-tailed
Final Cognitive Distortions score of 32+[13]	4.11	.05 2-tailed

A discriminant function analysis was performed on the data using those variables found to be significantly associated with short-term recidivism. This was done for both pre and mid/post treatment data.

A predictive model of short-term recidivism

A discriminant function analysis (using the enter method) was performed (SPSS, 1992) on the pre-treatment variables displayed in table 12.4. The same analysis was performed by adding the treatment-related data in table 12.5. In both cases, 3 of the sample were removed because of 1 or more missing variables.

A pre-treatment model

Only 1 canonical discriminant function (with a canonical correlation of r=.6) was derived in the analysis of pre-treatment variables discriminating between recidivists and non-recidivists. Table 12.6 presents the results of this analysis, containing pooled

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[11] Personal Reaction Inventory (PRI) score of 1 sd or more above the mean.

[12] Burt (1980) Rape Myth Acceptance score of 1 sd or more above the mean.

[13] From Beckett, 1993 (Children and Sex Questionnaire). Score of 2 sd or more above the mean.

within-groups correlations between the discriminating variables and the standardised canonical discriminant function. Variables are ordered by absolute size of correlation within the function.

Using the discriminant model of twelve risk factors, CSAs were classified into those likely to recidivate and those unlikely to recidivate. This predicted group membership was then compared to actual outcome. Table 12.7 presents the results from this comparison and shows that 92.6% of CSAs were correctly classified. The model correctly specified 93.1% (specificity) of non-recidivists and was sensitive to 87.5% (sensitivity) of those who reoffended sexually.

Table 12.6: Correlations of pre-treatment discriminating variables with canonical function

Variable (n=123)	Canonical correlation with function
MSI Sexual Obsessions score of 10+	.47
MSI Child Molest Lie score of 0-2	.38
High risk or medium risk/high deviance	.37
Victim Awareness score of 99+	.37
MSI Sexual Inadequacies score of 3+	.34
Has never lived with a sexual partner	.34
Was punished as a child when caught in sexual activity	.33
MSI Premature Ejaculation score of 2+	.32
Has never had sex with an adult	.32
Any extra-familial abuse	.3
Has had a victim under 11yrs of age	.28
High EC with children - score of 35+ (if a parent) or 26+ (if not a parent)	.26

Table 12.7: Accuracy of pre-treatment risk factor algorithm in classifying offenders who reoffended within 3 years and those who did not reoffend (n=126)

	Predicted group	
Actual group		
	Recidivists	**Non-recidivists**
Recidivists (n=8)	7	1
Non-recidivists (n=118)	7	111

The model was then converted to an algorithm by awarding points according to the size of the correlation. For any correlation of .4 or more, 3 points were awarded, 2 points for a correlation of .3 or more and 1 point for a correlation of .2 or more. Each individual's total points was then calculated and a cut-off point was set after examining the data. It was found that a score of 10+ (as a predictor of short-term recidivism) achieved a good balance of sensitivity and specificity. The total number of false negatives was 1 (12.5%) and the number of false positives was 7 (5.93%) when the algorithm was tested on the data. Table 12.7 illustrates these results.

Within/post-treatment model

An identical procedure was used to produce an algorithm which incorporates treatment data. This model included the variables described above but also those identified in Table 12.5. Again, 3 individuals were removed from the analysis due to 1 or more missing variables. As before, only 1 canonical discriminant function was derived in the analysis with a canonical correlation of r=.656. Table 12.8 presents the results.

Using the discriminant model of fifteen risk factors, CSAs were classified into those likely to recidivate and those unlikely to recidivate. This predicted group membership was then compared to actual outcome. Ninety three percent of CSAs were correctly

classified. The model correctly specified 95.7.% (specificity) of non-recidivists and was sensitive to 87.5% (sensitivity) of those who reoffended sexually.

Table 12.8: Correlations of post-treatment discriminating variables with canonical function

Variable (n=123)	Canonical correlation with function
Final Social Desirability score of 66+	.44
MSI Sexual Obsessions score of 10+	.4
MSI Child Molest Lie score of 0-2	.33
High risk or medium risk/high deviance	.32
Victim Awareness score of 99+	.3
MSI Sexual Inadequacies score of 3+	.3
Has never lived with a sexual partner	.29
Was punished as a child when caught in sexual activity	.29
MSI Premature Ejaculation score of 2+	.27
Has never had sex with an adult	.27
Any extra-familial abuse	.26
Has had a victim under 11yrs of age	.24
High EC with children - score of 35+ (if a parent) or 26+ (if not a parent)	.23
Final Rape Myth Attitudes score of 51+	.22
Final Cognitive Distortions score of 32+	.21

Table 12.9: Accuracy of post-treatment risk factor algorithm in classifying offenders who reoffended within 3 years and those who did not reoffend (n=126)

	Predicted group	
Actual group		
	Recidivists	**Non-recidivists**
Recidivists (n=8)	8	0
Non-recidivists (n=118)	9	109

The model was converted to an algorithm by awarding points according to the size of the correlation. For any correlation of .4 or more, 3 points were awarded, 2 points for a correlation of .3 or more and 1 point for a correlation of .2 or more. Each individual's total points was then calculated and a cut-off point was set after examining the data. It was found that a score of 9+ (as a predictor of short-term recidivism) achieved a good balance of sensitivity and specificity, as illustrated in Table 12.9. There were no false negatives (all recidivists were identified) and the number of false positives was 9 (7.63%). Total correct classification was 92.86%.

DISCUSSION

The majority of the predictions made about recidivism at the outset of the evaluation were shown to be correct. The most important finding was that, as hypothesis 1 postulated, offenders in the treated sample were less likely than members of the control group to be reconvicted for sexual offences. Hypotheses 2 and 3 predicted that actuarial risk and psychometric deviance respectively would be predictive of recidivism and this was found to be the case with both higher risk individuals and higher deviance individuals being more likely to reoffend. In fact, it was a combination of these factors that proved to be the most accurate predictor of both official and unofficial recidivism.

Whilst psychometric deviance was related to reoffending, no significant relationship was identified between level of progress in treatment and recidivism. Thus, whilst there was a trend in the predicted direction, hypothesis 4 could not be accepted.

Finally, an exploration of data which sought to identify links between numerous static and dynamic variables and early recidivism, made it possible to construct algorithms which were highly predictive of reoffending in this sample.

Unofficial recidivism rates were found to be twice as high as reconviction rates in the treatment group. Those in the treatment group who reoffended exhibited less progress in treatment than those who did not reoffend, although this difference was not statistically significant. This could be due to a number of reasons, including a failure to engage in the treatment process .

Finally, it was predicted that recidivism would be related to initial risk/deviance level. Again there was a trend in the predicted direction (i.e. the higher the risk and the higher the deviancy) but results were not significant.

Implications

The finding that offenders in the treated sample were less likely than members of the control group to be reconvicted for sexual offences endorses the view that sex offender treatment can be beneficial.. Even when allowing for differential times at risk, the treatment group recidivated at a much lower rate than the controls For example, by 2 years the proportion of treated offenders who had been reconvicted was half that of the untreated controls. These results suggest that sex offender treatment for child sexual abusers can reduce sexual recidivism considerably (at least in the short-term). This is consistent with the research outlined above (e.g. Hedderman and Sugg, 1996; Marques, Day, Nelson and West, 1994; Marshall, Jones, Ward, Johnston and Barbaree, 1991). The results cannot be explained in terms of differential levels of actuarial risk, since the groups have been adequately matched. Neither will this study

have been affected by differing base rates of reconviction because the control sample is from the same cohort as the treated sample.

The fact that actuarial risk was a reasonably strong predictor of recidivism, is not surprising, since such instruments are developed by using reconviction data e.g. Thornton (1997). However, it was felt that level of deviance must also be a factor in recidivism given the evidence that treated sex offenders are less likely to commit new sexual offences than untreated sex offenders. Initial level of deviance alone was found to have some predictive value but it was a combination of actuarial risk and level of deviance that proved to be a better predictor of recidivism[14]. When risk/deviance groups were transformed into binary variables it was observed that high risk **or** medium risk /high deviance were significantly more likely to reoffend than those in low risk **or** medium risk/low deviance groups. This suggests that if a method of standardising level of psychometric deviance can be achieved, we might have a useful indicator of those who are most at risk of reoffending in the short term.

Recidivists in this study appeared to have made less overall progress in treatment as measured by psychometric tests. This could not be accounted for by differential time in treatment since average stay in group did not differentiate recidivists and non recidivists. However, the differences observed were not statistically significant and further research would need to be done in this area to see whether progress (or lack of progress) in treatment has some potential for identifying those most at risk of reoffending. This research would clearly need to involve some standardisation of the measurement of in-treatment progress and perhaps an investigation into which areas of in-treatment change appear to relate to subsequent reoffending. This study has

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[14] The fact that unofficial recidivism is higher than actual reconvictions replicates the findings of Marshall and Barbaree (1988) when they discovered that access to unofficial data revealed 2.5 times the number of reoffences. Unfortunately, the kind of data obtained by the SOU on offenders who were or had been involved in groupwork was not available for the control group. However, there is no reason to believe that the controls would have committed fewer offences than the treated sample which did not result in conviction.

addressed this to an extent by looking at in/post-treatment predictors of reoffence.

Whilst not predicted, the fact that relationship history, childhood sexual trauma and victim age were found to be related to recidivism was not surprising. Several actuarial risk algorithms use victim data and relationship status, for example, in predicting subsequent reoffending (e.g. Hanson, 1997). What was surprising, however, was the degree of accuracy of the risk algorithms derived from discriminant function analyses. Both pre and in/post treatment algorithms present as highly accurate predictors of short term recidivism. Not only do they correctly identify the vast majority of recidivists but the numbers of false positives is small. Obviously, caution should be exercised in interpreting these data - both because of low sample numbers and because a number of variables previously found to be related to recidivism, such as previous sexual offences (e.g. Grubin, 1999), were not found to be statistically significant in this study. It will, of course, be necessary to test these algorithms on other data sets. However, this exercise has illustrated the potential usefulness of discriminant function as a predictor of sexual reoffending, as well as the importance of collecting as much information as possible about offenders.

CONCLUSION

The recidivism study reported here lends support to the mounting evidence that child sexual abusers can benefit from cognitive-behavioural groupwork and are less likely to reoffend sexually (or otherwise) than their untreated counterparts. Even when unofficial recidivism was taken into account, the treated offenders recidivated less than the controls. Both actuarial risk and level of pre-treatment deviance were found to predict recidivism but a combination of the two methods of assessment proved to be more useful. Even more useful, were algorithms derived from discriminant function analyses. Such algorithms have the potential for being used at the pre-sentence stage to determine whether or not an individual is suitable for community treatment (high

scorers may need prison-based/residential treatment first). The post treatment algorithm may be used with CSAs who have already completed some sex offender work.

Since treatment aims at reducing deviance and has also been found to lower recidivism rates, it is clear that the dynamic factors are implicated in reoffending. However, these factors are complex and more research needs to go into identifying better predictors of recidivism so that they can be directly targeted in treatment. In order to better understand how treatment can be made more effective by accurate targeting of resources it is essential that both treatment and evaluation research is standardised. This will increase sample sizes and make the comparison of "treated" recidivists and non-recidivists a meaningful exercise - less subject to error due to small numbers.

CHAPTER 13: DISCUSSION

SUMMARY OF AIMS AND HYPOTHESES

The aim of this study was to measure the effectiveness of a recently established community-based treatment programme for sex offenders. The West Midlands Probation Service (WMPS) Sex Offender Unit (SOU) was set up in 1993 to provide cognitive-behavioural groupwork aimed at reducing recidivism in sex offenders. The vast majority of offenders are child sexual abusers (CSAs)[1] and this study focuses on the impact of treatment on a sample of 126 CSAs (all males) who were referred to the programme in 1994 and 1995.

The principle objectives of the thesis were to ascertain whether treatment can reduce short-term (up to 3 years) recidivism levels and whether it has a positive impact on psychological variables (e.g. cognitive distortions about children, poor victim empathy, lack of accountability) associated with sexual offending. Recidivism in the treatment group was measured using both official (from the Home Office Offender Index) and unofficial (reports made to the SOU by police) data. Official data were available for a matched control group of 46 CSAs. In-treatment progress on psychological variables was measured using a battery of psychometric tests at several points in the programme: 0hrs (pre-treatment), 50hrs, 100hrs and 200hrs (post-treatment).

Aims not directly related to evaluation of outcome were to describe the SOU treatment programme and to describe a typical community sample of CSAs, both in terms of demographics and psychological profiles.

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[1] At the time of this study, CSAs made up 81.3% of group members

It was hypothesised that short-term reconviction rates would be lower in the treatment group than in the control group and it was postulated that treatment would have a positive impact on psychological variables which tend to discriminate between CSAs and non-offenders. CSAs were predicted to: be denying and minimising less; have more victim awareness; have fewer cognitive distortions; have better relapse prevention skills on leaving the treatment programme.

OVERVIEW OF CHAPTER CONTENT AND RESULTS

Chapter 1 reviewed the sex offender treatment evaluation literature and considered the methodological issues involved in undertaking such projects - in particular the identification of suitable control groups and the problem of undetected recidivism.

Chapter 2 briefly described the SOU treatment programme. Areas covered included: programme style and content; programme organisation; models used to effect change. The description indicates that, at least in terms of structure and organisation, the programme fulfils the requirements of treatment integrity (e.g. Hollin, 1992).

Chapter 3 presented the methodology of the study. It began by outlining a rationale, drawing on recent work by British researchers (in particular, Beckett, Beech, Fisher and Fordham, 1994). The quasi-experimental design was explained and brief sample descriptions (treatment, control and comparison samples) illustrated the fact that wherever possible data were obtained to compare the sample of CSAs on the SOU programme with untreated CSAs and non-offenders. Frequencies of non-completers and treatment dropouts were also presented here. As well as data collection procedures and sources, a thorough description of the psychometric measures employed was included.

Chapter 4 focused on describing the sample of 126 CSAs in relation to demographics, offence histories and background information about sexual and childhood histories. The data were compared to that published in the 1994 edition of Regional Trends

wherever possible, the purpose being to ascertain how representative a sample of the West Midlands population this group of CSAs was. An important finding was that non-white offenders were under-represented. However, other than this (and the fact that all offenders were male), there were no striking differences. Neither did the offenders differ greatly from those samples described in other studies (e.g. Beech 1997/98; Dobash, Dobash and Waterhouse, 1995; Elliot, Browne and Kilcoyne, 1995).

Chapter 5 presented pre-treatment psychometric test results. It was predicted that a number of the scales used in the evaluation would yield two factors corresponding to: offence-related denial/admission (e.g. denial of arousal to children; denial of offence-related behaviours; denial of the need for treatment) and pro-offending thinking (e.g. poor victim awareness; distortions about child sexuality; emotional congruence with children; lack of accountability). The results were as expected, with the two factors identified. Of the remaining scales, several were associated with sex-related denial, deviance and dysfunction but, because of qualitative differences, they were not considered suitable for factor analysis. Also, relapse prevention scales and a risk awareness scale were treated separately. As predicted, this group of CSAs was found to differ from non-offenders on those variables for which control data were available but not to differ in level of socially desirable responding. They had more distortions, higher or lower levels of emotional congruence with children than non offenders; poorer victim awareness; presented as more asexual and as having more problems with sexual dysfunction. In addition they were higher in denial and lower in accountability than is desirable. They thus presented as deviating from the norm in many respects but also as being fairly typical of a group of untreated CSAs.

Chapter 6 examined in-treatment movement in offence-related denial and admission. It began by presenting a review of relevant literature and hypothesising that the CSAs in this sample would demonstrate significant and positive in-treatment change on measures of denial when pre and post scores were compared. It was also hypothesised that significant movement would take place during the first 50hrs of the programme and that fewer CSAs would obtain high denial scores post-treatment when compared

to pre-treatment. The results demonstrated clear improvements and all hypotheses were accepted. Thus, the SOU programme was effective in significantly reducing levels of offence-related denial and admission.

Chapter 7 focused on sex-related denial, deviance and dysfunction. Few studies have reported on these aspects of sex offender functioning. However, there is increasing evidence for problems relating to social functioning (e.g. Marshall, 1999; Beech, 1998/99; Fisher and Beech, 1998a) and it seems reasonable to assume that sexual dysfunction/ignorance/dissatisfaction might be related in some way to sexual offending. It was predicted that CSAs would report higher levels of sexual dysfunction pre-treatment when compared to post treatment and that their level of knowledge relating to sexual anatomy and physiology would have significantly improved. Both hypotheses were supported by the results. No other predictions were made but it was found that there were moderate improvements in levels of "functional" scores on a number of scales measuring: social/sexual desirability; sexual dysfunction; and knowledge about sexual anatomy and physiology. There was evidence, then, for a positive effect of treatment on sexual dysfunction and level of sexual knowledge. In addition, CSAs were more likely to admit to "normal" sex drives and interests post-treatment.

Chapter 8 reviewed the literature on pro-offending thinking and reported the results of in-treatment changes. The predictions about treatment impact were all found to be true. CSAs demonstrated significant and positive change between pre and post treatment and reduction in pro-offending thinking was found to be a function of time spent in treatment, the longer in treatment the lower the levels of pro-offending thinking. Highly deviant scores on measures of pro-offending thinking were also more commonly found pre-treatment. Thus, on leaving the programme, CSAs were less likely to: have high levels of distortions about child sexuality; have abnormally high levels of emotional congruence with children; justify their offending; blame victims.

Chapter 9 presented results pertaining to awareness of risk and relapse prevention skills. After an introduction to the concept of relapse prevention, along with an

alternative model of the relapse process (Ward and Hudson, 1997), results of recent evaluation studies were considered. It was predicted that perception of risk, insight into offending and relapse prevention strategies would all show significant improvement as a result of treatment. There was indeed evidence for improvement in all of these areas. However, even at 200hrs (post-treatment), the average score on the Relapse Prevention questionnaire was only 50% of the total possible score.

Chapter 10 introduced a clustering method (first described by Beckett et al, 1994) for categorising CSAs according to risk/deviance group (i.e. according to actuarial risk and psychometric deviance). In addition, a simple procedure for classifying offenders into "treated" or "untreated" groups was presented. Risk/deviance groups were found to differ from one another on a majority of 0hrs psychometric test results, with higher deviance groups having the most deviant scores. Risk group was also found to be important with medium risk/high deviance offenders having more deviant scores than low risk/high deviance CSAs. Risk/deviance group did not predict rate of progress in treatment. As predicted, offenders with some experience of treatment were more likely to fall within the low deviance clusters. Finally, having a "treated" profile was predicted to be positively and significantly related to time in treatment. This was found to be the case and the hypothesis was accepted.

Chapter 11 presented a brief review of the literature on group environment and its relationship to effective treatment. It was expected that indicators of a positive group environment (cohesion and leader support) would be significantly to other indicators of a positive group environment and to progress in treatment. It was also hypothesised that SOU groups would be shown to have positive group environments where group member and group leader perceptions of the group process were very similar. There was evidence to support all hypotheses and SOU group environments were found to be generally very positive (as reported by members and facilitators), with some evidence for links between a positive group environment and treatment success.

Finally, Chapter 12 presented recidivism data. Only 4 (3.18%) of the treatment group were reconvicted of a sexual offence within the first 3 years at risk. This compared to

a figure of 10.87% (N=5) in the untreated controls. Even when unofficial recidivism was included to make a total of 8 (6.36%) recidivists, the treated sample were found to reoffend at a lower rate than the untreated sample. As expected, there was a positive relationship between recidivism and actuarial risk in both groups but the relationship was stronger in the controls (suggesting a mediating effect of treatment on actuarial risk) and between recidivism and psychometric deviance. However, a combination of risk and deviance proved to be a better predictor of reoffence in the treatment group. There was also a non-significant trend towards recidivists making less progress in treatment. In an attempt to identify a good predictive tool, a discriminant function analysis was performed on those static and dynamic variables found to be associated with recidivism in the treatment group. A surprisingly accurate algorithm was derived, producing few false positives and even fewer false negatives. This algorithm was then adapted for use with treated offenders.

IMPLICATIONS

Group environment was generally very positive and the programme has high levels of programme integrity. The meta-analytic literature suggests that these characteristics would predict a positive treatment outcome. The results of the evaluation would appear to support this prediction.

Recidivism

The main finding, that treatment can reduce recidivism (at least in the short-term) lends support to the view that cognitive-behavioural treatment of CSAs can reduce reconviction rates. Whilst Friendship and Thornton (1999) and Grubin (1999) warn of the variability of conviction rates over time, the fact that the control group in this study was a well-matched cohort increases the reliability of the results.

The fact that unofficial reoffence data of treated offenders doubled recidivism rates is

not surprising. It is well known that a great deal of sex offending goes undetected or simply doesn't result in convictions and Marshall (1988) obtained similar results when he took unofficial recidivism into account. A problem with such data is that it tends not to be available for control groups, thus limiting the comparisons that could be made. Also, it is probable that the existence of programmes such as that run by the SOU in itself increases the conviction rates. This is because there is a relationship with police and social services that facilitates the exchange of information. Examples of this are: the police sometimes contact the SOU when they have a profile of an offender they are seeking. If SOU staff believe that a group member might fit this profile, they pass this information to the police; offenders sometimes report reoffences (which might have gone unreported) to staff, who then contact the police (one of the recidivists in this sample contacted a Unit officer immediately after reoffending and was subsequently convicted of the offence).

Information on reoffending which is not based on reconvictions also adds to the knowledge we have about CSAs who reoffend. For example, in this case, it was possible to establish a significant relationship between recidivism and risk/deviance profiles and to devise an algorithm which discriminated very well between recidivists and non-recidivists in this sample. This is almost certainly because the non-recidivist sample was not contaminated with (so many) recidivists who had not been detected.

The Structured Anchored Clinical Judgement (SACJ: Thornton, 1997) algorithm, correlated significantly with recidivism as did level of psychometric deviance. However, it was a combination of the two factors which proved to have the strongest relationship to recidivism. The exception appeared to be in the high risk group, where low deviance did not appear to moderate the effect of high actuarial risk (possible reasons for this are discussed below).

Even more promising predictors of short-term recidivism are the pre and post-treatment risk algorithms described in Chapter 12. If these algorithms can be cross-validated and found to be useful predictors of short-term recidivism, they could be used to a) identify the riskiest individuals at pre-sentence stage so that appropriate

recommendations (i.e. custodial sentence with treatment) can be made to the courts and b) identify those individuals who have had some treatment but will need to be monitored very closely (and probably engage in further work).

In-treatment progress

An important feature of the algorithms described in Chapter 12 is that they support the existence of dynamic (and treatment related) predictors of sex offender recidivism and indicate that at least some of the goals of treatment (e.g. reducing cognitive distortions; increasing victim awareness; reducing/controlling sexually deviant fantasy and arousal) are appropriate treatment targets. Non-significant trends on a number of other measures (providing increased support for current treatment content) may prove to be more important as sample size increases. In addition, there was a (non-significant) trend in the direction of less overall progress in the recidivist group.

Whilst significant progress was made in a majority of target areas, it was not always dramatic improvement or change which resulted in post-treatment mean scores falling within functional ranges. For example, whilst denial and minimisation of offence-related fantasy, grooming and assaults fell significantly over the course of the programme, the post-treatment mean score on the Multiphasic Sex Inventory (MSI) Child Molest (CM) scale was still in the "expected minimum" range (falling short of the "probable true outlet" range). It is possible that the samples upon which some of these denial scales were normalised (Nichols and Molinder, 1984) were more deviant than the current sample of CSAs and thus had more to acknowledge. However, it could also be related to high levels of defensiveness in CSAs which are resistant to change. Even at the middle and later stages of treatment, there is a level of denial which would indicate a continued holding back of information about sexually abusive fantasies and activities.

Other areas where insufficient change was noted (or where post-treatment scores were outside of functional ranges) were: relapse prevention skills; social/sexual desirability;

immature cognitive distortions. In addition, where individuals were assigned "treated" or "untreated" status on the basis of test scores, it was found that post-treatment less than a third of the sample had treated profiles. It is almost certain that one of the reasons for apparent lack of change in some areas is due to the large numbers of non-completers. Only 31% (n=39) of the sample completed the SOU standard programme (although 4.76%, n=6, went into individual treatment or into a learning disabled group) and the average number of hours completed was 109 (sd=71.48). Added to this is the fact that sometimes offenders did not complete tests on leaving the programme (e.g. an individual might do 0hrs and 50hrs tests and leave just before 100hrs tests were administered). This means that there is no measurement of the progress they have made over sometimes quite considerable periods of treatment. Thus, post-test scores are very likely to under-estimate progress in treatment. Despite this, it is likely that some offenders simply need more intervention than others. Since it was found that rate of progress does not significantly relate to original level of deviance, it is clear than some offenders will need more time in treatment than others. It tended to be the originally lower deviance individuals who had treated profiles early on and on exit from the programme. This suggests that level of risk/deviance should be taken into account when planning interventions and that those higher in deviance are likely to need a longer programme than those who do not present as highly deviant.

An apparent exception to the pattern of higher risk and higher deviance indicating greater likelihood of sexual recidivism was the fact that 25% of high risk/low deviance offenders recidivated within 3 years. A number of factors may account for this. The first concerns the adequacy and range of psychometric tests used to define deviance. This is discussed below along with other methodological issues. The second refers to other factors which might affect response to treatment. It is believed that high risk offenders are more likely to fulfil the criteria for psychopathy - a disorder which appears to preclude a positive response to therapeutic interventions (Briggs, 1994).

Non-completers

Most of those individuals who did not complete the programme, left on expiry of their licenses (55%, n=49). There was a problem with people being on licenses as short as 3 months when this study was conducted. However, it is now possible to apply for extended licenses at the pre-sentence report stage and this means that a majority of those now leaving prison and mandated to attend a sex offender treatment programme will be attending for at least a year.

Those who dropped-out of treatment in the first 100 hours or for an unacceptable reason (i.e. breach/exclusion from group) were no more likely than other CSAs to reoffend. Neither did their scores on the risk algorithms presented in Chapter 12 differ significantly from those who remained in treatment. However, it is also the case that none of those who completed the programme are known to have reoffended. It is possible that longer-term recidivism data will identify a relationship between dropout rate and reoffending but this study found no evidence that non-completers were at higher risk of committing further sexual offences in the short-term. The small sample size might account for this and, since there is evidence that treated offenders are less likely to recidivate than untreated offenders, it seems reasonable to take steps to a) keep individuals in treatment for as long as possible and b) ensure that those on short licences do some relapse prevention work.

METHODOLOGICAL ISSUES

Non-laboratory research is fraught with practical difficulties. Many of these were discussed in Chapter 1. However, a number of them arose during the course of the evaluation. Unexpectedly high numbers of the original sample did not complete the programme. Fortunately, they were generally tested on more than one occasion so that at least two sets of tests were completed by a majority of individuals. However, it might have been more useful to find out when individuals were likely to leave (i.e. when their licenses expired) and ask them to do a final set of tests just before they left

the programme. This should mean that progress in treatment would be less likely to be underestimated.

The control group identified was rather small (n=47). This is because so many of those originally identified later joined the SOU programme following release from prison. Clearly, this affects the power of statistical tests and the sophistication of analyses that may be employed. Well-matched control groups are becoming increasingly difficult to identify because of the universality of sex offender treatment. The difficulties mentioned above with regard to the variability of conviction rates means that retrospective data are unlikely to be useful. We may become increasingly dependent on psychometric data to evaluate progress in treatment. If this is the case, administering tests at intervals after treatment completion would be a way of both identifying further treatment needs (such as a "booster" programme) and of assessing how much of the course material has been internalised.

Whilst this evaluation focused primarily on criminogenic variables associated with sexual recidivism (e.g. Hanson and Bussiere, 1997), there is increasing evidence that sex offenders have cognitive, social and relationship problems and that these differentiate them from non-offenders. For example, many CSAs: have a rather externalised locus of control; are emotionally isolated; have poor self-esteem; have poor coping skills (Cortoni and Marshall, 1998; Garlick, Marshall and Thornton, 1996; Marshall, Barbaree and Fernandez, 1995; Fisher and Howells, 1993). Treatment programmes do tend to include modules aimed at improving social and interpersonal functioning (as does the SOU programme). Including measures of such competencies in the current evaluation almost certainly would have given a more accurate picture of psychometric deviancy.

An example of how this might relate to the results of this evaluation is the case recidivism in the high risk/(apparently)low deviance group of offenders. These individuals may have had few distortions and presented as adequately accountable for their behaviour but perhaps they had social and interpersonal functioning problems (e.g. poor perspective-taking skills or poor coping skills) that might interfere with

motivation not to reoffend and with the effective acquisition of relapse prevention skills. Fisher and Beech (1998) suggest that such factors influence treatment requirements, response to treatment and level of risk.

Whilst many treatment programmes address these issues, most of the cognitive and social functioning deficits described are still not recognised as criminogenic because there is currently little or no support in the recidivism literature for a link between e.g. intimacy skills and recidivism. Once evaluation tools are standardised, the relationship of such variables to treatment outcome and to recidivism may become clear. Predictive tools are limited by the data which has been collected. The current study is a good example of how something which is not obvious or expected, such as being punished as a child when caught in sexual activity, appears to be predictive of short-term recidivism.

What we know about CSAs is probably the tip of the iceberg. An important problem with any model of treatment and any evaluation study is the fact that most abusers go undetected (or at least are not convicted for their offences) and so we only know about those who are within the criminal justice (and sometimes Social Services) system. For example, perhaps social inadequacies are a feature common to the type of CSA who is eventually convicted for his offences. It is widely known amongst sex offender workers that the few offenders they work with who are highly intelligent, middle-class, well-respected professionals may have been offending for years before they are caught. Not only do they present as low risk on actuarial scales but they are frequently socially skilled individuals who do not manifest any obvious deficits or distorted thinking about their victims. Whilst such offenders are under-represented on treatment programmes, the prevalence literature suggests that they exist in considerable numbers.

Finally, it is essential to obtain long-term recidivism data if we are to gain an accurate picture of the impact of treatment. We know that there are frequently long gaps between convictions (Barker and Morgan, 1993; Soothill and Gibbens, 1978). If the type of individual who is most likely to reoffend at some time in the future can be identified early on, post-treatment maintenance/monitoring can be arranged.

RECOMMENDATIONS

The evaluation of the SOU treatment programme has shown that it is largely achieving its main aim of reducing recidivism and promoting significant change in those psychological and behavioural variables associated with sexual offending. However, there are areas of concern, particularly the high level of non-completion of the programme. Whilst this is generally due to acceptable reasons (e.g. end of license), it still means that many individuals do not complete the programme of treatment that they were intended to complete. Based on the results of the evaluation, a number of recommendations are put forward.

1. Clients are assessed at the pre-treatment stage in order to inform treatment providers about risk/deviance. In addition, if the algorithms described in Chapter 12 are found to be reliable predictors of short-term recidivism, they could be used to assess short-term risk of reoffending and suitability for community treatment.

2. Higher deviance offenders require more time in treatment than lower deviance offenders if they are to achieve treated status and are likely to require more work in certain areas, such as deviant sexual arousal and sexual dysfunction.

3. High risk offenders could be screened for personality disorders. Those assessed as having a serious disorder may not benefit from the type of treatment described above.

4. In order to improve the completion rate, individuals on short licenses may need to be placed in a group as soon as they are released from prison (particularly if they have not completed the SOTP). It might also be appropriate for individuals to attend 2 sessions a week (rather than 1) once the assessment block is completed. This will, of course, depend on staff and other resources.

5. More motivational work may need to be done if level of denial and minimisation is to reach an acceptable level.

6. Relapse prevention skills and risk awareness should be approached in a manner which allows even those who do not complete the programme to achieve a level of understanding and competence in relation to their risk situations. A shorter programme for those who are not on long probation orders/licences might focus primarily on strategies for living an offence free lifestyle.

7. Maintenance or "booster" groups may be needed for high risk and deviance groups of offenders.

8. Sex offender treatment programmes would benefit from close relationships with other agencies such as the police and social services. Not only can they be of mutual assistance in detecting offenders but will also give a more accurate picture of those who are actually reoffending rather than just those who are reconvicted.

A final recommendation concerns an observation made over the course of the evaluation. During the seven years since the SOU was established, only one sex offender has referred himself (Social Services and NSPCC referrals are officially volunteers but are generally attending in connection with contact with their children). Since we know that a majority of CSAs are not convicted for their offences, it is a minority who are given the support and help they need to change. An important contribution to addressing this problem could be specialist treatment provision for individuals who recognise that they need help (the right kind of publicity might encourage individuals to face up to the fact that they have a problem). Potentially, many CSAs could be helped before deviant sexual arousal and behaviour became well-established. Clearly, this would have huge funding implications, would involve moral, legal and practical dilemmas (could treatment providers agree not to report undetected sexual offences to the police?, for example) and very tight guidelines would need to be in place. However, if treatment can have a positive impact on individuals and if the cost of not providing it is more victims, it should be available to all who need it.

PATHWAYS THROUGH TREATMENT

The results of the evaluation described in this thesis suggest that treatment should be tailored to meet the needs of offenders. In assessing need, several factors must be considered: level of actuarial risk; level of psychometric deviance; whether or not an individual has successfully completed the SOTP; length of license/probation order. Figures 8-10 present models of pathways through treatment which allows each of these factors to be taken into consideration. A separate model is presented for low, medium and high risk offenders. Integral to the models are structural alterations to the programme, as well as new labelling:

- **Induction:** This replaces Assessment and is simply a more accurate descriptor of the closed group (block week followed by 10 weekly sessions of 2.5hrs) that a majority of offenders will join on commencement of the programme. Offenders who have successfully completed the SOTP will not need to do the induction phase unless they are high risk individuals.

- **Treatment:** This is a rolling programme of 150hrs and is essentially unchanged (weekly sessions of 2.5hrs). High risk and/or high deviance offenders should do this programme if they are on a license which is long enough.

- **Relapse Prevention:** This is a new programme, specifically for those on short licenses or thought to be at low risk of reoffending. It is a rolling programme of 50hrs (20 weekly sessions) focused on relapse prevention and self-management.

- **Booster:** The Booster programme is essentially the RP programme delivered approximately one year after completion of treatment (specifically for higher risk/deviance offenders).

An individual will follow one of several possible pathways through treatment, as illustrated in Figs. 8, 9 and 10.

Fig. 8: Pathways through treatment for low risk offenders

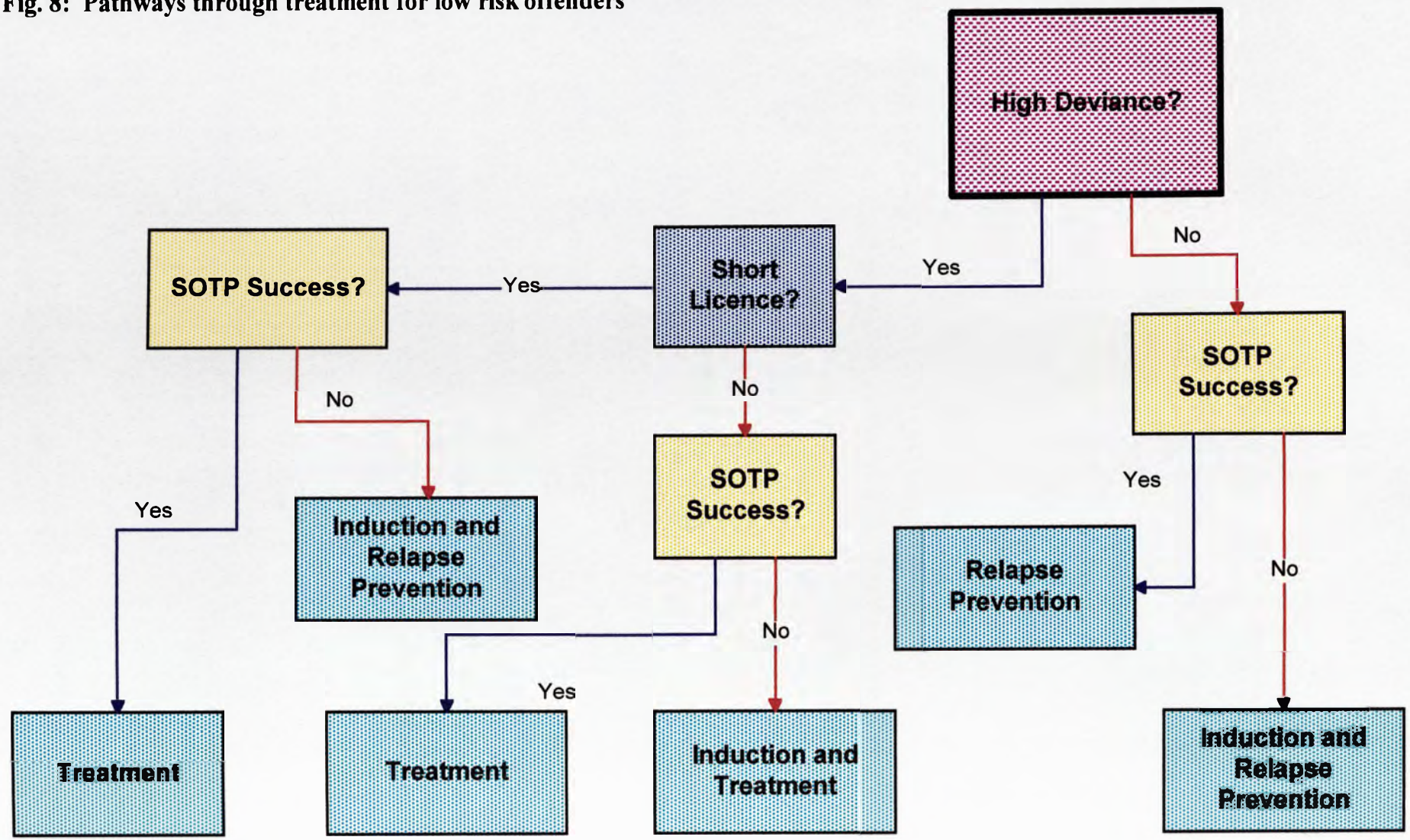
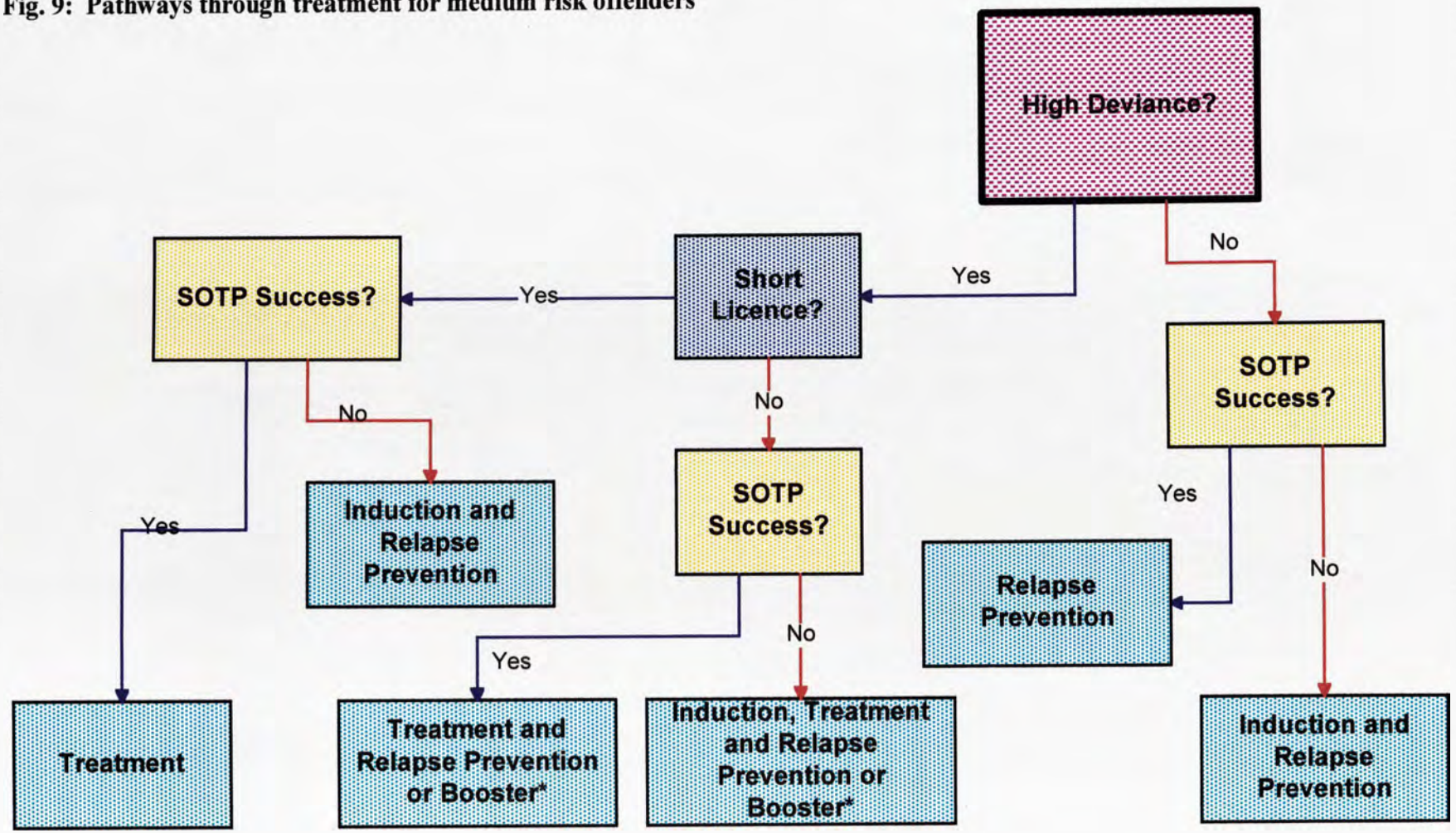
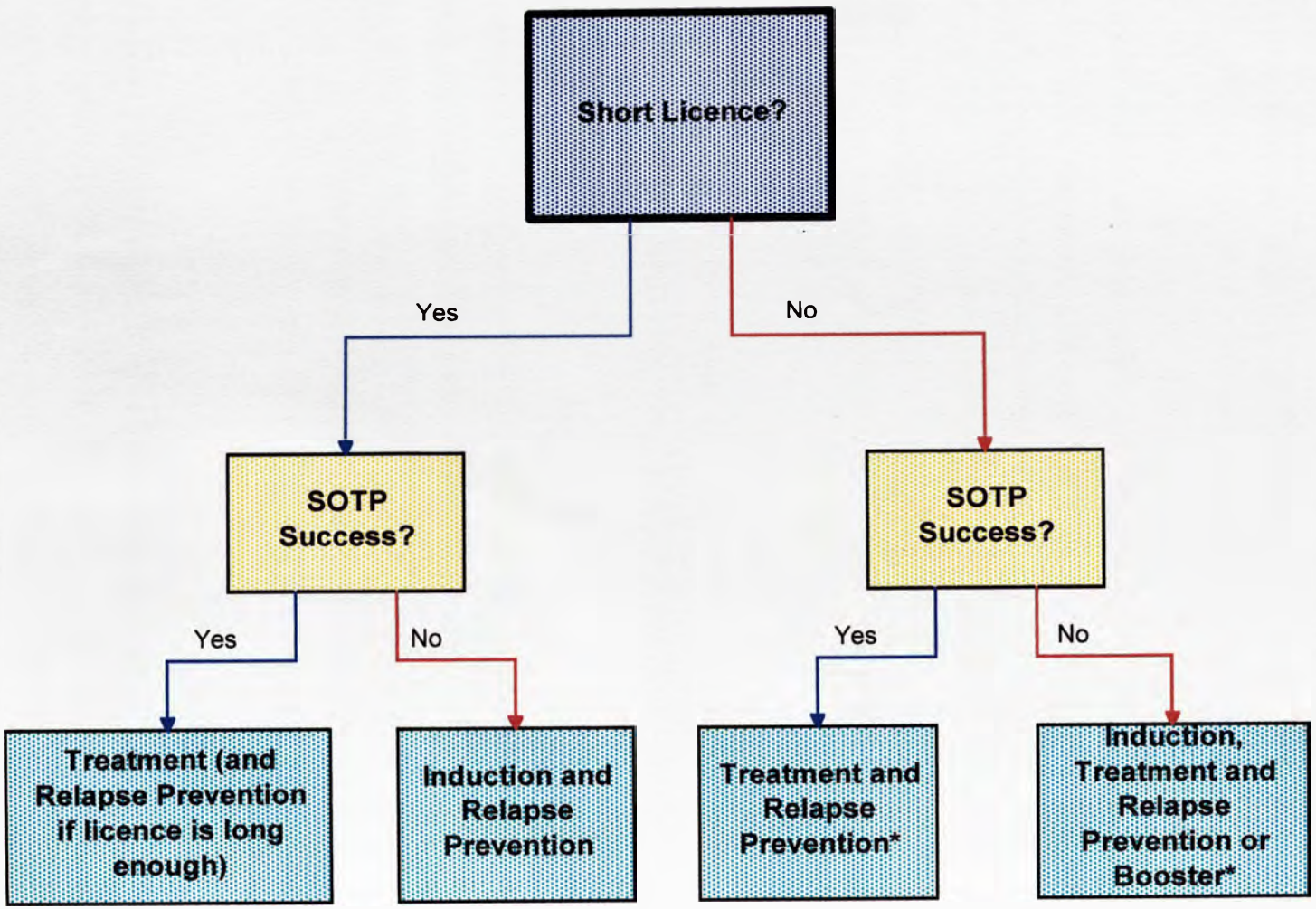


Fig. 9: Pathways through treatment for medium risk offenders



* If offender still presents as highly deviant following treatment, he should do Relapse Prevention and then do the Booster programme 1 year on.

Fig. 10: Pathways through treatment for high risk offenders



We know that the success of treatment programmes varies according to offender and treatment characteristics. In order to protect children, other measures must be in place if risk management of convicted CSAs in the community is to be effective. A number of sex offender acts have recently been implemented (Browne and Lynch, 1998). These include:

- The Sex Offender Act, 1997: This requires sex offenders to register their names and addresses with the Police and notify them of any changes.

- The Police Act, 1997: This extends access to criminal records and the release of relevant information on individuals who have or will have unsupervised contact with children.

- The Crime and Disorder Act, 1998: Here, the Police can apply for an order against any sex offender whose present behaviour in the community gives cause for concern.

Aside from the legislation described above, there are a number of measures in place which are intended to assist in the effective management of convicted sex offenders in the community. These include Public Protection Panels which meet regularly to review the level of risk posed by individual sex offenders in the community. They are chaired by the Police and attended by professionals such as probation officers and social workers, who pool their knowledge and decide on a strategy for monitoring and supervising those judged as being at significant risk of reoffending. Since the case of each individual is reviewed at regular intervals, response to treatment may be taken into account. Any future investigative and/or surveillance work can then be targeted more precisely at those seen as being at high risk of reoffending and highly dangerous to children.

New procedures for supervising and monitoring sex offenders depend on accurate assessment of risk. Recent work in this area (e.g. Thornton, 1997) is promising and risk assessment is being standardised and made more accessible to non-specialists who nevertheless have contact with convicted sex offenders. A number of agencies, e.g. Police, Social Services, Probation, are providing excellent training in sex offender risk assessment, which stresses the importance of reliable and accurate information and warns against attending to more subjective impressions. Good risk assessment depends on information from a variety of sources and multi-agency collaboration will help to ensure that all the relevant information is included in any consideration of risk.

It is too early to judge the impact of new sex offender legislation and policy on actual reoffending. Indeed, the fluctuations in conviction rates of sex offenders from year to year make it very difficult to judge the efficacy of these . However, it would seem logical that increased monitoring of CSAs together with multi-agency collaboration in the management of risk will help to direct resources to where they are most needed. An example of how multi-agency collaboration has worked in practice is described below.

This case involves two sex offenders who had befriended one another in prison and were identified by psychologists, probation officers and prison officers as potentially extremely dangerous to children. The police were informed (prior to their release on automatic license) as was the WMPS SOU where they were to attend a treatment programme. Assessments conducted by the SOU confirmed fears about their level of dangerousness. With the help of the Unit, an undercover police officer then became acquainted with the offenders in the guise of a sex offender himself. He found that they were planning to abduct, sexually abuse and murder young girls. Fortunately, he was able to amass enough evidence for them to be convicted. They were sentenced to life imprisonment.

CONCLUSION

The SOU sex offender treatment programme has been found to be successful in reducing short-term recidivism and in modifying a majority of those attitudes, cognitions and behaviours associated with sexual offending. Whilst sample sizes are relatively small, the data are encouraging and are consistent with a number of American and British evaluation studies (Marshall and Serran, 2000; Beech, Fisher, Beckett and Scott-Fordham, 1998; Nagayama Hall, 1995; Marshall, Jones, Ward, Johnston and Barbaree, 1991). Indeed, the results are somewhat better than those reported elsewhere. This is almost certainly related to those factors which have contributed to the programme having high treatment integrity. The programme has received a great deal of managerial support, staff are well-trained and committed to their work, they were involved in devising a cognitive-behavioural programme and producing a manual (which helps to prevent "programme drift") and they have access to training, supervision and counselling support.

Although there is still the important issue of lack of provision for CSAs who have not been convicted, the treatment of sex offenders in the community and the evaluation of programmes has progressed considerably since Barker and Morgan (1993) published a report detailing the provision of sex offender treatment in England and Wales. We have now reached a point where successful probation programmes are thoroughly reviewed and documented in order to gain accreditation by the Home Office. They are then adopted by other probation regions ensuring that treatment and evaluation are standardised. Through the widespread adoption and standardisation of best practice we are likely to learn far more about what works, how it works, and for whom it works. This is not only true of treatment programmes but also of sex offender risk management in general. Recent developments in the fields of risk assessment, monitoring and supervision, along with the adoption of multi-agency collaboration, are encouraging. It is hoped that we will eventually be rewarded by evidence of less recidivism and thus fewer victims.

APPENDIX 1

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Different clients, different needs? Practice issues in community-based treatment for sex offenders

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ABSTRACT *In 1993, The West Midlands Probation Service set up a sex offender unit (SOU), the largest in England, with the aim of providing a specialist treatment service for sex offenders serving a community sentence. This article presents a brief description of the treatment programme and discusses some of the issues which have arisen during the design and implementation of the programme. Although cognitive-behavioural groupwork is widely believed to be the most effective intervention for men who sexually abuse children, it is thought that there are some groups of offenders who may not derive maximum benefit from the standard programme and for whom it might be necessary to modify existing practice by providing alternative or complementary interventions. The SOU has attempted to address some of the problems identified by adapting the existing programme for clients with learning disabilities and for men who sexually abuse adult women. In addition, a victim-to-victimiser group is run parallel to the treatment group and is offered to clients who were themselves child victims of sexual abuse. As yet, the long-term effectiveness of tailoring treatment to suit offender characteristics is not known. Nevertheless, client and staff feedback has been positive. Treatment providers elsewhere may not have the resources to run different groups for different categories of offender. However, sex offenders are not a homogeneous group and greater programme flexibility may be needed to provide effective treatment for clients and adequate protection to the public.*

APPENDIX 2.1

FINKELHOR'S FOUR PRE-CONDITIONS TO ABUSE

The following was produced by Gary. He is an extra-familial child sexual abuser (CSA). He is in his twenties and this was his first conviction. This work was done in the first half of Assessment as homework (following a session where somebody else's "Finkelhor" was done). He was asked to think of his thoughts and feelings around the time of the abuse and to put these under the appropriate heading. He was then asked to try to challenge these thoughts and suggest ways of dealing with the feelings.

MOTIVATION - Desire

Sexually attracted to young girls.
I want to see them naked.
I want to abuse them.

This is wrong.
She is a child/person.
I need professional help.

OVERCOMING INTERNAL INHIBITORS - (inside your head - what you say to yourself that allows you to abuse)

She had already been abused.
I wasn't physically hurting her.
I wanted it.
I won't get caught.

So what if she's been abused - what right do I have to do the same.

She is a child/person.

Get help - yes you are hurting her - mentally.

I'll get caught.

OVERCOMING EXTERNAL INHIBITORS - (in the environment - obstacles- things you have to get around)

Arranged for Samantha to stay over at Mel's. [*another sex offender*]

Got her on her own.

Don't go to Mel's when Samantha is there.

Stop seeing Mel.

Get professional help.

OVERCOMING VICTIM'S RESISTANCE - (what did you do or say to the victim to get them to "go along" with the abuse or not to tell)

Bought her treats.

Gained her trust.

Showed her attention/affection.

Asked her not to tell.

It's not too late - get out now.

APPENDIX 2.2

OFFENDING CYCLE

The following was also produced by Gary during Assessment - this time in group.

Pro-offending thinking/attitudes/beliefs

Adult relationships sexually satisfying but not emotionally satisfying.
Sexual abuse is justified by what I am getting out of it.

Targeting

Female child, age 8-12 yrs (ethnicity and cultural background not relevant)
Short dresses/shorts
Commenced puberty
Bubbly (=more trusting) or shy and retiring (=vulnerable)
Loner
Browsing = pre-targeting. Parks, mostly, and passing schools.

Fantasy

Since 18yrs of age
Being with a child
Touching the child sexually
Full intercourse
No reaction from the child who tolerates the activity (just above hating it on a scale from enjoy - hate)

Afterwards, the child is discarded - she no longer exists - she is a thing

Grooming/Planning

Put phone number in public toilets with message "I like young girls"
Child who has been previously abused
Engage in small talk/games (card games)
Behaviour an extension of her friendship with Mel (co-defendant)
Bought sweets etc.
Took her out
Obtained place on NVQ in Child Care - work with under 12s - gave placements in schools, playgroups etc. (began in Oct 93, after commencement of offending).

Abuse

Touching child sexually
Performing oral sex on her
Simulating intercourse
Avoid looking at face or having contact with her face

After

Victim is discarded - sense of elation and of being fulfilled - masturbatory fantasy strengthens desire to repeat abuse, acts as a reinforcer

APPENDIX 2.3

SESSIONS FROM ASSESSMENT GROUP

"HOT SEAT" SESSIONS

PURPOSE OF SESSION: EACH MAN TAKES A TURN IN THE 'HOT SEAT' AND PRESENTS HIS OFFENCE TO THE GROUP

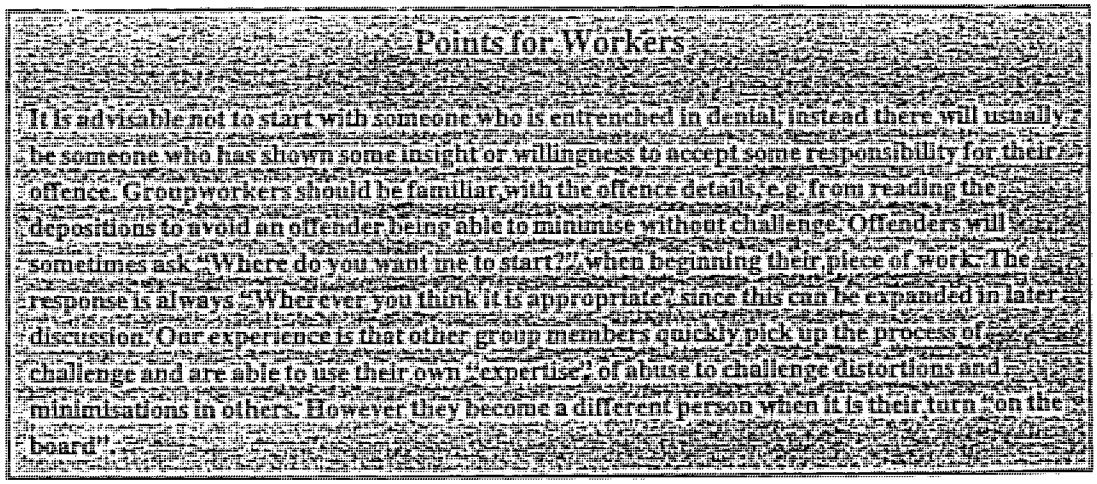
Materials: Flipchart

Time: Each man will probably take 1 1/2 - 2 hrs, therefore this session is repeated until all members have been in the 'Hot Seat'

Description of exercise:

Each man is asked to write on the flipchart "My Offence". Either they write up themselves, or a groupworker can write as they speak. Alternatively another group member can be asked to write as they speak.

After they have finished the rest of the group are asked to indicate which words or phrases they would like to have clarified or question. These words are then underlined with the "Help Pen". When everyone has finished the group workers can underline anything that requires challenge.
Beginning with the first words which were underlined ask the person who requested the underlining "What was your question/information that you wanted?" As a result of the challenge the offender will normally be required to change or add to what they have written. Continue until all underlinings have been discussed. At the end of the process ask offender to sign the flipchart sheet.



Set Homework:

Each man to write up their own "My Offence" ready for their turn in the "Hot Seat". Those who have been in it should be asked to rewrite their work using what they have learnt from the session.

SESSION 5

PURPOSE OF SESSION: TO BEGIN THE PROCESS OF COGNITIVE RESTRUCTURING.

Materials: Homework previously set; Flipchart

Description of exercise one:

Review homework of pro-offending thinking. Take first example from each man and write on flipchart. Clarify that members understand why these are distortions. Ask how they link into offending. Ask what would be a positive reframing of the thought.

Description of exercise two:

Ask one member to write on flipchart one statement of distorted thinking which can lead into a second, third etc. Continue until the process ends with a 'poor me' or 'sod it' statement and into abuse. Encourage the group to work on how to challenge each sentence and put a positive alternative. Continue around the group using examples from each member.

Points for Workers

It is important to discuss with the group the idea of choice. That they made choices to offend based on their pro-offending thinking. Telling themselves something often enough reinforces the distortions and the behaviour. Restructuring the thinking into positive alternatives can lead away from the 'poor me' route into abuse. Challenging and changing the thoughts makes the behaviour harder to sustain, as a result of the cognitive dissonance created. Later modules, particularly Victim Empathy, seeks to create an emotional dissonance so that both abusive pro-offending thinking and behaviour is at variance with the reality which the offender is forced to recognise.

SESSION 3

PURPOSE OF SESSION: TO INTRODUCE ASSERTIVENESS AND HIGHLIGHT THE GAINS POSSIBLE OF USING ASSERTIVE TACTICS AS OPPOSED TO THE NEGATIVE ATTRIBUTES OF ANGER. TO PROMOTE AND HIGHLIGHT COMMUNICATION SKILLS. TO BUILD TRUST AND LISTENING SKILLS.

Materials: Flipchart; '3 Situations' leaflet; Jigsaw and tray

Description of exercise:

'3 Situations' - ask group to split into pairs and role play the given situations.
On flipchart examine the feelings experienced by both the 'requesting' and the 'refusing' participants. How did they feel at the end after having given in or resisted the request. How did those trying to achieve the goal feel? What situations from their own experience can they relate to this exercise. How do they deal with not achieving their goals?

Points for Workers

Highlight the use or abuse of anger and focus on how assertiveness can appropriately be used. Look to emphasise the positive feelings gained by avoiding anger and using assertiveness appropriately. Discuss coping skills in both the abusive and non-abusive context.

Description of exercise two:

"Jigsaw" exercise: Designate two participants as subject A and subject B. A is to communicate to B how to complete the 'Jigsaw'; however, A and B sit back to back and B cannot verbally communicate with A, nor can any of the watching group participate in anyway. Continue until all have participated in both positions. *(Leaders can decide if they will allow other non-verbal communication to be used, eg "one tap for "yes, I understand", or two taps for "please repeat".)*

Points for Workers

The communicator will usually go too quickly for the recipient at first; however, once the process has been observed, each will learn from the mistakes. Discuss using the flipchart, participants feelings eg power, frustration, inadequacy and ask participants to relate the exercise to sexual offending (eg the speaker is in control, the listener does not have access to the knowledge the speaker has; therefore, they respond immediately and directly to what is told to them - they are the 'victim').

SESSION 2

PURPOSE OF SESSION: ENABLING MEN TO TALK ABOUT AND EXPRESS THEIR FEELINGS AND EMOTIONS

Time: Two Hours
Materials: Flipchart

Description of exercise one:

Divide the group up into pairs. Their task is to each share with their partner an experience which involved the biggest feeling of emotion that they can remember. Ask them to role play the event and recall the emotion, to really feel it. This can be done either remaining in pairs or in the large group. Remember to de-role into the present after the role play.

Begin the discussion in the large group by asking "What is the worst thing that can happen about showing your feelings?" "What are their biggest fears about showing true emotion?"

Points for Workers

The men will be limited in the range of emotions they express, try to expand the range. Expect far more negative emotions than positive. Draw out the connection between how they deal with emotions and their abusive behaviour.

Description of exercise two:

Large group discussion. Ask "How do men show feelings?" e.g. love, sadness, hurt "Are they any different from women?" If so "Why?". From the examples which they produce begin to role play the situations. Ask "What could have been done to deal appropriately with the feelings?" and rehearse again in role play. Ask "What needs to change in me?"

Points for Workers

Again draw out the link between inappropriate handling of emotions and how this triggers pro-offending thinking. Draw up cycles for individuals to identify this, and ask them to complete as homework. Some men may use the role-play to re-visit past traumas and say the things they were never able to express at the time. Remember to de-role afterwards. As the session progresses remember to keep the focus positive. "Change is possible", "You can grow emotionally long after you have stopped growing physically". The consequences from expressing emotions are never as bad as their fears, and most feel better.

SESSION FROM VICTIM AWARENESS/EMPATHY MODULE

SESSION 1

PURPOSE OF SESSION: TO BEGIN THE PROCESS OF DEVELOPING PERSPECTIVE TAKING. TO PRACTISE LOOKING AT SITUATIONS FROM ANOTHER PERSON'S POINT OF VIEW.

Time: 2hrs overall with 30/45 mins on exercise one and the remainder on exercise two

Materials: None

Description of exercise one:

A role play of a non-sexual situation concerning the arrest of a man who is caught shoplifting. He claims he needs to steal to feed his family. Assign the roles and play through the scene beginning after the theft has been discovered and the accused is being interviewed in the Store Manager's Office
Accused - has wife who is ill in hospital, dependant children, it is winter, has used money to avert electric disconnection - anxious - pushes store detective away when he panics - pleads just cause.
Store Detective - has job to do - has heard it all before - needs to deter others - gets paid on results. Was pushed over by accused in what he sees as unprovoked attack - wants police to prosecute.
Store Manager - needs to placate his store detective and is in any case losing money via thefts, But publicity would be bad in this case - happy to ask for caution.

Points for Workers:

This is a simple initial exercise to get used to being able to argue from another's point of view, something with which abusers seem to have difficulty. The focus should not be on the feelings i.e. what does it feel like for the accused, but on seeing the alternative points of view.

SESSION 1 (cont)

Description of exercise two:

Role play of a Case Conference or Child Protection Conference discussion. Assign roles such as:

Chair of Case Conference, Abuser, Non-Abusing Carer, Probation Officer, Social Worker, Teacher

Scenario such as:

- ☐ Non-abused child is missing Father (abused) - schoolwork is affected
- ☐ Mother - wants support of Abuser - finding it difficult to cope. Understands risks and states she will protect abused child.
- ☐ Abuser has done Core Programme in prison. Believes he is "cured" - wants to put the past behind him and make fresh start.
- ☐ Probation Officer / School/ Social Services are all represented.
- ☐ The question is "What would you decide was in the best interest of the children?" Remember: the victim and his/her brother or sister are living at the family home with the mother.

Points for Workers

Involve as many of the group as possible, even if they are not all assigned a role. For example invite non-roled members of the group to swap places with those in the scene and put the point of view attributed to that role. Check out at end how much of the view they were expressing was their own or belonged to the role. Get the men to switch to opposite roles to present a different point of view from that which they have already expressed.

SESSION 4

PURPOSE OF SESSION: TO IDENTIFY WHAT TRIGGERS THE USE OF FANTASY.

Time: 2 hrs Materials: Flipchart; Handout "Fantasy Diary"

Description of exercise one:

Review of homework set at the last session. Ask for volunteer to share an example of a sexually abusive fantasy. Trace the links back to when it was first used, and why they think it developed. Test out with rest of group if they can relate to this experience.

Description of exercise two:

Move onto discussion of non-sexual abusive fantasy. Explain that this is one of the most commonly used fantasises. You do not have to be an offender to have these, indeed most people do not put them into practice. They use inhibitors.

Identify how these fantasises are linked to emotions, triggered by events, need for revenge and the feeling of "poor me". Explain how these are part of the offence cycle. In order to be in control of these fantasises we need to recognise the vulnerable mood states which precede the move into fantasy, therefore for homework each man is required to keep a simple fantasy trigger diary, for discussion next week.

Points for Workers

Our experience has shown that it is not necessary to gain explicit detail of sexually abusive fantasises. It is much more productive to concentrate on making sure men have an understanding of the role which fantasy plays in their offending. If they are motivated to control their abusive fantasises we can give them the means to help do so. If they are not motivated to stop their use of abusive fantasises then there is no point in hearing the detail.

Set Homework:

"Trigger to fantasy" diary to be kept for one week.

NAME: ..... DATE: .....

TRIGGERS INTO FANTASY DIARY

COMPLETE AT THE END OF THE DAY OR FIRST THING IN THE MORNING

WHEN YOU BEGAN TO FANTASISE:

WHAT WERE YOU DOING:

WHAT MOOD WERE YOU IN:

WHAT WERE YOU THINKING:

WHAT WERE YOU FEELING:

TYPE OF FANTASY- ABUSIVE SEXUAL - YES / NO

- NON-ABUSIVE SEXUAL - YES / NO

- ABUSIVE NON-SEXUAL - YES / NO

DID YOU MASTURBATE? ..... YES / NO

HOW LONG DID YOU SPEND IN FANTASY THOUGHTS:

SESSION 5

PURPOSE OF SESSION: THIS SESSION IS TO ASSIST THE RE-BUILDING OF INHIBITORS AGAINST OFFENDING BY ABUSERS.

Time: 2 hrs
Materials: Homework previously set

Description of exercise one:

Warm up exercise by word storm on consequences of offending based on homework. Look especially for emotional consequences rather than practical consequences.

Description of exercise two:

Role play of the homework responses on the consequences of offending. Two chairs placed opposite each other in the middle of the room. Each man takes a turn to sit opposite the chair which represents a close relative, friend, victim etc. The other members of the group can challenge and ask questions from this chair.

Points for Workers

This is another approach to the "Ripple Effect" of offending and the exercise can be broadened to include the consequences on others not identified in the homework. Even those offenders still unable to develop victim empathy as an inhibitor to offending can benefit from this exercise by focusing on the negative consequences for themselves.

Set Homework:

Each man to list "The most important things I have learnt about my offending"

In addition each man to provide himself with a small box e.g. a shoebox. Into the shoebox each man should place phrases, pictures or items associated with attitudes, beliefs and behaviours which underpinned offending (metaphor material or representations are suitable). Each of these representations of pro-offending should be counteracted by postive/alternatives non-abusive lifestyle representations attached to the outside of the box.

APPENDIX 3.1

PERSONAL INFORMATION QUESTIONNAIRE

No: **Date:**

1 How old are you? Please give your date of birth:

2 Do you have a job? Yes No (Please circle)

3 If you have a job, what do you do?

If not, what do you usually do?

4 Please tick the level of education you have reached:

No qualifications	[ ]
Fewer than 5 GCSE's or 'O' levels at or above grade C	[ ]
5 or more GCSE's or 'O' levels at or above grade C	[ ]
'A' levels	[ ]
Degree	[ ]
Other	[ ]

(If you have answered "other", please give details)

5 Are you: Single [ ] Married [ ] Divorced [ ] Separated [ ]

Widowed [ ] Living with partner [ ] Seeing a sexual partner [ ]

(please tick)

6 Have you got any children? Yes No (Please circle)

Have you got any step-children? Yes No (Please circle)

7 Would any of these children normally live with you? Yes No (Please circle)

Age	Age	Age	Age	Age
Sex	Sex	Sex	Sex	Sex

8 What are your most recent sexual offences? (Please tick the appropriate box(es))

Indecent Assault Child	[ ]	Gross Indecency Child	[ ]
Buggery of a Child	[ ]	USI under 13	[ ]
USI under 16	[ ]	Incest	[ ]
Indecent Exposure	[ ]	Rape	[ ]
Indecent Assault Adult`	[ ]	Other	[ ]

If your answer was "other", please give details:

9 Do you admit that you committed the offence(s)? Yes No (Please circle)

10 What was your relationship to your victim(s)? (Please tick the box)

Natural Parent	[ ]	
Other blood relative	[ ]	Please say what the relationship is
Step-parent	[ ]	
Spouse (wife)/co-habitee	[ ]	
Friend	[ ]	
Responsible adult (e.g. teacher, baby sitter, youth leader, etc.)	[ ]	Please say what the relationship is:
No identifiable victim	[ ]	
Stranger	[ ]	
Other	[ ]	Please say what the relationship is:

11 How many people have you been convicted of/accused of sexually abusing (present offence)?

Give the age(s) of your victim(s):

If the abuse took place over a period of time, give the age(s) of the victim(s) when the abuse began and when it finished:

12 What was the sex of your victim(s)? (Please tick)

Female	[ ]
Male	[ ]
Both sexes	[ ]

13 Do you have any previous convictions for a sexual offence?

If so, give year and type of offence:

Year:	Offence:
Year:	Offence:
Year:	Offence:
Year:	Offence:
Year:	Offence:

14 Have you ever been accused of a sexual offence but <u>not</u> convicted? Yes No
(Please circle)

Give the age, sex and relationship to you of the person(s) who accused you:

15 (a) Do you have 4 or more previous convictions (of any kind)? Yes No
(Please circle)

(b) Have you ever been convicted of any violent offences? Yes No
(Please circle)

(c) Have you ever been convicted of any non-violent, non-sexual offences? Yes No
(Please circle)

If so, please say what they were and approximately how many?

16 Are you: On Probation [ ] Licence [ ] Voluntary [ ]

17 If you are on Probation or License, please give the date this began and when it finishes:

18 Who is your Probation Officer/Social Worker?

Which office is he or she based at?

19 Have you ever been in a sex offender treatment programme before?

If so, please give details:

Where?

When?

How long did the programme last?

20 (a) Do you believe your current offence is related to drinking or drug-taking? Yes No (Please circle)

(b) Did you have a problem with drink or drugs at the time of the offence? Yes No (Please circle)

(c) Do you believe you have a problem, with drink or drugs at the moment? Yes No (Please circle)

21 Have you ever lived with a sexual partner for two years or more? Yes No (Please circle)

22 Have you ever lived in local authority care, e.g. a children's home or foster care? Yes No (Please circle)

APPENDIX 3.2.1

MULTIPHASIC SEX INVENTORY (NICHOLS & MOLINDER, 1984)

The Multiphasic Sex Inventory (MSI) cannot be re-printed here due to copyright restrictions. However, some changes were made to the original layout and presentation (although the content has stayed the same). The following details: instructions (which have been slightly altered to allow for the difference in response procedure); examples of the difference in test layout; an example of clarification of words in the questionnaire; examples of clarification of statements; examples of flexibility of response type for statements relating to sexual anatomy and physiology (SKB scale); scoring information.

INSTRUCTIONS

Instructions: This is a sexual inventory constructed to study the full range of sexual behaviour. Answer each statement as honestly as possible. If a statement is true, write a "T" in the box. If a statement is false, write an "F" in the box. Answer all questions unless otherwise indicated.

Please note that "child" means anybody under the age of 17 years. If a question refers to sexual contact with a child, it refers to a whole range of sexual behaviours and not only to intercourse.

TEST LAYOUT

Rather than having to read questions on one page and transfer answers to an answer grid, it was decided to change the layout of the test and to allow respondents to place

their answers beside the question they are responding to. For example:

1. Occasionally I think of things too bad to talk about. [ ]
4. I have been attracted to boys sexually. [ ]

CLARIFICATION OF WORDS

Occasionally, a more commonly used word is added to a statement following a word or expression which may be less familiar to respondents. For example:

34. I have become sexually stimulated when somebody urinates (pees). [ ]

CLARIFICATION OF STATEMENTS

In order to reduce problems of misunderstanding negatively worded statements, words such as "never" and "not" are always underlined when they appear. In addition, below each statement constructed in this way is a bracketed reminder of how to answer. For example:

6. I don't often think about sex. [ ]
   (Put T if this is True and F if it is false)

18. I have never molested a boy. [ ]
    (Put T if this is True and F if it is false)

FLEXIBILITY OF RESPONDING ON THE SKB SCALE

Because the SKB (Sex Knowledge and Beliefs) scale refers to items of objective information, it was felt that respondents should have an opportunity to say that they did not know the answer to a question. For example:

35. The glans of the clitoris is generally about the size of a pea. [ ]
(If you don't know the answer, put ? in the box)

97. Women's genitals are less sensitive to physical stimulation than those of males. (If you don't know the answer, put ? in the box) [ ]

SCORING

Responses are transferred to the original MSI scoring grid and scored using templates - one template for each scale. Scores are calculated by simply counting the number of crosses which can be seen through the holes on the grid. On the SKB, however, whilst the above applies, there is an additional point added to the final score for every 2 statements answered by a question mark.

APPENDIX 3.2.2

MSI PROFILE FORM

Once scores have been calculated they are entered onto an individual's profile sheet. This sheet contains score ranges and interpretations, which gives an idea of how honest, how deviant and how distorted the thoughts of the respondent. Below is an example of how the scales appear on the profile form (the Sex History Section is not included).

MULTIPHASIC SEX INVENTORY PROFILE

VALIDITY SCALES

SCALES	ACCEPTABLE RANGE 1ST Q	2ND Q	3RD Q	DEVIANT RANGE 4TH Q
SOCIAL/SEXUAL DESIRABILITY (SSD) SCALE _____/35	"NORMAL" SEX DESIRES AND INTERESTS 35 - 28	QUESTIONABLE RANGE 27 - 24	DENIES SEX DESIRES AND INTERESTS 23 - 20	PRESENTS ASEXUAL IMAGE - CONSIDER DISSIMULATION 19 - 0
SEXUAL OBSESSIONS (SO) SCALE _____/20	DISCLOSING/ EXPECTED RANGE 2 - 9	DISCLOSING/ SEXUALLY OBSESSED 10 - 16	ACQUIESCENT RESPONSE/SET MALINGERING 17 - 20	FAKE GOOD RANGE 1 - 0
LIE (L)* CHILD MOLEST/ RAPE SCALE**_____/13	INTEREST IN SEX DEVIANCE ACKNOWLEDGED 0 - 2	QUESTIONABLE RANGE 3 - 4	SEX DEVIANCE INTERESTS SUPPRESSED 5 - 7	DISHONEST ABOUT INTEREST IN SEX DEVIANCE 8 - 13

* LIE SCALE is scored only when client acknowledges culpability to a sexual offense
** For the Exhibitionism Lie Scale score range, multiply number of items endorsed by 2

ACCOUNTABILITY SCALES and INDICES

COGNITIVE DISTORTION/ IMMATURITY (CDI) SCALE _____/21	ACCEPTABLE RANGE OF ACCOUNTABILITY 0 - 3	COGNITIVE DISTORTIONS/ IMMATURITY 4 - 9	CHARACTER DISTURBANCE VICTIM STANCE 10 - 14	SEVERE LACK OF ACCOUNTABILITY FOR ACTIONS 15 - 21
JUSTIFICATIONS (JU) INDEX _____/24	ACCEPTS ACCOUNTABILITY 0 - 1	JUSTIFIES SEXUAL DEVIANCE 2 - 6	JUSTIFIES SEXUAL DEVIANCE/ MARKED 7 - 10	SEVERE LACK OF ACCOUNTABILITY FOR ACTIONS 11 - 24
TREATMENT (TA) INDEX _____/8	HIGHLY MOTIVATED 8 - 6	MOTIVATED 5 - 3	MAY NOT BE MOTIVATED 2	NOT MOTIVATED 1 - 0

SEX DEVIANCE SCALES

CHILD MOLEST SCALE		RAPE SCALE		EXHIBITIONISM SCALE	
Fantasy	_____/10	Fantasy	_____/8	Fantasy	____/3
Cruising/Grooming	_____/10	Cruising/Grooming	_____/8	Cruising	____/4
Sexual Assault	_____/9	Sexual Assault	_____/7	Sexual Assault	____/9
Advanced Assault	_____/6	Advanced Assault	_____/5	Advanced Assault	____/3
Incest type	_____/4	Sado-Masochism	_____/10		
TOTAL	_____/39	TOTAL	_____/38	TOTAL	_____/19

Gender: Girl ___/3 Boy ___/3

T SCALE SCORES AND DESCRIPTION

(FOR CHILD MOLEST, RAPE AND EXHIBITIONISM SCALES)

SCALE	RAW SCORE	FRANKLY DISHONEST RANGE	MINIMIZED SEXUAL OUTLET	EXPECTED MINIMUM RANGE	PROBABLE TRUE OUTLET RANGE	HIGHLY OPEN ABOUT SEXUAL OUTLET
CHILD MOLEST	___	0-3 4-5	6-8 9-11	12-15 16-19	20-22 23-24	25-26 27-28 29-39
RAPE	___	0-3 4-5	6-8 9-11	12-14 15-18	19-22 23-25	26-27 28-29 30-38
EXHIBITIONISM	___	0-2 3-4	5-6 7-8	9-10 11-12	13-14 15-16	17-19
T Scale Equivalence		0-34 35-41	42-5 46-50	51-55 56-60	61-65 66-70	71-75 76-80 81-90

PARAHILIAS (ATYPICAL SEXUAL OUTLET)

		Critical Items
FETISH	___/9	___ ___ ___
VOYEURISM	___/9	___ ___ ___
OBSCENE CALL	___/4	___ ___ ___
BONDAGE/DISCIPLINE	___/6	___ ___ ___
SADO/MASOCHISM	___/10	___ ___ ___

SEX DYSFUNCTION SCALES

		Critical Items
SEXUAL INADEQUACIES	___/8	___ ___ ___
PREMATURE EJACULATION	___/4	___ ___ ___
PHYSICAL DISABILITIES	___/8	___ ___ ___
IMPOTENCE	___/12	___ ___ ___

SEX KNOWLEDGE AND BELIEFS (SKB) SCALE _____/24

A score of 17 or below indicates the need for accurate information about sexual anatomy and physiology.

APPENDIX 3.3

KIDS AND SEX QUESTIONNAIRE (BECKETT AND FISHER, 1993)

Cover Sheet/Instructions

This questionnaire is concerning your experience of children and your feelings and thoughts about them. Before you start, please answer the following questions:

Sex Male Female *(please circle)*

Age _____

Marital Status Single Married Divorced Separated Widowed
(please circle)

Number of children _____

Number of step children _____

How regularly do you talk to or have personal contact with children?

daily / more than 3 times a week / weekly / less than once a week / less than once a month
(please circle)

Were you working with children at the time of the offence? _____

FOR THE PURPOSE OF THIS QUESTIONNAIRE CHILDREN MEANS PERSONS OF 14 YEARS AND YOUNGER

INSTRUCTIONS

Read each question carefully. Put a tick (✓) in the area which is closest to your view or direct experience.

e.g. I like talking to children.

✓

Very true / Somewhat true / Somewhat untrue / Very untrue / Don't know

THANK YOU FOR YOUR HELP

Cognitive Distortions Items

- Children know a lot about sex.
- Children know more about sex than adults.
- Children want sexual contact with adults.
- There is nothing wrong with sexual contact between children and adults.
- Children are not as innocent as most people think.
- When adults and children have sexual relationships it is not always the adult's fault.
- If children want, they should be allowed to have sexual relationships with adults.
- Most sexual contact between adults and children does not cause any harm.
- Children can flirt with adults.
- Children can lead adults on.
- Children sometimes ask adults for sex.
- Children can lead adults astray.
- There is no harm in sexual contact between children and adults.
- People underestimate how much children know about sex.
- Some children could teach adults about sex.

Emotional Congruence Items

- I prefer to spend my time with children.
- I have loved a child at first sight.
- Thinking about children makes me feel good.
- I know when children are interested in me.
- Children stop me feeling lonely.
- Children are special for me.
- Children remind me of myself.
- I feel more comfortable with children than with adults.
- Sometimes I meet a child who I know has special feelings about me.
- I am better than most people at understanding children.
- I am better than most people at getting along with children.
- When I feel low children cheer me up.
- Some children prefer to be with me rather than their parents.
- Children seem to seek me out.

Scoring

Items are scored as follows:

Very True	4
Somewhat True	3
Somewhat Untrue	1
Very Untrue	0
Don't Know	2

APPENDIX 3.4

RAPE MYTH ACCEPTANCE SCALE (BURT, 1980)

Questionnaire

For the statements which follow, please circle the number that best indicates your opinion - what you believe. If you strongly disagree, you would answer, "1"; if you strongly agree, you would answer "7"; if you feel neutral, you would answer "4" and so on.

Disagree Strongly	Disagree Somewhat	Disagree Slightly	Neutral	Agree Slightly	Agree Somewhat	Agree Strongly
1	2	3	4	5	6	7

1. A woman who goes to the home or apartment of a man on their first date implies that she is willing to have sex.	1	2	3	4	5	6	7
2. Any female can get raped.	1	2	3	4	5	6	7
3. One reason that women falsely report a rape is that they frequently have a need to call attention to themselves.	1	2	3	4	5	6	7
4. Any healthy woman can successfully resist a rapist if she really wants to.	1	2	3	4	5	6	7
5. When women go around braless or wearing short skirts or tight tops, they are just asking for trouble.	1	2	3	4	5	6	7
6. Women who get raped while hitchhiking get what they deserve	1	2	3	4	5	6	7
7. A woman who is stuck-up and thinks she's too good to talk to guys on the street deserves to be taught a lesson.	1	2	3	4	5	6	7

8. Many women have an *unconscious* wish to be raped, and may then *unconsciously* set up a situation in which they are likely to be attacked.	1	2	3	4	5	6	7
9. If a woman gets drunk at a party and has intercourse with a man she's just met there, she should be considered "fair game" to other males at the party who want to have sex with her too, whether she wants to or not.	1	2	3	4	5	6	7
10. In the majority of rapes, the victim is promiscuous or has a bad reputation.	1	2	3	4	5	6	7
11. If a girl engages in necking or petting and she lets things get out of hand, it is her own fault if her partner forces sex on her.	1	2	3	4	5	6	7

Please use the following key to answer the following two questions.

Almost None	A Few	Some	About Half	Many	A Lot	Almost All
1	2	3	4	5	6	7

Circle the number that shows what fraction you believe to be true.

12. What percentage of women who would report a rape would you say are lying because they are angry and want to get back at the man they accuse?	1	2	3	4	5	6	7
13. What percentage of reported rapes would you guess were merely invented by women who discovered they were pregnant and wanted to protect their own reputation?	1	2	3	4	5	6	7

Please use the following key to answer the next questions.

Never	Rarely	Sometimes	Half the time	Often	Usually	Always
1	2	3	4	5	6	7

A personcomes to you and claims they were raped. How likely Would you be to believe their statement if the person were:

14. Your best friend?	1	2	3	4	5	6	7
15. An Indian woman?	1	2	3	4	5	6	7
16. A neigbourhood woman?	1	2	3	4	5	6	7
17. A young boy?	1	2	3	4	5	6	7
18. A black woman?	1	2	3	4	5	6	7
19. A white woman?	1	2	3	4	5	6	7

Scoring

Items 1-11 are scored on a 7-point scale from "Strongly Disagree" (scores 1) to "Strongly Agree" (scores 7) but the scoring is reversed on item 2. Numbers 12 and 13 are scored on a 7-point scale from "Almost None" (scores 1) to "Almost All" (scores 7). Items 14 to 19 are scored on a 7-point scale from "Never" (scores 7) to "Always" (scores 1).

The score range is 19-103.

APPENDIX 3.5

SEX OFFENCE ATTITUDES QUESTIONNAIRE (PROCTER, 1994)

Questionnaire

SEX OFFENCE ATTITUDES QUESTIONNAIRE

Please indicate how true or untrue you believe the following statements to be about the sexual offence(s) you have most recently been convicted of. Put a circle around the appropriate number:

1	=	Completely true
2	=	Mainly true
3	=	Half true/half untrue
4	=	Mainly untrue
5	=	Completely untrue

---

1. I offended because I have a preference for illegal sexual behaviours.	1	2	3	4	5
2. The consequences of this offence has caused me as much grief and pain as my victim.	1	2	3	4	5
3. It is likely that my victim has overcome most of the distress I caused her/him by now.	1	2	3	4	5
4. I think that I am at risk of committing further sexual offences.	1	2	3	4	5
5. I still believe that I am innocent and did not commit the sexual offence(s) I have been charged with.	1	2	3	4	5
6. I have committed other sexual offences for which I have not been caught.	1	2	3	4	5
7. This offence was an unfortunate accident.	1	2	3	4	5

8. I do not consider myself to have a serious sex offending problem.	1	2	3	4	5
9. I often made arrangements to ensure that I was alone with my victim.	1	2	3	4	5
10. Anyone close to me knows that I could never commit a sexual offence.	1	2	3	4	5
11. I think that I am in need of long term treatment to stop me from committing further sexual offences	1	2	3	4	5
12. I would deliberately set up situations to make it easier for me to offend.	1	2	3	4	5
13. This was a one off offence.	1	2	3	4	5
14. My victim is likely to have become withdrawn and depressed because of my actions.	1	2	3	4	5
15. I enjoyed having power over my victim.	1	2	3	4	5
16. I have never committed a sex offence in my life	1	2	3	4	5
17. The pleasure I get from sex offending helps to fill other gaps in my life.	1	2	3	4	5
18. I am certain that the stress I was under at the time led me to offend.	1	2	3	4	5
19. We have to share some of the blame because my victim knew how to sexually seduce me.	1	2	3	4	5
20. I made sure that my victim kept the behaviour a secret for as long as possible.	1	2	3	4	5
21. In the period leading up to the offence I fantasised about my victim sexually.	1	2	3	4	5
22. I think that the harm I caused to my victim will be fairly short lived.	1	2	3	4	5
23. I accept that I committed a sexual offence.	1	2	3	4	5
24. I am certain I will never commit further sexual offences.	1	2	3	4	5

25. My victim is bound to have problems forming loving relationships in the future.	1	2	3	4	5
26. This offence happened completely out of the blue.	1	2	3	4	5
27. I know that I acted illegally.	1	2	3	4	5
28. I would not have offended if it had not been for alcohol.	1	2	3	4	5
29. I gained some sexual satisfaction from the behaviour.	1	2	3	4	5
30. I do not need anybody to help me control my sexual behaviour.	1	2	3	4	5

Scales and Scoring

Each question is scored from 1-5 - the higher the score, the higher the level of distortions. The following items are reverse scored (i.e. 1 scores 5, 2 scores 4, etc.): 2; 3; 5; 7; 8; 10; 13; 16; 18; 19; 22; 24; 26; 28; 30.

Scale	**Item numbers**	**Score range**
Perception of Risk	4, 6, 8, 10, 11, 13, 17, 24, 30	9-45
Victim Empathy	2, 3, 14, 15, 22, 25	6-30
Denial	5, 16, 23, 27	4-20
Planning	7, 9, 12, 20, 21, 26, 29	7-35
Distortions/Justifications	1, 18, 19, 28	4-20
Total Distortions score	All items	30-150

APPENDIX 3.6

PERSONAL REACTION INVENTORY (GREENWALD & SATOW, 1970)

Questionnaire

PERSONAL REACTION INVENTORY

Please indicate to what extent the following apply to you using the following key.

1. very like me
2. quite like me
3. a little like me
4. neither like nor unlike me
5. a little unlike me
6. quite unlike me
7. very unlike me

1. No matter who I'm talking to I'm always good listener.	1	2	3	4	5	6	7
2. I have sometimes taken unfair advantage of another person.	1	2	3	4	5	6	7
3. I am always courteous, even to people who are disagreeable.	1	2	3	4	5	6	7
4. I sometimes try to get even, rather than forgive and forget.	1	2	3	4	5	6	7
5. I am quick to admit to making a mistake.	1	2	3	4	5	6	7
6. I have always faced up to the bad as well as the good consequences of things I have done.	1	2	3	4	5	6	7
7. I sometimes feel resentful when I don't get my own way.	1	2	3	4	5	6	7
8. I would never think of letting someone else be punished for my wrong-doing.	1	2	3	4	5	6	7
9. There have been occasions when I took advantage of someone.	1	2	3	4	5	6	7

10. At times I have wished that something bad would happen to someone I disliked.	1	2	3	4	5	6	7
11. I am always attentive to the person I am with.	1	2	3	4	5	6	7
12. There have been times when I felt like rebelling against people in authority even though I knew they were right.	1	2	3	4	5	6	7

Scoring

Items are scored on a 7-point scale from "very like me" to "very unlike me", with reverse scoring ("very like me" scores 7) on items 1, 3, 5, 6, 8, 11.

APPENDIX 3.7.1

VICTIM AWARENESS QUESTIONNAIRE (ALLAM, 1994)

Questionnaire

This questionnaire is about your attitudes towards sexual contact between children and adults. Here, "child" means anybody under 17 years, "adult" means a man of 21 years or over and "sexual contact" means any sexual activity - ranging from kissing to full intercourse.

Please read the questions carefully and then circle the number which is closest to your opinion. The meaning of the numbers is as follows:

1. Strongly agree
2. Mostly agree
3. Slightly agree
4. Neither agree nor disagree
5. Slightly disagree
6. Mostly disagree
7. Strongly disagree

	Agree				Disagree		
1. If the child smiles during sexual contact with an adult, he or she is enjoying the activity.	1	2	3	4	5	6	7
2. When a child has had sexual contact with an adult, he or she is likely to suffer from depression later in life.	1	2	3	4	5	6	7
3. Sometimes children don't tell anybody about their sexual contact with an adult because they enjoy the activity and don't want it to stop.	1	2	3	4	5	6	7
4. If a child resists sexual contact with an adult, it is always because the child is unhappy about the sexual contact.	1	2	3	4	5	6	7
5. It is <u>never</u> OK for a 15 year old to have sexual contact with an adult.	1	2	3	4	5	6	7

6. It is harmful to a child if the man shows the child his penis.	1	2	3	4	5	6	7
7. A child might not tell anybody about having sexual contact with an adult because he/she does not want the man to get into trouble.	1	2	3	4	5	6	7
8. Children who have sexual contact with an adult are likely to have sexual problems when they grow up.	1	2	3	4	5	6	7
9. Open-mouthed kissing between a child and an adult is <u>not</u> harmful to the child.	1	2	3	4	5	6	7
10. When a child and father or step-father have sexual contact, the child might not tell anybody for fear of breaking up the family.	1	2	3	4	5	6	7
11. It is <u>never</u> OK for a child to masturbate a man.	1	2	3	4	5	6	7
12. So long as the adult fondles the child over the child's clothes, the child is <u>not</u> likely to suffer.	1	2	3	4	5	6	7
13. It is <u>not</u> likely that a child who has sexual contact with a man will have problems forming loving relationships later in life.	1	2	3	4	5	6	7
14. If the child doesn't resist the adult, the child is probably enjoying the sexual activity.	1	2	3	4	5	6	7
15. Children who have sexual contact with adults are likely to grow up having little confidence.	1	2	3	4	5	6	7
16. Having sexual contact with an adult can help the child to have a better sex life later on.	1	2	3	4	5	6	7
17. It can be a positive thing for a child to be masturbated by an adult.	1	2	3	4	5	6	7
18. Most children who have had sexual contact with an adult do not tell anyone because they are frightened of the man.	1	2	3	4	5	6	7
19. There is not much harm done if an adult fondles a child under the child's clothing.	1	2	3	4	5	6	7

20. During sexual contact with an adult, a blank face suggests that the child doesn't mind the activity.	1	2	3	4	5	6	7
21. There is no reason why children who have sexual contact with adults should find it difficult to trust people later in life.	1	2	3	4	5	6	7
21. A 12 year old having sexual contact with a man is always unacceptable.	1	2	3	4	5	6	7
23. Sometimes a child is worried about not being believed and this is why he or she doesn't tell anybody about having sexual contact with an adult.	1	2	3	4	5	6	7
24. The reason some children don't tell anybody about their sexual contact with an adult is because they don't mind the activity.	1	2	3	4	5	6	7
25. Most children are perfectly capable of saying "no" if they don't want sexual contact with an adult.	1	2	3	4	5	6	7
26. It is unlikely that a child would not tell anyone about sexual contact with a child for fear of not being believed.	1	2	3	4	5	6	7
27. Even if the man isn't violent, it is always difficult for a child to resist sexual contact.	1	2	3	4	5	6	7
28. If a man penetrates a child with his penis or finger, it is bad for the child.	1	2	3	4	5	6	7
29. It is not necessarily a bad thing for an adult to give oral sex to a child.	1	2	3	4	5	6	7
30. Sometimes children don't tell anyone about their sexual contact with an adult because they feel such matters are private.	1	2	3	4	5	6	7
31. Sexual contact with a man is not always harmful to an 8 years old child.	1	2	3	4	5	6	7
32. It is unacceptable for a child to give oral sex to a man.	1	2	3	4	5	6	7

33. Not all sexual contact with a man are bad for a 4 year old.	1	2	3	4	5	6	7
34. It is unlikely that a child would not tell anybody about sexual contact with an adult for fear of being blamed.	1	2	3	4	5	6	7
35. If a child penetrates a man with finger or penis, it is unlikely to harm the child.	1	2	3	4	5	6	7

Scoring

This questionnaire consists of 38 items - each a statement rather than a question. For each item a score of 0-6 may be obtained. Lower scores indicate an awareness of how a child may react to and be affected by sexual abuse committed by an adult. High scores indicate poor victim awareness and a tendency to have cognitive distortions about children and the consequences of abuse. The total score range is 0-210.

For the following questions "strongly agree" receives a score of 6 and "strongly disagree" scores zero: 1; 3; 6; 12; 13; 14; 16; 17; 19; 20; 21; 24; 25; 26; 29; 30; 31; 33; 34; 35.

For the following questions "strongly agree" receives a score of zero and "strongly disagree" scores 6: 2; 4; 5; 7; 8; 9; 10; 11; 15; 18; 22; 23; 27; 28; 32.

APPENDIX 3.7.2

DEVELOPMENT AND STANDARDISATION OF THE VICTIM AWARENESS QUESTIONNAIRE

Questionnaire Development

The enhancement of empathy for victims and potential victims is a key goal in cognitive-behavioural programmes for sex offenders because it is believed that victim empathy might inhibit further offending - just as lack of empathy has disinhibited an individual and made it possible for him to abuse (e.g. Abel et al, 1989; Beckett et al, 1994).

Unfortunately, measuring all components of empathy for victims is extremely difficult. There are no pen and pencil measures which claim to mention the emotional aspects of victim empathy. Tests do exist which look at global distortions about child sexuality (e.g. Abel & Becker, 1984; Beckett & Fisher, 1993) and others which refer directly to distortions about the victim of the offender (e.g. Beckett, 1993; Procter, 1994). However, none exist which measure distortions and beliefs about children as victims of sexual assault.

The Victim Awareness (VA) Questionnaire was developed with the intention of providing a measure which would assess and individual's level of understanding about child victims who are sexually abused. It covers issues that concern: attitudes towards sex with children; how a child might feel during abuse; why a child might not disclose abuse; possible long-term consequences of abuse. Like other measures that attempt to uncover attitudes towards and understanding of victims, the VA questionnaire does not claim to be measuring empathy in the sense of feeling compassion and concern. What it does examine are cognitive aspects of victim awareness - understanding emotional expression, perceiving how another might be thinking and feeling, understanding what constitutes appropriate behaviour towards children.

The VA questionnaire (Appendix 3.7.1) comprises 35 items with a 7-point Likert response format, ranging from "strongly agree" to "strongly disagree". Scores for each question range from 0 (no distortion) to 6 (maximum distortion), with a total possible scale score of 0 - 210. Approximately half of the items are worded in an active format (i.e. as a distortion) and half in a passive format. Example items are: Sometimes children don't tell anybody about their sexual contact with an adult because they enjoy the activity and don't want it to stop; It is never OK for a child to masturbate a man; Children who have sexual contact with an adult are likely to have sexual problems when they grow up; Not all kinds of sexual contact with a man are bad for a 4 year old.

The final 35 items in the questionnaire are derived from an original set of 40. Ideas for the content of these questions came from several sources. The main source was the literature on cognitive distortions and victim empathy in sex offenders (e.g. Stermac & Segal, 1989; Segal & Stermac, 1990; Hudson et al, 1993; Beckett et al, 1994; Fisher, 1994), which pointed to global distortions about child sexuality, minimisations and justification of child abuse, an ignorance of the long-term consequences of child sexual abuse. However, the literature dealing specifically with victims, their experience of abuse and how it has affected them in later life was also consulted (Stein, Golding, Siegel, Burnam & Sorenson, 1988; Conte & Schuerman, 1988; Briere, 1992; Kilpatrick, 1992). The deficits in victim awareness in CSAs were confirmed both by limited groupwork observation and by consulting with probation officers specialised in the treatment of sex offenders. Once a list of questions were drafted, these officers were asked for their comments and a final draft was produced that was to be normalised on non-offending males.

Standardisation Procedure

An undergraduate psychology student was asked to normalise the questionnaire and to administer it alongside the Personal Reaction Inventory (PRI) in order to check the possible interference of socially desirable responding. A total of 104 student males were recruited for the study - 47 from a university psychology department and 57 from the engineering department. All were studying for degrees and the mean age of participants was 19 years with a range of 18 - 25 years. None had children and only 12% were married or in long-term relationships. Students were approached during lectures and asked to anonymously fill out the questionnaires and to return them to a postal box within the university. The 104 respondents represented an overall response rate of 49% (45% of the engineers and 54% of the psychology students). It was expected that following an analysis of student and CSA sample results, it would be shown that CSAs have poorer victim awareness than non-offenders.

Results

The data were found to be normally distributed and no significant differences were found between the VA means of engineers and psychologists (Morton, 1996). Therefore, the data were pooled. The mean score for the student sample was 42.78 (21.79). The range of scores was 4 - 109, with the majority (71.16%) of scores falling within 1 standard deviation (SD) of the mean. Only 1 student obtained a score of more than 3 SDs above the mean, 3 obtained scores of between 2 and 3 SDs above the mean and 11 obtained scores of between 1 and 2 SDs above the mean. Only 14 students scored more than 1SD below the mean. It seems that the general population of males tends to have relatively few distortions about children and sexual abuse. However, a small number of respondents here had very high levels of distortions. We know that what is regarded as the non-offender population is likely to include undetected sex offenders (e.g. Malamuth, 1981; Briere & Malamuth, 1983; Koss, Beezley & Oros, 1985) and we also know that at least one study has revealed a proportion of the (presumed) non sex offender population indicate a desire to and willingness to have sexual contact with children (Briere & Runtz, 1989). Thus, the results obtained appear

to be consistent with the literature.

Mean scores of engineers and psychology students were again extremely close on the measure of social desirability (PRI) so results were pooled to produce a mean of 51.79 (8.41). This score was very different from the mean PRI score of the normative sample used in the Beckett et al (1994) study. Their sample of 81 non-offender prison officer trainees obtained a mean PRI score of 57.83 (8.41), which did not differ significantly from their sample of sex offenders. It is possible that the difference in testing conditions has produced this difference but there could be other factors involved, such as age, level of education, or some other variable.

Reliability

The VA questionnaire has high internal consistency with an alpha of .89. A Split-half reliability test revealed a correlation of .91 between the two test halves. A sample of 12 students re-did the VA questionnaire 2 weeks after the first administration (these were known to the investigator and were asked to re-do the tests at a later date when they returned the first tests to her in person). Test re-test reliability was found to be $r = .72$.

Validity

Face validity of the test was good and minor changes were made following suggestions by probation officers (from the SOU) prior to questionnaire administration. Following administration, of the 40 original items, 5 were rejected following comments from respondents that the questions were difficult to understand, ambiguous or offensive.

Scores on the VA were found to have a small but statistically significant correlation with socially desirable responding ($r=-.25$, $df=102$, $p<.05$, 2-tailed), which suggests that those wishing to present in a good light were a little more likely to reveal few VA distortions. However, no such relationship was found between CSA VA scores and

PRI scores (r=.082, df=124, p>.05, 2-tailed).

The mean VA score of untreated CSAs in this study (n=126) was 48.74 (29.9). An independent t-test of the difference between the non-offender mean and CSAs found that scores differed significantly (t=9.38, df=228, p<.01, 2-tailed). Thus, the VA questionnaire appears to discriminate between victim awareness in non-offending males and child sex offenders, with CSAs having poorer victim awareness. The hypothesis that CSAs would have more distortions about child victims of sexual abuse was supported.

The VA scores of CSAs were correlated with several other relevant scales: the Victim Empathy sub-scale of the SOAQ (Procter, 1994); the Cognitive Distortions (CD) scale of the Children and Sex questionnaire (Beckett & Fisher, 1993); the Emotional Congruence (EC) scale of the Children and Sex questionnaire; the Justifications (Ju) scale of the MSI (Nichols & Molinder, 1994); the Rape Myth Acceptance Scale (Burt 1980). There were modest but significant correlations with all of the above: r=.47 with the SOAQ Victim Empathy scale (which refers to the offenders' own victim); r=.54 with CDs about child sexuality; r=.46 with EC with children; r=.39 with MSI Justifications; r=.54 with Rape Myth Acceptance attitudes. Clearly, then, the VA questionnaire is tapping into distortions about children in general, their sexuality, their experience of sexual abuse and its consequences and probably to distortions offenders have about their own victims.

Usefulness of the Victim Awareness Questionnaire in assessing child sex offenders

Whilst the VA appears to be measuring cognitive components of victim empathy, and whilst it appears to be able to discriminate between a group of non-offenders and a group of CSAs, the differences are not enormous. This may in part be explained by the difference in socially desirable responding. The CSAs in this sample obtained an average PRI score of 57.74 (12.32) compared to the 51.79 (8.41) of the student sample. This difference was highly significant (t=8.6, df=228, p<.001, 2-tailed) and

suggests that the CSA group are more likely to be faking somewhat on the VA questionnaire.

Another reason for the relatively small difference in scores may be the transparency of the questionnaire - the fact that many people might know what the answer should be and are able to give this answer rather than the one they really think.

Despite its shortcomings, the VA questionnaire is expected to contribute to an assessment of change over time in CSAs attending a treatment programme. One would expect better victim awareness with fewer distortions as CSAs progress through the treatment programme.

APPENDIX 3.8.1

RELAPSE PREVENTION QUESTIONNAIRE (ALLAM 1994)

Questionnaire

The following questions are designed to show us how much you understand about your own offending behaviour and how well you are able to cope with high risk situations. It is important that you answer the questions as fully as you can. If you need more paper, ask the person who has given out the questionnaire. If you don't understand a question, ask for help.

1. Why did you become a sex offender? What motivated you to abuse?

2. What thoughts did you have before the abuse that made it possible for you to offend? For example, "she can always say no if she doesn't like it", "he's old enough to have sexual feelings". Give as many of your own answers as possible.

   1

   2

   3

   4

3. Challenge these thoughts.

   1

   2

   3

   4

4. How were you feeling just before the first time you abused? Had anything happened to make you feel this way?

5. How did you usually feel before you abused (if you abused more than once)?

6. What justifications did you use that allowed you to continue the abuse? For example, "She doesn't really mind", "at least I'm giving him some love and attention". Give as many of your own examples as possible.

   1

   2

   3

   4

7. Challenge these justifications.

   1

   2

   3

   4

8. What excuses did you use to make yourself think you were not really responsible for the abuse? For example, "I'd had too much to drink. I didn't know what I was doing."

   1

   2

   3

   4

9. Challenge these excuses.

   1

   2

   3

10. How did you groom your victim? In other words, how did you prepare your victim before the abuse?

11. How did you groom other people and the environment?

12. What did you do immediately before the abuse in order to prepare yourself to abuse? For example, perhaps you used pornography or got drunk.

    The first time you abused?

    The other times you abused?

13. How did the abuse make you feel good?

14. Why is it important for people close to you to know about your sexual offending?

15. What happens in group that will help you to control your offending behaviour?

16. What kind of fantasy is it ok to use for masturbation?

17. Give at least four examples of situations and thoughts which might place you at risk of re-offending.

    1

    2

    3

    4

18. When you are in these situations or having these thoughts, what can you do to stop yourself from offending?

19. Describe a particularly high risk situation for you.

20. How would you deal with this situation in order to ensure that you did not re-offend?

21. Describe some of the things in your old lifestyle which you believe contributed to your committing abuse.

22. Describe the changes in your lifestyle that you have made (or intend to make) in order to help prevent you re-offend.

23. Are you still sexually aroused by the type of the abuse you committed?

24. If you replied "no" to question 23, please explain why you are no longer aroused to this type of abuse. If you replied "yes" to question 23, what do you think you could do to help reduce arousal?

25. Are you at risk of re-offending?

26. If you replied "no" to question 25, please explain why you believe you are no longer at risk of re-offending. If you replied "yes" to question 25, what can you do to reduce your risk?

Scoring

2 points: Respondent has given a full and detailed response to the question which is deemed to be truthful and relevant to his pattern of offending.

1 point: Respondent has partially answered the question but has given one word answers (when a fuller answer is more appropriate) or has left out important or relevant information.

0 points: Respondent has failed to answer the question, has given an inappropriate or implausible answer, or is not thought to be telling the truth.

The questionnaire consists of 2 sections. The first (qns 1-13) relates to Insight into sexually abusive behaviour patterns and the second (qns 14-26) relates to Risk Awareness and Strategies (to prevent re-offending).

Insight:	Score range 0 - 26
Risk Awareness and Strategies:	Score range 0 - 26
Total RP score:	Score range 0 - 52

Where a question is not applicable to a particular offender, points are scored as follows:

- Add all the points scored in the relevant section.
- Divide the number of points by the number of questions answered. This will give the average score for questions in this section.
- For the inapplicable question allocate points according to the average. If the average is closer to 2 than 1, score 2. If the average is closer to 0 than 1, score 0.

APPENDIX 3.8.2

DEVELOPMENT AND STANDARDISATION OF THE RELAPSE PREVENTION QUESTIONNAIRE

Questionnaire Development

Relapse Prevention (RP) work is an integral part of cognitive-behavioural treatment programmes (see chapter 2 for a detailed discussion of the concept) which works on two major assumptions. The first is that sex offenders cannot be cured but can learn to control their behaviour (RP work therefore requires motivation on the part of the offender not to re-offend). The second assumption is that sexual assaults are rarely impulsive acts. Whilst the actual abuse in some cases may have been opportunistic, there would have been a combination of antecedents. For example, sexual fantasies about children, attraction to a particular child, distortions about children or one child in particular, anxiety, substance abuse, etc.

Whilst there is much literature on RP and its place in treatment programmes (e.g. Laws, 1989; Pithers, 1990; Marques et al, 1994), there were no published RP questionnaires available at the start of this project. For practical reasons, it was felt that a questionnaire (rather than a client interview or group leader report) was the most appropriate way of obtaining a quantifiable measure of RP skills, particularly since assessment would take place on several occasions.

The RP literature distinguishes between two essential components of relapse prevention. The first component is that of insight into offending behaviour. Unless CSAs can identify the antecedents to their last offence(s), they may be unable to identify high risk situations in the future. The second component incorporates risk awareness and coping strategies - the ability to identify potentially risky situations and to detail ways of coping with these situations.

Clearly, RP treatment needs to be individualised to the extent that a client becomes aware of his own antecedents and risk situations, as well as developing the strategies that he needs to regulate his own behaviour and to avoid lapses and relapses. The RP questionnaire developed for the purpose of this evaluation (Appendix 4.8) takes into account the individual nature of RP. This is why questions frequently require some detail in the responses and why the scoring procedure allows for individual differences.

The questions were designed with the aid of: the SOU groupwork manual (which details the aims of the RP module and a number of exercises that offenders do); SOU probation officers (who were able to detail the processes of lapse and relapse illustrated with concrete examples); the literature on relapse prevention (Greer & Stuart, 1983; Laws, 1989; Pithers, 1990).

The scale comprises 26 questions, 13 of which relate to insight into past offending. Example questions are: How were you feeling just before the first time you abused? Had anything happened to make you feel this way?; How did you groom your victim? The remaining 13 questions deal with awareness of risk and coping strategies. Example questions are: Describe a particularly high risk situation for you; How would you deal with this situation in order to ensure that you did not re-offend? Each reply scores a maximum of 2 points and a minimum of 0 points. The RP scales are considered both separately and as a whole, since aptitude in both areas is required to prevent relapse. The scoring method is explained more fully in Appendix 4.8.

Validity and Reliability

The RP questionnaire has face validity and the content is consistent with the literature. In addition, since this evaluation began, a copy of the RP questionnaire used in the STEP Project (Beckett et al, 1994) has become available. The two tests appear to be quite similar. However, the STEP questionnaire is somewhat shorter and possibly easier to understand, tending not to require long and detailed answers.

My original intention was that group workers should score the RPs of offenders that they were working with. The scoring system was explained, as was the purpose of the RP. Whilst probation officers were willing to co-operate, there were difficulties obtaining accurately scored forms. The first was that officers were frequently too busy to score the RPs close to the time of administration. By the time they came to scoring them, they reported some problems in remembering the specifics of an individual's offences and also reported worries about contamination - the presentation of the offender in group was sometimes inconsistent with his replies to the RP (frequently because of a time lapse). In order to check the reliability of scorers (and the scoring system), the scores for each officer were collected and divided into scores for clients at 50 hours and 100 hours (not 200 hours because there were not enough tests). One-Way Anovas were conducted to check the null hypothesis of no difference in score averages between the 6 officers in question. At both 50 hours and 100 hours unacceptably high differences in scores were detected. Thus, it was decided that the tests be re-scored by the Author. I first re-scored the tests using the information I already had about offenders. I then went over my scoring with the officers concerned to check that nothing had been overlooked. I scored and re-scored (blind and after one month) 20 tests and found reliability to be adequate at .91. Clearly, reliability of scoring was extremely important, since respondents had to complete the same questionnaire on a number of occasions.

Internal consistency of the RP questionnaire was good. The combined scales (i.e. total RP score) had an alpha of .93 with a Spearman-Brown split-half reliability of .82. The first 13 questions (insight scale) had an alpha of .9 with a split-half reliability figure of .86. Questions 14-26 also had high internal consistency - again an alpha of .9 with a slightly lower split-half reliability of .83. Test re-test reliability was not undertaken - primarily because of the difficulty of locating offenders willing to participate in the study, who were no longer receiving sex offender treatment. Clearly, this is potentially an important criticism of the use of this RP questionnaire.

Since the RP questionnaire was not administered to non-offenders and was not intended to be a test which would discriminate between offenders and normative

samples, it was not subject to normalising. However, further validity checks were done by obtaining correlations between RP scores at 50 hours (which is when they were first administered) and tests which might be expected to be related to relapse prevention skills. It was felt that the strongest relationships would be with denial and minimisation (about the offences), motivation for treatment (implying motivation not to re-offend) and distortions about the sexuality of children (high distortions place the onus on the child and not the offender). As predicted, relationships were found. The following correlations are all highly significant ($p<.001$, $df=98$, 2-tailed). Total RP scores correlated with: the SOAQ total distortions score (-.63); the SOAQ Perception of Risk sub-scale ($r=-.59$); the MSI Treatment Attitudes Scale ($r=.56$); the MSI Child Molest (Sex Deviance Admittance) Scale ($r=.5$); the MSI Child Molest Lie scale ($r=-.48$); the Cognitive Distortions Scale of the Children and Sex Questionnaire ($r=-.35$). Thus, there is a trend towards those who display relapse prevention insight and skills: denying less; being more motivated for treatment; having fewer distortions about child sexuality.

Potential usefulness of the RP questionnaire

The RP questionnaire appears to have construct validity and to be a fairly reliable measure of relapse prevention insight and skills. It is extremely important that reliable means of assessing RP skills are available to assessors and evaluators. Marques et al (1994) reported relapse prevention skills to be the single best predictor of re-offending in their evaluation project at the Atascadero State Hospital. It is therefore of some concern to learn that the largest evaluation of community-based treatment programmes in Britain (Beckett et al, 1994) found that RP skills were generally inadequate at the end of treatment with some programmes devoting little or no time to RP work. Whilst the questionnaire reported here would benefit from further research into content validity (e.g. comparisons with other RP measures) and needs to be checked for test re-test reliability, it does present as being a potentially useful instrument for measuring relapse prevention related insight and coping skills at various stages of the treatment process.

APPENDIX 3.9

INSTRUCTIONS

You will be completing a number of questionnaires before beginning group and at various stages of the programme. This is to help us to look at your attitudes, thoughts and feelings in a way which might assist group leaders and probation officers to understand what help you might need. These questionnaires also help us to look at your progress once you have been in group for a while.

It is important that you answer every question and that you give definite responses. For example, if the choice of answers is True *or* False, you cannot put "both" - one answer will be always be more accurate than the other and usually this is the one that first came into your head. If you leave out questions or do not answer clearly, we will need to bring you into the office again so it is important that you check that you haven't missed anything before you leave.

If you are having problems understanding any of the questions or with reading or writing, please ask the person supervising the testing. They will be happy to help you. If you are having too much difficulty reading and writing, we will get somebody to read the tests to you (either today or on another occasion).

Thank You

APPENDIX 4

SACJ RISK ASSESSMENT SCALE (THORNTON, 1997)

Step one

Score one point for each of these factors:	Score
I. Index offence is sexual	.....
II. Has previous convictions/cautions for sexual offences	.....
III. Index offence is violence related	.....
IV. Has previous convictions for violence related	.....
V. Has four or more convictions of any kind	.....
TOTAL	.....

Score of:	one	=	Level I
	two-three	=	Level II
	four	=	Level III
			INITIAL RISK LEVEL .....

Step 2

Are any of these aggravating factors present?	TICK
I. Male victims (sexual offences)	☐
II. Non-contact offences	☐
III. Substance abuse evidenced	☐
IV. Victim was a stranger	☐
V. Never married or cohabited for 2 years	☐
VI. Has been in Local Authority Residential Care	☐

If two or more of these are present, put up risk level by one

ADJUSTED STEP TWO RISK LEVEL .....

Step 3

This part of the assessment covers events since the offender commenced a treatment programme.

1. Risk is **raised** one level if any of these are present

	Tick Box
I. Dropped out of treatment	☐
II. Relevant delinquent behaviour, e.g. assaults on staff, evidence of child pornography being used, suggestive behaviour towards staff	☐
I. Deterioration in treatment, e.g. angry responses to challenge, failure to own behaviour, lowered self-esteem	☐

2. Risk is **lowered** by any of these present ☐

I. Successful completion of treatment programme	☐
II. Improvement in Dynamic Risk Factors	☐
III. Acceptable level of Dynamic Risk Factors	☐

Original Risk Level .....

Adjusted Risk Level .....

Dynamic Risk Factors include:

- Sexual interest - children, coercive sex
- Cognitive distortions
- Deficits in empathy
- Emotional loneliness
- Sees self as victim - grievance, external locus of control, etc.
- Relapse prevention skills
- Attitudes of significant victims - helpful or not helpful
- Involvement in further crime

Risk Level	Sex Reconviction	Sex/Violence Reconviction
I	9%	21%
II	23%	39%
III	46%	56%

n=533

r=.032

It is suggested that Level I offenders pose a low risk in both short (3 years) and longer term (6 years). Level II pose a medium risk in the short term which rises over time. Level III pose a high short term and long term risk, and it is unlikely that their risk will ever be significantly reduced. This scale was developed by Dr David Thornton, head of HM Prison Service Programme Development, and has been accepted by the parole board as a valid means of assessment for decisions on release.

APPENDIX 5

EFFECTIVE PRACTICE IN WORK WITH SEX OFFENDERS

A Re-Conviction Study comparing treated and untreated offenders

Introduction

This study compares the reconviction data of "treated" and "untreated" sex offenders over a three year follow up period.

The "treated" samples consist of 155 adult male sex offenders who entered the West Midlands Probation Service Sex Offender Treatment Programme between January 1995 and June, 1996. The WMPS Sex Offender Unit runs a cognitive - behavioural groupwork programme which addresses sexual offending. Based around weekly attendance on the groupwork programme the total programme length is 200 hours and takes 18mths to 2 years to complete. In additional to the reconviction study offenders were also assessed using psychometric data to measure attitude and cognitive changes during the course of the programme. Offenders are directed to attend the programme either by Court Order (usually as part of a 3yr Probation Order) or as a condition of their release from prison. Apart from those who were found to have a learning disability, all offenders entering the programme participated in the study.

Of the 155 offenders in this sample, 126 had committed contact sexual offences against children of 16yrs or under (child sexual abusers). Of the remainder, 13 had either indecently assaulted or raped an adult (hereafter referred to as rapists) and 16 had committed non-contact offences (hereafter referred to as exhibitionists).

The "untreated" controls were obtained from a group of offenders for whom the Sex Offender Unit had recommended community-based sex offender treatment at PSR stage but who had been given alternative sentences. Some of this sample had received prison sentences followed by attendance at the unit for treatment until the end of their license. These had to be removed from the original control sample. The remainder received sentences ranging from fines and conditional discharges to short prison sentences or probation orders without a condition of treatment. Those who had been at risk for less than 1 year were also removed from the sample. The controls consisted of 47 child sexual abusers (CSAs), 19 rapists and 8 exhibitionists.

Analysis of data

Time at risk was assessed using a starting point which was the day of conviction in the case of community sentences and release date in the case of those who had been incarcerated. The shortest time at risk was 1 year and the longest was between 3 and 4 years. Reconviction data was obtained from the Home Office Offender Index and rates of reconviction were calculated at 1, 2 and 3 years. Percentage of sample reconvicted was also calculated as well as total number of offences (each court appearance counting as one offence) committed by each category. Because the Home Office Offender Index had no information on 2 of the "treated" child sexual abusers, they were removed from the analysis.

Overall reconviction rates

Table 1 below shows the number and percentage of each sample who were reconvicted of a sexual, violent, or other offence during the period at risk (average time at risk was 2.5 years).

Table 1: A comparison of reconvictions across groups

Group	Sexual	Violent	Other	Any Reconviction
Treated CSAs	4 (3.2%)	3 (2.4%)	7 (5.7%)	10 (8.1%)
Untreated CSAs	5 (10.6%)	6 (12.8%)	13 (27.7%)	15 (31.9%)
Treated Rapists	1 (7.7%)	1 (7.7%)	2 (15.4%)	3 (23.1%)
Untreated Rapists	5 (26.3%)	5 (26.3%)	9 (47.4%)	11 (57.9%)
Treated Exhib	3 (18.75%)	2 (12.5%)	5 (31.3%)	7 (43.8%)
Untreated Exhib	3 (37.5%)	3 (37.5%)	5 (62.6%)	5 (62.5%)

Table 1 illustrates large differences in overall reconviction rates of treated and untreated offenders - treated sex offenders having considerably lower rates of reconviction. This pattern is not confined to sexual offences but extends to both violent and other types of offending.

Reconviction rates according to time at risk

Both "treated" and control groups have been matched as closely as possible. They were all recommended for community-based treatment and average length of time at risk is approximately the same. However, in order to allow for differential periods of time at risk, lifetable analyses were conducted. Lifetable analysis enables an assessment of reconviction rates at (in this case) 1, 2, and 3 years. Table 2 illustrates the reconviction rates (i.e. the percentage of reconvictions) for all groups according to period at risk.

Table 2: A comparison of reconviction rates in treated and untreated sex offenders for 1, 2 and 3 years at risk

Group	Sexual (%)			Violent (%)			Other (%)		
	1yr	2yr	3yr	1yr	2yr	3yr	1yr	2yr	3yr
Treated CSAs	.9	5.5	5.5	.9	4	4	6.5	6.5	6.5
Untreated CSAs	7.1	10.8	21.3	4.8	15	23.9	18.8	32.6	32.6
Treated Rapists	8	8	8	8.3	8.3	8.3	8.3	8.3	38.9
Untreated Rapists	7.4	50.1	75.1	25.8	37.2	37.2	32.3	53.1	64.4
Treated Exhib	21.4	21.4	21.4	7.1	20.4	20.4	21.4	45.6	45.6
Untreated Exhib	26.7	45	45	26.7	43	43	37.5	65.3	65.3

There are clearly large differences in the re-conviction rates of controls and treated offenders at 1, 2 and 3 years, with controls being as much as 7 times more likely to commit a new offence. For example, by 3 years, untreated CSAs were almost four times more likely to have committed further sexual offences, more than five times more likely to have committed violent offences and more than five times more likely to have committed other types of offence. All of these differences were found to be statistically significant at $p<.05$.

The rapist and exhibitionist samples are rather small and statistically significant differences were not found in reconviction rates.

Number of reconvictions

A number of offenders committed more than one offence of the same kind during the risk period. Sample sizes (of recidivists) are too low to test for significant differences in the number of offences committed by controls and treated offenders. However, Table 3 illustrates what these offence patterns look like. The first figure in each column represents actual number of offences (separate court appearances) committed and that in brackets represents the number of recidivists.

Table 3: A comparison of groups on number of new offences committed

Group	Sexual	Violent	Other
Treated CSAs	4 (4)	2 (1)	7 (7)
Untreated CSAs	6 (5)	6 (5)	29 (12)
Treated Rapists	1 (1)	1 (1)	2 (2)
Untreated Rapists	8 (5)	6 (5)	18 (8)
Treated Exhib	9 (3)	2 (2)	7 (4)
Untreated Exhib	4 (3)	6 (3)	8 (4)

The table adds to the information that more untreated controls commit new offences. It demonstrates that of those who did reoffend, the untreated offenders were more likely to commit more than one offence. The exception here is that of sexual recidivism in exhibitionists. One of the treated sample committed 6 new offences of indecent exposure.

Unofficial Recidivism

Re-conviction rates under-estimate actual levels of re-offending. Unofficial sexual recidivism data (on offenders known to the SOU) has been available to the SOU because of close contact with other agencies, such as the police, social services and the NSPCC. Where an allegation has been made or there is a strong suspicion that somebody has re-offended, an individual is considered to have re-offended (unofficial recidivism).

Unofficial recidivism figures have been the same as re-conviction data in the case of rapists and exhibitionists in the SOU sample. However, whilst a total of 4 (3.2%) treated CSAs have been re-convicted of a sexual offence (one of whom committed the offences prior to commencing the programme), a total of 8 (6.4%) are suspected of having re-offended. At least one of these will never be convicted for new offences, since he died whilst awaiting trial. This figure still compares favourably to the official re-conviction data for the control sample, who are also likely to have committed offences for which they have not been re-convicted.

Relationship between re-conviction and recidivism with actuarial risk and deviance levels.

The child molesters (n=126) in this study were categorised according to both actuarial risk and level of deviation from the norm in psychometric questionnaire responses. Once they were assigned a risk group using actuarial data (SACJ, Thornton, 1997), cluster analyses on psychometric data were performed on each risk group. Each analysis resulted in a high and low deviance group emerging. For example, whilst all members of the high risk group had similar offending histories, there was a considerable difference in levels of denial, cognitive distortions, accountability, victim empathy, etc. Those in the high risk/low deviance group present with non-deviant psychometric profiles relative to those in the high risk/high deviance group. Indeed, they also have less deviant psychometric profiles than those in the medium risk/high deviance and low risk/high deviance groups.

Table 4. illustrates the proportion of re-offenders in each category. Clearly, numbers are low. However, there does appear to be an interaction of risk and deviancy with respect to medium and low risk (actuarial) groups. This does not seem to be the case where high risk offenders are concerned, i.e. deviance according to psychometric test profiles may not be very relevant with these groups.

Table 4: Re-offending of treated CSAs by risk/deviance group

High Risk/Low Deviance (n=9) *Total sexual re-offences = 2 (22.22%)* Official = 1 Unofficial = 1	*Medium Risk/Low Deviance (n=30)* *No sexual re-offences* Official = 0 Unofficial = 0	*Low Risk/Low Deviance (n=22)* *No sexual re-offences* Official = 0 Unofficial = 0
High Risk/High Deviance (n=9) *Total sexual re-offences = 1 (11.11%)* Official = 1 Unofficial = 0	*Medium Risk/ High Deviance (n=30)* *Total sexual re-offences = 4 (13.33)* Official = 2 Unofficial = 2	*Low Risk/High Deviance (n=25)* *Total sexual re-offences = 1 (0.4%)* Official = 0 Unofficial = 1

Conclusion

The effect of treatment appears to have extended to offence types other than sexual and suggests that cognitive-behavioural group work for sex offenders tends to be successful in promoting pro-social behaviour in general. These results are similar to those obtained by the STEP team in 1996, who found that a 2 year follow up found that untreated offenders were twice as likely to be convicted of further sexual offences and 5 times more likely to be convicted of non-sexual offences.

Whilst only short-term reconviction rates could be considered here, and whilst samples are relatively small, there is little doubt that the treated sex offenders are far less recidivistic than untreated sex offenders. This difference in reconviction rates was found to be statistically significant in child sexual abusers and strong trends were found in the much smaller groups of rapists and exhibitionists. Differential rates of reconviction here could not be accounted for by initial risk levels and criminal histories - indeed the treatment groups tended to be at higher risk (using an actuarial predictor) with approximately half of them on license following release from prison. Thus, sex offenders who participate in community-based cognitive behavioural groupwork programmes are less likely to be convicted of new sexual offences (as well as violent and other offences) and treatment can be seen as effective in reducing recidivism.

Finally, initial level of risk/deviance appears to have some predictive powers with respect to the likelihood of treated offenders re-offending. There is potential here for assessing relative benefits of treatment for individual CSAs and thus for more effective targeting of treatment resources.

Report prepared by Jayne Allam for West Midlands Probation Service, Dec '98.

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