

Background and Definitions

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

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

Throughout the text, we will be referring to high-risk, high-need sexual offenders. As a shorthand manner of describing this population we will typically only use the term high-risk populations or refer to offenders treated at the RTCSTP, who, for the purpose of this discussion, represent a group of high-risk sexual offenders. When referring to risk, we are referring to assignments based on the results of actuarial assessment instruments specifically designed to assess risk of sexual or violent recidivism. Actuarial instruments are measures that have a specific set of items and clear directions for scoring those items. The scores on the individual items are tallied in a pre-defined manner such that the assessor arrives at an overall risk score for general, violent or sexual recidivism. The best of these measures have been shown in a number of studies, using a variety of different groups of offenders, to be accurate predictors of risk (e.g., Hanson & Morton-Bourgon, 2009; Hare, 2003; Quinsey et al., 2006). A few of the better known (and more extensively researched actuarial instruments) are the Static-99/99R, developed by Hanson et al. (2000; Helmus et al., 2012), the Violence Risk Appraisal Guide

(VRAG), and the Sex Offender version of the VRAG (SORAG; Quinsey et al., 1998, 2006).

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

In addition, there has been some confusion in the literature as to whether antisocial personality disorder (APD) is synonymous with the term psychopathy. The criteria for a diagnosis of the latter, listed in the *Diagnostic and Statistical Manual* (DSM 5; American Psychiatric Association, 2013), serve to identify individuals who have been persistently antisocial. However, many of the individuals who meet the diagnostic criteria for APD would not meet the stricter criteria for psychopathy as measured with the PCL. With reference to forensic populations, the base rate for psychopathy (15–25%) is much lower than the base rate for APD (50–80%; Hare, 1998, 2003).

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As Rogers et al. (2000) noted, the DSM relegates the personality features of psychopathy (e.g., lack of concern for the suffering caused to others) to associated features of the disorder. These authors also caution that it is unlikely that the PCL-R and APD measure the same construct. Hare (2003) acknowledges that these constructs are highly correlated, but argues that this does not amount to saying that they are the same clinical disorder.

Hare (2003) has also noted that arguments have been made that question the evidentiary reliability of APD for forensic evaluations and testimony. Given the evidence in favor of reliability and validity regarding the PCL-R, as well as the very clear scoring criteria that exist for the measure, it is hard to argue with the psychometric properties of the scale (see Hare, 2003 for a detailed discussion of these matters). With reference to high-risk sexual offenders, we have found that, among those offenders treated at the RTCSTP, offenders who scored high on the PCL-R (defined as a score at or above a cut-off of 25) recidivated at significantly higher rates than sexual offenders scoring low on the PCL-R (Looman et al., 2005b). However, we have failed to find significant differences in terms of recidivism among those with or without a diagnosis of a personality disorder (Abracen & Looman, 2006). In our view, these findings are not surprising in that the diagnosis of APD is hardly informative with reference to the RTCSTP. Given the many convictions typically found on the official summaries of these offenders' criminal histories and the many years of antisocial behavior that have been associated with such behavior, a diagnosis of APD could likely be applied to the majority of the offenders attending the RTCSTP. As such, the diagnosis would be of little value in distinguishing between recidivists and non-recidivists.

A review (Seto & Quinsey, 2006) of research on treatment with psychopaths chose to discuss studies related to both APD and psychopathy. These authors argue that evolutionary perspectives may be best able to account for psychopathy and argue that psychopaths are a discrete natural class (taxon – for discussions, see Harris and Rice, 2006; Quinsey et al., 1998). Seto & Quinsey (2006) rationalize their approach by noting that there are few controlled treatment outcome studies with reference to psychopathy and that they are therefore

justified in discussing the literature on both psychopathy and APD when evaluating the research on psychopathy. From our perspective, it is problematic to argue that psychopathic offenders represent a discrete taxon (i.e., they are qualitatively different), but that the literature related to the majority of offenders (i.e., those with a diagnosis of APD) is relevant to the assessment of whether psychopathic offenders can be treated.

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

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

(see Chapter 5 for a complete discussion). Tony Ward and his colleagues (e.g., Ward & Stewart, 2003; Ward & Maruna, 2007; Yates & Ward, 2009) have criticized the emphasis on so-called criminogenic needs and have suggested that a focus on basic “human goods” is also critical in the treatment of offender populations. We will discuss the “Good Lives Model” and its relevance to the treatment of high-risk offenders later in the text.

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

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

With reference to mental health, when we refer to a mental or psychiatric disorder, we mean diagnoses and the associated criteria

that are present in one of the editions of the DSM. One notable exception to this is the use of the term psychopathy by which, as noted earlier, we refer to the offender's score on the PCL-R.

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

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