

A REVIEW OF EVIDENCE-BASED PRACTICE IN THE ASSESSMENT & TREATMENT OF SEX OFFENDERS

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Incidence of Sex Crimes

Highlights

- ✓ *Overall crime rates for sex offenses, both nationally and in Pennsylvania, have decreased, including rates of forcible rape.*
- ✓ *The portion of inmates incarcerated by the PA DOC for a primary offense of a sexual nature has remained constant relative to the total population.*
- ✓ *A high incidence of undetected and/or under-reported sex crimes may result in an underestimation of sex offense incident rates (as possible with any type of offense).*
- ✓ *A small portion of sex offenders are responsible for the vast majority of sex crimes.*
- ✓ *Sex offenders are not typically “specialists”, but commit a variety of non-sexual crimes as well.*

Incidence of Sex Crimes

Sex offenders elicit a great deal of public apprehension and fear. The public's apprehension and abhorrence toward sex offenders is compounded by the fact that their victims are oftentimes women, children, and persons for whom the psychological impact of the crime is often very traumatizing. Although the fear is high, these offenses are less prevalent today than they were 10 to 20 years ago. In fact, crime rates for sex offenses nationally, and in Pennsylvania, have decreased, and incarceration rates for sex offenses in the Pennsylvania Department of Corrections (DOC) have remained constant relative to the total population. Clearly, crime and incarceration rates underestimate the prevalence of sexual offenses, and accurate estimates of the incidence of sexual crimes are difficult to obtain for a number of reasons (several of which are identified below). Yet, while the accuracy of the estimates related to the incidence of sex crimes is questionable, research related to sex crimes has produced a number of common themes. Specifically, it is a well-established finding that a small portion of offenders are responsible for the vast majority of sex crimes. Further, we know that sex offenders are not typically "specialists", but commit a variety of non-sexual crimes as well.

National Sex Crime Statistics

- According to the Bureau of Justice Statistics, while the downward trend in crime rates stabilized during 2004, violent crime rates remain at the lowest levels recorded since 1973, including the rates for rape and sexual assault. From 1993 to 2004 the rate for rape/sexual assault was down 64%, from approximately 3 to 1 victimizations per 1,000 persons age 12 or older.

Pennsylvania Sex Crime Statistics

- Crime rate trends - Pennsylvania State Police Uniform Crime Statistics reported the following (2003):
 - ✓ Part I Sex Offenses: Total Forcible Rape offenses decreased 5.3%, from 3,503 in 2002 to 3,318 in 2003. Forcible rape comprised 1.0% of the crime index and 7.2% of the violent crime index, at a rate of 26.9 per 100,000 residents.
 - ✓ Part II Sex Offenses
 - Prostitution and commercialized vice offenses (N = 2,719) decreased 1.5% from 2002 to 2003, a rate of 22.0 per 100,000 residents.
 - Sex offenses (N = 8,094, not including 02 and 160) decreased 6.6% from 2002 to 2003, a rate of 65.6 per 100,000 residents.
- Incarceration rate trends – Pennsylvania Department of Corrections reported the following (2003):
 - ✓ Part I Sex Offenses: Inmates incarcerated for forcible rape represented a constant portion of the DOC inmate population from 2002 to 2003, accounting for 8.3% (N = 3,338) and 8.4% (N = 3,411) of offenders, respectively.
 - ✓ Part II Sex Offenses
 - Statutory rapists represented a constant portion of the DOC population over this period from 288 (0.7%) in 2002 to 333 (0.8%) in 2003.
 - "Other" sex offenders also represented a constant portion of the DOC population over this period, from 327 (0.8%) in 2002 to 371 (0.9%) in 2003.

Common Themes in Sexual Offending

- There is a high incidence of undetected, unreported, and/or under-reported sex crimes (as may be true with many types of crimes):
 - ✓ Many victims fail to report such offenses for fear of reprisals, shame, or embarrassment. Besserer & Trainor (2000) found that sexual assault had the highest percentage of incidents that were not reported to police (78%). Finkelhor et al., 1990 – surveyed 2,626 American men and women and found that 16% of the men and 27% of the women reported a history of sexual abuse.
 - ✓ Police and prosecutors have been reluctant to pursue certain types of complaints (e.g., domestic violence).
 - ✓ The legality of some sexual acts has changed the "counting" or recording of these behaviors.
 - ✓ Incidence rates reported in crime statistics vary depending on the particular sex crime and method of measurement.
- A relatively small portion of offenders are responsible for the vast majority of sex crimes:
 - ✓ Zolondek et al., 2001 – surveyed 485 juvenile sex offenders from different sites in the United States and Canada and found that each juvenile offender (ages 11 – 17 years) reported between nine and 46 offenses.

- ✓ Abel, Mittelman, & Becker, 1985 – interviewed 411 adult sex offenders about their criminal histories and found substantial numbers of crimes and victims per each offender.
- Sex offenders are not typically “specialists” who commit exclusively sex crimes; many commit a variety of nonsexual crimes as well.
 - ✓ Weinrott & Saylor (1991) – 99 institutionalized sex offenders reported 19,518 offenses that were not sex related offenses (non-sex offenses).
 - ✓ Maletzky (1991) – of 5,000 sex offenders treated in an outpatient clinic, 24% had histories of non-sex offenses.
 - ✓ Soothill et al. (2000) – 7,000 sex offenders revealed that approximately 60% were convicted of a nonsexual offense.

Profile of DOC Sex Offenders

Highlights

- ✓ *Sex offenders accounted for less than 6% of DOC total admissions and 5% of total releases during 2004.*
- ✓ *Currently, there are approximately 6,000 sex offenders incarcerated by the DOC, representing 14% of the state inmate population.*
- ✓ *Most sex offenders in the DOC were sentenced for rape (36%), involuntary deviate sexual intercourse (29%), or some form of aggravated sexual and/or indecent assault (27%).*
- ✓ *Relative to the total DOC demographic breakdown, the sex offender sub-population is more predominately white and is composed of fewer females.*
- ✓ *The majority of sex offenders have 5-20 year minimum and 10-30 year maximum sentence lengths.*
- ✓ *It appears that sex offenders with child victims who are incarcerated by the DOC typically have shorter sentences than sex offenders who victimized adults.*
- ✓ *The vast majority of sex offenders secured for a parole violation are technical violators.*
- ✓ *Approximately one-quarter of DOC sex offenders have previously been arrested for a sexual crime.*

Profile of Sex Offenders in PA DOC Custody

The following provides a summary of sex offenders admitted to and released from the DOC during 2004 as well as a snapshot of the current DOC sex offender population by offense, age, gender, race, sentence, parole status, and prior record on July 31, 2005. This information is provided in more detail in Appendix A.

Admissions (2004)

- Sex offenders represented 5.6% of offenders admitted to the DOC during 2004 (N = 857).
- At least 1/5th (N = 173) of the sex offenders admitted to the DOC had victims under age 18.
- The portion of the sex offender sub-population admitted to the DOC through court commitments (79%) is greater than the portion of all DOC admissions through initial court commitments (55%). Similarly, the portion of the sex offender sub-population admitted to the DOC for parole violations (18%) was smaller than the portion of all DOC admissions for parole violations (38%).
- The vast majority (83%) of sex offender admissions were for five primary offense categories:
 - ✓ Involuntary Deviate Sexual Intercourse (IDSI) - 22% (N = 189)
 - ✓ Forcible Rape – 20% (N = 175)
 - ✓ Aggravated Indecent Assault – 16% (N = 135)
 - ✓ Sexual or Indecent Assault – 13% (N = 114)
 - ✓ Statutory Sexual Assault – 12% (N = 99)

Releases (2004)

- Sex offenders represented 5.1% of inmates released from the DOC during 2004 (N = 762).
- At least 18% (N = 136) of the sex offenders released from the DOC had victims under age 18.
- The vast majority (72%) of inmates released from the DOC were paroled, yet the majority of inmates in the sex offender sub-population maxed out (50%) while a smaller portion of inmates were paroled (41%).

Population (2005)

- As of July 31, 2005, there were nearly 6,000 inmates incarcerated by the PA DOC for sexual offenses, representing 14% of the state inmate population. It should be noted that this figure (N = 5,921) represents only those inmates serving time for a primary offense which is a sexual crime and does not, therefore, capture inmates incarcerated with secondary sex offenses (e.g., an offender whose primary offense is robbery and secondary offense is a sex-related crime would not be included in this figure).
- **Offense**
 - ✓ 36% rape
 - ✓ 29% involuntary deviate sexual intercourse (IDSI)
 - ✓ 11% aggravated indecent assault
 - ✓ 9% indecent or sexual assault
 - ✓ 7% statutory rape or statutory sexual assault
 - ✓ 8% other sex offense
- **Age**
 - ✓ Current age
 - 60% of all sex offenders incarcerated in the DOC are between ages 30-49
 - 59% of sex offenders with victim(s) under age 18 are between ages 21-39.
 - ✓ Age at sentencing
 - 62% of all sex offenders incarcerated in the DOC were between ages 25-44 at the time of sentencing, while 19.5% were under 25 and 18.5% were 50 and older.
- **Gender**
 - ✓ Nearly all (N = 5,813) sex offenders incarcerated in the DOC are male (98.2%).
 - ✓ Females represent a greater portion of the total DOC population (4.5%) than they do the sex offender sub-population (1.8%). There are currently only 108 females with a primary offense for a sexual crime in the DOC.
- **Race**
 - ✓ While the DOC sex offender sub-population is predominately of white ethnicity/race (60%), the general DOC population is predominately black (52%) with a smaller percentage of Caucasian inmates (36%).
 - ✓ An even larger majority (68%) of sex offenders with victims under age 18 are white.

- **Sentence**
 - ✓ Minimum sentence
 - The majority (57.2%) of sex offenders have minimum sentence lengths between 5 to 20 years (average minimum sentence length is 8.9 years).
 - The vast majority (78%) of sex offenders with victims under age 18 have minimum sentences between 1 to 5 years (average minimum sentence length is 3.6 years).
 - ✓ Maximum sentence
 - The majority (55.6%) of sex offenders have maximum sentence lengths between 10 to 30 years (average maximum sentence length is 21 years).
 - The vast majority (65%) of sex offenders with victims under age 18 have maximum sentences between 2 to 10 years (average maximum sentence length is 9.6 years).
 - ✓ *It should be noted that the average minimum and maximum sentence lengths will be inflated if they are considered as sentences for only the primary offense. Consecutive sentences may be aggregated to form one sentence which has one effective date, one minimum date, and one maximum date (e.g., an offender serving two consecutive sentences for a primary offense of rape and secondary drug offense will have a sentence length which aggregates the primary and secondary minimum and maximum sentence lengths to form one sentence which has one effective date, one minimum date, and one maximum date. To illustrate more specifically, an inmate serving a minimum of 5 years for rape and 1 year for drugs will, therefore, have an automated record reporting “rape, 6 years minimum sentence”. Clearly, this could be deceiving for those considering sentence lengths by offense type).*

- **Parole status**
 - ✓ Parole violators represent only a small portion (7%, N = 396) of the DOC sex offender population.
 - ✓ The majority of sex offenders secured by the DOC for a parole violation are technical violators (67%), while 16% are convicted parole violators, and 17% are technical/convicted parole violators.

- **Prior record**
 - ✓ Approximately 27% of sex offenders in the DOC have one or more previous sex offenses on their criminal records.

Sex Offender Typologies

Highlights

- ✓ *A number of different sex offender typologies have been developed to organize sub-groups of child molesters, rapists, female sex offenders, and adolescent sex offenders by common characteristics.*
- ✓ *Sex offender typologies have important prognostic implications, and have proven useful in anticipating the risk posed by offenders based on the characteristics of their assigned sub-group.*
- ✓ *As an example, Groth's Typology for classifying child molesters suggests "fixated" child molesters are at very high risk for sexual recidivism, while "regressed" child molesters present lower risk, especially with treatment.*
- ✓ *While typologies may often be useful, caution must be exercised when making decisions based on an offender's assigned typology since nearly 50% of sex offenders engage in "crossover", exhibiting behaviors from two or more categories in a typology.*

Sex Offender Typologies

In the ongoing effort to develop an understanding of characteristics that would allow for better classification of sex offenders into specific groups for management, supervision, and treatment purposes, researchers have proposed a number of sex offender typology schemes. These typologies, or classifications, utilize offender and situational characteristics (e.g., victim choice/preference information, degree of injury/force, type of sex crimes, motivation, pervasiveness of anti-social behaviors, etc.) to outline a framework for analysis. The following outline provides a summary of select sex offender typologies and motivations. Generations of sex offender typology schemes have expanded, collapsed, and reorganized sex offender sub-groupings for child molesters, rapists, female, and adolescent sex offenders (refer to Appendix B for more detail, including the specific traits of each of the types identified below). The groupings may also be considered relative to risk for sexual recidivism, since research findings indicate that sex offender typology schemes have important prognostic implications (e.g., assessing/anticipating the risk posed by an offender and recognizing the behaviors exhibited by an offender that are precursors to sexual re-offending).

Child Molester Typologies

- **“Groth Typology”** (Dr. Nicholas Groth & H. Jean Birnbaum, 1979)
 - ✓ Fixated/pedophile child molester (*very high risk for sexual recidivism*)
 - ✓ Regressed/situational child molester (*lower risk for sexual recidivism, especially with treatment*)
- **“FBI Typology”** (Kenneth Lanning) – expanded Groth Typology to develop 7 sub-groups
 - ✓ Preferential (from Groth’s “fixated” type)
 - Seductive
 - Fixated (introverted)
 - Sadistic
 - ✓ Situational (from Groth’s “regressed” type)
 - Regressed
 - Morally indiscriminate
 - Sexually indiscriminate
 - Inadequate
- **“Knight-Prentky Typology”** (Massachusetts Treatment Center Child Molester Version 3, MTC:CM3)
 - ✓ Examined on two axes:
 - Axis I (degree of fixation with children, level of social competence)
 - Axis II (amount, type, and meaning of contact with children/amount & type of threats, force, & physical injury involved in contact)
 - ✓ Based on earlier work of Cohen, Seghorn, & Calmas (1969) who identified 4 types of child molesters:
 - Fixated (most likely to exhibit deviant sexual arousal/sexually recidivate)
 - Regressed
 - Exploitative
 - Aggressive/sadistic (most likely to exhibit violence/violently recidivate with non-sexual offense)
 - ✓ Replication Research – Looman, Gauthier, & Boer (2001) replicated the MTC:CM on a sample of child molesters and found the offenders were classified into all subgroups with an acceptable level of reliability, with the exception of the sadistic types (probably due to a low number of offenders in this subgroup).

Motivating Factors

- Finkelhor & Araji (1983) suggested offenders commit sexual acts against children due to the interaction between two or more of the following four factors:
 - ✓ Emotional incongruence
 - ✓ Sexual arousal
 - ✓ Blockage
 - ✓ Disinhibition

Rapist Typologies

- **“Groth Typology”** (Dr. Nicholas Groth & H. Jean Birnbaum, 1979)
 - ✓ Anger rapist
 - ✓ Power rapist
 - ✓ Sadistic rapist
- **“Hazelwood Typology”** (1994) – expanded Groth's typology into 6 sub-types
 - ✓ Power-reassurance (compensatory)
 - ✓ Power-assertive (exploitative)
 - ✓ Anger-retaliatory (displaced)
 - ✓ Anger-excitement (sadistic)
 - ✓ Opportunist
 - ✓ Gang rape
- **“Knight-Prentky Typology”** (Massachusetts Treatment Center Rapist Version 3, MTC:R3) – revised Groth Typology, organizing 9 types and validated (including a 25-year recidivism study & a generalizability study by Looman, 2000). The typology includes 4 overarching motivational themes (opportunistic, pervasive anger, vindictiveness, and sexual gratification), which are further “sub-classified” based on the degree of psychopathy, followed by the degree of sexualization defined by sexual preoccupation, sexual compulsivity, sexual drive, and sexual deviance.
 - ✓ Opportunistic
 - Assertive
 - Non-assertive
 - ✓ Pervasively Angry
 - ✓ Vindictive
 - Assertive
 - Non-assertive
 - ✓ Sexual
 - Sadistic
 - Non-fantasy
 - Fantasy
 - Non-sadistic
 - Non-assertive
 - Assertive

Non-Contact Sex Offenders *(very high risk for sexual recidivism)*

- Voyeurs
- Exhibitionists

Female Sex Offender Typologies

- Matthews et al. (1991) described the first 3 typologies, and the fourth was added by Syed et al. (1996):
 - ✓ Teacher/Lover
 - ✓ Male coerced/Male accompanied
 - ✓ Predisposed
 - ✓ Angry/impulsive
- Common Elements/Factors With Female Sex-Offenders
 - ✓ typically commit sex offenses with male cohort –rarely, if ever, coerce others to serve as accomplices.
 - ✓ use force or threats of violence during sex offense far less often than male sex offenders.
 - ✓ less likely to deny and typically accept responsibility for their crimes more readily than male offenders (different source reported “more likely to have denial, perceive sex offending as more deviant, more resistant to investigation, and fewer think the behavior can be changed”).
 - ✓ typically initiate offenses at a later age than male sex offenders – offenses committed prior to adulthood are extremely rare.
 - ✓ victim characteristics: equally male and female, mostly related (mostly biological children)
 - ✓ typically have more significant histories of domestic violence, traumatic childhoods (physical, emotional, and/or sexual abuse histories), and less stable marital relationships than male sex offenders/counterparts.

Adolescent Sex Offender Typologies

Typologies – O'Brien (1986)

- Naïve experimenters
- Under-socialized child exploiters
- Sexual aggressives
- Sexual compulsives
- Disturbed impulsives
- Peer-group influenced

Crossover

- While sex offenders may often be organized into sub-typologies, there is a degree of “crossover”. Most sex offenders have some preference for a particular victim type or specific sexually deviant behavior, yet research has demonstrated that oftentimes various types/sub-types/preferences/behaviors will co-occur and interact with each other. Crossover refers to the finding that sex offenders commit multiple crimes against multiple types of victims with whom they have varying types of relationships (adults, children, male, female, known and unknown). For example, an incest molester may be fixated on consanguineous boys, or a sadist may have both adult and child victims.
- Crossover was illustrated in the findings of several researchers (Abel et al., 1985, 1987, Becher & Coleman, 1988, Cumming & Buell, 1997) who consistently found that nearly 50% of sex offenders engage in multiple sex offending behaviors. In one more recent study (English, 1998), consideration of sex offender “crossover” found the following:
 - ✓ 25.7% victimized male & female
 - ✓ 50% victimized juvenile & adult
- These findings suggest the need to exercise caution when making decisions based on offender classifications/groupings. Both practitioners delivering individual services as well as decision-makers charged with developing public policies must remain cognizant of the fact that sex offenders may exhibit behaviors from two or more categories in a typology, engaging in multiple paraphilias and assaulting various victim types (male/female, adult/child, etc.).

Recidivism of Sex Offenders

Highlights

- ✓ *The level of sexual recidivism in sexual offenders is much lower than is commonly believed.*
- ✓ *Studies consistently find sexual recidivism rates in sex offenders to be around 13-14% during 4-6 year follow-up periods.*
- ✓ *Even after lengthier follow-up periods, most sexual offenders do not re-offend sexually. In fact, research found nearly ¾ of sex offenders were not charged/convicted of another sexual offense even after 20 years.*
- ✓ *The overall sexual recidivism rate of sex offenders is significantly lower than in other types of offender "specialists", such as property offenders (e.g., thieves, larcenists, and burglars).*
- ✓ *As a heterogeneous group of offenders, not all sex offenders are equally likely to re-offend. Certain sub-types are much more likely to recidivate with another sex offense than others.*
- ✓ *Research studies commonly report the following results in order of likelihood of sexual recidivism from highest to lowest risk by sex offender sub-type: non-contact sex offenders (e.g., exhibitionists, voyeurs, etc.), extra-familial boy-victim child molesters, rapists, extra-familial girl-victim child molesters, then incest offenders.*
- ✓ *Sex offenders who feel emotionally closer to children, have paraphilic interests, and/or are sexually pre-occupied are more likely to sexually recidivate.*
- ✓ *Non-contact sex offenders are more likely to recidivate sexually than those who touch or penetrate their victims.*
- ✓ *Sex offenders who are adolescents and adults over age 50 are less likely to re-offend with a sexual crime than sex offenders from other age groups.*
- ✓ *Research examining the relationship between sentence length and sexual recidivism has produced mixed results, suggesting there is currently no clear, agreed-upon association between how long sex offenders are incarcerated relative to their rates of re-offending sexually.*
- ✓ *Sex offenders with prior sexual offense convictions have recidivism rates nearly double the rates observed for first time sex offenders.*
- ✓ *Sex offenders are more likely to recidivate with a non-sexual crime than a sexual crime.*
- ✓ *The general (any) recidivism rate of sexual offenders is lower than that observed in other types of criminals, including property, drug, and public order offenders. Both National and Pennsylvania findings indicate that sex offenders released following incarceration for rape or other sexual crimes were found to be among those with the lowest rates of recidivism.*
- ✓ *Research has found that ¼ of sex offenders recidivate with a violent crime (including sexual and non-sexual), and rapists are much more likely to re-offend with non-sexual violence than child molesters. As well, relatively low rates of non-sexual violent recidivism were found for those who selected related victims and male victims.*
- ✓ *Sex offenders who recidivate are more likely to be re-arrested for less serious crimes than non-sex offenders.*
- ✓ *Most general (any) recidivism by sex offenders within the first three-years following release occurs in the first year (56%). In fact, studies found 40% of sexual crimes were committed within the first 12 months following release from state prison. And, the longer sex offenders remained offense-free, the less likely they were to recidivate.*

Recidivism of Sex Offenders

The level of sexual recidivism in sexual offenders is much lower than is commonly believed. In fact, even after lengthy follow-up periods, most sexual offenders do not re-offend sexually. Further, sex offenders are less likely to recidivate with any, general crime than most other offender sub-types. Yet, some sex offenders are much more likely to recidivate with sexual (violent or non-violent) and/or non-sexual (violent or non-violent) crimes than others. The following section examines sexual, general, and violent recidivism rates of sexual offenders. Consideration is also given to which sex offenders are most likely to re-offend, how the recidivism rates of sexual offenders compare to other types of offenders, how length of incarceration relates to recidivism, and the length of time sex offenders spend in the community prior to re-offending.

Sexual Recidivism Rates

- Studies consistently find sexual recidivism rates in sexual offenders to be low, contradicting the popular view that sexual offenders inevitably re-offend (compared to BJS 2002 study which found nearly 68% of general criminal offenders are re-arrested for a new crime within 3 years following release):
 - ✓ Hanson & Bourgon (2004) – meta-analysis found the observed sexual recidivism rate for the sample of sex offenders was 13.7% (N = 31,000, average follow-up period was 5-6 years).
 - ✓ Hanson & Bussiere (1998) – meta-analysis found the observed sexual recidivism rate among typical groups of sexual offenders was 13.4% (N = 23,393, average follow-up period was 4-5 years). Even studies examined in the meta-analysis with lengthier follow-up periods (15-20 years) reported recidivism rates which almost never exceeded 40%.
 - ✓ Langan et al (2003) conducted the largest follow-up ever conducted of convicted sex offenders following discharge from U.S. state prisons (included 15 states which represented 2/3 of all male sex offenders released from state prisons that year, N = 9,691 – Pennsylvania was not included) and tracked them for 3 years after release. The researchers found that 5.3% (N = 517) of sex offenders were re-arrested for another sex crime and 3.5% (N = 339) were reconvicted for a sex crime.
 - ✓ Harris & Hanson (2004) – studies of adult male sexual offenders in Canada, United States, England, and Wales (N = 4,724) found most sexual offenders do not re-offend sexually. In fact, 73% of sex offenders had not been charged with or convicted of another sexual offense after 20 years. Overall, sexual recidivism rates (new charge or conviction) at three distinct follow-up periods were:
 - 14% after 5 years
 - 20% after 10 years (additional 6% during the second 5-year period)
 - 24% after 15 years (additional 4% during the third 5-year period)
 - 27% after 20 years (additional 3% during the fourth 5-year period)
 - ✓ Pennsylvania DOC findings – Pennsylvania offenders who were incarcerated for a sexual offense and released between 1997 through 2003 returned less than 25% of the time over a 3-year at-risk period. This compared to an overall DOC recidivism rate of between 42 – 46% during this same period.
- The overall sexual recidivism rate of sexual offenders is lower than that observed in other samples of offender “specialists”.
 - ✓ Langan & Levin (2002) - In their recidivism study examining 3-year follow-up rates in sex offenders released from prisons in 15 states (N = 272,111), the researchers considered “specialists” (prisoners who, after release, commit the same crime for which they were in prison) and found a degree of “specializing” evident in the recidivism data. Offenders released for specific crimes were those most likely to be re-arrested for those specific crimes. Further, while 33.9% of those released for larceny/theft were re-arrested for larceny/theft and 23.4% of those released for burglary were re-arrested for burglary, only 2.5% of released rapists were re-arrested for another rape.
 - ✓ Sample & Bray (2003) – examined Illinois arrest data from 1990 to 1997 to consider the degree to which sex offenders have higher proportions of repeat offending than other criminal categories. The researchers found that offenders charged with property damage had the highest rates of re-arrest for the same crime (38.8%), followed by non-sexual assault (37.2%), and larceny (30%). Sex offenders had lower offense-specific re-arrest rates during the 5 year follow-up period than did arrestees in most other categories (with the exception of homicide 5.7%, kidnapping 2.8%, and stalking 5%).
- Sex offenders are less likely to recidivate with a sexual crime than a non-sexual offense (refer to section, “Non-sexual/General Recidivism Rates”).
- Sex offenders are more likely to recidivate with a sexual crime than a non-sex offender. While sex offenders are more likely to recidivate with a non-sexual crime, non-sexual offenders rarely recidivate with sexual offenses.
 - ✓ Langan et al (2003) – found sex offenders released from state prisons were four times more likely to be re-arrested for a sex crime than non-sexual offenders, 5.3% versus 1.3%, respectively.

- ✓ Other research supports this finding - Hanson & Bussiere (1998), Bonta & Hanson (1995), Hanson, Scott, & Steffy (1995), Soothill et al. (2000).
- As mentioned in the previous section, “Incidence of Sex Crimes”, recidivism figures should be considered underestimates of the “true” recidivism rates because not all sexual offenses are detected. A low base rate problem is common to sexual offender recidivism studies.
- In reviewing sexual recidivism rates, it is important to recognize that appropriate interventions have been associated with reductions in sexual recidivism rates among sex offenders and it is unlikely the majority of sex offenders in the recidivism studies received effective, appropriate treatment (refer to “Treatment” section for more detail).

Sexual Recidivism Rates by Offender Characteristics

- Sex Offender Typologies - Not all sexual offenders are equally likely to re-offend. As suggested in the preceding section, “Sex Offender Typologies”, there are identifiable subgroups whose observed recidivism rates are much higher than “typical” sex offenders.
 - ✓ Harris & Hanson (2004) – examined sexual recidivism rates by sex offender sub-groups and found similarities *between* major subgroups, yet significant differences *within* sub-groups. Specifically, rapists (24%) and child molesters (23%) had similar sexual recidivism rates at three follow-up periods. However, there were significant differences within the child molester sub-group, with the highest rates observed among extra-familial boy-victim child molesters (35% after 15 years) and the lowest observed rates for incest offenders (13% after 15 years). These findings are consistent with other evidence that incest offenders recidivate at significantly lower rates than offenders who target victims outside the family, and that child molesters with male victims recidivate at significantly higher rates than child molesters that only have girl victims.

Sub-group/Sample	5 years	10 years	15 years
Rapists	14%	21%	24%
Extended incest child molesters	6%	9%	13%
“Girl victim” child molesters	9%	13%	16%
“Boy victim” child molesters	23%	28%	35%
All child molesters	13%	18%	23%
All sex offenders	14%	20%	24%

- ✓ Langan et al (2003) – examined recidivism rates by offender types in 4 overlapping categories, and found the following results:

Recidivism	All Sex Offenders	Rapists	Sexual Assaulters	Child Molesters	Statutory Rapists
Re-arrest	5.3%	5.0%	5.5%	5.1%	5.0%
Re-conviction	3.5%	3.2%	3.7%	3.5%	3.6%
# offenders	N = 9,691	N = 3,115	N = 6,576	N = 4,295	N = 443

Note: by definition, all sex offenders are either rapists (forcible rape/violent) or sexual assaulters (some data is missing) and all statutory rapists are included in the child molester category.

- ✓ Hanson & Bussiere (1998) - found that subgroups of sex offenders recidivated at higher rates. Rapists were more likely to re-offend sexually than child molesters:

Type of Recidivism	Overall	Rapist	Child Molester
Sexual	13.4%	18.9%	12.7%
Any/General Criminal	36.3%	46.2%	36.9%
Non-sexual Violent	12.2%	22.1%	9.9%

- ✓ Marshall & Barbaree (1990) found in their review of studies that the recidivism rates for specific types of offenders varied:
 - Incest offender ranged between 4-10%

- Rapists ranged between 7-35%
- Child molesters with female victims ranged between 10-29%
- Child molesters with male victims ranged between 13-40%
- Exhibitionists ranged between 41-71%
- ✓ Hanson & Bourgon (2004) – while this study focused on mixed groups of sex offenders and made no effort to identify distinct predictors for specific offender sub-typologies (e.g., rapists, exhibitionists, etc.), the researchers were able to identify factors common to the profiles of sexual crime “recidivists” (refer to next section, “risk factors” for more detail):
 - those with sexual interests in children (i.e., feel emotionally closer to children than to adults – as common in extra-familial child molesters, have children as friends, have child-oriented lifestyles, and feel like children themselves);
 - those who have paraphilic interests (e.g., exhibitionism, voyeurism, cross-dressing, etc.);
 - those with sexual preoccupations (e.g., high rates of sexual interests and activities, such as masturbation, pornography use, and impersonal sex);
 - those who committed non-contact sex offenses were more likely to recidivate than those who sexually touched or penetrated their victims (degree of sexual intrusiveness was negatively related to sexual recidivism).
- Demographic Characteristics & Sentencing Factors
 - ✓ Age – research shows sexual offenders age 50 and older are less likely to recidivate than their younger adult counterparts, and adolescent sex offenders demonstrate lower rates of recidivism than adults.
 - Langan et al (2003) - While recidivism studies typically find that the older the prisoner is when released, the lower the rate of recidivism, this study did not find the familiar pattern. While the lowest rate of re-arrest for a sex crime (3.3%) did belong to the oldest sex offenders (those age 45 and older), other comparisons between older and younger prisoners did not consistently show older prisoners’ having the lower re-arrest rate.
 - Harris & Hanson (2004) – found age had a substantial association with sexual recidivism, with offenders over age 50 less likely to re-offend sexually than younger offenders. Those age 50 at release re-offended at half the rate of younger (under 50) offenders, 12% versus 26%, respectively, after 15 years.
 - Hanson (2001) found a markedly low recidivism rate for sex offenders – the age grouping of “60 and older” at release had a reconviction rate under 5%.
 - It is well established in the research literature that adolescent sexual offenders re-offend at significantly lower rates than their adult counterparts, with recidivism rates ranging from 3-14% in various studies (Medoff, 2004).
 - ✓ Sentence Length
 - Langan et al (2003) – On average, sex offenders released in 1994 had 8 year terms and served 3 ½ years of their sentences. The research found no clear association between how long sex offenders were in prison and their recidivism rates. The following findings examining the relationship between time served and recidivism (re-arrest) illustrate how the mixed results from this data do not warrant any general conclusions about the association between these two variables:
 - All sex offenders (mixed results) – Sex offenders who served the shortest amount of time in prison before being released (6 months or less) had a higher re-arrest rate (45.7%) than those who served the longest (over 5 years, 39.9% re-arrest rate). Yet, among sex offenders who served 1 to 1 ½ years in prison before being released, 38.9% were re-arrested for all types of crimes, compared to 46.7% of sex offenders who served a bit longer, 1 ½ to 2 years.
 - Rapists (serving more time was not linked to lower recidivism) – Rapists released after about 1 to 1 ½ years in prison had a 37.6% re-arrest rate, while those imprisoned a little longer – from about 1 ½ to 2 years – had a higher rate, 51.1%.
 - Child molesters (mixed results) – Child molesters released after serving about 2 to 2 ½ years had a higher rate of re-arrest for all types of crimes (39.4%) than those who served somewhat longer – about 2 ½ to 3 years (27.2%). However, the re-arrest rate rose (31.5%) among molesters who served more time, 3 to 5 years.
 - ✓ Prior Record
 - Langan et al (2003) – found the more prior arrests sex offenders had, the greater their likelihood of being re-arrested for another (any) crime after leaving prison, as illustrated in the following recidivism rates:
 - 3% for those with 1 prior arrest (sex crime for which they were in prison)
 - 4% for those with 2-3 prior arrests for some type of crime

- 6% for those with 4-6 prior arrests
- 7% for those with 7-10 prior arrests
- 8% for those with 11-15 prior arrests
- Harris & Hanson (2004) – found that first time sexual offenders were significantly less likely to sexually re-offend than those with previous sexual offenses. Offenders with prior sexual offense convictions had recidivism rates almost double the rates observed for first-time sexual offenders, 19% versus 37% after 15 years.

Non-Sexual/General Recidivism Rates (violent & non-violent)

- The finding that many sex offenders engage in criminal behavior which is not limited to deviant sexual activity is supported by recidivism data. In fact, research consistently finds that sex offenders are more likely to recidivate with non-sexual offenses:
 - ✓ Bench, Kramer, & Erickson (1997) – followed 408 sex offenders for 4 years and found that 25% recidivated with a sexual offense, and 27% recidivated with a nonsexual offense.
 - ✓ Hanson & Bussiere (1998) – conducted a meta-analysis and found the general (any) recidivism rate for the sample of sex offenders was 36.3% (while only 13.4% for sexual recidivism, as noted above).
 - ✓ Hanson & Bourgon (2004) – conducted a meta-analysis and found the general (any) recidivism rate for the sample of sex offenders was 36.9% (while only 13.7% for sexual recidivism, as noted above).
- The overall general (any) recidivism rates of sexual offenders are lower than that observed in other samples of offenders:
 - ✓ Langan et al (2003) – compared to non-sexual offenders released from state prisons, sexual offenders had lower overall re-arrest rates. When rearrests for any type of crime (not just sex crimes) were counted, the study found that 43% (N = 4,163) of sex offenders were re-arrested while 68% (N = 179,391) of non-sex offenders were re-arrested. Further, 24% (N = 2,326) of the sex offenders were reconvicted for a new offense (any crime) and 38.6% (N = 3,741) were returned to prison (for a new crime or technical violation) during the 3 year follow-up period.
 - ✓ Langan & Levin (2002) – Found those prisoners with the highest re-arrest rates were property (73.8%), drug (66.7%), and public-order (62.2%) offenders. Those offenders released following incarceration for rape or other sexual assault (categorized as “violent offenders”) had the lowest rates of re-arrest (46.0% and 41.4% respectively), with the exception of those incarcerated for homicide (40.7%).
 - ✓ Pennsylvania DOC findings – While varying methodologies and definitions in measuring recidivism do not allow for actual comparison between jurisdictions (e.g., PA DOC defines recidivism as return to state incarceration rather than by re-arrest), patterns of re-offending by offense categories mirror those found in national recidivism studies. The 3-year post release recidivism rates for sex offenders released for the 1998-2000 3-year aggregate period were lower than those of offenders incarcerated for all other types of crimes. In fact, sex offenders recidivated at approximately one-half the rate of both property and drug offenders. The overall, aggregate 3-year recidivism rate was 44% for all offender categories, and the rates by committing offense from 1998-2000 were:
 - 48.9% (N = 6,734) for property offenders (burglary, theft/larceny, and stolen property)
 - 44.5% (N = 9,927) for drug offenders
 - 38.4% (N = 996) for murderers (1st, 2nd, 3rd degree and unspecified)
 - 36.0% (N = 3,281) for assaulters (aggravated and other assaults)
 - 22.3% (N = 1,281) for sex offenders (forcible rape, statutory rape, and other sex offenses)
- Sex offenders were re-arrested for fewer serious crimes following release from state prison than non-sex offenders. Langan et al (2003) found the re-arrest offense was a felony for 75% of re-arrested sex offenders and, by comparison, 84% of the re-arrested non-sex offenders.

Violent Non-Sexual Recidivism Rates

- Hanson & Bussiere (1998) – conducted a meta-analysis on more than 23,000 sex offenders (average 4 ½ year follow-up period) and found the non-sexual violent recidivism rate was 12%. Child molesters showed a non-sexual, violent recidivism rate of 10%, and rapists a rate of 22%. These findings suggest that rapists are much more likely to recidivate with non-sexual violent offenses than child molesters.
- Hanson & Bourgon (2004) – conducted a meta-analysis and found the violent non-sexual recidivism rate for a sample of sex offenders was 14.0%.

Violent Recidivism Rates (sexual & non-sexual)

- Hanson & Bourgon (2004) – conducted a meta-analysis and found the violent recidivism rate (sexual and non-sexual violence) for the sample of sex offenders was 25.0%.

Time to Failure

- Most recidivism by sex offenders occurs within the first year (12 months) following state prison release. Langan et al. (2003) found that 56% of new crimes (not necessarily other sex offenses) were allegedly committed by released sex offenders within 12 months of release (16% at 6 months, 24% at 12 months, 36% at 2 years, 43% at 3 years).
- Sex offenders who remained offense-free (no new sexual or violent non-sexual offense) in the community were at reduced risk for subsequent sexual re-offending (Harris & Hanson, 2004). Whereas the average 10-year recidivism rate from time of release was 20%, the 10-year recidivism declined to 12% after 5 years offense-free and to 9% after 10 years offense-free. The five year recidivism rate for those who had been offense-free for 15 years was 4%.

Risk Factors for Sex Offenders

Highlights

- ✓ *The factors that predict non-sexual recidivism (violent and non-violent) among sexual offenders are similar to those found among non-sexual offenders. Anti-social orientation (antisocial personality, antisocial traits, and history of rule violation) was the major predictor of non-sexual recidivism (violent and non-violent) in sex offenders. Other general risk factors in sex offenders include negative social influences, employment instability, and substance abuse.*
- ✓ *While there is significant overlap in the predictor variables for sexual and non-sexual offenders, there are some factors which are unique to sexual offending. The most robust of these include deviant sexual interests, sexual interest in children, paraphilic interests, and sexual preoccupations. Other risk factors which significantly predict sexual recidivism include pro-sex-offending attitudes, emotional identification with children, conflicts with intimate partner relationships, problems with sexual self-regulation, and victim characteristics (boy, stranger, and extra-familial victims).*
- ✓ *Sexual deviancy is the strongest predictor of non-violent sexual recidivism, while anti-social orientation is the strongest predictor of violent sexual recidivism.*
- ✓ *Most well-established risk factors for sexual recidivism are either static, historic variables which cannot be changed (e.g., prior sex offenses, victim characteristics) or stable, dynamic characteristics which typically require long periods of time to change (e.g., personality disorders, deviant sexual interests). Recent research has focused on identifying both the stable dynamic risk factors of sex offenders to consider targets for change as well as acute dynamic risk factors (e.g., intoxication, negative mood, hostility/anger, victim access) to inform the urgency for/timing of intervention.*
- ✓ *Several research studies found that sex offenders who failed to complete treatment were at higher risk for re-offending than those who completed treatment, and that ratings of progress in treatment were significantly, negatively related to recidivism rates.*
- ✓ *A number of highly plausible factors thought to be related to sexual recidivism, and therefore commonly examined by risk assessment instruments, have not been found to be predictive of sexual recidivism. These factors include sexual fantasies, pornography, an adverse childhood environment, social skills deficits, loneliness, child molester attitudes, low sexual knowledge, degree of force used, a host of general psychological problems, and various clinical presentation variables.*

Risk Factors for Sex Offenders

Remembering that recidivism in sex offenders is not limited to sexual crimes, it is not surprising that research evidence has found significant overlap in the risk factors for sexual and non-sexual offenders. While there are some risk factors specific to sexual offending, research has shown that many of the major risk factors used to predict non-sexual recidivism apply to sexual recidivism as well. Yet, the level of importance general criminal and sex-offense-specific risk factors have varies by the prediction of risk for sexual, general, and/or violent recidivism. The following section summarizes research examining general and sexual-specific risk factors as related to sexual, general, and violent recidivism and identifies factors commonly considered in sex offender evaluations which have not been found to have predictive value.

Risk Factors for General Recidivism

Hanson & Bussiere (1998) and Hanson & Bourgon (2004) found the predictors of non-sexual violent recidivism and general (any) recidivism in sex offenders were similar to those predictors found among non-sexual criminals. Known predictor variables for any (general) criminal recidivism include the following static and dynamic risk factors:

- Anti-social history
- Anti-social attitudes, beliefs, values
 - ✓ Specific indicators:
 - Negative attitudes toward law, law enforcers, and convention, attitudes tolerant of law violations.
 - Cognitive distortions (e.g., verbalizations, rationalizations, neutralizations, minimizations, denial, and lack of empathy).
 - History of rule violations
 - ✓ Research related to sex offenders (Hanson & Bourgon, 2004):
 - Researchers found that anti-social orientation (antisocial personality, antisocial traits, and history of rule violation) was the major predictor of violent (sexual and non-sexual) recidivism and any, general recidivism in sex offenders.
 - Researchers found “lack of victim empathy” and “minimization” had little (weak) or no significant relationship to sexual recidivism, violent non-sexual recidivism, violent recidivism (any), and general (any) recidivism.
- Anti-social associations and settings
 - ✓ Specific indicators:
 - Association with anti-social others
 - Placing oneself in settings and situations where antisocial activities and attitudes predominate
 - Isolation from pro-social others
 - ✓ Research related to sex offenders - while some clinicians have considered sex offenders to be social isolates, awkward in social interactions, and very introverted, some researchers found antisocial associations, settings, & situations to be strong predictors of sexual offending:
 - Hanson & Bourgon (2004) – found “any violent recidivism” and “any general recidivism” in sex offenders were significantly related to general “people problems” and “negative social influences”.
 - Hanson & Scott (1996) – found child molesters reported knowing other child molesters, rapists reported knowing other rapists, but non-offenders reported having no sex offenders in their social networks.
 - Underwood (1999) – found that 38% of child molesters reported another adult was present during the commission of the offense.
 - Williams & Burns (1988) – reports of sexual abuse by multiple offenders in day care clinics
 - Thorstad (1991) – use of the Internet for deviant sexual purposes
 - Delmonico (1997) – underworld of child pornography & sex rings
- Temperamental and personality factors conducive to criminal activity
 - ✓ Specific indicators:
 - psychopathy
 - weak socialization skills
 - impulsivity & poor self-control/self-regulation
 - restless/aggressive energy, anger, hostility
 - egocentrism
 - taste for risk/sensation-seeking
 - weak decision-making, problem-solving, and coping skills
 - weak self regulation/self-management skills
 - ✓ Research related to sex offenders (Hanson & Bourgon, 2004):

- “Antisocial personality and antisocial traits” (under the general category “antisocial orientation”) were predictive of violent (sexual and non-sexual) and any general recidivism in sex offenders, to include: psychopathy, self-regulation problems, impulsivity, hostility, and recklessness.
 - Poor cognitive problem solving and weak social skills were not predictive of violent (sexual and non-sexual) recidivism in sex offenders.
- Low levels of educational, vocational, and/or financial achievement
 - ✓ Specific indicators:
 - low levels of educational and vocational achievement
 - low levels of financial achievement
 - ✓ Research related to sex offenders (Hanson & Bourgon, 2004):
 - Employment instability was predictive of violent, non-sexual recidivism in sex offenders.
- Familial factors, including criminality and psychological problems in the family of origin
 - ✓ Specific indicators:
 - low levels of affection, caring, and cohesiveness
 - poor parental supervision and discipline practices
 - outright neglect
 - physical and/or emotional abuse
 - sexual abuse
 - negative relationship with father
 - negative relationship with mother
 - ✓ Research related to sex offenders (Hanson & Bourgon, 2004):
 - Hanson & Bourgon did not find any of the indicators of “adverse childhood environment” significantly related to violent, non-sexual recidivism. However, this general category of indicators did tend to be significantly related to any violent and any general recidivism in sex offenders, but the effect sizes were small. The following were predictive: separation from parents, childhood neglect, and childhood physical and/or emotional abuse. In contrast, childhood sexual abuse and negative relationship with father and/or mother were not significant predictors of any violent recidivism in sex offenders.
- Substance abuse
 - ✓ Research related to sex offenders - Hanson & Bourgon (2004) found “any substance abuse” and “intoxicated during offense” were predictive of violent, non-sexual recidivism in sex offenders.
- Other factors significantly related to violent and any general recidivism in sex offenders:
 - ✓ Severity of the index sexual offense - degree of force used and sexual intrusiveness were significantly related to violent, non-sexual and any general recidivism in sex offenders.
 - ✓ Sexual deviancy - deviant sexual interests, sexual preferences, sexual interest in children, and sexual interest in rape/violence were significantly (but weakly) related to violent and any general recidivism in sex offenders. One indicator in this category, “sexual preoccupations” was a significant and consistent predictor of violent and any general recidivism in sex offenders.

Risk Factors for Sexual Recidivism

While there is significant overlap in the predictor variables for sex offenders and non-sex offenders, there are still some traits unique to sexual deviance which are strongly correlated with sexual recidivism.

- Several research studies have been conducted to identify the most robust predictors of recidivism in sex offenders:
 - ✓ Hanson & Bussiere (1998) – meta-analysis reviewed 61 longitudinal studies with nearly 29,000 sex offenders (rapists and child molesters) for an average follow-up period of 4-5 years to identify the factors most strongly related to recidivism among sexual offenders.
 - ✓ Hanson & Morton-Bourgon (2004) – meta-analysis reviewed 95 studies with more than 31,000 sex offenders and more than 2,000 recidivism predictions to examine the research evidence concerning recidivism risk factors for sexual offenders. While the earlier work (1998) examined primarily static/historical risk factors (e.g., never married, diverse sex crimes, victim characteristics – male, unrelated, strangers, etc.), the 2004 research focused on dynamic risk factors.
 - ✓ Dynamic Predictors Project (1998) – Canada-wide file review study with interviews compared a sample of sexual recidivists (N = 208) to sexual non-recidivists (N = 201) to identify the dynamic factors predictive of sexual recidivism.
- The empirical evidence derived from the work of Hanson and colleagues has produced general consensus that sexual recidivism is associated with a few broad factors. The most robust predictors of sexual recidivism are:

- ✓ Deviant sexual interests (e.g., deviant sexual preferences and prior sexual offenses) – while all sexual offending is deviant, not all offenders have an enduring interest in sexual acts that are illegal (e.g., children, rape, etc.) or highly unusual (e.g., fetishism, auto-erotic asphyxia, etc.). Sexual recidivism increases when such deviant interests are present. Hanson & Bourgon (2004) found that sexual deviancy was the strongest predictor of non-violent sexual recidivism. Specifically, all of the following measures were significantly predictive of sexual recidivism:
 - any deviant sexual interest
 - sexual interest in children
 - paraphilic interests
 - sexual preoccupations (strong predictor)
 - high feminine scores on MMPI masculinity/femininity scale (strong predictor)
- ✓ Anti-social orientation/lifestyle (e.g., anti-social lifestyle, history of rule violation, “crime prone personality”) – those with deviant sexual interests will not commit sex crimes unless they are willing to hurt others to obtain their goals, can convince themselves they are not harming their victims, or feel unable to stop themselves. This is a particularly important predictor of violent non-sexual recidivism and general recidivism. In addition, Hanson & Bourgon (2004) found that anti-social orientation was the most robust, major predictor of violent sexual recidivism. Specifically, all of the following measures were significantly predictive of sexual recidivism:
 - Antisocial personality
 - Antisocial personality disorder (PCL-R psychopathy)
 - Psychopathic deviate (MMPI scale)
 - General/antisocial personality disorder (most common personality disorder diagnosed among sexual offenders)
 - Antisocial traits
 - Self-regulation problems (impulsivity, recklessness, lifestyle instability) – feelings of sexual entitlement or the tendency to cope with negative affect through sexual thoughts or behavior, poor self-control, and inability to follow conventions of society.
 - Employment instability
 - Substance abuse
 - Intoxicated during offense
 - Hostility
 - Antisocial history/history of rule violations
 - Non-compliance with supervision (strong)
 - Violation of conditional release (strong)
 - Childhood behavioral problems
 - Childhood criminality
 - Any prior criminal history
 - History of sexual crimes (1998 study – diverse crimes, early onset, etc.)
 - History of non-sexual crime
 - History of violent crime
- Research by Hanson and colleagues has also identified other categories of risk factors which were found to significantly predict sexual recidivism (yet not as strongly as the major categories above). These categories include the following:
 - ✓ Sexual attitudes – while the general category, “sexual attitudes” was significantly related to sexual recidivism, the effect size was small. Only one indicator in this category was predictive, “attitudes tolerant of sexual crime” (e.g., “some women like being raped”, “adult child-sex is harmless”).
 - ✓ Intimacy deficits – (problems in forming satisfying relationships) again, only some of the indicators in this general category were found to significantly predict sexual recidivism. These included:
 - emotional identification with children (e.g., having children as friends, child-oriented lifestyle, etc.)
 - conflicts with intimate partners/in intimate relationships
 - ✓ Victim characteristics – sex offenders who have offended against stranger, extra-familial and/or male victims are more likely to recidivate.
 - ✓ Demographic variables – only two demographic variables were found to be significantly related to sexual recidivism (Hanson 1998). Age (young age) and marital status (single) were predictive of sexual re-offending, yet the effect sizes were small.
- Findings from the Dynamic Predictors Project (1998) identified 9 dynamic risk predictor domains, organized as either stable dynamic or acute dynamic risk factors (from which the SONAR was developed):
 - ✓ Stable dynamic (5 risk factors)

- Intimacy deficits
- Negative social influences*
- Pro-sex-offending attitudes*
- Problems with sexual self-regulation
- Problems with general self-regulation
- ✓ Acute dynamic (4 risk factors) “gateways to sexual offending”
 - Substance abuse
 - Negative mood
 - Anger/hostility
 - Opportunities for victim access

* These factors were also examined by Hanson & Harris (2000). The researchers conducted an all-encompassing review of probation officer files and conducted interviews with officers regarding the behavior and circumstances of sex offenders on their caseloads. The final analysis provided a similar list of 3 stable dynamic (sexual entitlement, “sees self as no risk”, and poor social influences) and 3 acute dynamic risk factors (non-cooperation with supervision, anger, and access to victims).

Factors NOT Predictors of Sexual Recidivism

- Correlation versus risk predictor - A number of factors which are important correlates of sexual offending do not appear to play causal roles in sexual recidivism. For example:
 - ✓ Sexual fantasies – researchers report that deviant sexual fantasies (which have been differentiated from the function of attitudes on behavior) are unlikely to have an etiological role in sexual aggression (Langevin et al., 1998).
 - ✓ Pornography – researchers found that while pornography may serve to stimulate sexually deviant fantasies, it does not appear to have a causal role in sexual aggression (Seto, Maric, & Barbaree, 2001).
- Initiation factors versus risk factors – Contemporary theorists suggest a variety of the factors which are correlated with sexual offending (e.g., indicators in the general categories “negative family background”, “intimacy deficits”, and “sexual attitudes”) are “initiation factors” (factors associated with becoming a sex offender). Not all “initiation factors”, however, are “risk factors” (i.e., predictive of persistent sexual offending/recidivism). Hanson & Bourgon (2004) found the following categories had little (weak) or no relationship with sexual recidivism:
 - ✓ Adverse childhood environment – none of the following were predictive of recidivism:
 - Neglect & abuse - while the personal histories of sex offenders were frequently marked by physical, emotional, and sexual abuse, indices of neglect and abuse (physical, emotional, sexual) had minimal to no relationship with sexual recidivism in sex offenders.
 - Separation from biological parents
 - Negative relationship with father
 - Negative relationship with mother
 - ✓ Intimacy deficits – while “conflicts in intimate relationships” and “emotional identification with children” were found to predict sexual recidivism, other indicators in this general category were not predictive of sexual re-offending:
 - Social skills deficits
 - Loneliness
 - General people problems (this was found to be predictive in other recent studies)
 - Negative social influences (this was found to be predictive in other recent studies)
 - ✓ Sexual attitudes – while “attitudes tolerant of sexual assault” is a proven risk factor, other initiation factors in this general category were not found to predict sexual recidivism:
 - Child molester attitudes
 - Other deviant sexual attitudes
 - Low sexual knowledge
- Intuition versus scientific proof – Some highly plausible factors may not be related to recidivism, so research evidence is important. In fact, there are some factors commonly examined by risk assessment instruments which have not been found to be related to/predictors of sexual recidivism risk. These factors include:
 - ✓ Seriousness of the index offense:
 - Degree of force used (small effect size) – differences between those who did or did not use weapons or physically injure their victims were trivial

- Degree of sexual intrusiveness (negatively related to sexual recidivism) – those who committed non-contact sex offenses were more likely to recidivate than those who sexually touched or penetrated their victims.
- ✓ General psychological problems, internalizing disorders:
 - Anxiety
 - Depression
 - Low self-esteem
 - Severe psychological dysfunction (psychosis)
 - General psychological functioning
- ✓ Clinical presentation:
 - Lack of victim empathy
 - Denial of sexual crime
 - Poor problem solving skills
 - Minimizing culpability
 - Low motivation for treatment
 - Poor progress in treatment
- Static factors predictive of general and violent recidivism – several factors found to be predictive of general and/or violent recidivism were not found to be predictive of sexual recidivism:
 - ✓ Prior non-sexual violent offenses
 - ✓ Prior non-sexual, non-violent offenses

Summary of Risk Factors for Sexual Recidivism

Static Factors	Stable Dynamic Factors	Acute Dynamic Factors
Sexual criminal history	Deviant sexual interests:*	Substance abuse/intoxication
<i>Prior sex offenses</i>	<i>Sexual preoccupations</i>	Negative mood/emotional collapse
<i>Early onset of sexual offenses</i>	<i>Sexual interest in children</i>	Anger/hostility
<i>Diverse sex crimes</i>	<i>Paraphilic interests</i>	Victim access
<i>Non-contact sex offenses</i>	<i>High feminine scores</i>	Collapse of social supports
Victim characteristics	Anti-social orientation/lifestyle:**	Sexual pre-occupations
<i>Male victim</i>	<i>Anti-social personality</i>	Rejection of supervision/disengaged
<i>Stranger victim</i>	<i>Psychopathy</i>	Psychiatric symptoms
<i>Unrelated victim</i>	<i>DSM-III personality disorder</i>	Low remorse/victim blaming
Age (young)	<i>Sexual self-regulation problems</i>	Sees self as no risk to recidivate
Marital/co-habitation status (single)	<i>General self-regulation problems</i>	
Lifestyle instability/criminality	<i>Employment instability</i>	
<i>Childhood behavior problems</i>	<i>Substance abuse</i>	
<i>Juvenile delinquency</i>	<i>Anger & hostility</i>	
<i>Employment instability</i>	Intimacy deficits:	
<i>Any prior offenses</i>	<i>Emotional identification with children</i>	
Non-compliance with supervision	<i>Conflicts in intimate relationships</i>	
Violation of conditional release	Attitudes tolerant of sexual offending	
Completion of treatment/drop-out	Poor/negative social influences	
	Victim access	
	Uncontrolled release environment	
	Rejection of/problems with supervision	
	Sees self as no risk to recidivate	
* <i>strongest predictor of non-violent sexual recidivism in sex offenders</i>		
** <i>strongest predictor of violent sexual recidivism in sex offenders</i>		

Assessment of Sex Offenders

Highlights

- ✓ *Evaluators must consider a variety of empirically-derived factors in order to assess the risk levels and needs of sexual offenders. Effective and comprehensive sex offender evaluation requires measurement of well-established risk factors for general and sexual recidivism, as well as the assessment of static, stable dynamic, and acute dynamic risk factors.*
- ✓ *Actuarial risk assessments have consistently been found to have the greatest predictive accuracy over other measures used to combine multiple risk factors into an overall sex offender assessment. Psychological tests, unguided professional judgment, and empirically-guided methods do not show the consistent predictive accuracies of pure actuarial instruments.*
- ✓ *Historically, actuarial tools designed to predict sexual recidivism, such as the RRASOR, Static-99, SORAG, and MnSOST-R, focused on measuring static (unchangeable) factors. More recent work has focused on assessing dynamic (changeable) risk factors in order to improve the criminal justice system's ability to control recidivism, rather than solely predict it.*
- ✓ *Tools such as the SONAR, Stable-2000, Acute-2000, and SVR-20, which incorporate dynamic factors in their measurement equations, attempt to assess risk factors to inform treatment targets, the timing of needed intervention, and to measure treatment progress. In addition, research has shown that dynamic variables make independent contributions to prediction, which may serve to strengthen the predictive value of sex offender assessment when measured in combination with static predictors.*
- ✓ *The three main types of risk factors play unique, yet oftentimes overlapping roles in informing a variety of criminal justice system decisions. Static factors are especially important in decision-making related to the imposition of long-term sanctions and community placement/supervision. Stable dynamic factors are most useful in decisions related to release, treatment planning, and in evaluating treatment progress. Acute dynamic risk factors are valuable to revocation decision-making and in identifying the need for immediate, crisis intervention.*
- ✓ *No one, single actuarial instrument has been found to provide the field with superior predictive capability in predicting sexual recidivism outcomes in adult sex offenders. A combined approach, utilizing a battery of general and sexual risk assessment tools, may improve the strength of prediction. Several models have been developed to combine measures.*
- ✓ *Tools designed for the purpose of predicting sexual recidivism have unique strengths and weaknesses relative to their value in predicting general, sexual, and violent recidivism, appropriateness for use with various sex offender typologies, utility in informing criminal justice decisions, and in their methods and costs of administration.*
- ✓ *The SORAG has consistently been found to have a higher correlation with violent (sexual and non-sexual) recidivism than other instruments designed for use with sex offenders. Yet, other tools designed for the prediction of sexual recidivism, such as the RRASOR and Static-99 have also been found to significantly predict serious (violent and sexual) recidivism.*
- ✓ *Tools designed to measure general recidivism (e.g., LSI-R) as well as those designed specifically to predict sexual recidivism (e.g., Static-99) are appropriate for use in the prediction of general (any) recidivism in sex offenders. Further, general recidivism risk prediction tools are successful in predicting sexual recidivism in sex offenders.*
- ✓ *A number of actuarial tools have been designed specifically for use with adolescent sex offenders, to include the J-SOAP-II, ERASOR, and JSORRAT-II, yet research on the validity and reliability of these tools is in its infancy.*
- ✓ *Plethysmographic measurement may be useful to complement actuarial assessment efforts, but it will not provide a comprehensive assessment when used alone. Polygraphy, on the other hand, has little to no value in sex offender assessment.*

Assessment of Sex Offenders

Knowing that both general criminal and sexual-specific factors are predictive of sexual re-offending in sex offenders, and that none of the individual risk factors for sexual recidivism are sufficiently prognostic to be used in isolation, evaluators must consider a variety of factors to effectively and comprehensively assess the risk levels and needs of sex offenders. Pure actuarial risk assessments have consistently been found to have the greatest predictive accuracy over other measures used to combine multiple risk factors into an overall sex offender assessment. To this end, the following section will compare the value of various types of sex offender assessment methods, but will focus on the usefulness, appropriateness, strengths and weaknesses of common actuarial risk assessment tools. The following material provides detailed information on the specific data collected by each of the common assessment tools, considers each tool relative to its validity and utility in informing various types of sex offender management and treatment decisions, and discusses the appropriateness of each specific tool relative to offender type and prediction of various forms of recidivism (sexual, general, violent).

Measures of Sexual Recidivism in Adult Sex Offenders

- Actuarial Sexual Offending Risk Tools – a number of instruments have been developed for use in specifically predicting sexual recidivism. While, historically, actuarial tools designed to predict sexual recidivism focused on measuring static factors, more recent work has focused on assessing dynamic risk factors. This effort stems from the reasoning that while the best actuarial tools may have *predictive* value, they do little to add to our ability to *control* recidivism with sex offenders. Assessment tools incorporating risk measures have, therefore, been developed to inform treatment *targets* and the *timing* of needed intervention as well as to measure treatment *progress*. The following table identifies common sexual recidivism assessment tools, as organized by the type of risk factors each tool was designed to measure (i.e., static, dynamic, or both). More detail on each of the instruments is provided in Appendix C.

Sexual Recidivism Risk Assessment Tools by Type of Risk Factor(s) Measured		
Static Risk Factors	Dynamic Risk Factors	Both Static & Dynamic Risk Factors
RRASOR	SONAR	MnSOST-R
Static-99	Stable-2000	SVR-20
Static-2002	Acute-2000	VASOR
SORAG	SRA (<i>process, not tool</i>)	RSVP
MnSOST-R (<i>abbrev. static version</i>)	SARA*	MASA
SACJ-Min		RRAS (NJ DOC)
FRED*		J-SOAP**
* <i>Newly developed tools by the Wisconsin Department of Corrections</i>		ERASOR**
** <i>for use with adolescent sex offenders</i>		J-SORRAT-II**

- Dynamic Supervision Project (2001) – a static measure, the Stable-2000, and the Acute-2000 were used in combination to provide a comprehensive assessment of the static, stable dynamic, and acute dynamic risk factors of sex offenders. The project used the following methodology to apply this combined risk approach: static (unchangeable) factors were assessed once, stable dynamic (require months or years to change) factors were assessed every 6 months, and acute dynamic (require only hours or days to change) factors were assessed at every supervision (e.g., weekly, monthly). This combined approach was intended to inform the following three decisions:
 - ✓ What is the likelihood of sexual re-offending? – static measure
 - ✓ What should treatment target? – Stable-2000 (& Acute-2000 to a limited extent)
 - ✓ When should we intervene? – Acute-2000

Clearly, this approach highlights the value of considering the types of information collected by specific sex offender assessment tools relative to the type of decision-making the tools will be used to inform. As an example, the following table illustrates the degree of value each type of risk factor has in informing criminal justice system decisions regarding sex offender sanctions, supervision, treatment, and public safety.

Use of Static, Stable Dynamic, and Acute Dynamic Risk Factors in Sex Offender Management & Treatment			
	Static Factors	Stable Dynamic Factors	Acute Dynamic Factors
Long-term sanctions			
<i>Imposition</i>	υ	ο	ι
<i>Release</i>	ο	υ	ο
Community supervision			
<i>Placement</i>	υ	υ	ο
<i>Revocation/change</i>	ο	ο	υ
Treatment			
<i>Identification of goals/needs</i>	ι	υ	ο
<i>Evaluating/measuring change</i>	ι	υ	ο
Child protection			
<i>Long-term safety (placement)</i>	υ	ο	ι
<i>Need for crisis intervention</i>	ο	ο	υ
Key:			
	υ	very important	
	ο	relevant	
	ι	relevant, but not important	

- Sex Offender Assessment in Pennsylvania – In 1999, the Pennsylvania Sex Offender Assessment Board (SOAB) & Pennsylvania Board of Probation & Parole (PBPP) adopted the RRASOR, Static-99, and MnSOST-R to determine appropriate post-release supervision levels for sex offenders on parole. The results of the validation and reliability studies examining the usefulness and appropriateness of these tools for Pennsylvania’s sex offender population are as follows (Austin et al., 2003):
 - ✓ MnSOST-R reliability – study reported low inter-rater reliability for the MnSOST-R, attributed to a lack of available information in offender files which was required to score the tool.
 - ✓ RASOR & Static-99 reliability – study reported higher levels of reliability for these tools. Unlike the MnSOST-R, the comprehensiveness/completeness of DOC & PBPP records was not an issue in scoring these instruments. Yet, the study highlighted the importance of staff training and item clarification to reliable scoring/inter-rater reliability.
 - ✓ RASOR & Static-99 validity – study reported the items on the tools were associated with recidivism and the tools were able to accurately distinguish risk levels relative to likelihood of recidivating.

Physiological Measures of Sexual Recidivism

- Plethysmographic measurement
 - ✓ Purpose – To determine presence of deviant sexual interests.
 - ✓ Description – Instrument directly measures sexual arousal (i.e., degree of penile tumescence) in response to audio-tapes depicting sexual interactions with children or adults while manipulating levels of compliance/consent (i.e., various vignettes in random order).
 - ✓ Research – Phallometric assessments have proved reliable, have considerable face validity, and their utility has been supported by several studies. In general, offenders with the most deviant sexual histories tend to show deviant or abnormal sexual interests on phallometric assessments. While these measures are able to measure sexual interest/deviant arousal patterns, they do not provide information on other valuable factors related to sexual as well as general/non-sexual and violent re-offending. Therefore, such methods of assessment may be useful measures to complement other assessment efforts, but do not provide a comprehensive assessment of offender recidivism risk when used alone. For example, deviant sexual interest in children as found through plethysmograph is not included in most recidivism risk scales, yet is important to note/consider when the information is available since it is a strong predictor of relapse. Since phallometric test results are not commonly available on sexual offenders, they are not typically factored into actuarial and empirically-guided assessment scores (the SORAG is an exception, as it *does* incorporate phallometric assessment). Clearly, however, risk factor constructs such as “deviant sexual interest in children” may also be scored through self-report, criminal file review, treatment notes, and other available sources (e.g., documented existence of a child pornography collection). Of the available physiological assessment methods, plethysmography is currently the best investment since it measures the presence of a risk factor known to be reliable in predicting recidivism.

- Hanson & Bussiere (1998) found penile plethysmography to be the single best/most effective predictor of sexual recidivism. Deviant sexual interest in children as measured by phallometry was found to be the largest single predictor of sexual recidivism in this study. Yet, Hanson & Bourgon found smaller effects in their later review.
 - Barabee & Marshall (1989)
 - Freund & Watson (1991)
 - Quinsey (1984, 1986)
- Polygraph
 - ✓ Purpose – For detecting deception or verifying truth of statements made by the examinee/offender, such as to determine denial or acceptance of a sexual crime (obviously, *cannot* be used in court cases to determine guilt).
 - ✓ Description – instrument that records continuously, visually, permanently, and simultaneously any changes in cardiovascular, respiratory, and electrodermal patterns.
 - ✓ Research – Denial has not been consistently shown to affect sex offender treatment/have relevance in treating sex offenders. Therefore, again, of the available physiological assessment methods, plethysmography would be a better choice/investment since it measures a reliable factor in predicting recidivism (i.e., sexual deviance), whereas polygraph measures a factor (i.e., denial of crime) which appears to be relatively insignificant in predicting recidivism risk. Even if denial was consistently shown to affect sex offender treatment outcomes and, in turn, success rates, there are neither convincing data to suggest that polygraphy is reliable in general nor any controlled studies of using polygraphy with the sex offender population (Becker & Murphy, 1998).
- Hormone testing
 - ✓ Purpose – designed to assess increased testosterone levels, which are believed to increase sexual arousal rates, sexual activity, sexual drives, and aggression in sex offenders.
 - ✓ Description – serum testosterone level testing
 - ✓ Research –

Measures of Sexual Recidivism with Juvenile Sex Offenders

- Actuarial Sexual Offending Risk Tools designed specifically for use with juveniles include the following (refer to Appendices C & D for more detail):
 - ✓ Juvenile Sex Offender Assessment Protocol II (J-SOAP-II) – Prentky & Righthand (2003)
 - ✓ Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR) – Worling & Curwen (2001)
 - ✓ Juvenile Sex Offense Recidivism Risk Assessment Tool (JSORRAT-II) – Epperson (2005)
 - ✓ Juvenile Risk Assessment Tool for Sexual Re-Offending (J-RAT) – Stetson School (2001)
 - ✓ Child and Adolescent Risk Evaluation (CARE SO)– Seifert (2005)

Measures of Violent Recidivism Used with Adult Sex Offenders

- Actuarial Risk Tools include, but are not limited to, the following:
 - ✓ Psychopathy Checklist Revised (PCL-R) – Hare (1991, 2002)
 - ✓ Violent Risk Appraisal Guide (VRAG) – Quinsey, Harris, Rice, Cormier (1998)
 - ✓ Sex Offender Risk Appraisal Guide (SORAG) – Quinsey, Harris, Rice, Cormier (1998)
- Predictive Accuracies:
 - ✓ Hanson & Morton-Bourgon (2004) found the actuarial risk tools which demonstrated the strongest association with violent, non-sexual recidivism (of the tools examined in their study) were the SORAG and SIR scales. The Static-99, SVR-20, and RRASOR were significantly related to violent, non-sexual recidivism, but the magnitude of their relationship was less than the SORAG and SIR.
 - ✓ Hanson & Morton-Bourgon (2004) found the actuarial risk tools which demonstrated the highest levels of predictive accuracy in predicting any violent recidivism (sexual and non-sexual) were those designed to predict general recidivism. The VRAG, SIR, and SORAG showed large relationships with any violent recidivism and were significantly better predictors than the Static-99 and RRASOR.
 - ✓ Barbaree et al. (2001) – found general risk tools, such as the VRAG and PCL-R, predicted general and serious (violent and sexual) recidivism in sex offenders. While the VRAG also predicted sexual recidivism, the PCL-R did not. This study also found that tools designed to predict sexual recidivism were also useful in predicting serious (violent and sexual) recidivism in sex offender, including the SORAG (highest AUC for this outcome), RRASOR, and Static-99. The MnSOST-R was not found to be predictive of serious recidivism in this study.

Measures of General Recidivism with Adult Sex Offenders

- Research consistently shows that most tools specifically designed for use with the sex offender population/to measure sexual recidivism can also predict general recidivism. The following research studies illustrate this point:
 - ✓ Barbaree et al. (2001) – examined numerous general and sexual-risk-specific actuarial instruments as well as one guided clinical instrument designed to assess risk for recidivism in sex offenders and found the SORAG, RRASOR, Static-99, and MnSOST-R predicted general recidivism. The guided clinical assessment (Multifactorial Assessment of Sex Offender Risk for Recidivism) was also found to predict general recidivism.
 - ✓ Hanson & Morton-Bourgon (2004) - found the sex offender risk assessment scale that most strongly related to general recidivism was the SORAG, which was a better predictor than the Static-99, SVR-20, or RRASOR.
- Research has also consistently shown that tools designed to measure general recidivism are appropriate for use with sex offenders, and prove especially useful in filling in the gaps toward understanding general recidivism in a population that more often re-offends in a nonsexual way.
 - ✓ Hanson & Morton-Bourgon (2004) - The most accurate method for predicting general recidivism in sex offenders involved actuarial risk scales designed to predict general recidivism, such as the Statistical Information on Recidivism (SIR) scale (rather than clinical or empirically guided assessment methods).
 - ✓ Barbaree et al. (2001) – found the VRAG and PCL-R predicted general recidivism in sex offenders.
- The assessment battery currently utilized by Pennsylvania includes a number of general assessment tools which may be considered relative to their appropriateness for use with sex offenders.
 - ✓ LSI-R - Simourd & Malcolm (1998) asserted the LSI-R is an important complement to sex offender assessment since it addresses the more common risk of general recidivism that is oftentimes missed when evaluators focus solely on sexual recidivism outcomes for sex offenders. Simourd's work indicated there is decent reliability and validity in using the LSI-R with the sex offender population (although the study's sample size was fairly small, N = 216). Simourd's study not only supported the general validity of using the LSI-R with a sex offender population, but also illustrated that the LSI-R measures distinctly different information from what is gleaned from other measures specific to sexual recidivism (such as deviant sexual interests).
 - ✓ Hostile Interpretations Questionnaire (HIQ) – Simourd & Mamuza (2000) explored the psychometric properties and construct validity of the HIQ, finding acceptable internal consistency reliability and construct validity with relevant anger/hostility measures. In their discussion, the authors reported that research is “currently examining the psychometric properties and discriminate validity of the HIQ among different risk samples”, including sex offenders. The results should prove informative to the PA DOC in considering the appropriateness of this tool for use with its sex offender population. Given what is known about the similarities/overlap between sex offenders and general offenders, it is likely that this tool will be appropriate for the sex offender population.
 - ✓ Criminal Sentiments Scale Modified (CSS-M) – Like the HIQ, it is probable that the CSSM is appropriate for sex offenders. Yet, at the present time, while a number of studies have established the validity and reliability of the CSS-M among adult and juvenile offenders, there is limited research examining the appropriateness of the CSSM for assessment of the sex offender population. Mills & Kroner (1997) found the CSS (original version) to be unrelated to reconvictions and parole violations among a sample of violent offenders, and their later component analysis (Kroner & Mills, 1998) among a sample of violent and sexual offenders did not find the factors to be associated with recidivism. As with the HIQ, future research should prove informative in considering the appropriateness of this tool for use with the PA DOC sex offender population.

Comparison of Actuarial Measures of Sexual Recidivism

There are few studies in which several scales have been scored on the same samples, and those that have generally have not found statistically significant differences between the various scales in predictive accuracy. A combined approach, utilizing a battery of actuarial assessment tools, may improve the accuracy of risk prediction.

- Hanson & Morton-Bourgon (2004) – examined several general and sex-offending-specific scales related to the prediction of general and sexual recidivism and found:

- ✓ All individual risk scales were in the moderate to large range (i.e., VRAG, SORAG, Static-99, RRASOR, MnSOST-r, and SVR-20).
- ✓ No single measure was consistently superior across samples, and there were no significant differences in the validities/accuracies of the various actuarial risk scales considered in the prediction of sexual recidivism (confidence intervals for all risk scales overlapped).
- ✓ Tools developed for predicting general criminal recidivism also predicted sexual recidivism among sexual offenders (e.g., Statistical Information on Recidivism, or SIR). In fact, the general measures predicted sexual recidivism as well as did measures designed to predict sexual or violent recidivism (e.g., SORAG, Static-99).
- ✓ Three risk scales had significant variability in their predictive validities across studies (i.e., Static-99, RRASOR, and SVR-20).
- Predictive Accuracy
 - ✓ Combined approach - Research findings examining the predictive accuracy of using a single assessment scale for predicting sexual recidivism, versus a combination of scales, found that combining scales results in improved accuracy (Seto et al, ATSA, 2002). A number of models have been suggested for combining measures and attaching recidivism rates to combined scores:
 - Two-Dimensional Model (Canton et al, 2002) – report two robust dimensions in sexual recidivism risk predictors (general anti-sociality/violence and sexual deviance) which both contribute independently to prediction.
 - Additive/Linear Model – simplest model is a linear, additive one where risk increases as you move up either of the underlying dimensions.
 - Interaction Models (two contradicting models are described below):
 - High is High (Doren) – if any is high, then it is high risk
 - Doren’s rework of Hanson & Thornton’s (2000) follow-up data found high on RRASOR & Static-99 was associated with high risk for sexual recidivism.
 - The Deadly Combination (Hare) – high psychopathy & high deviant sexual interest (neither is significant in and of itself).
 - Rice & Harris (1997) – high PCL and sexual deviance specifically predicts sexual recidivism, yet alone they are much less predictive.
 - Gretton et al (2001) – reported an additive model with both independently increasing risk.
 - ✓ Independent measures - The following table reports the value of various actuarial measures in predicting risk for general, violent, and sexual recidivism:

Strength of Prediction for Various Assessment Tools			
	General Recidivism (AUC)*	Violent Recidivism (AUC)*	Sexual Recidivism (AUC)*
LSI-R			
PCL-R	.68	.63	.61
VRAG	.76	.66 - .76	.58 - .60
SORAG	.78 - .82	.71	.63 - .68
RRASOR	.61	.65	.62 - .77
Static-99	.76	.69 - .74	.68 - .73
MnSOST-R	.65	.58	.65 - .77
From Hanson, ATSA (2000):			
	high		
	moderate		

* AUC gleaned from various studies, using Barbaree et al. (2001) as the foundation for the estimates.

- Strengths & Weaknesses – the following information attempts to provide a summary of the strengths and limitations of select actuarial measures in predicting risk for re-offending in sex offenders (note this is not an exhaustive, comprehensive list of strengths and limitations, but rather a brief overview):

RRASOR	
Strengths	<ul style="list-style-type: none"> Well validated and empirically based on 4 most robust risk factors/predictors. Easy to score & interpret – quick, uses available/basic criminal records, trained non-clinician, able to code w/out psych tests/clinical assessment/or interview (no offender cooperation required). Useful for screen or baseline assessment. Non-proprietary/in public domain (training costs).
Limitations	<ul style="list-style-type: none"> Disregards valuable information – while tool uses only 4 strong predictors, it disregards other valuable factors in considering risk (e.g., stable dynamic factors - deviant sexual preferences were strongest predictors in Hanson's meta-analyses, yet not included in this assessment, similarly, successful completion of treatment and cooperation with supervision are not factored into the calculation, etc.). As a static tool, it cannot be used to select treatment targets, measure change/treatment progress, or predict when an offender is likely to recidivate. Measures only sexual re-offending, not a measure of general/non-sexual or violent re-offending. Only normed on adult males who have previously been incarcerated – not yet normed/tested to be appropriate for use with females, juveniles, mentally ill, or probationers (unless the probationers have previously been incarcerated).
Static-99	
Strengths	<ul style="list-style-type: none"> Well validated (developed and normed on 4 different data sets, total sample size N = 1,208, cross-validated). Superior to RRASOR – higher correlation w/recidivism & collects more comprehensive info/looks at more factors. “Well-rounded” instrument - shown to predict violent (including violent sexual) recidivism in sex offenders approximately as well as it predicts sexual recidivism & it predicts recidivism in incest offenders approximately as well as it will extra-familial/out-of-home child molesters (unlike the MnSOST-R). Easy to score – can be scored from easily obtained/available records (no offender cooperation required). Non-proprietary/in public domain (training costs).
Limitations	<ul style="list-style-type: none"> Static tool – cannot be used to select treatment targets, measure change/treatment progress, or predict when an offender is likely to recidivate. Normed only on adult, male, incarcerated sex offenders – extrapolating use with probationers, females, juveniles, and/or mentally ill would not be appropriate. Risk level cut-offs for the “highest risk” sex offenders – the highest re-offense group only re-offended at the 52% level, which raises questions related to whether or not an offender with a 53% known rate of re-offending in reality has a “much more likely than not” chance of re-offending. Therefore, this tool may be more valuable for some public policy decisions than others (e.g., more valuable for community notification and determining supervision levels than civil commitment evaluation). Results in counterintuitive scorings – in rare cases, counterintuitive scores may result from the scoring of items on the tool. For example, the score for an offender with a conviction for index non-sexual violence may decrease if he subsequently re-offends with a sexual offense. Evaluators must consider advanced age in their overall estimate of risk since research has suggested that its methods of accounting for the offenders’ ages may be insufficient to capture declines in recidivism risk associated with advanced age. Hanson (2005) examined this concern and reported that older offenders did, in fact, display lower sexual recidivism rates than would be expected based on their assigned/assessed Static-99 risk categories.
Static-2002	
Strengths	<ul style="list-style-type: none"> More consistency in scoring criteria/coding rules than Static-99 (facilitates training and increases inter-rater reliability). The content areas have increased conceptual clarity over the Static-99. For sexual recidivism, the predictive accuracies of the Static-99 & Static-2002 were similar, and the Static-2002 had less variability across samples/settings than the Static-99 (Hanson & Thornton, 2003). For any violent recidivism, the predictive accuracy of the Static-2002 was greater than that of the Static-99. The Static-2002 predicted any violent recidivism as well as it predicted sexual recidivism. Attempts to eliminate the counterintuitive scorings generated by the Static-99. Provides additional variables and refined definitions from Static-99, which aims to increase its predictive accuracy. Easy to score – can be scored from easily obtained/available records (no offender cooperation required). Non-proprietary/in public domain (training costs).
Limitations	<ul style="list-style-type: none"> Static tool – cannot be used to select treatment targets, measure change/treatment progress, or predict when an offender is likely to recidivate. Newly developed tool – further research is necessary before the tool can be used in applied contexts – results should be replicated in independent data sets, replication studies should include at least 10, ideally 15-year, follow-ups on a combined sample size of over 1,000 sexual offenders before it is possible to associate specific risk levels to specific ranges of scores.
SORAG	
Strengths	<ul style="list-style-type: none"> * Higher correlation with violent recidivism than other instruments designed for use with sex offenders. More comprehensive than Static-99. Incorporates phallometric assessment (strongest predictor in Hanson's research).
Limitations	<ul style="list-style-type: none"> Static tool – cannot be used to select treatment targets, measure change/treatment progress, or predict when an

	<p>offender is likely to recidivate.</p> <ul style="list-style-type: none"> • More timely & difficult to score - relies on PCL-R ratings as part of measurement equation, requires more resources & more qualified personnel (i.e., psychologists) to administer/complete.
MnSOST-R	
Strengths	<ul style="list-style-type: none"> * Higher correlation with sexual recidivism than any other instrument currently available. • Well validated (some reduction in predictive power from validation to cross-validation sample as commonly expected, however). • Separate version (1st 12 items are the “static version”) does not require previous incarceration to score, so the tool may be utilized for offenders on probation as well as those incarcerated or on parole (yet it has not been normed on probationers, so while there is theoretical reason to expect the reduced scale to predict well, this is only an assumption to date). • Easy to score – all items can be scored from available criminal records (no offender cooperation required). • Non-proprietary/in public domain.
Limitations	<ul style="list-style-type: none"> • Primarily a static tool – does not comprehensively inform treatment targets, measure change/treatment progress, or predict when an offender is likely to recidivate. While it may be a strength to include some dynamic factors, such as treatment behavior in its scoring, the tool’s predictive validity has been shown to increase when the treatment variables are not scored. • Higher scores on this tool were rarely attained in the validation and cross-validation studies, so policy targeted at those assigned this risk level using the tool will be made based on a small sample of offenders (N=18). • Does not perform well in the prediction of sexual recidivism in incest offenders. Therefore, the tool is not recommended for use with offenders who have no known offenses outside the home, unless the incest involves rape (i.e., penetration in a child under 13 or forcible presentation in a child over 13). • Developed for and normed on adult males who have been incarcerated – not normed on females, juveniles, or the mentally ill. While the abbreviated version is available for use with probationers, norms have not been developed. • More difficult to score – file intensive, all information required to score may not be readily available in the offender file to score the tool (inmate files sometimes have varying levels of comprehensiveness/completeness).
SONAR	
Strengths	<ul style="list-style-type: none"> • Measures dynamic variables – as a measure of dynamic, rather than static, risk factors, this tool allows for the assessment of change in risk level (e.g., progress resulting from therapy) and informs targets for intervention. • Developed on offenders under community supervision – this is one of the only scales developed for this sub-population of offenders (those not previously incarcerated). • Non-proprietary/in public domain.
Limitations	<ul style="list-style-type: none"> • Current research on tool does not support any direct translation of SONAR scores into expected recidivism rates since an artificial (elevated) base rate was used (in applied settings the sex offense recidivism rate would be much lower than the 50% used by the researchers, approximately 5% per year). • Validated tool (note: there were significant differences between recidivists and non-recidivists in static factors which may have influenced the results of the study), but not cross-validated. Therefore, it is impossible to know the extent to which the results will replicate on a different sample – since the same data set was used to develop the test items, the extent to which the results will generalize is unknown. • Methodology – Information for the research study which identified the 5 stable & 4 acute dynamic risk factors used by this tool was obtained from probation officers who were aware of which offenders had recidivated, allowing the possibility for retrospective recall biases. “Selective memory” and/or “unconscious bias” may account for the findings, rather than genuine differences in dynamic factors between recidivists and non-recidivists.
Stable-2000	
Strengths	<ul style="list-style-type: none"> • Measures stable dynamic variables – as a measure of stable dynamic risk factors, this tool allows for the assessment of change in risk level (e.g., progress resulting from therapy) and informs targets for intervention. Stable dynamic risk factors are the only type of risk factors which may be targeted to affect enduring, long-term offender behavioral change. • Widely applicable • Theoretically based & empirically supported • Non-proprietary/in public domain (training costs).
Limitations	<ul style="list-style-type: none"> • Plausible, but not yet validated. • Consideration should be given to combining tool with static risk factors/predictors.
Acute-2000	
Strengths	<ul style="list-style-type: none"> • Measures acute dynamic variables – as a measure of acute dynamic risk factors, this tool may predict the timing of the re-offense and related decisions regarding the appropriate timing of intervention. • Widely applicable. • Theoretically based & empirically supported. • Non-proprietary/in public domain (training costs).
Limitations	<ul style="list-style-type: none"> • Plausible, but not yet validated. • Consideration should be given to combining tool with static risk factors/predictors.

Less Effective or Ineffective Assessments with Adult Sex Offenders

- Psychological Testing – Many tools used for risk assessment of sex offenders, such as general personality tests, appear to have no success in measuring the important personal factors associated with sexual deviant behaviors.
 - ✓ These tools examine clinical factors based on the theoretical foundations of a psychopathological model of sexual deviance, such as general personality characteristics and personal distress, which are not predictive of sexual deviance.
 - ✓ The Minnesota Multi-phasic Personality Inventory (MMPI) is one example. Murphy & Peters (1992) – examined the MMPI literature on pedophiles and found that the most frequent elevations were on the very same scales on which criminals score high, and they could not identify any specific type of significant profile for pedophiles.
- Clinical judgment and empirically guided assessments – Hanson & Morton-Bourgon (2004) found unguided clinical opinions and empirically guided assessments were consistently less accurate than all other methods (actuarial risk instruments) in predicting sexual, violent non-sexual, and any general recidivism in their meta-analysis reviewing the research findings of 95 studies on more than 31,000 sex offenders (nearly 2,000 recidivism predictions).
 - ✓ Unguided professional judgment – (based on expertise and unique features of the case) while significantly related to recidivism, the accuracy of this method was not as consistent as actuarial measures in predicting sexual or any general recidivism.
 - ✓ Empirically-guided professional judgment – (structured around empirically tested risk factors) while a better predictor than unguided professional judgment, this method still did not show the consistent, predictive accuracies of pure actuarial methods in predicting sexual or any general recidivism.

Sex Offender Treatment

Highlights

- ✓ *Over the past decade, a number of meta-analyses have reported positive outcome findings resulting from sex offender treatment programs. Sex offenders who successfully complete treatment programs have demonstrated lower average rates of sexual recidivism than untreated comparison groups. In fact, the most recent and comprehensive research on treatment outcomes with sex offenders found an overall positive effect on sexual, general, and violent recidivism (Losef & Schmucker, 2005).*
- ✓ *Appropriate sex offender treatment programs should have both selection and exclusionary criteria to encourage appropriate matching of offenders to the treatment services they receive and to allocate resources most effectively in promoting sex offender change. In general, the impact of sex offender treatment programs will be optimized when interventions target the highest risk sex offenders. Little to no intervention is required for low risk sex offenders who are unlikely to re-offend even if untreated, and may possibly increase their risk levels with intervention.*
- ✓ *High risk sex offenders identified as having high levels of sexual needs (e.g., deviant sexual interests) should be prioritized for sex offender treatment. In contrast, high risk sex offenders who are assessed as having high levels of "general" criminal needs (e.g., anti-social orientation) should be prioritized for general criminal treatment programs.*
- ✓ *Based on the consistent finding that failure to complete sex offender treatment is a predictor of recidivism and that treatment "failures" are more likely to recidivate than comparable "refusers", researchers have suggested the practice of identifying those most at risk for treatment failure as early as possible to inform appropriate placement decision-making and to proactively address potential failures.*
- ✓ *Both the external and internal responsivity factors which are common to sex offenders have important implications for increasing the likelihood of successfully treating this offender sub-population. Characteristics which warrant consideration in treating sex offenders may include psychopathy, motivation, denial, age, marital status, level of cognitive functioning, personality/temperament, mental health, and sub-typology. These factors, in addition to characteristics of the therapist and setting, should be considered when matching sex offenders to appropriate interventions and assigning them to the most appropriate professional staff.*
- ✓ *Although group therapy is the preferred sex offender treatment modality, research findings have produced mixed evidence relative to the efficacy of group versus individual sex offender treatment. Some suggest the best approach is to assign sex offenders to group or individual therapy based on their responsivity needs (e.g., sex offenders with high levels of responsivity needs receive individual therapy while those with fewer, less significant responsivity issues are assigned to groups). As a guideline, group therapies should be limited to 8-10 participants per session and should not mix low-risk with high-risk sex offenders.*
- ✓ *Since we know that the criminogenic needs of sex offenders are not limited to their sexual behaviors, but these offenders have non-sexual criminogenic needs which are just as relevant, treatment must target both sets of dynamic risk factors. Targets specific to sexual re-offending include sexual deviancy indicators, such as sexual preoccupations, paraphilic interests, deviant sexual interest, and deviant sexual arousal. General criminogenic targets include anti-social orientation indicators, such as anti-social personality, anti-social traits, self-regulation problems, impulsivity, substance abuse, and hostility.*
- ✓ *The sequencing of sexual versus general treatment targets should be guided by individual assessment results. Sexual deviancy should be the primary targets for intervention with non-violent sex offenders and antisocial orientation should be secondary. On the other hand, antisocial orientation should be the primary target for intervention with violent sex offenders and sexual deviancy should be secondary.*
- ✓ *Treatment dosage should be informed by each sex offender's risk/need profile. Higher risk/need offenders should receive the largest dosage (longer duration & more intensive services). Unlike the 3 to 9 month program duration recommended for the general offender population, the research literature suggests that sex offender treatment be delivered for at least 12 months, with no "upper limit". As with the general offender population, successful treatment completion should be determined based on demonstrated progress in meeting specified individual behavioral objectives.*
- ✓ *Cognitive-behavioral treatments have been touted as the most promising throughout the sex offender research to date. Hormonal, behavioral, and relapse prevention models may be promising, especially when delivered concurrently with cognitive-behavioral treatment. Other methods, such as general psycho-social treatment, have not proven effective.*

Sex Offender Treatment

Sex offender program evaluation is in its early stages, so there is a lack of research in this area to inform practice. Further, quality evaluation of the effectiveness of sex offender treatment is challenged by a number of methodological limitations unique to this topic of study and, in turn, research findings have been somewhat inconsistent and inconclusive. Clearly, the heterogeneity of outcomes within similar types of program models may partially be explained by methodological design quality, confounded by a number of treatment fidelity variables and offender characteristics. While a paucity of high-quality evaluations specific to sex offender programs warrants further investigation relative to “What works for which sex offenders under which circumstances?”, the results of recent studies are promising, finding that sex offender treatment has some moderately positive effects relative to sexual, general (any), and violent recidivism. Further, the extant research has examined specific program elements relative to their influence on treatment outcomes (e.g., offender characteristics, program model, dosage, treatment targets, program setting, etc.). These findings serve to provide important information relative to the design and delivery of effective sex offender treatment.

Does treatment work with sex offenders?

There has been a significant increase over the past decade in positive outcome findings resulting from sex offender program evaluation. In fact, a number of meta-analyses have suggested that a moderately positive effect may be achieved through sex offender treatment, which produces a lower average rate of sexual recidivism in treated groups than in control or comparison groups:

- Losel & Schmucker (2005) – conducted a meta-analysis of 69 controlled outcome studies on both psychological and biological treatments for sex offenders (published through mid-2003) and found that treated sex offenders showed 6.4 percentage points less sexual recidivism than controls (37% reduction). Effects for general and violent recidivism were in a similar range. The average violent recidivism rate for treated sex offenders was 5.2 percentage points lower than for untreated sex offenders (44% reduction). The average general (any) recidivism rate for treated sex offenders was 10.1 percentage points lower than for untreated sex offenders (31% reduction).
- Hanson et al (2002) – integrated 43 studies on psychological treatment and found the average sexual offense recidivism was 4.5 percentage points lower for treatment groups than for comparison groups, 12.3% and 16.8% respectively ($d = 0.13$).
- Losel (2000) – conducted a meta-analysis of 20 studies on medical and psychological treatments for sex offenders and found an effect, yet it was of non-significant size ($d = 0.08$).
- Gallagher et al (1999) – quantitatively synthesized the results of 22 studies (25 effect sizes) of relatively good quality and found that the treated groups showed 10 percentage points less sexual recidivism than controls (5% vs. 15%, respectively) and the overall effect size was relatively large ($d = 0.47$).
- Polizzi et al (1999) – evaluated 13 sex offender prison and non-prison based treatment programs (8 of the original 21 were excluded for methodological/scientific concerns) and found that approximately 50% showed statistically significant findings in favor of sex offender treatment programs.
- Alexander (1999) – integrated 79 studies on psychosocial sex offender treatment and found a mean difference in recidivism of 5 percentage points in favor of treatment ($d = 0.12$).
- Hall (1995) – integrated 12 controlled sex offender treatment studies (published after 1989) and found the average rate of sexual recidivism was 19% in treated groups/successful completers and 27% in a comparison group of sex offenders who did not receive treatment ($d = 0.24$).

While these and other studies have reported some positive effects resulting from sex offender treatment, promising sex offender treatment research findings must be considered in the appropriate context, with the following considerations in mind:

- Early stages of research & lack of high quality studies - Sex offender program evaluation research is in its infancy, and there are significantly fewer well-controlled sex offender treatment studies from which to draw firm conclusions than in the field of general offender treatment.
- Methodological limitations – Sex offender program evaluation is complicated by a number of research design limitations. For example, quality research design is challenged by a lack of “untreated” sex offenders to form randomized untreated control groups (majority of studies contain no control group which is Level 1 on the Maryland Scale of Methodological Rigor, Sherman et al, 1997), insufficient numbers of sex offenders to produce sample sizes required to reveal a significant effect in a population with a relatively low base rate of sexual re-offending, selective dropout rates, and a lack of official data (undetected crimes). Further, since the treatment of sex offenders commonly addresses a broad range of needs (offenders do not necessarily

receive a “program”, but a “package” of programs), a complex evaluation would be required to “disentangle” the impact of a specific program offering for this population.

- Inconsistent and/or inconclusive results – While the studies identified above have suggested positive outcomes resulting from sex offender treatment, other recent studies have produced less promising results (rather small or no positive effects) and/or adopted a more pessimistic perspective relative to the potential for effective sex offender programming:
 - ✓ Marques et al (2005) – follow-up of one of the most frequently cited and soundest evaluations (notably, this was a longitudinal design which used random assignment to treatment and control groups – and, is the only random assignment study examining current sex offender-specific treatment) found no significantly positive effect. Yet, a number of program quality limitations must be examined in considering the evaluation results. The original (1999) and follow-up work of Marques et al is referred to as the “California Sexual Offender Treatment Evaluation Program” (SOTEP). The treatment program was extensive and intensive, providing at least 1 year of treatment while incarcerated (requiring 40 to 50 hours per week) followed by extensive community supervision for up to 2 years following release (requiring treatment). While a treatment effect was not found, the program had a number of drawbacks which may have dampened its effect. For example, the program eligibility criteria targeted low to moderate risk sexual offenders. And, when the program involved offenders representative of all risk levels (low to high), offenders were mixed.
 - ✓ Hanson & Bourgon (2004) – found rates of sexual recidivism for the treatment and comparison groups were not statistically significantly different (21.1% vs. 21.8%, respectively), and that treatment progress showed little relationship to recidivism in sex offenders.

Mixed evidence on the overall effectiveness of sex offender treatment programs may be explained, in large part, by the differential effectiveness of various treatment programs as influenced by a number of important program quality indicators. In addition to the treatment model (e.g., cognitive-behavioral, psycho-educational, etc.), a number of program variables, such as an appropriate target population, the use of offender assessment results, matching based on responsivity factors, appropriate treatment targets, and sufficient program dosage have the potential to negatively or positively influence treatment outcomes. The remainder of this section of the sex offender research review will briefly consider several of the many program variables able to influence treatment outcomes.

Which sex offenders should be targeted & prioritized for sex offender treatment?

Appropriate sex offender treatment should have selection (e.g., high risk offenders) and exclusionary criteria (e.g., low risk offenders) to encourage appropriate matching of offenders to the treatment services they receive, and to ensure resources are allocated most effectively in promoting long-term change. Further, assessment should be used to measure risk, need, & responsivity factors required to inform placement decisions.

Target Those At High Risk for Re-offending

- Risk principle – studies have consistently demonstrated that the impact of sex offender treatment will be optimized (contributing to public safety and efficient resource allocation) when interventions are directed toward the highest risk offenders. The treatment of low risk sex offenders has not been found to demonstrate significant treatment gains, and may even serve to *increase* offender risk levels.
 - ✓ Lowenkamp & Latessa (2004) – examined the effectiveness of community-based correctional programming relative to offender risk levels, to include 390 sex offender cases. The research served to validate the risk principle, finding that while programming decreased recidivism levels of high risk sex offenders, it actually increased recidivism levels for low risk sex offenders.
 - ✓ Hanson et al. (2003) – research found that higher risk sex offender samples demonstrated a highly significant gain from treatment while lower risk samples failed to demonstrate a significant gain.
 - ✓ Nicholaichuk (1996) – conducted outcome research on Canadian sex offender treatment programming and found support for the risk principle as applied to sex offenders. Recidivist (federal) sex offenders who had the highest initial risk levels demonstrated the greatest treatment effects, while treatment for non-recidivist (provincial) sex offenders did not appear to affect risk. Based on these findings and consistent with the risk principle, the researchers suggested that sex offenders in their thirties with no previous sex offenses, a limited history of non-sex offenses, and sentenced to less than two years should be directed into low-intensity, low-cost programming. More intensive programming should be reserved for the highest risk who will benefit most from the resources allocated for sex offender intervention.

- Assessment – decisions related to the level of risk posed by each individual sex offender should be informed by actuarial instrumentation, such as the tools discussed earlier in this sex offender research review. Once objective risk measures are administered, scored, and risk levels are assigned, informed decision-making related to the assignment of sex offenders to appropriate interventions can occur. As an example, the Sex Offender Risk Appraisal Guide (SORAG) could be useful in determining which sex offenders should be assigned to which level of intervention. More specifically, low-risk offenders may be assigned to receive either no treatment or low-intensity programming, while high-risk offenders may be referred to intensive pre-release treatment programs.

Target Those With High Sexual Needs

- Research has demonstrated the importance of individually prescribing and sequencing programs based on formal assessment results measuring sexual versus non-sexual needs. As one recent example, Losel & Schmucker (2005) found that only programs designed specifically for sex offenders had a significant effect on *sexual* recidivism. The few other programs in their study showed negative outcomes.
 - ✓ Therefore, sex offenders identified as having high levels of/multiple sexual need factors (e.g., deviant sexual interests), who are at high risk for *sexual* recidivism, should be prioritized for sex offender treatment.
 - ✓ In contrast, sex offenders who are assessed as having high levels/multiple “general” criminal needs (e.g., anti-social orientation), who are at high risk for general/non-sexual and/or violent re-offending, should be prioritized for general criminal treatment programs. As an example, a rapist at high risk for general or violent recidivism, yet low-risk for sexual recidivism (rapists do not necessarily score high on deviant sexual arousal) who participates in a sex offender treatment program that focuses on curbing deviant sexual arousal will not benefit from the intervention.
- Yet, knowing that sex offenders are more likely to recidivate with a non-sexual offense, that there is significant overlap in their sexual and non-sexual risk factors, and that those with deviant sexual interests would not offend unless they also had antisocial orientations, both sexual and general treatment programs would be appropriate for sex offenders. While offenders targeted for sex offender treatment due to high levels of sexual deviancy would also be appropriately matched to general criminal programs (and vice versa), assessment results should be used to *prioritize* either sex-specific or general criminal programming for sex offenders based on their levels of sexual versus general criminogenic needs.

Consider Risk for Treatment Failure

- Consistent research findings suggest that failure to complete sex offender treatment is a reliable predictor of recidivism. Specifically, studies demonstrate that sex offenders who fail to complete treatment (e.g., are discharged, escape, quit, etc.) represent not only less than optimal resource allocation, but also position themselves to be at a particularly high risk for re-offending once at large. In fact, those sex offenders who start, but fail to complete treatment (“non-completers”) demonstrate higher recidivism rates than not only those who complete treatment, but also those who *never participated* in treatment (e.g., “refusers”).
 - ✓ Losel & Schmucker (2005) – research found higher recidivism among treatment dropouts than in those sex offenders who completed treatment successfully.
 - ✓ Hanson et al (2002) – reported that studies comparing treatment completers to dropouts consistently found higher recidivism rates for the dropouts, regardless of the type of treatment provided. Hanson further suggested that “interrupted treatment makes offenders worse”. This work argued that “the initial stages of treatment can introduce offenders to deviant role models, cognitive distortions, and a wide range of novel, sexually deviant fantasies and behaviors”.
- With these findings in mind, researchers have suggested the practice of identifying those most at risk for treatment failure as early as possible to inform appropriate program selection/placement decisions (e.g., “pre-treatment” versus formal phase of sex offender program) and to proactively address potential failures. While Strassberg & Reynolds (2005) found that assessment tools, such as the MnSOST-R, have proven useful in predicting treatment completion (e.g., months of treatment), targeting high-risk sex offenders for program placement and assigning treatment groups by offender risk level will also serve to address this important issue.

What characteristics of the sex offender, treatment provider, and setting should be considered relative to achieving successful treatment outcomes?

Responsivity principle – Consistent with the need to address responsivity factors in successfully treating general criminal populations, the external and internal responsivity factors common to sex offenders have important implications for increasing the likelihood of successfully treating this offender sub-population. The following responsivity factors are among those which may warrant consideration when matching sex offenders to appropriate interventions and assigning them to the most appropriate professional staff.

Internal Responsivity Factors

- Psychopathy – A debate continues in the general criminal research area relative to whether psychopaths should receive treatment and to what extent they are responsive to intervention. Although mixed research evidence cannot yet support firm conclusions, there is some indication that at least some sexual offenders who are psychopaths may respond positively to treatment. However, this would require that effective treatments for this type of offender be identified and responsivity considerations unique to psychopathic sex offenders be addressed.
 - ✓ Are psychopathic sex offenders able to benefit from treatment? - Looman et al (2005) found that high-psychopathy sex offenders (i.e., PCL-R scores higher than 25) who were assessed as having benefited from treatment reoffended at a rate more similar to the low-psychopathy offenders than their high-psychopathy counterparts who were not assessed as benefiting from the treatment.
 - ✓ How are psychopathic sex offenders who benefit from treatment different from those who do not? – Looman et al (2005) found that men who score high on the arrogant, deceitful factor (Cooke & Michie's Factor 1, which divides Hare's Factor 1 into two separate categories) were less likely to complete treatment. Based on these findings, the authors suggest that sex offenders who score high on psychopathy, yet low on "Cooke & Michie's Factor 1", would be more responsive to treatment than those who score high on both psychopathy and "Cooke & Michie's Factor 1".
 - ✓ What are the "principles" for providing treatment to sex offenders with psychopathic traits? (Thornton & Blud)
 - Assess for psychopathy using PCL-R cut-off scores between 25-30.
 - Avoid vulnerable methods (un-checkable self-reports, requiring displays of emotion, etc.)
 - Target general criminogenic factors first, then sexual risk factors
 - Train staff to maintain appropriate boundaries and to reduce opportunities for manipulation
 - Ensure pro-social behavior during treatment leads to better consequences than anti-social behavior
 - Ensure fluctuations in behavior do not lead to major reductions in service provision (withdrawn from services – find ways to sustain/continue treatment without compromising safety and security)
 - Respond to diversity (there is heterogeneity in the combination of psychopathic traits & how they should be addressed individually)
- Motivation & related cognitive distortions – Sex offenders, who frequently use cognitive distortions, such as denial, minimization, & justification, are oftentimes unmotivated for treatment and uninterested in changing their sexually deviant behavior.
 - ✓ Researchers have identified a number of behaviors which are associated with sexual offenders' motivation to change sexually assaultive behavior, to include:
 - Treatment participation - agreeing to participate in treatment (Marshall, 1993)
 - Treatment behavior – acceptance of problem, use of cognitive distortions (denial, minimization, & justification), attendance, promptness, level of participation (Jenkins-Hall, 1994)
 - Treatment persistence & dropout (Lee, Proueve, Lancaster, & Jackson, 1996)
 - Use of relapse prevention strategies (George & Marlatt, 1985 & Hall, 1989)
 - ✓ Researchers have also examined the relationship between denial and motivational indicators (treatment readiness, participation, and completion), hypothesizing that absolute denial is reflective of low motivation for treatment and complete admission is related to high degrees of motivation.
 - Levenson & Macgowan (2004) – reported that a strong relationship exists between denial and engagement in group therapy in a sample of 61 child molesters, less denial was associated with higher levels of engagement.
 - McKenzie et al. (2002) – examined a sample of high-risk sexual offenders and found that denial of index offense significantly differentiated treatment completers from dropouts, offenders who denied their offenses were more likely to drop out.
 - Malcolm (2001) – reported that denial was significantly related to treatment readiness, offenders who admitted to their sexual offenses were more motivated to participate in treatment.

- Geer, Becker, Gray & Krauss (2001) – found that sexual offenders who had lower scores on the MSI accountability subscale were more likely to complete treatment.
- ✓ Recidivism – Since evidence has consistently indicated that sex offenders who drop out of treatment have poorer outcomes (higher rates of recidivism), research has further examined the role of responsivity factors, such as readiness, motivation, and denial, in delivering effective treatment for sex offenders. Interestingly, while these factors have historically been important considerations in delivering sex offender treatment, recent research findings have not produced evidence to support or explain the relationship between these factors and desired treatment outcomes.
 - Hanson & Bussiere (1998) – found that sex offenders who failed to complete treatment were at higher risk for re-offending than those who completed treatment, yet clinical presentation variables examined by the study (i.e., denial and low motivation for treatment) were not found to relate to recidivism.
 - Losel & Schmucker (2005) - found that voluntary treatment lead to a slightly better outcome than mandatory participation. While sexual offenders who participated voluntarily in treatment experienced average effect sizes which were significantly positive, obligatory participation and mixed conditions resulted in no effect. However, these differences were *not* statistically significant.
- ✓ Theoretical Models Designed to Explain Motivational Constructs & Inform Motivational Interventions – a number of models have been devised to explain and address personal motivation to change. Research efforts have examined the application of these models specific to sex offenders:
 - Transtheoretical Model (Stages of Change) - Prochaska, DiClemente & Norcross (1992)
 - Kear-Colwell & Pollack (1997) examined different treatment techniques in a group of child molesters (of unspecified risk level) and reported that in the pre-contemplation and contemplation stages of change, motivational interviewing techniques were more successful than confrontational techniques in moving offenders from one stage to another.
 - Serin & Mailloux (2003) identified difficulties with applying the Transtheoretical Model to offender populations in institutional settings, including the challenge of providing sufficient opportunities for sex offenders to practice new skills required to progress through the stages of behavioral change.
 - Treatment Readiness, Responsivity, and Gain (TRRG) – Serin & Kennedy (1997)
 - Marshall et al. (1993) – reported that the motives for a sexual offender to participate in treatment are oftentimes unclear, particularly when incentives are offered for treatment completion (decrease custody level/reclassification, increased privileges, outside clearances, etc.). Therefore, the TRRG model accounts for multiple factors (both internal and external) - which may or may not be related to the sex offender's desire to change his behavior (e.g., fear of reprisals within a prison setting if identified as a sex offender) – yet, linked to treatability.
 - Serin & Kennedy's (1997) work in developing the TRRG protocol for the assessment of treatment responsivity in offenders included a sample of sex offenders (21 treated & 20 untreated).
 - Multifactor Offender Readiness Model (MORM) – Ward, Day, Howells, & Birgden (2004)
 - Looman et al. (2005) – Unlike the previous two theoretical models, this author suggests that Ward's (2004) formulation of the responsivity principle and treatment readiness focuses on what prevents treatment responsiveness, suggesting that the focus needs to be more on what facilitates treatment engagement. Therefore, Looman suggests that since, as a group, high-risk sex offenders often do not have the internal or external factors identified as facilitating treatment engagement, it is critical to have a model that articulates how to work with the obstacles that interfere with treatment responsiveness.
- Demographic Variables – two demographic variables which are proven risk factors, age and marital status (single, never married), are also important responsivity considerations. Clearly, IQ must also be considered.
 - ✓ Age
 - Losel & Schmucker (2005) - found that treatment of age-homogeneous groups tended to be more successful than age-heterogeneous (mixed) groups. This finding may result for a number of reasons:
 - Younger offenders are less receptive to treatment due to a lack of maturity and inability to understand the detrimental effects of their attitudes and behaviors. When delivering age-heterogeneous groups, older sexual offenders become frustrated by the younger offenders' lack of motivation and engagement.
 - Older sexual offenders may serve as role models for the younger sex of offenders.

- Thornton & Doren (2002) - found that age does not mediate the expected treatment response in high-risk sexual offenders unless they are older than 60 years. In other words, while there is a gradual decline in recidivism as low- to moderate-risk sex offenders age, this gradual decline does not appear to occur with high-risk sexual offenders. With high-risk sexual offenders, the likelihood of sexual recidivism increases with age until the age of 60. Offenders older than 60 have the lowest recidivism rates regardless of risk level.
- ✓ Marital Status & Level of Education
 - Strassberg, Whittaker, & Dillinger (2002) – reported that age, marital status, and level of education were predictive of treatment completion.
 - Shaw et al. (1995) – reported that being married was predictive of treatment completion.
- ✓ Intellectual functioning
 - Looman et al. (2005) – noted research findings examining the relationship between sex offender risk level and IQ, suggesting the potential incidence of low IQ in higher risk sexual offenders may contribute to poorer treatment outcomes.
 - Langevin & Pope (1993) – reported that substantial numbers of sexual offenders have histories of learning difficulties, which may lead to resistance in treatment and treatment response (since they oftentimes co-occur with social skill & self-regulation problems, such as impulse control, attention disorders, restlessness, and hyperactivity).
 - Baldwin & Roy (1998) – reported that sexual offenders who were in denial scored lower on intelligence tests than did admitters.
- Hostility – both the emotional and physical factors comprising the construct of hostility may affect treatment outcomes. Emotional hostility (e.g., resentment and suspicion) could interfere with appropriate treatment behaviors (e.g., participation), while physical hostility could lead to discharge from treatment.
 - ✓ Preston (2000) – found that a hostile interpersonal style impacts a sexual offender’s response to sex offender treatment in a group setting.
 - ✓ McKenzie et al. (2002) – reported that hostility and aggressiveness significantly predicted attrition in a high-intensity sexual offender treatment program.
- Personality profile – in addition to hostility (as mentioned above), other attributes of sex offenders’ temperaments and personality types influence the effectiveness of various treatment strategies. Further, personality disorders may predispose certain sex offenders to be more or less amenable to treatment.
 - ✓ Abel (1989) & Moore et al. (1999) – examined the impact of personality disorder on sexual offender treatment outcome in terms of attrition and found that dropouts were more likely to have a personality disorder.
 - ✓ Barbaree et al. (1996) – reported that sex offenders who refused treatment were more likely (21.2% vs. 7.2%) to have a diagnosis of antisocial personality disorder.
 - ✓ Lussier et al. (2001) – investigated whether personality characteristics were related to treatment gain in terms of strategies learned to cope with deviant sexual fantasies and negative emotional states and found the most effective strategies were specific to the sex offender’s usual personality characteristics. Two personality profiles, “dramatic” (greater social skills, inclined to assert self, higher self-esteem) and “anxious” (social skills deficits, difficulty relating to others, lower self-esteem, more negative expectations regarding oneself and one’s behaviors) were examined. Those sex offenders with an “anxious” profile preferred “avoidance” coping strategies, whereas those sex offenders with dramatic profiles reported “approach” strategies as most successful for their personality type.
- Mental health & abuse history – mental health variables and past abuse have the potential to affect a number of factors influencing treatment outcome in sex offenders. Knowing the rate of sexual abuse in the sexual offender population is higher than in the non-sexual-offender population, treatment providers must remain cognizant that a history of sexual abuse may influence the ability of some sexual offenders to successfully participate in some forms of treatment which trigger emotional difficulties stemming from their own victimization issues.
 - ✓ Craissati & Beech (2001) – reported that noncompliance was significantly associated with variables suggestive of psychological difficulties or trauma. Sex offenders who had increased levels of contact with mental health services, two or more childhood disturbances, and a history of sexual victimization were more likely to drop out.
 - ✓ Craissati & McClurg (1997) – reported that one of the strongest predictors of attrition in sex offender treatment was a history of childhood sexual victimization.
- Sex offender type – given the differential treatment outcomes reported among child molesters, incest offenders, exhibitionists, and rapists, it is reasonable to assume that certain responsivity factors play a differential role in treatment outcomes for specific types of sexual offenders.

- ✓ Porter et al. (2000), Serin et al. (2001), Seto & Barbaree (1999) – As one example, much research supports the notion that adult rapists differ from child-only molesters in terms of psychopathy, with the rapists showing higher psychopathy than child molesters. Overall, rapists have similar rates of psychopathy to that found in the general prison population and child molesters actually have a lower rate of psychopathy than that found in general population.

External Responsivity Factors

- Therapist characteristics – Andrews & Bonta (2003) identified a number of staff qualities associated with better treatment outcomes, to include interpersonal sensitivity, awareness of social rules, appropriate modeling of pro-social behavior, and the exhibiting of disapproval for anti-social behaviors (Core Correctional Practices). The work of Andrews & Bonta was applied to sex offenders by Marshall et al (2005). Marshall et al. identified several therapist characteristics as being associated with sex offender treatment outcomes. The following staff qualities were found to be most effective in affecting change in sex offenders:
 - ✓ Empathic
 - ✓ Warm
 - ✓ Rewarding
 - ✓ Directive
 - ✓ Non-confrontational
- Delivery mode/Treatment modality – As the most common form of sex offender treatment, group therapy warrants further consideration:
 - ✓ Group size – research findings have resulted in the recommendation that group size not exceed 8 – 10 offenders per facilitator (and, group size may be even smaller for those sex offenders with special responsivity needs, such as cognitive impairment or social deficits – as discussed in the following point).
 - ✓ Group composition – treatment groups should not mix low and high risk sex offenders, but rather separate groups should be offered based on risk levels.
 - ✓ Group versus individual modalities - While some authors have suggested that group treatment is far more effective than individual delivery for sex offenders (Henggeler, Blaske, & Stein, 1990), other researchers have challenged this belief. These researchers argue that those supporting the superior efficacy of group modalities may confuse cost and time effectiveness with treatment efficacy. Recent studies have found no significant differences relative to the efficacy of group versus individual treatment of sex offenders.
 - Losel & Schmucker (2005) – research found no significant differences in the outcomes resulting from treatment delivered in individual versus group formats.
 - Di Fazio, Abracen, & Looman (2001) – study examined the relative efficacy of group therapy versus individual therapy in treating and subsequently reducing the risk of sexual recidivism among high-risk/high needs sex offenders.
 - The research found no significant difference in the effectiveness of either the full treatment program (including group modality) or the individual treatment program in reducing rates of sexual recidivism. Follow-up periods of 5 years or more found that 14.7% of those in the full treatment program versus 19.4% in the individual treatment program were convicted of a new sexual offense.
 - More detailed consideration of the study is of special interest in examining the responsivity principle. No differences were found between group and individual modalities despite the fact that the intensity of the two treatments provided was dramatically different. Sex offenders in the individual treatment program sample received less total treatment (direct contact hours) than did those in the full/group treatment program. Those sex offenders receiving individual therapy were assigned to that modality due to responsivity considerations, such as psychiatric problems, low functioning, and/or social skills deficits.
- Setting characteristics – Andrews & Bonta (2003) reported that appropriate community treatment is more effective than appropriate institutional treatment for general criminal populations. However, research has produced mixed evidence relative to the effectiveness of institutional vs. community treatment for sex offenders. The inconsistent findings may be related to aftercare. While effective sex offender treatment must incorporate an aftercare component (e.g., follow-up calls/contacts, “booster” sessions, etc.), many institutionally-based programs may focus on short-term treatment gains and offer little to no follow-up. Marshall & Williams (2000) insists there “seems to be no reason to force a choice between settings (prison vs. community)”. They suggested providing the most intensive phase of treatment while the offender is incarcerated, then reinforcing what was learned once he is reintegrated into the larger community.

- ✓ Losel & Schmucker (2005) – research found the context of treatment was relevant for outcome. Although the setting variable revealed no significant difference, there was a strong tendency for relatively larger effects resulting from ambulatory (outpatient) programs than institutions. Mixed settings had an intermediate effect size. A linear order from institutional to outpatient treatment showed a significant correlation.
- ✓ Hanson et al (2002) - found similar effect sizes for institutional and community-based treatment for sex offenders, both were associated with reductions in sexual recidivism.
- ✓ Hall (1995) – found that outpatient settings had a larger effect than inpatient settings.

What should treatment for sex offenders target?

Need principle - As with any type of offender, appropriate interventions for sex offenders must address the enduring characteristics associated with recidivism risk, referred to as “criminogenic needs” or “dynamic risk factors”. More specifically, targeting *stable* dynamic factors in treatment is most effective in reducing long-term risk potential. In contrast, acute factors have demonstrated less predictive value and, therefore, are less effective targets in promoting *enduring* change. Further, since we know that the criminogenic needs of sex offenders are not limited to their sexual behaviors, but these offenders have nonsexual criminogenic needs which are just as relevant, treatment must target both sets of dynamic risk factors. Regardless of whether treatment focuses on sex-specific or general criminogenic needs, the vast majority of program targets, if not all, should be criminogenic. As a general guideline, the ratio of criminogenic to non-criminogenic targets should be *at least* 4 to 1.

Which factors should be targeted for sexual and non-sexual/general re-offending?

- Hanson & Bourgon (2004) – updated review from the 1998 study focused on the dynamic (changeable) risk factors predictive of sexual recidivism and identified a number that are significantly related to sexual recidivism. It is unknown to date whether or not *changes* in these factors are related to reductions in sexual recidivism risk levels. Yet, it is assumed from our current knowledge base that these factors are the most appropriate targets in attempting to change a sex offender’s sexual recidivism risk since they are founded on empirical evidence:
 - ✓ Specific sexual offending/recidivism targets:
 - sexual deviancy
 - sexual preoccupations
 - paraphilic interests
 - sexual interest in children
 - any deviant sexual interest
 - deviant sexual arousal
 - antisocial orientation
 - antisocial personality
 - antisocial traits (i.e., self-regulation problems, impulsivity/recklessness, employment instability, substance abuse, hostility)
 - intimacy deficits (i.e., conflicts in intimate relationships, emotional identification with children)
 - sexual attitudes (i.e., attitude tolerant of sexual crime/assault)
 - ✓ General offending/recidivism targets:
 - antisocial attitudes, values, beliefs, cognitive-emotional states
 - antisocial associations
 - personality/temperamental factors conducive to criminal activity
 - low levels of personal, financial, educational/vocational achievement
 - substance abuse

Which factors should be prioritized for targeting in which offenders?

- The level of attention dedicated to addressing non-sexual/general criminal vs. sexual criminogenic needs depends on the risk level and needs of the individual sex offender as informed by assessment. As with all offender types, painting the sex offender with one brush and providing the same “cookie cutter” intervention programs for all sex offenders is not an economical use of resources.
 - ✓ Non-violent sex offenders - Sexual deviancy factors (identified/listed above) should be the priority/primary targets for treatment interventions delivered to non-violent sexual offenders, “antisocial orientation” factors should be secondary targets, intimacy deficits may be tertiary targets, and attitudes tolerant of sexual assault may also be considered (yet, sexual attitudes should be a low priority/not

emphasized since this set of indicators showed a smaller relationship with sexual recidivism than others).

- ✓ Violent sex offenders - Antisocial orientation factors (identified/listed above) should be the priority/primary targets for treatment interventions delivered to violent sexual offenders, “sexual deviancy” factors should be secondary targets, intimacy deficits may be tertiary targets, and attitudes tolerant of sexual assault may also be considered.

Which factors should ***not*** be targeted for treatment in sex offenders?

- A number of factors which are not predictive of recidivism have been identified. While these factors are “non-criminogenic”, many of them should still be assessed as part of a responsivity assessment battery and addressed/considered (rather than “targeted”) during treatment. The following indicators examined by Hanson & Bourgon (2004) were *not* found to be predictive of recidivism (sexual, violent, or general) in sex offenders and, therefore, should *not* be emphasized for *targeting* by an appropriate intervention:
 - ✓ General psychological maladjustment – anxiety, depression, low self-esteem and psychological dysfunction were all common correlates of sexual offenders, but were not found to be predictive of recidivism. Hanson & Bourgon (2004) suggested these factors may be “triggers”, or even “strategies” used to address “trigger” situations. As such, these factors not only have implications for addressing responsivity, but also provide valuable information for supervision and timing the need for intervention. As “acute” factors, these indicators signal the time period during which the sex offender is most likely to re-offend. For example:
 - Weak social skills and loneliness may lead to feelings of inadequacy and rejection, which leads to emotional identification with children when lonely and unable to share intimacy with adults.
 - Anxiety and depression – sex offenders who are stressed and anxious may respond to these emotional states with sexual acts and fantasies.
 - ✓ Clinical presentation variables – clinical presentation variables had little or no relationship with sexual or non-sexual recidivism in sex offenders. This includes:
 - Denial – Denial appears to be of little relevance in treating sex offenders. While it is commonly one of the first targets that many sex offender treatment programs work toward, there is essentially no evidence that offenders who admit their crime will respond more positively than offenders who are in denial. In Hanson & Bussiere’s (1998) meta-analysis, neither denial of the offense nor verbal statements of treatment motivation were found to predict sexual offense recidivism over the long term. This finding appears to be fairly robust.
 - Low motivation for treatment
 - Lack of victim empathy
 - ✓ Sexual attitudes – while one indicator of the “sexual attitudes” category was predictive of sexual recidivism (i.e., attitudes tolerant of sexual crime/assault), all other indicators organized in the category were not found to be predictive, making them inappropriate treatment targets:
 - child molester attitudes
 - other deviant sexual attitudes
 - low sex knowledge

What is the appropriate treatment dosage for sex offenders?

Duration: How long should treatment last?

- Meet recommended guidelines
 - ✓ With general criminal populations, evidence has suggested that programs last between 3 to 9 months, and not exceed 12 months for the vast majority of offender participants. The recommendation to limit the duration of treatment is based on the finding that programs which last longer than 9 months generally have diminishing returns (effect becomes less and less apparent/significant). Sex offenders are, however, a notable exception to these “duration” guidelines. Sex offender treatment is, typically, expected to last longer than 9 months due to the “relapsing nature” of the behavior.
 - The Evidence Based Correctional Program Checklist (CPC) requires that sex offender treatment provide services for *at least* 12 months or the program does not receive credit for offering the appropriate length of treatment. Further, the instrument notes there is no “upper end” for sex offender treatment (unlike the 12 month limit for the general population).
 - Aytes et al. (2001) – found the observed effects of sexual offender treatment were particularly strong for offenders who remained in treatment for one year or more.

- Provide aftercare
 - ✓ It should be noted that the above guidelines for treatment length (i.e., 12 months or more) do not include time spent in aftercare or receiving “booster” sessions. Aftercare should be provided *in addition to* the sex offender’s time spent in the core treatment phase.

- Individualize length of service
 - ✓ The *duration* of each sex offender’s treatment should be determined by his risk/need profile. Higher risk offenders should receive services for a longer duration. The general rehabilitation literature has provided the following guidelines for total dosage:
 - standard 100 hours can be effective for offenders with moderate risk and few needs
 - minimum of 200 hours required for offenders with *either* high risk *or* multiple needs
 - *in excess of* 300 hours required for offenders with high risk *and* multiple needs
 - ✓ Successful completion should be driven by progress in meeting specific behavioral objectives (acquiring pro-social behaviors, attitudes, and beliefs, decreases in level of sexual deviancy, etc.) rather than based on the sex offender’s time spent in the program. Ideally, completion decision-making related to program termination should be informed by assessment instruments which measure the sex offender’s progress in the risk/need areas identified in his individualized treatment plan.

- Promote treatment completion
 - ✓ The research reported earlier which found higher recidivism among treatment dropouts than in those sex offenders who completed treatment successfully (Losel & Schmucker, 2005 & Hanson & Bussiere, 1998), and than those who did not participate in treatment (Hanson et al., 2002), suggests that remaining in treatment is absolutely crucial to achieving lasting behavioral change in sex offenders.
 - ✓ Therefore, it is important for treatment providers to identify and proactively address the responsivity needs of potential treatment failures.
 - ✓ Researchers have demonstrated the value of actuarial risk prediction tools (Strassberg & Reynolds, 2005) in predicting treatment completion (i.e., MnSOST-R). This finding has important clinical implications. For example, those identified early as most at risk to fail to complete treatment might be allotted additional, more intensive treatment (e.g., more hours of individual therapy, more sessions, more homework assignments, more opportunities for practice, more supervision, etc.) to increase their chances for success. Alternatively, program resources might be disproportionately allotted among the high-risk sex offender population to those at least risk for program failure.

Intensity: How intensive should treatment be?

- Meet recommended guidelines – One of the well-established principles of effective intervention is “to provide intensive services”. More specifically, the standard guideline suggests that offenders spend at least 40-70% (35 to 50 hours/week) of their time involved in therapeutic activities while participating in a treatment program.

- Follow the risk principle - In accordance with the risk principle, the intensity of offender intervention should match the risk level of the offender. This principle should be applied to sex offenders just as it is to general criminal populations.
 - ✓ High risk sex offenders should receive the most intensive interventions and low risk sex offenders should receive the least intensive interventions (if any).
 - ✓ Mailloux et al (2003) – compared sex offenders who attended treatment programs with demonstrated efficacy, yet different program intensity levels (high, medium, low). This work demonstrated the applicability of findings from the general rehabilitation literature with reference to treatment intensity by offender risk level to the sex offender population. Mailloux et al suggested that “certain groups of sexual offenders may require more than one sex offender treatment program whereas others may be receiving too many programs relative to their risk level”.

- Use professional discretion – In accordance with the professional discretion principle, professional discretion must be exercised when determining the appropriate level of treatment intensity for a particular sex offender. For example, a lower-risk offender near sentence expiration who repeatedly discusses his plans to re-offend may require high intensity treatment, and a moderate-risk sex offender may receive high-intensity treatment service if no other treatment is available. These types of discretionary “overrides” should be limited to the extent possible and should remain cognizant of other factors/unintended consequences which could negatively influence outcomes (e.g., mixing risk levels).

- Deliver as “compactly” as possible - It is preferable to offer a given dosage over a shorter, rather than longer period of time (i.e., make the service more intensive) since services which are “spread out” may lose their impact by failing to hold the sex offenders’ interest and being too “watered down”. An intensive program may make a larger impression on the offender by seeming to be a bigger part of his life while in the program. For example, if a sex offender spends 20 hrs/wk in a program for 3 weeks (dosage = 60 hrs), the program will be on his “radar”, while a program which occupies only 2 hrs/wk over 30 weeks (also dosage of 60 hrs) may get “lost in the shuffle” of his life.

What treatment methods should be used with sex offenders?

Cognitive-behavioral treatments have been widely supported in the general rehabilitation literature, and touted as the most promising throughout the sex offender research to date. Hormonal, behavioral, and relapse prevention models *may* be promising when cognitive-behavioral treatment is delivered concurrently.

- Losel & Schmucker (2005) – found through regression analysis that only three modes of treatment had a significant impact on sexual recidivism in sex offenders, including: hormonal, cognitive-behavioral, and behavioral approaches. After controlling for methodological limitations and study characteristics, the cognitive-behavioral orientation showed an independent treatment effect.
- Latessa et al (2005) – The “Evidence Based Correctional Program Checklist (CPC) Scoring Guide”, developed by the Center for Criminal Justice Research, University of Cincinnati to guide correctional program assessment efforts, requires that a sex offender treatment program deliver “cognitive-behavioral interventions and/or hormonal treatment” to receive credit for its treatment approach.
- Gallagher et al (1999) – found that cognitive-behavioral and surgical castration (not chemical castration) treatment groups had significantly lower sexual reoffense rates than comparison groups. Other methods did not produce statistically significant effects.
- Hall (1995) – research found that cognitive-behavioral and hormonal treatments observed larger effect sizes than other sex offender treatments.

What Works?

Cognitive-Behavioral

Cognitive-behavioral techniques examine a sex offender’s thought content and processes and teach skill-building strategies necessary to control deviant behavior. Treatment attempts to alter behavior by teaching sex offenders such skills as self-reinforcement, “internal dialogue” monitoring, modeling, and cognitive restructuring.

Effectiveness of Approach

The findings summarized below on the effectiveness of cognitive-behavioral approaches for sex offender treatment are consistent with the general rehabilitation literature, which supports the use of cognitive-behavioral interventions in successfully addressing recidivism.

- Losel & Schmucker (2005) – research found that among psychosocial interventions, cognitive-behavioral programs revealed the most robust effect (based on 35 independent comparisons).
- Hanson et al (2002) found that cognitive-behavioral treatment is associated with reductions in sexual recidivism rates from 17% to 10% after 5 years of follow-up.
- Gallagher et al (1999) – found strong evidence that cognitive-behavioral approaches lead to reductions in future offending of sex offenders relative to other methods of treatment.
- Polizzi et al. (1999) – found that of the six studies that showed a positive treatment effect in their analysis of sex offender treatment outcomes, four incorporated a cognitive-behavioral approach.

What’s Promising?

Hormonal Agents

Since the primary target for sex offender treatment has historically been to reduce sexual arousal levels, two physiological methods have commonly been used to treat sex offenders:

- *Surgical castration – removal of the testes, where approximately 95% of testosterone is produced, to reduce the availability of androgen and, therefore, reduce levels of sexual arousal (not permitted in United States).*
- *Chemical castration/hormonal medication – periodic injection of different dosages of a hormonal drug, or anti-androgen, to lower the physiological drive of sex offenders (e.g., medroxy-progesterone acetate, such as Depo Provera, in U.S. and cyproterone acetate, such as Androcur, in Europe).*

Effectiveness of Approach

- Losel & Schmucker (2005) – research found that physical/organic treatments (e.g., surgical castration and hormonal medication) showed much larger effects than non-physical (psychosocial) interventions. The main source for this difference was a very strong effect of surgical castration, and the strength of this effect must be considered in the context of some methodological limitations.
 - ✓ Surgical castration – Very large effects of surgical castration were well replicated in the study. Yet, none of the castration studies were of methodological rigor (i.e., level 3 on the Maryland Scale). Equivalence could not be assumed between the treatment and comparison groups. Sex offenders who received surgical castration voluntarily applied for the intervention, so were highly selected and motivated.
 - ✓ Chemical castration – Effects of hormonal treatments showed relatively good outcomes, also producing larger effects than any of the non-physical (psychosocial) methods. Yet, similar to the ethical, legal, and medical limitations of castration, the use of hormonal medication poses a number of issues which must be taken into account when considering the usage and outcomes of this approach.
 - Most sex offenders do not have abnormally high levels of male sex hormones. Therefore, treatments do not normalize extreme testosterone levels, but typically serve to strongly reduce normal levels of sexual arousal.
 - There are serious negative side effects associated with hormonal medication which frequently lead to noncompliance and dropout (a significant risk predictor). Termination of medication, therefore, may rapidly increase the risk of recidivism.
- Gallagher et al (1999) – research concluded that the current evidence was not sufficient to support the effectiveness of hormonal treatment of sex offenders.
 - ✓ Surgical castration – *only one* evaluation of castration (in Germany) qualified for inclusion in Gallagher’s study. While the comparison group (i.e., applied for surgery, but denied or withdrew) had a high rate of failure (46% recidivism over 11 year follow-up), the castrated group demonstrated remarkable success, with almost no post-surgery sexual offense recidivism reported.
 - ✓ Chemical castration – examined four studies which evaluated the treatment outcomes of hormonal injections and found that three studies produced positive effects, yet they were non-significant. The author concluded that “the current level of evidence does not allow for claims of effectiveness of the hormonal treatments of sex offenders.”

Behavioral

Behavioral therapies, based on the principles of conditioned learning, attempt to either reduce deviant sexual arousal by linking the targeted behavior (i.e., sexual deviance) with a negative physiological stimulus, or to increase the offender’s arousal to more appropriate sexual behaviors. Three behavioral methods include:

- Aversion therapy – administration of a highly aversive stimulus (e.g., noxious odor, electric shock) in conjunction with the inappropriate behavior (i.e., stimuli depicting sexually deviant acts).
- Covert sensitization – pairs unpleasant stimulus with deviant sexual fantasies rather than actual behaviors.
- Satiation – inappropriate response is eliminated by repeatedly eliciting it until the desire for the stimulus is abolished.

Effectiveness of Approach

- Gallagher et al (1999) – found that strictly behavioral approaches resulted in positive, though not statistically significant, effects with sizes ranging from .45 to .61. The magnitude of the observed reductions in recidivism for the strictly behavioral studies was comparable to that of the cognitive-behavioral approach. Yet, the two studies examined were conducted by the same researchers on the same program setting. Therefore, the author concluded that the “positive, albeit non-significant, findings must be confirmed by other researchers applying the same therapeutic methods to new groups of sex offenders.”
- Losel & Schmucker (2005) – research found that classic behavior therapy (7 independent comparisons) had a significantly positive effect while non-behavioral treatments did not demonstrate a significant impact.

Relapse Prevention

The sex offender research literature has also explored the use of relapse prevention approaches, which promote the use of cognitive-behavioral and social learning strategies. The strong influence of these strategies on relapse prevention methods is clear when examining the typical components of relapse programs:

- ✓ Recognizing relapse warning signs – physiological symptoms, thought processes/patterns, etc.
- ✓ Identifying “triggers” - high-risk situations, settings, individuals

- ✓ Developing cognitive and behavioral strategies for successfully avoiding high-risk situations and/or dealing with them in a non-deviant, pro-social fashion – coping skills to “derail the chain of events leading to sexual re-offending”.

Effectiveness of Approach

- ✓ Gallagher et al. (1999) – meta-analysis evaluated programs employing a relapse prevention method of sex offender treatment and found that 10 effect sizes of relapse prevention programs produced a mean effect size of 0.43 (half were statistically significant). Gallagher concluded, consistent with Hall (1995) and others, that “there is strong evidence that cognitive-behavioral techniques with relapse prevention components are effective in reducing the post-treatment recidivism among sexual offenders.” Important to note, however, is Gallagher’s finding that cognitive-behavioral treatments without a relapse prevention component produced statistically significant effect sizes comparable to those cognitive-behavioral treatments which incorporated relapse prevention.

What Doesn’t Work?

- Losel & Schmucker (2005) – research found that cognitive-behavioral and classic behavioral treatments were the only psycho-social approaches which had a significant impact on sexual recidivism. All other approaches (as identified below) did not reveal a significant treatment effect with sex offenders.
 - ✓ insight-oriented treatments
 - ✓ therapeutic communities
 - ✓ other psychosocial, “unclear” therapies
 - ✓ non-behavioral programs
- Gallagher et al (1999) – research identified a number of treatment methods which produced either negative or near zero results:
 - ✓ augmented behavioral approaches (incorporating other forms of treatment, such as sex education and psychotherapeutic techniques)
 - ✓ chemical castration
 - ✓ generalized psycho-social treatment
- Latessa et al (2005) – The “Evidence Based Correctional Program Checklist (CPC) Scoring Guide” notes the following approaches are ineffective in reducing recidivism:
 - ✓ non-directive
 - ✓ client-centered
 - ✓ psychoanalytic
 - ✓ group milieu
 - ✓ talking cures
 - ✓ bibliotherapy
 - ✓ lecture
 - ✓ acupuncture
 - ✓ medical model
 - ✓ self-discovery
 - ✓ self-help
 - ✓ “punishing smarter”

What additional factors influence effective, quality service delivery for sex offenders?

Several program characteristics found to promote effective service delivery with general criminal populations (and measured by the CPC) are also appropriate considerations for the successful treatment of sex offenders. As such, these program characteristics provide additional recommendations for effective service delivery with sex offenders, to include:

- Implementation & Monitoring – consistent with research findings from program evaluations for general criminal populations, Losel & Schmucker (2005) found that programs for sex offenders which were more thoroughly implemented and monitored had larger effect sizes. A few of the program characteristics which influence successful program implementation and service delivery include:
 - ✓ Literature review – comprehensive review of all major criminological, psychological, sociological, etc. journals should be conducted in designing, developing, and revising program components.

- ✓ Pilot test – original program, as well as any modifications, should be pilot-tested for a period of at least one month prior to formal implementation.
- ✓ Treatment manual – program manuals should be developed and referenced throughout service provision to ensure services are being delivered as designed.
- Program Leadership & Staff Qualifications – program director should be qualified with an appropriate/relevant degree, experienced with sex offenders, and involved in the program through direct service, trainings, and clinical supervision. Similarly, program staff should be qualified with appropriate/relevant degrees and experienced with sex offenders. Staff should attend regular clinical meetings, provide input into the program, receive sufficient training, and adhere to ethical guidelines.
- Program Support – program goals, values, and mission should be supported by other criminal justice stakeholders, the community at-large, the parent agency (e.g., institution, private/corporate affiliate, etc.), and all staff (treatment and custodial).
- Quality Assurance – both internal and external audit/evaluation mechanisms should exist to regularly monitor the quality of services being delivered and formally evaluate program outcomes. These efforts should include providing clinical supervision, conducting file reviews, soliciting staff input, re-assessing offenders, soliciting feedback from program participants, collecting follow-up data, and working with consultants/external evaluators to conduct formal program evaluations.

How do other states treat their sex offender populations?

A survey conducted and summarized by the Colorado DOC, “Trends in State Sex Offender Treatment Programs” (2000) provides information collected from 50 states on the provision of treatment services to sex offenders (Appendix D):

- 39 states had formal sex offender treatment programs in their institutions
- all states reported using a cognitive-behavioral model, with a focus on relapse prevention
- almost 50% of states offer more intensive treatment in a therapeutic community setting
- 30 states had waiting lists for program entry
- program capacity ranged from 70 (Vermont) to 1,200 (Pennsylvania)
- vast majority of states offer one year or more of sex offender treatment
- 12 states require treatment for some types of sex offenders

Are there proven-effective program models?

Since sex offender program research requires analysis of sexual re-offending over relatively long follow-up periods, evaluation results typically provide information about programs which no longer represent the current “state of the art”. In addition, the outcomes of treatment often decline when model projects are transformed into routine practice (Losel, 2001). Yet, a number of programs have demonstrated positive results when evaluated for their effectiveness in reducing recidivism rates in sex offenders. Clearly, these programs may provide guidance in designing effective interventions for this population. A few “model” program examples follow:

- *Regional Treatment Centre Sexual Offender Treatment Program (RTCSOTP)*
Looman, Abracen, and Nicholaichuk (2000) reported on a follow-up study of this program and found that 23.6% of offenders in the treated group were convicted of a new sexual offense, whereas 51.7% of offenders in the comparison group recidivated sexually (treatment effect of .54). When considering Barbaree’s suggestions relative to the range of treatment effects for offenders in institutional programs (.50), RTCSOTP would be considered a particularly successful program.
- *Clearwater Sexual Offender Treatment Program*
Nicholaichuk, Gordon, Gu, and Wong (2000) conducted a study at the Regional Psychiatric Centre which followed 296 treated offenders and 283 untreated offenders (comparison group) for an average of 6 years. They found a sexual recidivism rate of 14.5% for the treated men and 33.2% for the untreated men.
- *The Phoenix Program*
Aylwin, Clelland, Kirkby, Reddon, Studer & Johnston, 2000; Alwin et. al., in press; Clelland et. al., 1998; Studer et. al., 1996; Studer & Reddon, 1998; Studer et. al., 2000; Studer et. al., in press) have recognized this program as one of the most effective sex offender treatment programs. The Phoenix Program has reported sexual recidivism rates as low as 3.3% for 120 treatment completing offenders, over an average follow up period of 38.8 months.

References

- Andrews, D. & Bonta, J. (2003). *The Psychology of Criminal Conduct*. Cincinnati: Anderson Publishing Co.
- Austin, J., Peyton, J., & Johnson, K. (2003). "Reliability and Validity Study of the Static-99/RRASOR Sex Offender Risk Assessment Instruments", Washington, D.C: The Institute on Crime, Justice and Corrections, George Washington University.
- Abracen, J. & Looman, J. "Issues in the Treatment of Sexual Offenders: Recent Developments and Directions for Future Research", *Aggression and Violent Behavior*, 9 (3), 229 – 246.
- Barbaree, H., Seto, M., Langton, C., & Peacock, E. (2001). "Evaluating the Predictive Accuracy of Six Risk Assessment Instruments for Adult Sex Offenders", *Criminal Justice and Behavior*, 28 (4), 490 – 521.
- Bartosh, D., Garby, T., Lewis, D., & Gray, S. (2003). "Differences in the Predictive Validity of Actuarial Risk Assessments in Relation to Sex Offender Type", *International Journal of Offender Therapy and Comparative Criminology*, 47 (4), 422 – 438.
- Catalano, S. (2005). "Criminal Victimization, 2004", National Crime Victimization Survey, Washington: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
- Center for Sex Offender Management, "Training Curricula", Office of Justice Programs, U.S. Department of Justice retrieved August 29, 2005 from www.csom.org.
- Crime in Pennsylvania: Annual Uniform Crime Report, Pennsylvania State Police retrieved August 30, 2005 from www.psp.state.pa.us.
- Criminal Offender Statistics, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics retrieved August 29, 2005 from <http://www.ojp.usdoj.gov/bjs/crimoff.htm>.
- Di Fazio, R., Abracen, J. & Looman, J. (2001). "Group versus Individual Treatment of Sex Offenders: A Comparison". CSC Forum Research In Brief, 13 (1).
- Federal Bureau of Investigation (2004). "Uniform Crime Reports: Crime in the United States", retrieved August 30, 2005 from www.fbi.gov.
- Flaherty, R. (2004). "Recidivism in Pennsylvania State Correctional Institutions, 1996-2002", Camp Hill: Pennsylvania Department of Corrections.
- Gallagher, C., Wilson, D., Hirschfield, M., Coggeshall, M. & MacKenzie, D. (1999). "A Quantitative Review of the Effects of Sex Offender Treatment on Sexual Reoffending", *Corrections Management Quarterly*, 3 (4), 19 – 29.
- Gasswint, B. (2005). "Number of Sex Offenders Admitted to & Released from the PA DOC in 2004", Camp Hill: Pennsylvania Department of Corrections.
- Gordon, A. & Nicholaichuk, T. (1996). "Applying the Risk Principle to Sex Offender Treatment", *Forum*, 8 (2).
- Hanson, R., K. Morton, A. Harris (2003). "Understanding and Managing Sexually Coercive Behavior", *Annals of the New York Academy of Sciences*. (Thornton presentation, 2003)
- Hanson, R. & Bussiere, M. (1998). "Predicting Relapse: A Meta-Analysis of Sexual Offender Recidivism Studies", *Journal of Counseling and Clinical Psychology*, 66 (2), 348 – 362.
- Harris, A. & Hanson, R. (2004). "Sex Offender Recidivism: A Simple Question", retrieved August 2005 from <http://www.psepc-sppcc.gc.ca>.
- Hanson, R. & Harris, A. (2000) "Where Should We Intervene?: Dynamic Predictors of Sexual Offense Recidivism", *Criminal Justice & Behavior*, 27 (1), 6 – 35.

- Hanson, R. & Harris, A. (2000). *"The Sex Offender Need Assessment Rating (SONAR): A Method for Measuring Change in Risk Levels*, Ottawa: Department of Solicitor General of Canada.
- Hanson, R. (2005). *"The Validity of Static-99 with Older Sexual Offenders"*, Ottawa: Department of Solicitor General of Canada.
- Hanson, R. (2000). *"Risk Assessment": First in a series of ATSA Informational Packages*, Beaverton: Association for the Treatment of Sexual Abusers.
- Hanson & Morton-Bourgon, K. (2004). *"Predictors of Sexual Recidivism: An Updated Meta-Analysis"* retrieved August 2005 from <http://www.psepc-sppcc.gc.ca>.
- Hanson, R. Morton, K. & Harris, A. (2003). *"Sexual Offender Recidivism Risk: What We Know and What We Need to Know"*, *Annals of the New York Academy of Sciences* 989 (1), 154 – 166.
- Hanson, R. Gordon, A., Harris, J., Murphy, W., Quinsey, V. & Seto, M. (2002). *"First Report of the Collaborative Outcome Data Project on the Effectiveness of Psychological Treatment for Sex Offenders"*, *Sexual Abuse: A Journal of Research and Treatment*, 14 (2), 169 – 194.
- Hartman, M. (2004). *"2003 Annual Statistical Report"*, Camp Hill: Pennsylvania Department of Corrections.
- Langan, P. & Levin, D. (2002). *"Recidivism of Prisoners Released in 1994"*, Washington, D.C: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice.
- Langan, P., Schmitt, E. & Durose, M. (2003). *"Recidivism of Sex Offenders Released from Prison in 1994"*, Washington, D.C:U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
- Looman, J., Dickie, I. & Abracen, J. (2005). *"Responsivity Issues in the Treatment of Sexual Offenders"*, *Trauma, Violence, & Abuse*, 6 (4), 330-353.
- Losel, F. & Schmucker, M. (2005). *"The Effectiveness of Treatment for Sexual Offenders: A Comprehensive Meta-Analysis"*, *Journal of Experimental Criminology*, 1, 117 – 146.
- Mailloux, D., Abracen, J., Serin, R., Cousineau, C., Malcolm, B. & Looman, J. (2003). *"Dosage of Treatment to Sexual Offenders: Are We Overprescribing?"* *International Journal of Offender Therapy and Comparative Criminology*, 47 (2), 171 – 184.
- Marques, J. (1999). *"How to Answer the Question, "Does Sex Offender Treatment Work?"*, *Journal of Interpersonal Violence*, 14 (4), 437 – 451.
- Marshall, W. & Williams, S. (2000). *"The Assessment and Treatment of Sexual Offenders"*, *Compendium 2000 on Effective Correctional Programming*, 135 – 146.
- Medoff, D. (2004). *"Developmental Considerations in the Forensic Assessment of Adolescent Sexual Offenders: Victim Selection, Intervention, and Offender Recidivism Rates"*, *The Forensic Examiner*, 26 - 30.
- Nicholaichuk, T. (1996). *"Sex Offender Treatment Priority: An Illustration of the Risk/Need Principle"*, *Forum*, 8 (2), 30-32.
- Pallone, N. (2003). *"Without Plea Bargaining, Megan Kanka Would Be Alive Today"*, *Criminology and Public Policy*, 3 (1), 83-96.
- Polizzi, D., MacKenzie, D. & Hickman, L. (1999). *"What Works in Adult Sex Offender Treatment? A Review of Prison- and Non-Prison-Based Treatment Programs"*, *International Journal of Offender Therapy and Comparative Criminology*, 43 (3), 357-374.

Sample, L. & Bray, T. "Are Sex Offenders Dangerous?", *Criminology and Public Policy*, 3 (1), 59-82.

Strassberg, D. & Reynolds, S. (2005). "A Recidivism Risk Measure as a Predictor of Sex Offender Treatment Completion". *Journal of Sexual Offender Civil Commitment: Science and the Law*, 1, 11-16.

Terry, K. & Tallon, J. (2002). "Child Sexual Abuse: A Review of the Literature", retrieved September 2005 at <http://www.usccb.org/nrb/johnjaystudy/litreview.pdf>.

Van Voorhis, P., Braswell, M. & Lester, D. (2004). Correctional Counseling & Rehabilitation, 5th Edition. Cincinnati: Anderson Publishing Co.

Wright, R. (2003). "Sex Offender Registration and Notification: Public Attention, Political Emphasis, and Fear", *Criminology and Public Policy*, 3 (1), 97-104.