

# **SEX OFFENDER TREATMENT PROGRAMS**

**JOHN HOWARD SOCIETY OF ALBERTA  
2002**

## EXECUTIVE SUMMARY

Although the number of convicted sex offenders grew from 2,768 in 1990 to 3,875 in 1995, the rate of reported sexual offences generally declined in recent years. In 1997, the rate of reported sexual offences was 101 per 100,000 people, a massive decline from a high of 135 per 100,000 people in 1993. Furthermore, there is an increasing amount of research that supports the idea that sex offenders can be treated successfully to allow them to lead crime free lives upon release. For example, one recent meta-analysis found that, across several studies, 19% of treated sex offenders and 27% of untreated sex offenders sexually recidivated. Given research such as this and the experience of the John Howard Society in working with sex offenders, the rest of this paper rests on the presumption that sex offenders are treatable and treatment programs do work. The question is: How can sex offenders be treated most effectively?

Overall, research has found that sexual recidivism for all sex offenders is quite low, with rates of only 10% to 15% five years after release. Also, research has found that sex offenders can be categorized into three groups that have different recidivism rates and, thereby, require different treatments. These groups are incest child molesters who victimize related children, rapists who victimize adult women and non-incest child molesters who victimize unrelated children.

Incest child molesters were found to sexually recidivate at the lowest rate at 8.4%. Since this rate was so low, it has traditionally been believed that, comparatively, incest child molesters require minimally intrusive forms of therapy. An example of such a minimally intrusive program is the Violence Interdite Sur Autrui (VISA) Program delivered by the Correctional Service of Canada, that encourages incest child molesters to take six steps that reduce recidivism. The 14 week program consists of 28 psychotherapy group meetings, 13 sex education work shops and 10 individual interviews. VISA has shown great success in reducing recidivism and, as of 1996, only two of over 130 of its participants were reconvicted for a further sexual offence.

However, recent research has challenged traditional thinking about incest child molesters, by taking into account offenders' self reported sex offences that did not result in a conviction. It turns out that many offenders labelled first time incest child molesters, actually had prior incestuous and/or non-incestuous victims, and the offences performed on those victims never resulted in a conviction. When these sex offences are considered, sexual recidivism rates jumped up to 22% for the incest child molesters, a rate nearly three times the original rate of 8.4% that has been found.

Furthermore, the fact that some offenders labelled incest child molesters actually had non-incestuous victims and the offences performed on those victims did not result in conviction brings into question the practice of categorizing sex offenders according to their first convictions. This practice is brought further into question when erotic preferences are examined. In a study that attempted to find a difference in the erotic preferences of incest and non-incest child molesters, a majority of offenders were indistinguishable as either type of offender according to their erotic preference.

Next to the incest child molesters, rapists were second most likely to sexually recidivate at a rate of 17.1%. What is interesting is that most research has found that rapists are a distinct group of offenders who are distinguishable from child molesters. In particular, rapists tend to be younger than

child molesters, having average ages of 32 and 38, respectively, in one study. Also, rapists are more likely to recidivate non-sexually than are child molesters. In terms of treatment, research suggests that adequate treatment would need to address general crime issues as well as sexual crime issues, to ensure that rapists do not reoffend. Additionally, Cognitive Skills Training and behavioural conditioning that reduces deviant sexual behaviour are two treatment methods for rapists that are supported by the research.

Of the three groups of sexual offenders outlined above, non-incest child molesters were found to sexually recidivate at the highest rate at 19.5%. Moreover, long term follow up of these offenders has shown that they are at risk of reoffending throughout their lives. One long term follow up study found that 42% of the total sample was reconvicted for a sexual and/or violent offence, and 10% of the total sample was reconvicted between 10 and 31 years after release. Among the non-incest child molesters, the highest rate of recidivism was found for offenders who had prior sexual offence convictions, victimized boys and were never married.

Academic research suggests that long term, intensive treatment is essential for the treatment of non-incest child molesters. Again, behavioural conditioning and Cognitive Skills Training are suggested by much of the research, to be incorporated in treatment because of their proven success in treating all types of sex offenders. Finally, relapse prevention and long term follow up are recommended to be part of any sex offender treatment program, because of their ability to enhance sex offender treatment efforts.

Examples of the practical application of sex offender treatment can be observed by examining two local sex offender treatment programs operating in Alberta. First, the Phoenix Program provides treatment for adult male sex offenders through an intensive 32-35 hours per week of therapy. Major forms of treatment include: psychotherapy, victim empathy, cognitive restructuring, anger management, relapse prevention, life planning, goal attainment and more. The Phoenix Program staff believe that successful results are produced from an interaction of the program environment, staff, individual offender issues and the entire range of treatments offered by the program. This comprehensive approach takes into consideration a wide array of issues pertaining to sex offender treatment, and has proven to be very successful with low recidivism rates for offenders treated by the program.

A similar local program that operates under the same comprehensive approach as the Phoenix Program is an adolescent sex offender program called Counterpoint House. Although the majority of the Counterpoint House participants' day is occupied by school, work, chores and other activities, Counterpoint House does manage to provide a multitude of therapy programs. Essentially, therapy offered at Counterpoint House is divided into three main groups: a cognitive/behavioural group, a psychotherapy group and a skills therapy group.

The cognitive/behavioural group focusses on dealing with offence patterns, and is based on the premise that sexual offending behaviour is fantasy driven. Offenders are required to keep a fantasy log that details the amount and content of their sexual fantasies, so that deviant fantasies can be identified and dealt with appropriately. The psychotherapy group is based on the assumption that sex offenders lead secretive lives, and are often the victims of sexual abuse themselves. The theme

of this spontaneous, non-agenda driven group is “getting the secrets out,” and offenders are encouraged to discuss their sexual offending issues openly. Finally, the skills therapy group is separated into three eight week sessions that provide sex education, relapse prevention and anger management therapy for participants.

There are several steps that can be taken to improve the success of sex offender treatment programs, such as proper categorization of sex offenders and specialized treatment programs for each category. What remains clear is that sex offender treatment does work, and can be carried out successfully. Therefore, the John Howard Society of Alberta believes that such treatment programs should be offered routinely, as an effective, just and humane response to the causes and consequences of crime.

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## INTRODUCTION

Over the years, public fear of sex offenders has led to serious misconceptions regarding sex offender treatment. The atrocious acts carried out by some sex offenders are very hard for the public to understand, and present society with complex challenges. Society often finds it easier to turn a blind eye to the crime, lock up the offender and throw away the key than attempt to address the challenge appropriately. This lack of public understanding toward sex offenders has created the myth that sex offenders cannot be treated, and therefore should never be returned to the community. This paper is intended to dispel the myth of the untreatable sex offender, and provide conclusive evidence that sex offender treatment is not only possible but to a large extent is successful in reducing the recidivism of sex offenders. First, the sex offender population in Canada must be examined so that we know what we are dealing with.

## SEX OFFENDERS

In 1995, Correctional Service of Canada examined its sex offender population and found some interesting results (Motiuk & Belcourt, 1996). Virtually all federally sentenced sex offenders were male (99.7%), and a majority were Caucasian (74.8%). The average age of a sex offender upon admission to a federal corrections facility was age 38, with the oldest sex offender being age 83, and the youngest being age 15. However, a more disturbing finding was that the sex offender population was growing at that time. Between 1990 and 1995, the federal sex offender population grew 40% from 2,768 offenders to 3,875.

Although the number of convicted sex offenders was growing at that time, the rate of reported sexual offences has been declining since 1993 (Canadian Centre for Justice Statistics (CCJS), 1999). The CCJS has recognized that, since reformed sexual assault legislation was introduced in 1983, there had been a steady increase in the rate of reported sexual offences, until 1993 when the rate peaked at 135 incidents per 100,000 people. Then, from 1993 to 1996, there was a steady decline in the rate of reported sexual offences. Finally, in 1997 (the last year of the study that CCJS examined the rate of reported sexual offences), the rate was 101 incidents per 100,000 people, a rate that had remained relatively unchanged from 1996. Also, between 1996 and 1997, Alberta's rate of reported sexual offences declined (CCJS, 1999), and it had the fourth lowest rate of reported sexual offences in Canada, at 117 per 100,000 people. The three lowest rates of reported sexual offences in Canada belonged to Quebec (58 per 100,000), Ontario (89 per 100,000) and Prince Edward Island (113 per 100,000). The three highest rates were found in the North West Territories (947 per 100,000), the Yukon Territory (421 per 100,000) and Saskatchewan (183 per 100,000).

In 1997, the Prairie Region had the highest proportion of sex offenders in its federal correctional facilities compared to any other region in Canada. The Prairie Region held 29% of all federally sentenced sex offenders, while the Ontario Region incarcerated 25.9%, the Quebec Region incarcerated 17.8%, the Pacific Region incarcerated 15.1% and the Atlantic Region incarcerated 11.6%.

## SEX OFFENDER TREATMENT

Although many community members believe that sex offenders cannot be treated, an increasing amount of support has been collected that attests to the success that can be achieved by treating sex offenders. In fact, Correctional Service of Canada has continually been implementing more sex offender treatment programs since it began offering sex offender treatment in 1973. Capacity for sex offender treatment increased from 200 in 1987 to over 1700 in 1995 (Blanchette, 1996). In addition, Correctional Service of Canada has recently “expanded and refined its programs for sexual offenders so that it now funds numerous institutional programs” (Marshall, 2000). The massive implementation of sex offender treatment programs by Correctional Service of Canada has put Canada at the forefront of research and knowledge about sex offender treatment, and many of the Canadian sex offender treatment programs illustrate promising results. Therefore, many offenders are able to receive adequate treatment that allows them to lead crime free lives upon release.

The success of sex offender treatment is evident when recidivism rates among treated sex offenders are compared to untreated sex offenders. For example, in one meta-analysis of treatment studies, Hall (1995) found that across several studies, treated offenders sexually recidivated at a rate of 19%, whereas untreated offenders sexually recidivated at a rate of 27% (as cited in Blanchette, 1996). This suggests that, overall, the treatment provided was able to produce an 8% reduction in the recurrence of sexual recidivism for treated sex offenders. This is a very promising result when it is considered that sex offenders often victimize more than one person, and there are usually multiple victims before an offender is caught. Therefore, even a small reduction in recidivism for sex offenders translates into a large reduction in the amount of sexual offences that occur (Blanchette, 1996). Given research such as this and the experience of the John Howard Society in working with sex offenders, the rest of this paper rests on the presumption that sex offenders are treatable and treatment programs do work. Therefore, it is important to determine what specific kinds of treatment methods work best for which sex offenders, so that they may all be treated effectively.

In order to lay the foundation for an examination of sex offender treatment, it is essential to review the academic research that has recently emerged about sex offender treatment. In most research studies, the term “sex offender” encompasses a wide range of offenders who have different treatment needs and different recidivism rates. The two most common types of sex offenders referred to in the research are child molesters who mainly victimize children, and rapists who mainly victimize adult women. Both sex offender types can be further sub-divided based on their relationship to the victim, as either incest offenders (familial relation) or non-incest offenders (not familial relation). Overall, research has shown that sexual recidivism for all sex offenders is quite low, with rates of only 10% to 15% five years after release (Hanson & Bussiere, 1998). However, researchers have found that different groups of sex offenders recidivate at varying rates.

One study using data from 10 follow up studies of adult male sex offenders (a combined sample of 4,673 offenders) divided sex offenders into three separate groups that are believed to be distinctly different from each other and, thus, require different treatments (Hanson, 2001). These three groups

consisted of incest child molesters who victimize related children, rapists who victimize adult women, and non-incest child molesters who victimize unrelated children.

### **Incest Child Molesters**

Of the three groups, incest child molesters were the least likely to sexually recidivate, at a rate of 8.4% (Hanson, 2001). This finding carries with it many important implications for treatment. Since the rate is relatively low, it has traditionally been believed that the best form of treatment for incest child molesters is a minimally intrusive form of therapy that reduces sexual recidivism.

One program currently offered by Correctional Service of Canada does exactly that. The Violence Interdite Sur Autrui (VISA) program is meant to treat incestuous fathers who are at low risk for sexual reoffending. VISA emphasizes developing empathy for the victim and preventing recidivism by encouraging participants to complete six initiatives that have been proven to reduce recidivism for this type of offender:

- offenders work to overcome fear and shame so that they can acknowledge what they have done
- offenders take full responsibility for the abuse, both in front of the people involved in the offence and the therapy group in which the offender is treated
- offenders come to terms with the damage done to their victims, their families and themselves
- offenders take steps to amend and establish healthy relationships with their victims and those close to them
- offenders learn about incestuous sexual offending so that they can look critically at their sexual conduct, and eventually lead sexually responsible lives
- offenders recognize the factors that contributed to the abuse, and take steps to reduce the influence of these factors in their lives (Bernie, Mailloux, David & Cote, 1996).

The 14 week program consists of 28 psychotherapy group meetings, 13 sex education work shops and 10 individual interviews that encourage participants to support each other, to seek out community support and to incorporate their victims and families back into their lives. The success of the VISA program has been exceptionally promising. As of 1996, 130 offenders had participated in the VISA program, and only two had been reconvicted for a further sexual offence. Clearly, as an evaluation of the program notes, “[t]he VISA Program has, therefore, demonstrated not only that it is possible to treat incest in a context of respect for abusers, their victims and their families, but also suggests that it may be more effective to treat the man/father than the deviant” (Bernie et. al., 1996).

However, one recent study challenges traditional thinking about incest child molester treatment, and questions the validity of the distinction made between incest child molesters and non-incest child molesters (Studer, Clelland, Aylwin, Reddon & Monro, 2000). First, the study suggests that sexual recidivism rates among incest child molesters are actually higher than most statistics report. This is because during treatment, several offenders admitted to having committed sexual offences on additional incestuous victims that did not result in a sexual offence conviction. Of the total sample

of 150 incest child molesters, 7.3% had had a previous sexual incestuous conviction, and an additional 15.3% had admitted to committing sexual offences on additional incestuous victims that did not result in a conviction (p. 18). In sum, 22% of incest child molesters in the sample sexually recidivated; a rate of almost three times higher than Hanson (2001) found (8.4%).

Second, the study reveals another issue that has often been ignored by previous research. Because most research studies separate sex offenders based on their first convictions, past sexual offences that did not result in a conviction have often not been taken into consideration. Studer et. al. (2000) reported that 58.7% of the sex offenders classified as incest child molesters had reported other non-incestuous victims. In fact, only 33% of the incest child molesters and 18.5% of the non-incest child molesters reported that they had only victimized the individuals that lead to the current conviction and had not victimized any other individuals. Therefore, the notion that sex offenders can be classified into distinctly different groups based on their first convictions is open to scrutiny. The distinction drawn between incest and non-incest child molesters is brought further into disrepute when erotic preferences of child molesters are examined. In one research study, first offence convictions were used to separate 103 incest child molesters from 114 non-incest child molesters, so that their erotic preferences could be compared (Studer, Aylwin, Clelland, Reddon & Frenzel, in press). Erotic preferences were then examined by having offenders undergo phallometric testing while being exposed to visual stimuli (mostly slides) of people who differed in age, gender and body type. The test results were used to determine the two groups' erotic preference for four categories of people, namely: 1) prepubescent children; 2) pubescent partners; 3) adult partners; and 4) women of all ages.

When a comparison of erotic preferences of incest to non-incest child molesters was made, only two statistically significant differences were found. The non-incest child molesters were significantly more likely to prefer prepubescent children as partners than were their incest offender counterparts. Specifically, 29.8% of the non-incest child molester group preferred prepubescent partners, while only 12.6% of the incest child molester group did so ( $p < .01$ , two tailed). Not surprisingly, it was found that incest child molesters were significantly more likely to prefer adult partners (36.9%) while only 19.3% of non-incest child molesters did so ( $p < .01$ , two tailed). However, preferences for pubescent partners and women of all ages were not significantly different between the two groups of sex offenders.

Table 1 (Source: Studer et. al., in press)

<u>Erotic Preference</u>	<u>Incest Child Molesters</u>	<u>Non-Incest Child Molesters</u>
Prepubescent	12.6% (n=13)	29.8% (n=34)
Pubescent	40.7% (n=42)	43.0% (n=49)
Adult	36.9% (n=38)	19.3% (n=22)
Women of all Ages	9.7% (n=10)	7.9% (n=9)

The researchers concluded that “erotic preference testing, although somewhat informative, could not distinguish with certainty incestuous from nonincestuous child molesters” (Studer et. al., in press). In fact, when both groups of sex offenders were combined, the majority had pubescent preferences

or a preference for all ages of women, the two categories that were not significantly different from each other. Thus, the majority of sex offenders in the study were indistinguishable as either incest or non-incest child molesters, according to their erotic preferences.

From the evidence cited above, classifying sex offenders and recommending minimal interventions may be a questionable practice. Many factors, such as officially unrecorded sexual offences and the indistinguishability of erotic preferences of most sex offenders from each other, must be taken into account before minimal interventions may be carried out most effectively.

## **Rapists**

According to Hanson's study (2001), rapists were the second most likely group of sex offenders to sexually recidivate, at a rate of 17.1%. Most research done on rapists indicates that they are a distinct group of offenders who are distinguishable from child molesters. For instance, rapists tend to be younger than child molesters, each having average ages of 32.1 and 38, respectively (Hanson, 2001). More importantly, a meta-analysis of sex offender treatment programs found that rapists were more likely to recidivate non-sexually than were child molesters (Hanson & Bussiere, 1996). In fact, it has been noted that "rapists share more characteristics with the general criminal population than do child molesters." Characteristics that identify general criminals, such as prior criminal records and antisocial personality, are similar to characteristics that identify rapists. Furthermore, research has found that rapists are more likely than are child molesters to breach their conditional release. In one sample of 132 subjects who were conditionally released, 40.7% of rapists breached, while only 25% of child molesters did so (Barbaree, Seto & Maric, 1996).

Since rapists engage in a variety of criminal behaviours and have high recidivism rates, they are difficult to rehabilitate effectively. However, there is hope for treating rapists. In a research study examining treatment effects on 74 rapists, treatment completing rapists were compared to treatment non-completing rapists. It was found that treated rapists recidivated sexually at a substantially lower rate than did their non-completing counterparts. Although the difference was not statistically significant, only 16.6% of treatment completers sexually recidivated, while 28.9% of treatment non-completers did so (Clelland, Studer, Reddon, 1998). The 14.3% decrease in sexual recidivism for treated rapists suggests that treating rapists successfully is possible, and difficulties in treatment can be overcome.

To successfully treat rapists, research suggests that adequate treatment must address general crime issues, as well as sexual crime issues, to ensure that the offenders do not reoffend. Promising sex offender treatment research suggests that effective treatment for rapists focusses on changing deviant sexual behaviour, and incorporates Cognitive Skills Training in treatment programs (Robinson, 1995; Quinsey, Lalumiere, Rice & Harris, 1995).

It must be remembered that only factors that can be changed should be the focus of treatment, not only for rapists, but for all offenders who require treatment. Factors such as prior criminal record or family background are related to sexual offending, but are not changeable and, therefore, should not

be the focus of treatment. However, sexually deviant behaviours are changeable. One study on sex offender recidivism found that laboratory assessed deviant sexual behaviours were the only changeable factor related to recidivism for sex offenders (Quinsey et. al., 1995). Deviant sexual behaviour was defined as use of prostitutes, deviant sexual preference (for example, a preference for young boys), frequent masturbation, and so on. When such behaviours are performed by sex offenders, chances of their reoffending increase. Therefore, treatment that reduces these deviant behaviours of sex offenders may help to reduce recidivism. Current effective methods used to decrease deviant behaviours come from a cognitive/behavioural conditioning approach, and include shaming, covert sensitization, masturbatory conditioning, and many other forms of behavioural conditioning.

Also, Cognitive Skills Training programs have been known to reduce reconvictions among sex offenders. In a research study conducted by Correctional Service of Canada, sex offenders were the most successful type of offender in reducing recidivism rates by completing Cognitive Skills Training. The Correctional Service of Canada study examined 3,531 offenders from the correctional population who participated in Cognitive Skills Training, and 541 offenders who met the criteria to be included in the program were placed on a waiting list to be used as a control group. There was a 57.8% reduction in any form of reconviction, and a 39.1% reduction in readmission to a correctional facility for sex offenders who completed the Cognitive Skills Training program when compared to the control group. Although the study expresses doubt about such impressive results being observed in further studies, the data do suggest that sex offenders would greatly benefit from Cognitive Skills Training (Robinson, 1995).

### **Non-incest Child Molesters**

Of the three groups of sex offenders classified by Hanson (2001), the highest rate of sexual recidivism (19.5%) was recorded for non-incest child molesters. These offenders are at significant risk of reoffending throughout their lives (Hanson, Steffy & Gauthier, 1992). A research study that illustrates this point examined the long term recidivism of child molesters. In the study, these offenders were classified into three groups: a treated group; control group one; and control group two. Both control groups were used to control for cohort effects. A total of 197 child molesters, a majority of them being non-incest child molesters, released from Canadian correctional facilities between 1958 and 1974 were tracked over an extensive period of time (31 years for control group one offenders). Results showed that 42% of the total sample was reconvicted for a sexual and/or violent offence. The long term risk of recidivism for non-incest child molesters is based on the fact that 10% of the total sample was reconvicted between 10 and 31 years after release.

The study divided child molesters into three separate types of offenders, based on the type of individual who was victimized. Child molesters were classified as either incest child molesters, heterosexual paedophiles (non-incest child molesters) or homosexual paedophiles (non-incest child molesters). Concurrent with most research, the incest child molesters were reconvicted at the lowest

rate. Homosexual paedophiles were reconvicted at the highest rate, and heterosexual paedophiles were reconvicted at an intermediate rate between the other two groups.

Again, these results suggest that special attention should be paid to non-incest child molesters. In particular, non-incest child molesters who victimize boys must be given extensive treatment and require long term supervision, since much of the research has found that offenders (whether male offenders or female offenders) with boy victims are the most likely to recidivate (Hanson et. al, 1992; Hanson & Bussiere, 1996). In fact, one research study has revealed that one of the highest recidivism rates among sex offenders was for those with previous sexual offences, who victimized boys from outside the family, and were never married. These sex offenders recidivated at a rate of 77% (Hanson, 1996).

Fortunately, sex offender treatment for non-incest child molesters does suggest promising results, if a long term commitment to treating them is maintained. It is important for child molesters to have support throughout their lives, and view their condition not as a curable disease, but rather as an undesirable outcome that can be prevented. As a long term recidivism study on child molesters states:

“Sexual offender recidivism is most likely to be prevented when interventions attempt to address the life long potential for reoffences and do not expect child molesters to be permanently “cured” following a single set of treatment sessions” (Hanson, Steffy & Gauthier, 1993, p. 651).

Thus, most research suggests that intensive, long term treatment programs are essential to the rehabilitation of non-incest child molesters. Again, Cognitive Skills Training and behavioural reconditioning of deviant sexual behaviours must be part of the program, because of their proven success in treating all types of sex offenders.

Finally, most research further suggests that one essential component of sex offender treatment that should be part of any program aimed at sex offenders is relapse prevention. Since relapse prevention is inherently a part of any cognitive/behavioural intervention, it is a part of most Canadian sexual treatment programs. Relapse prevention teaches offenders to recognize risky situations where they may be more likely to reoffend. Then, coping, avoidance and escape strategies that deal with the situation appropriately are formulated for each individual offender (Blanchette, 1996). This technique is highly individualized and tailored to an offender’s specific circumstances, and it further promotes self management skills.

## THE PHOENIX PROGRAM: ALBERTA

To properly examine sex offender treatment programs, not only should the academic research be considered, but the practical application of sex offender treatment programs must also be taken into account. Sex offender treatment programs do not only employ empirically tested treatment methods that have been proven to reduce recidivism, but also incorporate many other rehabilitative components, such as life skills training, recreation, anger management, Alcoholics Anonymous meetings, psychotherapy and many more. This comprehensive approach to dealing with sex offenders focusses on treating the whole person, rather than just the criminal offender. Offenders are treated having regard to their own individual situations, and clinicians believe that it is a combination of several therapies in a treatment environment that produce the most desirable results.

The Phoenix Program, a treatment program located in Edmonton run by the Alberta Mental Health Board, is a perfect example of such a comprehensive treatment philosophy. It is a 19 bed minimum to medium security unit that features private bedrooms, visiting areas, laundry facilities, kitchenettes, a dining area, chapel, canteen, barbershop, open aired courtyard, swimming pool and a gymnasium. The Phoenix Program mainly treats convicted sex offenders who volunteer for treatment from the federal and provincial correctional systems; very few of the program participants are referred to the program directly from the community (for other admission requirements, see Studer & Reddon, 1998). Offenders are required to stay for a minimum of six months, but they progress through treatment at varying rates, with the average stay being 10 months. Although the program has numerous amenities, intensive treatment and a strict schedule are the main elements of the program. Offenders are required to attend 32-35 hours of therapy per week. The therapy is delivered in many forms, including: psychotherapy, victim empathy, cognitive restructuring, anger management, human sexuality, recreation, substance abuse, relapse prevention, life planning, goal attainment and more (for more information, see Studer, Reddon, Roper & Estrada, 1996). Psychotropic medication used to decrease the sex drive of offenders is rarely used in the program, and anti-androgens have only been used with a small proportion of program participants.

Treatment is delivered throughout three phases of the program. The first phase is an intensive, six to 12 month treatment schedule, focussing on treatment forms discussed above that is delivered entirely within the program facility. The second phase spans a period of four to eight months of daily, four hours per evening treatments delivered while the offender is in the community. Finally, the third phase consists of a weekly follow up group that can be accessed over the long term (Studer & Reddon, 1998). Offenders have somewhat of a life time membership in the program, and are offered continuing support from Phoenix Program staff after release. Since the program is voluntary and offenders are not required to fully attend all three phases, a continuum of supervision is offered that provides individualized supervision programs tailored to the individual needs of participants.

The Phoenix Program has been recognized as one of the most effective sex offender treatment programs in much of the academic research (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). It has gained international recognition as a reputable sex

offender treatment program, having presented research findings in many European countries. The Phoenix Program is at the forefront of sex offender treatment, and 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 (Studer et. al., 1996). This remarkably low sexual recidivism rate has afforded the program a great deal of respect in the treatment arena.

Furthermore, more recent research produced by the Phoenix Program has demonstrated that successful treatment changes the risk that sex offenders pose in a community setting, if released from a correctional institution. It is a common belief in the criminal justice system that the best predictor of future offences is the number of the offender's past offences. However, after successful treatment at the Phoenix Program, even for offenders with several past offences, prior sexual offences were not significantly related to sexual recidivism. On the other hand, unsuccessful completion of treatment did produce a significant correlation between prior sexual offence convictions and sexual recidivism (Studer & Reddon, 1998). Thus, the predictive value of prior sexual offence convictions for future reconvictions seems to change at some point during treatment completion; specifically, its predictive value declines. Results suggest that a re-evaluation of the release criteria for treated sex offenders is necessary, and that current criteria are not suitable for treatment completers. More importantly, this research, as is much of the research done by the Phoenix Program, is supportive of treatment interventions for sex offenders.

From personal communications with staff at the Phoenix Program, it is apparent that the staff are committed to a comprehensive treatment philosophy. They make a point of not highlighting any specific treatment that could be singled out as being superior to another type of treatment offered at the facility. Instead, emphasis is placed on the interaction of all of the treatments, in combination with a suitable environment and capable staff. Also, it has been mentioned that offenders are, to some degree, handled on an individual basis that is in accordance with the specific needs and situations of the offender. Furthermore, staff strongly caution against attempting to pin point specific sex offender treatment therapies that will act as the solution to the sex offender recidivism problem. Staff believe that an evaluation in isolation of the program environment, staff, and individual offender issues does not take into account the whole picture of all relevant factors that must be addressed.

### **COUNTERPOINT HOUSE: EDMONTON**

Another local program that shares the same comprehensive philosophy as the Phoenix Program is Counterpoint House, a treatment program that focusses on adolescent sex offenders. Although Counterpoint House is run independently from the Phoenix Program, it is also operated by the Alberta Mental Health Board. Counterpoint House is an eight bed community based residential facility, similar to a group home. Having served over 100 adolescent sex offenders between the ages of 13 and 18 since its inception in 1986, Counterpoint House has been constantly evolving to become one of the most effective adolescent sex offender treatment programs available. The program's main goals include: reducing adolescent sex offender recidivism, promoting mental health and facilitating reintegration of offenders back into the community. While residing at Counterpoint

House, offenders are expected to participate in a day program, usually school, part time or full time work, and attend four community recreation outings per week (for more information on Counterpoint House, see Aylwin et. al., 2000, and Aylwin et. al., in press).

The intensive therapy schedule that has been observed in the examination of the Phoenix Program is also a major element of the Counterpoint House Program. Again, a minimum stay of six months is required for offenders. The focus of therapy provided at Counterpoint House can be categorized into three main forms: cognitive/behavioural therapy, psychotherapy and skills therapy. Although the majority of the adolescents' day is occupied by school, work, chores and other activities, Counterpoint House does manage to provide a multitude of therapy programs for adolescent sex offenders.

### **Cognitive/Behavioural Therapy**

A weekly cognitive/behavioural group therapy session is offered to allow offenders to deal with their offence patterns, in order to prevent further offences. The session is based on the premise that sexual offending is fantasy driven behaviour and, as such, offenders are required to record and discuss their sexual fantasies. The offenders record data in fantasy logs detailing the number and content of their sexual fantasies. The number of fantasies that the youths were able to stop, masturbatory frequency and the frequency and effectiveness of prevention strategies are also recorded in the fantasy journal. Then, information given by the offender is analysed, in order to uncover and appropriately deal with cognitive distortions that permit and reinforce deviant fantasies. Deviant fantasies are discouraged, and appropriate sexual fantasies are encouraged. At Counterpoint House, deviant sexual fantasies are defined as including any of the following criteria:

- no consent from the partner (coercion, sadism, noncompliance)
- age inappropriate (three years older or younger than the offender)
- fantasy object was past victim
- the fantasy would in some way be detrimental if the fantasy were carried out
- sexual fantasies about staff members are also discouraged

Conversely, appropriate sexual fantasies include:

- consent to sexual contact
- age appropriate
- non-related to the offender
- never been victimized by the offender

Covert sensitization, a treatment technique that teaches offenders how to imagine social consequences or incorporate unpleasant or aversive thoughts into their deviant fantasies (eg., the offender's mother looking over his/her shoulder while in the act of deviant activity), is used to control

deviant sexual fantasies. Finally, the number of deviant and normal fantasies are graphed by the offender, and dates of significant therapeutic disclosures or events are recorded.

Recently, CounterpointHouse staff presented a research study that examined the short and long term outcomes of the cognitive/behavioural group therapy sessions. The study included exclusively adolescent males serving a custodial sentence under the Young Offenders Act (1985), who participated in treatment for between one and 13 months (Ledi, 2002a). Fantasy log information of offenders was compiled to produce graphs similar to those formulated by the offenders. Short term outcomes were evaluated by examining the first 12 weeks of therapy results, and long term outcomes were evaluated by examining therapy results over 13 months of treatment. Five different aspects of the fantasy logs were plotted on a graph based on the reported frequency of normal fantasies, deviant fantasies, stopped deviant fantasies, normal masturbation and deviant masturbation.

For the short term analysis, the average number of weekly self reported fantasies were graphed over the first 12 weeks of treatment. Initially, reported deviant fantasies were relatively low and only minimally outnumbered normal fantasies. Staff contend that this phenomenon is due to the fact that offenders tend to under report fantasies in the early stages of therapy, because of a lack of trust in the therapeutic process. However, the graph shows a sharp and steady increase in the number of reported deviant sexual fantasies over the 12 week period. Although the average number of reported deviant fantasies was initially about 50 for the first week, numbers for the latter weeks in the short term analysis were much closer to 100, ranging from 84 to 143 per week. Reported normal fantasies also showed an increase, but not to such a great extent. Over the short term, a notable difference was established between the normal and deviant fantasies, with deviant fantasies largely outnumbering normal fantasies by the end of the 12 weeks. These results suggest that, without treatment, sex offenders tend to under report the number of deviant sexual fantasies they have, and over emphasize the degree to which their fantasies are normal.

Although the frequency of normal masturbation remained relatively constant over the course of the 12 weeks, success in treatment, even over the short term, was noticed when the frequency of deviant masturbation and number of stopped deviant sexual fantasies were examined. Masturbation to deviant fantasies reached a high of 11 in the second week of treatment, and steadily declined to reach a low of two in the 12<sup>th</sup> week. Not surprisingly, the number of stopped deviant sexual fantasies steadily increased over the 12 week period. Therefore, treatment was successful in stopping deviant fantasies, and lessened the number of times an offender successfully masturbated to a deviant fantasy. As mentioned above, it is believed that deviant sexual fantasies lead to sexual offending. Thus, it follows that reducing deviant sexual fantasies will reduce sexual offending and, thereby, reduce sexual recidivism.

In the long term analysis, the average monthly self reported numbers were graphed at intervals over 13 months, and illustrated more promising results in reducing deviant sexual fantasies than did the short term analysis. The most notable success can be observed by examining the number of reported deviant fantasies that occurred over the time period. Although the first five months showed a steady and drastic increase in the number of reported deviant sexual fantasies, the last eight months showed

a gradual decline, suggesting that deviant fantasies are declining over the course of treatment. Additionally, both the number of stopped deviant fantasies and normal fantasies showed a gradual increase over the long term. Finally, although normal masturbation remained relatively constant over the 13 months, deviant masturbation showed a steady decrease from the beginning toward the end of treatment. In fact, the frequency of deviant masturbation initially outnumbered normal masturbation, but by the end of the 13 months, the frequency of normal masturbation outnumbered deviant masturbation.

Unfortunately, by the end of the 13 months, deviant fantasies still outnumbered normal fantasies, although the study noted that “residents appeared to be making successful efforts to interrupt and stop deviant fantasies” (Ledi, 2002a). If the premise that sexual offending is based on deviant sexual fantasies is true, then the effort to stop deviant fantasies will, hopefully, translate into a reduction in sexual offending behaviour. In this way, treatment may be able to reduce sexual recidivism, as participation in the Counterpoint House has proven to do, and treatment would be successful.

### **Psychotherapy**

The second type of treatment provided at Counterpoint House is psychotherapy, which is also offered in a group counselling setting once a week. This spontaneous, non-agenda driven group is based on the idea that sex offenders live secret lives, and are often victims of sexual abuse themselves. For example, Aylwin et. al. (in press) found that among 103 adolescent child molesters, 77.9% were sexually abused at some point in their lives. The Counterpoint House Program acknowledges this correlation and attempts to address issues surrounding sexual abuse while treating adolescent sex offenders. The theme of the psychotherapy group is “getting out the secrets,” and success in the group is measured by an offender’s participation, personal disclosure, ability to discuss sexual offending issues knowledgeably and ability to provide insight into personal and other group member issues. It has been noted by Counterpoint House staff that the psychotherapy group is where offenders in the program learn to trust and feel support, often for the first time. From this sense of trust and support, offenders are able to disclose relevant issues about themselves, and help treatment efforts progress with more ease. Furthermore, issues brought up in the psychotherapy group are followed up in individual counselling sessions that are carried out on an ongoing basis by most staff members involved in the Counterpoint House Program. Also, issues raised in individual counselling sessions are often later disclosed in the group sessions, so that the offender can gain the benefit of his peers’ insights into the issues and obtain necessary support.

### **Skills Therapy**

Skills therapy is divided into three eight week sections that include: anger management, relapse prevention and psychosexual education. The anger management component assumes that sex offenders have anger management difficulties, and that sexual offences are one of the manifestations of this misplaced anger. Counterpoint House staff have developed their own program for addressing anger management of adolescent sex offenders, that encompasses 13 sessions where offenders learn

about various anger management issues. Triggers, reactions and consequences of expressions of anger are explored, as well as the presentation of various models of anger. Additionally, cognitive distortions surrounding destructive expressions of anger are identified, and attempts are made to eliminate such distortions. Finally, in the latter sessions, a distinction is made between aggressive and assertive behaviour. The main goal of anger management therapy is to replace destructive expressions of anger with appropriate methods of communicating.

Methods used in the delivery of the relapse prevention component of skills treatment are drawn primarily from the work of Charlene Steen, and a relapse prevention workbook written by Steen (1993) supplements the therapy. Relapse prevention at Counterpoint House attempts to help offenders identify and appropriately address high risk factors and scenarios that promote their own sexual offending, so that the offenders will learn to avoid reoffending. Steen's 160 page workbook includes 12 chapters that discuss different relapse prevention issues associated with sexual offending, such as empathy, urge control and cognitive restructuring. Furthermore, 58 writing exercises allow offenders to apply learned knowledge about relapse prevention.

Finally, the psychoeducational component provides offenders with the opportunity to learn about sexual offending issues. For instance, offenders learn about the effects of victimization, sex offender treatment, the law, offender and victim characteristics, and statistics of abuse and victimization. Again, cognitive distortions are identified, and offenders learn to recognize and discuss their own general sexual offending issues knowledgeably.

Along with the various forms of treatment offered at Counterpoint House, a psychiatrist visits each offender weekly to assess mental health and therapeutic progress. Psychotropic medications are rarely prescribed by the psychiatrist, and anti-androgens are even less likely to be used at Counterpoint House. Additionally, the psychiatrist does advise staff on treatment issues, and is available on a 24 hour on call basis.

Counterpoint House offers an intensive therapy program within the time constraints of adolescent offenders' schedules. There is preliminary research available that shows that Counterpoint House is successful at reducing recidivism. Recently, Counterpoint House staff have presented research on the recidivism rates of offenders who completed the Counterpoint House Program and of those who did not (Ledi, 2002b). In the study, an offender was considered to have recidivated if they received any further convictions or charges. A total of 76 program completers and 37 non-completers were followed up for an average of 53 months (ranging from six to 120 months). The results showed that 7.9% of program completers and 18.9% of non-completers were charged for a further sexual offence. Even better results were observed when sexual convictions were examined. Only 3.9% of Counterpoint House treatment completers were convicted for a further sexual offence after release, compared to 10.8% of treatment non-completers. The percent of charges and convictions among program completers is notably lower than the percent of charges and convictions among program non-completers, and this finding suggests that the treatment offered at Counterpoint House does, in fact, reduce recidivism of sex offenders.

Staff at Counterpoint House also warn against the singling out of any one aspect of the program that works best at treating adolescent sex offenders. Rather, staff believe that it is their comprehensive approach to treating sex offenders that is the reason that the program works so well. Again, the interaction between the staff, the clients, the environment and the treatment therapies is emphasized as the driving force that allows the program to succeed.

Furthermore, general life skills (which are not officially regarded as part of the treatment program) that are learned by offenders who reside at Counterpoint House are believed by staff to enhance treatment success. For example, each offender prepares a meal once a week, and is responsible for their own laundry and cleaning up after themselves. These skills can be used throughout offenders' entire lives and promote their own personal productivity. Likewise, actions carried out by staff supplement sex offender treatment by way of positive role modelling for the youth. Researchers who take into consideration all the factors above describe Counterpoint House as "a non-threatening environment where residents can begin to adopt anti-offending attitudes and behaviours" (Aylwin et. al., 2000, p.116). Since Bremer (1992) has noted that a caring environment where offenders are treated well is an important factor in effective adolescent sex offender treatment, it is evident that the treatment offered cannot be separated from the environment at Counterpoint House, and it is the comprehensive philosophy towards treatment that Counterpoint House staff emphasize that is the underlying reason for the program's success.

## **DISCUSSION**

Sex offender treatment can be successful in reducing the recidivism of sex offenders if the following steps are taken when approaching the idea of treating sex offenders. First, sex offenders must be properly categorized as a certain type of sex offender, while taking into account all the relevant factors that effect this categorization, such as unofficially recorded sexual offences and erotic preferences for certain types of victims. Only through the proper categorization of sex offenders can treatment be the most effective. The three types of offenders discussed in the research are incest child molesters, rapists, and non-incest child molesters.

Second, once sex offenders are properly categorized as one of these types, the following treatment methods must be used. Incest child molesters require minimally intrusive forms of treatment that focus on reintegrating the sex offender with their community, family and victim. The VISA Program has shown that success can be achieved when this method is used. As for rapists, more intensive treatment programs like Cognitive Skills Training and conditioning of deviant sexual behaviours are needed to produce successful results in reducing recidivism. Also, these treatments for rapists must be accompanied by treatments that reduce general criminal offending, since rapists tend to perform more general types of crime than other sex offenders. Finally, non-incest child molesters require the most intensive treatment in order to reduce their recidivism rates. Treatment programs must focus on sexual offending issues, Cognitive Skills Training and the conditioning of deviant sexual

behaviours. Furthermore, long term follow up treatment should be used with non-incest child molesters, since they have been found to be at risk for reoffending throughout their entire lifetimes.

Once it is determined which type of treatment is required, it is imperative to offer the treatment in an appropriate environment. As the examination of the Phoenix Program and Counterpoint House Program illustrate, adequate facilities, competent staff and proper activities for the sex offenders to engage in can go a long way in reducing sex offender recidivism rates. Thus, it is the use of appropriate treatments that focus on sex offenders' specific needs, delivered in an appropriate environment that will lead to the optimal reduction in recidivism among sex offenders.

Relapse prevention should also be an essential component of all sex offender treatment programs, because it has proven to be a significant factor that facilitates the reduction of sex offender recidivism. As well, long term follow up of all offenders is an important factor that is conducive to successful sex offender treatment, especially for non-incest child molesters who have demonstrated a risk to reoffend throughout their entire lifetimes. By following these steps, sex offender treatment will prove to be even more successful in the future.

What does remain clear and is emphasized and supported in this paper, is that sex offender treatment does work and can be carried out successfully. Programs such as the Phoenix Program and Counterpoint House demonstrate precisely this point. Thus, if anything can be said with certainty about sex offender treatment programs, it is that they must continue to have a strong presence in the criminal justice system, so that we reduce victimization and make communities safer. Therefore, John Howard Society of Alberta believes that such treatment programs should be offered routinely, as an effective, just and humane response to the causes and consequences of crime.

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