

**STANDARD VERSUS SPECIALIZED TREATMENT; A
COMPARISON OF INCARCERATED CHILD SPECIFIC SEX
OFFENDERS ABILITY TO CONTROL PARAPHILIC AROUSAL
WHEN THE ATTRACTION / OFFENSE PATHWAY ATTRIBUTES
ARE TARGETED OR NOT.**

BY

Thomas J. Weber

A dissertation submitted to the faculty of Maimonides University in partial fulfillment of the requirements of the degree of Doctor of Philosophy.

**North Miami Beach, Florida
December 2006**

DISSERTATION COMMITTEE

**WILLIAM A. GRANZIG, Ph. D., MPH
Professor and Dean**

**RYAN C. MOORE, Ph. D.
Associate Professor**

**BRENDA M. GARMA, Ph. D.
Associate Professor**

Approved by the Dissertation Committee

**Maimonides University
North Miami Beach, Florida**

William A. Granzig, Ph. D **Date**

Ryan C. Moore, Ph. D **Date**

Brenda M. Garma, Ph. D **Date**

ACKNOWLEDGEMENTS

This paper is dedicated first to Elohim, Creator of the Universe, with whom all things are possible. I wish to thank my father and mother for their support and encouragement from the beginning. I wish to acknowledge my committee; Dr. William Granzig, Dr. Brenda Garma and Dr. Ryan Moore whose support and indefatigable efforts throughout this process has been invaluable. I wish to express gratitude to my former professor and colleague, Michael Boniello, who shaped much of what I know today and taught me how to apply it. I wish to thank Robert Longo for his contributions to the field and for his support of my work. I wish to thank Deputy Warden, Kyle Deere, of the Kansas Department of Corrections as well as my uniformed and nonuniformed colleagues who are too numerous to mention. I wish to thank the survivors whose courage inspires us all and lastly, I wish to thank the men I have worked with for their efforts and accomplishments towards remaining offense free and having happier, healthier lifestyles.

Abstract

This study was designed to examine if there is a difference in Standard versus Specialized treatment of incarcerated child specific sex offenders ability to control paraphilic arousal when the Attraction / Offense Pathway attributes are targeted or not. The Penile Plethysmograph and Sexual History Disclosure Polygraph were utilized as assessment instruments on offenders participating in both forms of treatment. A Chi Square was utilized to compare bivariate tabular data at the 0.5 level of significance. Results indicated no significant difference in the ability of either group to control paraphilic arousal. A clear need was established to improve research designs and develop increased treatment efficacy with the specific issues of the aforementioned target populace.

TABLE OF CONTENTS

Committee Approval Page	2
Acknowledgements	3
Abstract	4
Table of Contents	5
Chapter 1 Introduction	
I. Background to Research Problem	
A. Introduction	8
B. The Public Policy and legal Environment	12
C. Generalist / Specialist Debate	17
D. Influence of Treatment on Child Sex Offender Recidivism	20
E. Treatment Effect Measurement and The Time Lag Dilemma	26
Chapter 2 Review of Literature	
I. Introduction	28
II. The Evolution of Sex Offender Treatment	31
III. The Current CBT Model	39
IV. Risk Assessments	48

TABLE OF CONTENTS

V.	Typologies of Sex Offenders	55
VI.	Treatment Efficacy Studies	65
VII.	Conclusion	83
Chapter 3 Method		
I.	Statement of the Research Question	85
II.	Study Hypothesis	85
III.	Description of the Research Setting	86
IV.	Research access to and Professional Role Within the Research Setting	87
V.	Description of Treatment Programs	88
	A. Standard Treatment	90
	B. Specialized Treatment	94
VI.	Study Design	
	A. Overview	98
	B. Study Variables	99
	C. Data Gathering Methods	100
	D. Statistical Analysis Procedures	102
VII.	Study Populace	
	A. Description of Study Sample	103
	B. Recruitment of the Study Populace And Study Group Formation	103
	C. Ethical Considerations	104

TABLE OF CONTENTS

VIII. Limitations and Significance of Study	
Findings	99
IX. Additional Treatment Considerations	107
X. Sample Size Concerns	108
XI. Clinician Training	108
XII. Description of Study Participants	109
Chapter 4 Results	110
Chapter 5 Discussion	
A. Study Implications	123
B. Study Limitations	124
C. Applicability	124
D. Future Research Considerations	129
References	131
Appendices	140
Program Information Appendices	155

Chapter I

Introduction

I. Background to the Research Problem

A. Introduction

There is a substantial disparity between the American public's heightened demands for increased protection against child sex offenders and the capacity of treatment professionals to furnish assurances that these demands can be met, even in part, through therapeutic programs aimed at reducing recidivism risk. Since the early 1990s, state legislatures across the nation have responded to their constituents' outrage over heinous crimes committed by sex offenders in general and child abusers in particular, by enacting severe statutes that utilize formal and informal controls to shield the public from the predations of what are presumed to be incorrigible paraphilics. Among the most prominent of these measures are civil commitment provisions that enable states to incarcerate convicted violent sex offenders in secure psychiatric facilities for an indefinite period of time after they have completed their prison sentences. The rationale for such laws is that sex offenders including, and most especially, child molesters, constitute a special class of criminal because they have

"mental abnormalities" that cannot be effectively addressed through treatment. Clearly, the motivation behind remanding convicted sex offenders to psychiatric institutions does not stem from an interest in their long-term rehabilitation, but from the perceived necessity of keeping offenders behind bars as the only reliable way of safeguarding prospective victims (Alexander, 2004). Criminal justice policy in this area has moved away from rehabilitation and towards an incapacitation model that depends primarily upon permanent confinement for some and intense community supervision for the remainder.

Neither researchers who have studied child sex offenders nor clinical practitioners who have worked with them possess the requisite knowledge to confirm or to challenge the core presumptions upon which the current incapacitation approach has been justified. Re-offense studies have not conclusively demonstrated that child sex offender recidivism can be significantly reduced through therapeutic interventions of any type. Somewhat ironically, however, the passage of laws premised on the notion that many, if not all, child sex abusers are simply beyond help has occurred at a time when widespread pessimism about the efficacy of treatment with this populace has been replaced by a renewed, if still cautious, optimism. At the very

least, the long-standing generalization that "nothing works" with child sex offenders no longer prevails among researchers and practitioners within the field. There is, in fact, considerable evidence that recent advances in the treatment of child sex offenders have yielded significant improvements in outcomes, including reduced propensity for re-offense.

Yet it has also become increasingly clear that while the dominant treatment model in the field, that is, cognitive-behavioral therapy (CBT) within a relapse prevention (RP) framework, is considerably more effective than its predecessors, it does not work well with all subtypes of child sex offenders. Indeed, continuing developments in offender taxonomies and actuarial risk assessment models have underscored the heterogeneity of child offenders as a treatment populace: even the most prominent practitioners of the CBT/RP model have acknowledge its shortcomings as "one-size-fits-all" approach to the needs of individuals who follow diverse pathways to offending. The logical alternative of tailoring treatment to sub-groups of child-specific sex offenders differentiated by victim age/gender, attraction/arousal patterns, and other established risk variables accords closely with current knowledge and could conceivably

enhance program outcomes. Nevertheless, this approach has not been implemented in American correctional institutions. The reasons for continued reliance on a single standardized CBT/RP treatment package with incarcerated child sex offenders are many and varied: recent versions of CBT/RP therapy have shown stronger (although still modest) effects on recidivism; financial and logistical constraints deter the initiation of new (and untested) programs; organizational/bureaucratic inertia is ubiquitous. At the same time, the effect of the highly charged policy environment in which treatment programs are lodged has contradictory implications for innovations of this type. On the one hand, an intensified focus on the risk that child sex offenders pose upon their release has been accompanied by some increase in institutional treatment and community supervision resources. On the other hand, in the current incapacitation model, treatment assumes diminished importance. In a variation on a familiar dilemma, until such time as specialized treatment programs for distinctive sub-types of sex offenders have proven their efficacy, they are not likely to be adopted, and until such time as they are implemented, such programs cannot demonstrate treatment effects greater than those of standardized CBT/RP.

B. The Public Policy and Legal Environment

Consistent with broader trends in American criminal justice policy, the 1990s witnessed a dramatic surge in the passage of "get tough" sexual predator laws. "Passionately and angrily passed by state legislatures," Alexander wrote in a 2004 issue of *The Prison Journal*, "these new laws were said to be needed to protect women and vulnerable children from predatory repeat sex offenders" (p.361). The focal point of these statutes were convicted sex offenders who had served lengthy prison sentences and were about to be released into the community at-large. State law-makers mobilized both formal and informal controls over this targeted group by enacting community registration and notification acts, and by effectively extending their prison sentences through civil commitment laws. This was not the first time that the latter had been used to protect the American public from convicted sex offenders. During the 1930s, a number of states promulgated analogous legislation, singling out convicted sex offenders for civil commitment. But in the 1960s and 1970s, most of these statutes were repealed following heavy criticism from the Group for the Advancement of Psychiatry and the American Bar Association's Criminal Justice Mental Health Standards committee (Alexander, 2004).

By the 1980s, however, the pendulum began to swing in the opposite direction, and while Kansas was not the first state to move forward on this front, its Sexually Violent Predator Act would become the key test case in the civil commitment of convicted sex offenders. In the wake of a highly publicized 1993 rape-murder committed by a paroled sex offender, the state of Kansas enacted series of sex offender acts in 1994. These included the Kansas Sexual Offender Registration Act requiring all first-time sex offenders sentenced after April, 1994 to register with Kansas Bureau of Investigations and to re-register every 90 days thereafter for ten years following their release, while all repeat offenders and aggravated offenders were required to register for life. Ultimately, the Kansas Supreme Court ruled that the state's sex offender registration act was constitutional.

The core of the 1994 package, however, was the Sexually Violent Predator Act. At the time of its passage, Kansas had a civil commitment statute on the books to confine individuals with serious mental illnesses, but state lawmakers deemed it inadequate as a means of addressing the threat of violent sex offenders. The definition of a "sexually violent predator" was spelled out in that statute as "any person who has been convicted or

charged with a sexually violent offense and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in the predatory acts of sexual violence" (Kansas Statute Annotated 59-29a 01, 1994). Such persons could be involuntarily committed to secure psychiatric institutions for an indefinite period of time, and although procedural safeguards required a finding of a "mental abnormality" or "personality disorder" associated with re-offense risk, the definition forged by the Kansas legislature was intentionally broad.

As it turns out, Leroy Hendricks was among the first group of convicted sex offenders in Kansas to be subjected to the provisions of the 1994 law. Hendricks had a history of forceful child sexual abuse dating back to the mid-1950s, Hendricks had completed a thirty-year prison sentence, and under the 1994 statute, Hendricks was immediately committed to the predator unit of Larned State Security Hospital. Hendricks appealed this disposition on the grounds that the state's Sexually Violent Predator Act violated the offender's rights under the due process, double jeopardy, and *ex post facto* clauses of the U.S. Constitution. A lower state court ruled against Hendricks, but in 1996, the Kansas Supreme Court heard the case on appeal and found the 1994 Act to be unconstitutional. The

matter then moved to the United States Supreme Court as *Kansas v. Hendricks* (1997). In a 5 to 4 decision, the nation's highest tribunal declared that Kansas's civil commitment law was, in fact, constitutionally permissible. The minority opinion argued that the language of the statute remained overly broad and that there was an inherent contradiction between the inclusion of a psychiatric diagnosis to trigger its application and the state's concurrent contention that such individuals did not have recourse to an insanity defense in criminal proceedings. The *Hendricks* majority, however, citing the Court's decision in *Minnesota ex rel. Pearson v. Probate Court of Ramsey County* (1940) as precedent, asserted that it was not within the scope of the federal judiciary's authority to second guess civil (as opposed to criminal) code statutes passed by state legislatures. In light of *Hendricks*, the US Supreme Court remanded similar cases in Minnesota (*Linehan v. Minnesota*, 1997), and Washington (*Seling v. Young*, 2001) back to their respective supreme courts, both of which reversed original findings that sexual predator civil commitment statutes were unconstitutional.

Five years after its decision in *Hendricks*, the United States Supreme Court clarified its stance on the criteria

for civil commitment in *Kansas v. Crane* (2002). In a 7 to 2 ruling, the majority stated that the threshold for an abnormality was a mental abnormality or a personality disorder that makes it *difficult* for that individual to control their criminal behavior. In Kansas and elsewhere, a state did not have to show that an individual had *no control* over violent sexual acts, but merely that they had difficulty in controlling a psychologically based predisposition toward re-offense. Writing for the minority, Justice Ginsburg observed that any individual diagnosed with an anti-social personality disorder under sex offender civil commitment procedures would fulfill the criteria for remand to a secure psychiatric facility since the very presence of this "abnormality" would indicate that they had some difficulty in controlling a penchant toward violent crimes.

In essence, state legislatures had created a new type of mental disorder for violent sexual offenders that had not been recognized by the psychiatric community and was, therefore, beyond the scope of treatment. As some of the 1994 Kansas Act's supporters openly acknowledged in the course of legislative debates, the measure did not contemplate the possibility that the mental "abnormalities" or "disorders" it referenced could be treated; it was

proposed because lawmakers were looking for a way to keep some sexual offenders locked up permanently (Alexander, 2004). Indeed, at the time of the Kansas Supreme Court's ruling in *Hendricks*, although the state had authorized the establishment of a Sexually Violent Predator Program, it did not have a director, the legislature had not provided any funding for the treatment of offenders consigned to it, and Hendricks had been incarcerated at Larned for more than a year without receiving any type of psychiatric care (Alexander, 2004). In the final analysis, the state legislature of Kansas and its peers had effectively circumvented constitutional protections on the grounds that violent sexual offenders are afflicted with a psychiatric disease that is not merely incurable, but untreatable.

C. The Generalist/Specialist Debate

Ironically, while Sexual Predator Laws were opposed by mental health professionals, their backers adopted a position to justify their enactment that the latter had consistently championed, arguing that sexual offenders are inherently different from other types of criminals. In both *Hendricks* and *Crane*, the majority of the Supreme Court declared that violent sex offenders "must be distinguishable from other dangerous persons who are

handled by the criminal justice system" (Alexander, 2004, p.369). By doing so, as Lussier (2005) has recently observed, the Court embraced the "specialization" hypothesis concerning the criminal activity of sexual offenders. This hypothesis contends, "sexual offenders are a special case of offender, having a specific propensity to commit sexual crimes" (Lussier, 2005, p.270). The rival "generalization" hypothesis maintains that sex offenders do not restrict themselves to any one type of crime, that they are versatile in their criminal activity, and that the cause of their anti-social behavior is virtually indistinguishable from that of non-sexual offenders. Although they differ in their respective opinions about whether sex offenders can benefit from specialized treatment, virtually all scholars recognize that this populace is, in fact, different from other categories of law-breakers despite the fact that sexual offenders do engage in a diverse array of non-sexual crimes.

One overlooked aspect of the specialization hypothesis, according to Lussier, is its presumption "that sexual offenders constitute a homogeneous group of specialists in sexual crimes" (2005, p.273). This assumption, in its turn, has inadvertently "created a taxonomic trap (by) confining every individual having

committed a sexual offence to a single category" (p.288) for the purposes of treatment. The notion that all sex offenders share a uniform set of characteristics that distinguishes them from other criminals runs directly contrary to what theorists and researchers have long accepted, i.e., that sex offenders are a heterogeneous group, that child-specific offenders differ from those who commit crimes against adults, and that there are major in-group differences among child sex offenders (Becker, 1994; Becker & Murphy, 1998; Johnston & Ronken, 2005; Hanson, Morton, & Harris, 2003; Marshall, Anderson & Fernandez, 1999). From the time of Groth's (1978) work in the late 1970s onward, child sex offender researchers have demonstrated that there are distinct types of "child molesters" that differ from each other in terms of the age/gender of their victims, the degree of their pedophilic interest/attraction, their social competency, and their retention of "pro-offending" attitudes (Beckett, Beech, Fisher & Fordham 1994; Beech 1998; Beech, Friendship, Erikson, & Hanson 2002; Fisher, Beech & Browne 1999; Howells, 1981; Knight & Prentky, 1989; Knight, Carter & Prentky, 1990). Although there is no current consensus on a single, standard taxonomy for child sex offenders, there is ample cause to believe that they vary substantially in

terms of the etiology and nature of their disorders, of recidivism risks, of treatment needs, and of their responsiveness to specific therapeutic approaches/program components.

D. The Influence of Treatment on Child Sex Offender

Recidivism

Reflecting the public's over-arching interest in recidivism risk among convicted child sex offenders, the salient question in treatment research has not been what types of programs reduce the likelihood of re-offense with what types of child specific offenders, but, instead, whether any type of treatment has an impact on this populace taken as a whole. Indeed, many large-scale reviews as well as a considerable proportion of individual studies on treatment effects include results for all categories of sexual offenders, combining child molesters with subjects who have committed rapes against adult victims.

With this proviso in mind, the available research does not conclusively indicate that the clinical treatment of sex offenders as a whole or child sex offenders in particular has a significant effect upon recidivism. Starting with Furby, Weinrott, and Blackshaw (1989), several literature reviews, meta-analyses, and large-scale studies

concluded that the sexual re-offense rates of treated offenders do not vary substantially from those of their untreated counterparts. In fact, some researchers continue to question whether there is any value whatsoever in providing treatment to sex offenders beyond measures addressed to general criminogenic factors (Rice & Harris, 2003). Nevertheless, owing to a host of methodological problems, the conclusion that sex offender treatment has no impact upon recidivism rates has evoked sharp critiques (see, for example, Marshall & Pithers, 1994). Indeed, recent reviews and meta-analyses (Alexander, 1999; Grossman, Martis & Fichtner, 1999; Gallagher, Wilson, Hirschfield, Coggeshall & Mackenzie, 1999; Hall, 1995; Hanson, 2000; Hanson Gordon, Harris, Marques, Murphy, Quinsey, & Seto, 2002; Hanson, Morton, & Harris 2003)) have concluded with cautiously optimistic assessments. Of greatest importance, there are grounds to believe that advances in program design and practice have yielded substantially stronger treatment effects and that these "newer" therapies are far more effective than their predecessors. This tentative finding has been reported in both meta-analysis (Hanson et.al., 2003) and in long-term recidivism studies of convicted offenders released from a single facility that upgraded its therapeutic programs

(Maletzky & Steinhauser, 2002). More specifically, newer versions of CBT combined with an RP component appear to have a substantially greater impact on reducing recidivism among some types of sex offenders and, within their ranks, at least some identifiable categories of child sex offenders.

Currently, the CBT model is by far the most widely used paradigm for the treatment of sex offenders in general and child specific offenders in particular (Vivian-Byrne, 2004). During the 1980s, the emphasis placed upon aversive behavioral condition with child sex offenders was replaced by greater reliance upon cognitive techniques aimed at addressing to offenders' denial/minimization of harm, their pro-offending attitudes and their deficits in victim empathy. In working practice, CBT is often augmented by a relapse prevention component based on teaching offenders to recognize pre-cursors to offending and to take steps to avoid these acute risk factors and to break the chain stretching from precursors to the commission of a sexual offense. Originally developed for use in substance abuse treatment programs, RP has become an integral element in the treatment of sex offenders within both institutional and community settings.

Despite the recent tendency on the part of reviewers to ascribe stronger child sex offender treatment effects to improvements in CBT/RP, the available research also suggests that this approach is not a "silver bullet" that can be relied upon without qualification. There is, to begin, the disappointing recidivism results reported Marques and associates on recidivism rates for sex offenders treated in California's correctional system with a CBT/RP model. Starting with their preliminary report Marques, Day, Nelson, and West (1994) and thereafter reiterated in a series of long-term recidivism investigations (Marques, 1999; Marques, Nelson, Alarcon, & Day, 2000; Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005), Marques and colleagues have not been able affirm that CBT/RP treatment has exerted a significant upon child molester re-offense risks. Since this research project is considered to be among the "best designed" tests of the CBT/RP model, the fact that it has not generated definitive findings is, in itself, troublesome. At the same time, while CBT targets offender denial of harm and victim empathy deficits as dynamic risk variables, from the results of their meta-analysis of recidivism risk factors among sex offenders Hanson and Bussiere (1998) concluded that neither denial nor victim empathy is a significant

predictor of re-offense among convicted sex offenders. Concurrently, some scholars (Ward & Hudson, 1998; Maletzky, 1998; McConaghy, 1998) have questioned a core premise of the RP framework, i.e., that a standard chain of events can be identified as a precursor sequence to sexual re-offending. Even if a linear sequence could be identified, there is good reason to believe that RP overlooks pathways in which offenders harbor positive attitudes about their paraphilic sexual behavior and overtly plan their offenses. As in substance abuse abstinence programs, relapse prevention with sex offenders is not effective with individuals who harbor "pro-offending" attitudes (Launay, 2001) and there is substantial evidence that many child sex offenders hold such attitudes even after they have completed an extensive CBT program (Tierney & McCabe, 2004).

In their most recent study, Marques and associates (2005) speculated about the factors that may have contributed to their disappointing results in this and prior investigations. They concentrated their post hoc evaluation on the shortcomings of CBT/RP as it had been practiced in California's correctional institutions. More specifically, they noted that in that state's SOTEP, virtually identical therapeutic regimens were used with

child molesters and rapists, child-specific offenders were assigned to therapy groups with inmates who had committed crimes against adults, and there was no effort to discriminate between child molesters who saw their behavior as a problem and those who denied that their sexual acts with children were paraphilic and/or harmful. The basic problem, as Marques and associates saw it, was that the CBT/RP model had been implemented without due consideration of in-group differences among convicted sex offenders, notably variations in dynamic risk variables.

Echoing this assessment, several scholars have recently argued that imposing a "one-size-fits-all" CBT/RP model on a heterogeneous treatment population of sex offenders and/or child sex offenders is bound to yield "mixed" results (Mann, 2004). As Becker and Murphy (1998) have asserted, the treatment of child sex offenders should address known risk factors that vary across taxonomical categories. It is, in fact, quite likely that inconclusive findings for treatment effects that have been reported in investigations and research reviews covering child sex offenders reflect a failure to accommodate diversity across and within offender categories, most notably differences in identified dynamic risk variables. At present, as Grossman et.al. (1999) have observed: "Little is known definitively

about which treatments are most effective, or for which offenders, over what time span, or in what combinations" (p.358). The accumulated database on child sex offender treatment effects is virtually devoid of findings from comparative treatment program studies. With very few exceptions (McGrath, Hoke, & Vojtsek, 1998), control groups in these investigations have been constructed from subjects who have not received any form of specialized child sex offender treatment.

E. Treatment Effect Measurement and the Time Lag Dilemma

From a public policy perspective, the bottom line (if not the only significant) finding from sex offender treatment research is evidence that the therapy or therapies used reduce recidivism risk. This presents a major dilemma for the advocacy of innovations, including efforts to enhance efficacy by systematically modifying treatment programs for use with different offender types. Not only do recidivism studies pose substantial methodological challenges, because incarcerated child sex offenders may re-offend long after the time of their release, conclusive evidence that a program does reduce the probability of re-offending requires many years to unfold. As an alternative, researchers can measure the influence of

treatment upon changes in known dynamic risk factors, specifically paraphilic arousal, which several scholars have identified as one of the strongest (if not the strongest) predictors of child sex crime recidivism among convicted child sex offenders (Hanson & Bussiere, 1998; Prentky, Knight & Lee, 1997). Granted, this approach does not directly measure the impact of treatment upon child sex offense recidivism. Nevertheless, it does furnish a meaningful indication that a given program is effectively addressing key variables that have consistently shown robust correlations with re-offense rates in studies of child sex offenders. In light of manifest skepticism among policy-makers concerning the value of sex offender treatment at-large and the treatment of child "molesters" in particular, a finding of significant effects upon established recidivism predictors would lend some measure of empirical support to program innovations that are clearly justifiable on theoretical grounds and that have been endorsed by leading scholars in the field.

Review of Literature

I. Introduction

The literature on sex offender therapies reflects what Marshall and Laws (2003) have recently characterized as the "explosion" of treatment programs that has taken place in the United States and other developed nations since the late 1980s. During the past fifteen years or so, the accumulated body of theoretical, descriptive, and empirical works dedicated to sex offender treatment has displayed extraordinary growth. There can be little doubt that the principal driver behind this phenomenon has been the proliferation of cognitive-behavioral treatment (CBT) programs within institutional settings, spurred, in its turn, by the perception that offender exposure to state-of-the-art CBT regimens reduces recidivism risk. Although some scholars continue to challenge the validity of investigations that have reported positive treatment effect findings, most of the meta-analyses, narrative reviews, and large-scale studies published of late plainly provide some grounds for optimism. Taken collectively, their findings strongly suggest that advancements in treatment program design and practice have significantly enhanced outcomes with at least some sex offender sub-groups, including some

types of incarcerated "child molesters." But despite the emergence of a reasonably firm consensus concerning the potential value of current treatment approaches, as Grossman and colleagues have observed, "little is known definitively about which treatments are most effective, or for which offenders, over what time span, or in what combinations" (Grossman, Martis & Fichtner, 1999, p.358). In essence, the field of sex offender treatment at-large (and the sub-discipline of child sex offender therapy in particular) is one in which the pace of practice innovation has vastly surpassed empirical demonstrations of long-term efficacy.

What is by now acutely evident is that child sex offenders are not only different from other categories of offenders; they constitute an extremely heterogeneous population in terms of the etiology and nature of their disorders, of recidivism risk, of treatment needs, and of their responsiveness to specific therapeutic approaches/program components. It is patently apparent that there are multiple pathways to sexual offending against children, each of which may embody diverse causal factors, including biological influences, psychodynamic variables, and paraphilic cognitions (Becker, 1994; Becker & Murphy, 1998). The etiological models that presently predominate

within the field may be placed under the broad rubric of behavioral theory or learned behavioral theory in their common focus upon the conditioning of paraphilic sexual arousal and the development of cognitions that justify and maintain paraphilic sexual behavior (Becker & Murphy, 1998, p.120). Consistent with this orientation, CBT treatment approaches have concentrated on the reconditioning of paraphilic sexual interests and the alteration of distorted cognitions, notably the denial/minimization of harm to victims. At the same time, however, it is also clear that a substantial proportion of child sex offenders do not meet the DSM IV's diagnostic criteria for pedophilia, that many, if not most, "child molesters" have other paraphilias in addition to their paraphilic interest in children, and that the incidence of co-morbidity with other Axis I and Axis II disorders is quite high. As it now stands, there is a need for typologies of child sex offenders that go beyond the victim attributes of gender, age, and familial/non-familial relationship to the perpetrator to include variance in offender motivation and behavior. At this juncture, it is through the construction and validation of fully articulated child sex offender profiles and the development of correlative treatment plans that address variations

among categories of offenders that the therapeutic efficacy of current approaches can best be enhanced.

II. The Evolution of Sex Offender Treatment

"As with many approaches to mental health treatment," Becker and Murphy have recounted, "very early treatment of sex offenders tended to use psychoanalytic and psychodynamic models to focus on identifying and resolving early life conflicts and traumas" (1998, p.127). The controlling objective of these "depth psychology" approaches was the reconstruction of the offender's underlying personality by bringing repressed childhood experiences to light and working through their traumatic effects. Although the results of these therapeutic interventions were difficult to assess, on the whole the reported outcomes were, in Becker and Murphy's words, "very disappointing" (p.127).

It was not until the mid-1950s that institutional programs for sex offenders were established in the United States, and given both the poor results obtained from psychodynamic therapies and severe resource constraints, they were not highly specialized. Instead, as Marshall and Pithers (1994) observed, treatment of incarcerated sex offenders typically took the form of non-directive group

therapy aimed primarily at general criminogenic attitudes and behaviors. Offenders against adult victims were often assigned to group therapy with offenders against child victims, and with possible exception of incest offenders, virtually no effort was made to distinguish among the latter. These programs did not work well as means for reducing sexual or non-sexual recidivism (Marshall & Pithers, 1994).

The 1970s witnessed the introduction of phallometric assessment procedures. Penile plethysmography (PPG) continues to serve as a reliable sex offender assessment technology, particular for the determination paraphilic sexual arousal/interest in children (Seto & Lalumiere, 2001). In the early 1970s, PPG was used as a technology for the reduction or modification of pedophilic sexual urges through aversive behavioral conditioning. Based on the prevailing assumption that paraphilic sexual desire alone drove child molestation, convicted child sex offenders were simultaneously exposed to images that aroused their paraphilic fantasies and to an aversive electrical shock or olfactory stimulus. The working assumption was that these "strict behavioral" techniques would reduce (or even extinguish) paraphilic arousal as measured through subsequent PPG testing. Although electro-shock therapy has

since fallen into disfavor, covert sensitization and shame aversion, intended to reduce inappropriate sexual arousal remain in use. In the late 1970s, Marshall (1979) introduced a satiation therapy in which sex offenders were instructed to masturbate during the refractory period after orgasm while repeatedly evoking paraphilic fantasies. Variations on satiation therapy have also remained as a module within some CBT programs for child sex offenders (Marshall & Laws, 2003).

In the late 1970s, clinicians realized that efforts to repress paraphilic sexual arousal in "child molesters" were not sufficient to re-direct their drives towards appropriate objects of gratification. Hence, in addition to more humane forms of aversion therapy, treatment professionals began to employ orgasmic reconditioning, directing their patients to masturbate to orgasm while watching or fantasizing normal sexual behavior with adult partners (Marshall & Laws, 2003). These techniques were often augmented by social skills training on the premise that many child sex offenders were impaired in their capacity to form normal sexual relationships by skills deficits (Mann, 2004). Strict behavior modification approaches to the normalization of sexual interest have become less common since the mid-1980s, but social skills

enhancement to address isolation and low self-esteem is still a prominent component of CBT with child sex offenders.

In the late 1970s and particularly after the publication of Bandura's (1977) social learning theory, cognitive psychology began to enter the field of sex offender treatment. According to Marshall and Laws, the "transition from relatively strict behaviorism to cognitively based behavioral approaches occurred quite rapidly such that by the end of the decade strict behaviorists had become members of an endangered species" (2003, p.97). Cognitive techniques addressed to offender denial/minimization of harm, pro-offending attitudes and deficits in victim empathy were introduced into an emergent CBT repertoire and have since become mainstays of sex offender treatment. Both confrontational techniques (including group challenges) and sexual educational components are used to attack the offender's distorted cognitions (Mann, 2004).

Meanwhile, the notion that paraphilic sexual urges were the exclusive source of child sexual offending behavior came under challenge. In 1984, Finkelhor introduced a four-factor model which posited that child molesters were: (1) more emotionally congruent with

children than with adults; (2) sexually aroused by children; (3) blocked in ability to get needs met in adult relationships and, (4) that at time of offense, socialization processes that might have prevented offending were disinhibited. This construct directed scholars away from an exclusive preoccupation with sexual urges as the motive behind child sex offenses and toward the possible role of unmet intimacy needs. Five years later, Marshall (1989) published an influential essay in which he argued that for many "child molesters" attraction toward children was not grounded in a desire for sexual gratification, but instead, by unmet intimacy needs grounded in the offender's failure to establish secure attachments to parents during childhood. For at least some child sex offenders, Marshall argued, paraphilic interest in children is not a consequence of sexual urges per se, but of a desire for intimacy that is enacted through sexual behavior.

Recent efforts to reduce recidivism among child sex offenders have included the targeting of information-processing schemas (Mann & Beech 2003). This approach presumes that paraphilic cognitions are embedded in deeply held beliefs about the self and about others (including victims) that can be altered through therapist

interventions. Changing the premises upon which offenders base their worldview, however, is a complicated, arduous and time-consuming process, since these core "maps" are presumed to have been established in childhood and to remain relatively stable throughout the individual's life (Vivian-Byrne 2004).

On the other end of the spectrum, concurrent with the growing acceptance of CBT as a general treatment approach, according to Marshall and Laws (2003), the "most significant innovation" in the treatment of sex offenders during the 1980s "was the adaptation from the addictions field of the relapse prevention model" (p.98). Relapse prevention (or RP) was originally developed within smoking cessation and alcohol/drug treatment programs as a framework for the maintenance of abstinence and was applied with "great enthusiasm" to treatment of sex offenders during the late 1980s and early 1990s (Launay , 2001, pp.38-39). Pithers, Marques, Gibat and Marlatt (1983) are generally credited with having introduced a modified version of RP into the treatment of sex aggressors; shortly thereafter, Pithers established an RP program for sex offenders in Vermont while Marques and associates established the SOTEP program in California. The RP model posits that sex offenders, including child molesters, can

never be cured. Offenders can, however, be taught to recognize the immediate cognitive and behavioral precursors (or "acute risk factors") to sexual abuse behaviors and to cope through pre-set patterns of thoughts and behaviors (e.g., avoidance of high re-offense risk situations), thereby by breaking the "chain" between paraphilic urges and the commission of sexual offenses. Although taught to offenders in both in-patient and out-patient settings, the RP assumes a need for periodic "refresher" courses following an offender's release from a correctional/mental health facility and a further need for external monitoring in the community by trained parole/probation personnel (Becker & Murphy, 1998, p.128).

Although there are variations on RP, a typical program was recently described and assessed by Launay (2001) in a study conducted at the Offending Behaviour Programme Unit of Rochester Prison in the United Kingdom. In addition to participation in CBT, sex offenders at this facility are taught to recognize a sequence or chain of events that have preceded crimes in the past, and then to "find and implement alternative thoughts, feelings and behaviours to avoid, control or escape risky situations' (Launay, 2001, p.40). Prior to release, participants are taught to intervene as early as possible in the relapse sequence, and

progress on this front is measured primarily by increased skill in recognizing "early" precursors of offending, e.g., thoughts about visiting a locale in which target-aged children are present. Like Marques and associates, Launay (2001) reported that RP, *in and of itself*, is not an effective means for reducing re-offense risk. Instead, Launay concluded that RP should only be offered to "suitable participants, who are free from pro-offending attitudes and motivated not to re-offend" (Launay 2001, p.48). As will be brought forth in a subsequent section of the review at hand, there is substantial evidence that many child sex offenders are not "free from pro-offending attitudes" even after their completion of an extensive CBT program. In addition, Launay asserted that RP is *only* effective when accompanied by behavior therapy that reduces paraphilic urges and, in some instances, by drug treatment, notably anti-androgenic medications.

Launay (2001) was by no means the first researcher to challenge the efficacy of RP. In 1996, an entire issue of the journal *Sexual Abuse* was devoted to critical comments about the value of the relapse prevention approach in application to sex offenders. Since then, many scholars (Ward & Hudson, 1998; Maletzky, 1998; McConaghy, 1998) have questioned the "classic" RP assertion that a definite chain

of events can be identified as a precursor sequence to sexual re-offending. Like Launay, others argued that the RP construct effectively overlooks pathways in which offenders harbor positive attitudes about paraphilic sexual behavior and, in fact, overtly plan offenses. Recent research has affirmed that RP is *not* an effective stand-alone treatment and may *not* have any value for a significant proportion of all sex offenders (Mann, 2004; Marques, Nelson, Alarcon & Day, 2000).

Lastly, as noted in passing above, pharmacological treatment, including anti-androgenic medications and antidepressants has been used with some success in populations of child sex offenders. As Becker (1994) has pointed out, however, while anti-androgens appear to reduce the intensity of sexual urges experienced by some pedophiles, anti-androgens do not influence the direction of sexual interest toward age-appropriate objects and offender compliance with prescribed dosage consumption requires periodic monitoring.

III. The Current CBT Model

According to Grossman and associates (1999), "the psychological treatment of sex offenders showed little success until the advent of cognitive-behavioral

techniques" in the 1970s (p.354). At present, the CBT paradigm is by far the most widely utilized approach to therapy with all sex offenders, including all sub-groups of child sex offenders. Indeed, as Vivian-Byrne (2004) has noted, the relevant literature suggests that CBT may be the *only* approach that is effective with sex offenders. In working practice, cognitive-behavior therapy is frequently combined with or "lodged within" an RP framework, and it is often augmented by certain psychopharmacologic approaches, e.g., use of anti-androgens (Becker & Murphy 1998, p.128). While acknowledging the regnant status of the CBT model, two major provisos must be kept in mind. First, CBT programs vary substantially in terms of the specific techniques used to achieve desired targets. Second, although the empirical literature on treatment program efficacy (see below) tends to support CBT programs in comparison to other therapeutic approaches, whether cognitive-behavioral techniques are effective (or equally effective) with all sub-types of child sex offenders is an open-ended question.

With these qualifications in mind, Becker and Murphy (1998) have grouped targets for CBT programs with sex offenders under five headings. First, CBT aims at the reduction of offender denial, cognitive distortions or

minimizations that support paraphilic sexual behavior by challenging the offender's belief systems. Second, it includes an RP educational component that encompasses the identification of immediate precursors to sexual offending and techniques for disrupting cognitive-behavioral chains that lead to paraphilic sexual acts. Third, CBT specifies the individual offender's paraphilic arousal pattern and paraphilic sexual fantasies and then uses behavioral techniques to reduce the intensity of such urges while providing the offender with skills for blocking or decreasing said urges. Fourth, CBT aims at improving the offender's social competence by training in anger management, social skills, and appropriate expressions of self-assertiveness. Lastly, CBT addresses the offender's victim empathy deficits. Becker and Murphy (1998) add that anti-androgens and anti-depressants may be used as an adjunct to therapy.

A similar (but not identical) roster of CBT treatment goals has been delineated by Craissati (1998). Craissati maintains that CBT therapy with child sex offenders should follow a six-step sequence consisting of (1) breaking down denial and minimization; (2) developing victim empathy; (3) challenging justifications and cognitive distortions; (4) addressing low self-esteem, fear of adult intimacy, and

inappropriate assertiveness; (5) modifying and controlling paraphilic fantasies; and (6) helping offenders to recognize risky situations, feelings, moods, and thoughts, and to develop strategies to prevent relapse.

Some scholars have tended to emphasize the cognitive aspect of CBT, construed primarily as psycho-educational process. Thus, for example, Becker (1994) has written that the goal of CBT with sex offenders "is to teach individuals how to recognize and change inaccurate beliefs (for example, that a victim enjoys being victimized), and to teach specific means to control inappropriate impulses and behaviors" (p.188). Others, Grossman and associates (1999), for instance, place considerably greater emphasis upon behavioral techniques aimed at the reduction or elimination of paraphilic arousal, including "aversion treatment, covert sensitization, imaginal desensitization, and masturbatory reconditioning" (p.188), with cognitive restructuring assuming an ancillary role to behavioral reconditioning. Consequently, while there is certainly considerable over-lap among descriptions of what CBT with sex offenders should or may include, as critics of treatment efficacy studies have periodically observed, the designation of a particular program as a "cognitive-behavioral" treatment does not ensure that a specific

component of the generalized model is present, nor does it indicate anything about the mode(s) through which such components are delivered to the patient.

There are, however, at least two elements that are shared by virtually all CBT programs for child sex offenders in existence today: (1) techniques to increase offender motivation for change by reducing "problem" denial and the "pro-offending" attitudes that reinforce it; and (2) techniques to increase offender empathy with victims of sexual abuse, including prior victims. From the 1991 review of literature on treatment of sex offenders at large, McGrath concluded that therapy can be effective *only* if the offender acknowledges culpability for the commission of an offense, considers sexual offending to be a problem, wants to stop, and is willing to participate fully in treatment. Tandem investigations by Tierney and McCabe (2004) strongly suggest that while child molesters may acknowledge commission of one or more criminal offenses, willingness to change often falls well short of McGrath's roster of necessary preconditions for effective treatment. In the first of these studies, Tierney and McCabe administered a Stages of Change Questionnaire (SCQ) to a sample of 36 incarcerated male sex offenders against children who were on a waiting list for enrollment in a treatment program.

The researchers reported that the majority of the subjects in this study were *not considering* changing sexually offending behavior despite having volunteered for program. Tierney and McCabe then used the SCQ with a sample of 47 incarcerated male sex offenders against children who had been accepted into a treatment program, assessing readiness to change at pre-treatment, mid-treatment, and post-treatment intervals. These researchers found that a majority of the child molesters in this group were not contemplating changes in sexual offending behavior even *after the completion of treatment*. These results imply that participants in both study groups had volunteered to receive treatment for reasons other than changing deviant sexual behaviors, with Tierney and McCabe speculating that *most* had enrolled in and/or completed treatment to obtain better housing and/or increase the likelihood of being paroled.

Tierney and McCabe's (2004) findings provide evidence that "denial" is prevalent even among those incarcerated child sex offenders who enroll in treatment and even after therapy has been completed. Contrary to McGrath's findings, however, from the meta-analysis of sex offender recidivism studies, Hanson and Bussiere (1998) challenged the importance of overcoming offender denial for treatment

outcomes. Both reported that neither admitting nor denying the existence of a sexual behavior problem was predictive of re-offense outcomes regardless of whether the offenders were treated or not.

According to Fisher, Beech, and Browne (1999) enhancing offender empathy for victims of sexual abuse is *the* most common module in the current treatment of sex offenders. As Marshall, Hamilton and Fernandez (2001) have remarked:

The primary focus of these programs is on training sexual offenders to recognize the harm that they have done to their victims. Very few, if any, programs, have an explicit component that attempt to elicit distress from the offenders once they have recognized that harm; it seems to be assumed that remorse and compassionate concern for the victim will simply emerge as a natural result of recognizing the harm that they have done (p.124).

Primary appraisal of harm is a well-known component of substance abuse treatment, but whether an appreciation of harm necessarily yields affect that increases motivation for change and/or reduces relapse risk among sex offenders is problematical. Marshall et.al. (2001) questioned whether purported empathy deficits attributed to child molesters exist independently of cognitive distortions that support denial of harm. These researchers noted that child molesters may express empathy towards crime victims at large and towards victims of sexual abuse, but nevertheless

display "empathy deficits" towards their own victims. From a study involving 34 incarcerated non-familiar child molesters, 24 incarcerated non-sex offenders, and 28 non-offenders (prison guards), Marshall and colleagues concluded that the child molesters in the sample were as or even more empathetic towards victims of crime and towards victims of sexual crimes at large as subjects in the other two study groups, but that they were nevertheless not empathetic towards their own victims. Once again, however, Hanson and Bussiere (1998) meta-analysis of recidivism risk factors among sex offenders calls into question the importance of victim empathy: as with denial, from the data in their meta-analysis, Hanson and Bussiere found that victim empathy deficits are not significant predictors of sex offender recidivism.

Social skills training has become a salient component of many "CBT" treatment programs for sex offenders, including child molesters. At least some theorists have recently argued that a "strengths-based" or "good life" component that encourages sex offenders to set and to achieve personally-relevant life goals should either replace or augment the "risk avoidance" orientation common to RP (Ward & Stewart, 2003). The working premise here is

that sex offenders can be directed towards objectives that are incompatible with re-offending.

As time has elapsed, greater attention has been paid to the influence of therapy process variables upon treatment outcomes with sex offenders. Thus, for example, Beech and Fordham (1997) have argued that therapeutic climate may exert a significant influence upon the attainment of CBT objectives. More particularly, they asserted that the success of sex offender therapy groups varies according to such process factors as group cohesion, group openness to expressions of feeling, and collective "hope" for improvement. Similarly, Marshall and colleagues (Marshall, Serran, Fernandez, Mann, & Thornton 2003; Marshall, Serran, Mouldeon, Mulloy, Fernandez, Mann, & Thornton, 2002) have asserted that outcomes of sex offender treatment programs are influenced by variance in attributes of therapist style, including empathy, warmth, directiveness, and the use of rewards.

Although virtually all CBT treatment programs for sexual offenders still address both paraphilic arousal and cognitive distortions, as Mann (2004) has pointed out, during the past ten or fifteen years, "there has been an incorporation of additional factors into the formulation of sexual offending and treatment programme design" (p.142).

Concurrently, the presumption that a "standard, "one-size-fits-all" CBT regimen (with or without an RP framework) is sufficient to meet the diverse needs of all sex offenders, or of all child sex offenders, has been challenged of late (Mann 2004). The expansion of the treatment repertoire and its potential for greater individualization of therapy is clearly a positive development. Indeed, as will be brought forth later in this chapter, there is some inferential evidence that CBT treatment programs have become increasingly effective in reducing recidivism, and while a portion of this trend may be ascribed to improved implementation of "standard" treatment components, the impact of technical innovations appears to be significant. Somewhat ironically, as the basic CBT model has undergone ramification, it has become increasingly difficult to arrive at generalizations about "what works" with specified sub-groups among all child sex offenders.

IV. Risk Assessment

Although improvements in psychological and social functioning may be included as intermediate or secondary goals, the primary objective of any treatment program for sex offenders is the reduction of recidivism risk. Despite decades of research, the available data does not provide

reliable baseline recidivism rates for identified child molesters (Grossman et.al., 1999). Becker and Murphy (1998) have speculated that, as a group, sex offenders probably do not re-offend at a rate that is significantly higher than that of other violent criminals. Since there is good cause to believe that many, if not most, incidents of sex abuse against children are not detected and that self-report information from released offenders is inherently suspect, the establishment of reasonably accurate rates of re-offense has proven to be an extremely difficult task. In a unique self-report investigation conducted under federal waivers, Abel and associates (Abel, Becker, Mittelman, Cunningham-Rathner, Rouleau, & Murphy, 1987) found that some sub-groups of child sex offenders commit an inordinately large number of crimes. Thus, for example, interviews with 159 non-incarcerated male, non-familial child molesters who offended exclusively against same sex victims led Abel et.al. to calculate that they had committed over 43,000 acts against nearly 23,000 victims. The available evidence indicates that, as a sub-group among all child molesters, convicted male pedophiles who offend against boys that are not family members are at extremely high risk of re-offending, and that this is true within both treated and untreated samples. Nevertheless, even

among offenders in substantially lower risk categories, the harm that child molesters inflict on their victims is so severe that correctional and treatment professionals must interpret indications of positive therapeutic effects with caution.

Although reliable baseline recidivism rates have not been established for child molesters as a whole (or for any category within this populace), there is clear-cut evidence that criminological factors combined with sex offender specific factors allow for the prediction recidivism risk among child sex offenders. More specifically, the number of prior child sex offenses combined with the measured intensity of the offender's fixation with children discriminates among "low" and "high" risk cases. During the late 1980s, the use of actuarial approaches to risk prediction among child sex offenders enhanced the capacity to determine which offenders are most likely to recidivate if they are allowed to remain within or to re-enter the community. The Static-99 assessment device, for example, has demonstrated a high degree of predictive power on the basis of the individual offender's past behaviors (Marshall & Laws, 2003). Researchers have consistently shown that actuarial methods are superior to clinical judgment in the prediction of recidivism among child sex offenders (Becker

& Murphy, 1998; Hanson, Morton, & Harris, 2003; Prentky, Knight, & Lee, 1997; Rice & Harris, 1997; Seto & Barbaree, 1999). In addition to the number of prior child sex offenses, victim gender and the victim's relationship to the offender are plainly significant recidivism risk variables. Thus, among male pedophiles, researchers have consistently found higher rates of recidivism among those who offend against unrelated boy victims, followed by those who offend against unrelated girl victims, and, finally, by incest offenders (Hanson, Morton, & Harris, 2003). In a sample of 256 child molesters released from prison after long periods of incarceration, Hood, Shute, Feilzer and Wilcox (2002) found that over a four-year period, only 7.8 percent of incest offenders had been convicted of another crime of any type, and that none of these crimes were sex offenses. By contrast, within four years of release, 21.2 percent of the extra-familial child sex offenders in Hood et.al.'s study had been convicted and re-imprisoned and 9.1 percent had been incarcerated for another act of child molestation.

As Marshall and Laws (2003) have observed, the major limitation of actuarial risk assessment devices is that while they are exceedingly valuable for sentencing decisions, they are based on static and unchanging offender

attributes which cannot be modified through treatment. The ongoing search for dynamic risk factors that *may* be amenable to modification is based on the acknowledgement that criminological variables alone are unlikely to furnish adequate grounds for recidivism risk assessment among child sex offenders or for decisions concerning their need for and/or prospective benefit from treatment program components.

In a sample comprised of 111 male extra-familial child molesters released from the Massachusetts Treatment Center for Sexually Dangerous Persons, Prentky, Knight, and Lee (1997) studied correlations between seven risk variables--- (1) amount of contact with children, (2) degree of preoccupation with children, (3) impulsivity, (4) anti-social behavior, (5) alcohol use history, (6) paraphilias, (7) social competence---and recidivism rates as measured by both re-arrest and parole violation data. Prentky et.al. reported that "degree of sexual preoccupation with children, paraphilias, and number of prior sexual offenses predicted sexual recidivism, whereas those variables that reflected impulsive, anti-social behavior predicted nonsexual, victim-involved recidivism and violent (sexual and non-sexual) recidivism" (p.147). As in virtually all studies of recidivism risk variables among child molesters,

sexual pre-occupation with children was *the* strongest predictor of sex crime recidivism and this factor showed a high degree of correlation with the presence and/or number of prior child sex offenses. Indeed, Seto and Lalumiere (2001) recently demonstrated that an author-constructed screening assessment instrument comprised exclusively of static risk factors (child sex offense history, victim gender and so on) predicted pedophilic interests in a sample of 1,113 incarcerated child molesters as measured by both the Screening Scale for Pedophilic Interests and by phallometric testing of paraphilic arousal.

As cited in passing above, Hanson and Bussiere's (1998) meta-analysis of results from 61 sexual offender recidivism investigations (encompassing a composite subject populace of 28,792) enabled them to measure the influence of multiple variables upon re-offense rates for specific sub-groups, including child sexual offenders. Among all of the latter, the strongest predictor of recidivism was PPG measurement of sexual interest in children, followed by paraphilic sexual preferences as reflected in non-PPG assessment devices, both of which were significantly stronger than subject's prior child sex offense history. Within the child sex offender studies, moreover, other than personality disorders, psychological maladjustment showed

little or no relationship with reported recidivism rates. Of even greater interest, prominent dynamic risk factors, including measures of victim empathy, denial or minimization of child sex offense/harm to victims, and lack of motivation for treatment did *not* display significant relationships with recidivism despite the prominence accorded to them in most CBT programs.

More recently, Hanson, Morton, & Harris (2003) discriminated among static, stable and acute recidivism risk factors. They argued that acute factors equivalent to RP precursors, have lower levels of reoffense prediction power than stable risk variables such as paraphilic sexual interests. Hanson and colleagues concluded, "many supposedly dynamic risk factors are actually proxies for enduring characteristics that are difficult if not impossible to change (e.g., intimacy deficits as a symptom of personality disorder)" (2003, p.163). Simply because a recidivism risk variable *appears* to be dynamic does not mean that it can be successfully altered to reduce recidivism risk.

V. Typologies of Child Sex Offenders

Both static and dynamic risk variables have been incorporated into typologies of child sex offenders that are intended to facilitate risk assessment and/or assist in the matching of offenders with individualized treatment plans. The development of such taxonomies has underscored the heterogeneity of "child molesters." "Individuals who sexually offend against children are an extremely diverse group," Johnston and Ronken (2005) have observed, adding that, "they differ in terms of their choice of victims, their criminal backgrounds, their sexual arousal patterns, their social functioning, and their risk of reoffending" (p.2). Ongoing efforts to differentiate among types of offenders have provided insights into our understanding of etiology and significant improvements in the assignment of individual offenders to treatment (Becker & Murphy, 1998). Taken collectively, current taxonomies strongly imply that therapeutic efficacy can (and should) be significantly enhanced by matching offenders with treatment programs that are congruent with their preferences, their motivations, and their offense-related behaviors.

Early attempts to construct typologies of child molesters concentrated on broad psychiatric diagnostic

categories or on overt offense-specific factors. As noted in passing above, intra-familial incest offenders appear to constitute a distinct group among all child molesters, while victim gender has been established as an important variable in recidivism risk studies, with same-sex offenders having substantially greater probability for re-offense. However, in a study of 561 non-incarcerated sex offenders, Abel, Becker, Cunningham-Rathner, Mittelman, and Rouleau (1988) reported that a significant proportion of child molesters engage in both incestuous and non-incestuous crimes and that some molesters target children of both genders. In themselves, long-standing distinctions based on victim gender or familial relation to the offender, while useful, are simply too crude to serve as grounds for risk assessment and/or the formulation of treatment programs (Parkinson, Shrimpton, Oates, Swanston, & O'Toole, 2004).

Recidivism risk studies have consistently shown that interest in or paraphilic preoccupation with children is a critical classification variable, discriminating between those individuals who have an otherwise "normal" pattern of sexuality but who impulsively or opportunistically engage in paraphilic acts and those who have a consistent paraphilic sexual interest. Groth (1978) is generally

credited as the first scholar to differentiate among "fixated" child molesters, who are preoccupied with children as objects of sexual interest, and "regressed" molesters who are willing to use children as a convenient sexual outlet but who do not prefer children to alternative objects of gratification. Howells (1981) subsequently reformulated Groth's dichotomy under the respective headings of "preferential" and "situational" child molesters.

Both Groth's (1978) and Howell's (1981) dichotomies were based upon extensive clinical observations informed by emergent theory. But it was not until the late 1980s that an empirically derived and refined typology of child molesters appeared in the literature in a series of studies conducted by Knight and Prentky (Knight & Prentky, 1989; Knight, Carter & Prentky, 1990). In these investigations, the researchers divided the fixated-regressed dimension of Groth's taxonomy into two independent variables: (1) intensity of pedophilic interest, and (2) social competency exhibited before and during acts of molestation. The first variable was operationalized by Knight and Prentky through both phallometric tests of paraphilic arousal and an author-construed assessment instrument comprised of items that measure the extent to which children are a major focus

of the offender's thoughts and attention. The second variable was measured through a social competency assessment scale. The explanatory utility of Knight and Prentky's four-cell typology has since been affirmed by Marshall and Fernandez (2003) after their examination of results from several studies using PPG and/or social competency questionnaires with child molesters. Marshall and Fernandez reported that only about half of convicted extra-familial child molesters display sexual arousal when exposed to paraphilic images of children and that the social competency attributes of those who exhibit arousal vary significantly from those of molesters who do not display a fixation with children.

Beckett, Beech, Fisher and Fordham (1994) subsequently outlined a "high paraphilia" versus "low paraphilia" typology of child sex offenders grounded in two variables: (1) pro-offending attitudes and (2) social inadequacy. Beckett et.al. (1994) posited that male "high paraphilia" child molesters characterized by pro-offending attitudes and low levels of social competency on scales measuring experienced loneliness, anger control, and self-esteem, have more victims, are more likely to offend against victims outside of their families, are more likely to have committed offenses against boys, and are at higher risk for

reconviction on a child sex offense than their "low paraphilia" counterparts. In a study of 140 molesters who had offended exclusively against children, Beech (1998) found that subjects classified as "high paraphilia" conformed to Beckett et.al.'s profile; they displayed a significantly higher degree of paraphilic obsession with children, were more socially inadequate, reported higher levels of personal distress, displayed substantial empathy deficits, and had far more victims than subjects categorized by Beech as "low paraphilia" molesters. Beech (1998) reported that the high paraphilia men in the sample harbored an abnormally high level of emotional identification with children while the low paraphilia molesters had abnormally low levels of emotional identification with children.

Using this sample in conjunction with a control group of 81 non-offenders, Fisher, Beech and Browne (1999) reported that the high paraphilia subjects in the experimental group had higher levels of cognitive distortions about children, significantly poorer empathy for victims of sexual abuse, and significantly higher levels of emotional fixation on children than both the low paraphilia molesters and the non-offenders in their study. When compared to the non-offenders, the low paraphilia

molesters showed lower levels of empathy towards sexual offense victims, but did not show higher levels of emotional identification with children. When compared to non-offenders, both high and low paraphilia types of molesters had lower self-esteem, higher emotional loneliness, and deficits in victim empathy.

Consistent with Beckett et.al.'s (1994) hypotheses, the high paraphilia subjects in Fisher et.al.'s investigation had much more extensive histories of sexual offending, were more likely to have committed offenses against same-sex victims, and were more likely to have committed extra-familial offenses.

Following up with the 140 subjects in Beech's (1998) study and in Fisher et.al.'s (1999) offender groups, Beech, Friendship, Erikson, & Hanson (2002) found that over a mean six-year period, 15 percent of the entire sample had been reconvicted for a sexual offense, but that recidivism rates for the high and low paraphilia groups differed dramatically. The high paraphilia molesters had a sexual offense recidivism rate of 30 percent as compared to a 3 percent rate among the low paraphilia molesters. Beech et.al. (2002) used 14 separate instruments to measure a set of dynamic risk variables. They reported that dynamic "factors such as low self-esteem, emotional identification

with children, and justifications for sexual offending contribute meaningfully to offenders' risk for sexual recidivism" (p.164). Beech and colleagues (2002) argued that the "high paraphilia" versus "low paraphilia" scores on the scale devised by Beech (1998) for years earlier, had significantly greater recidivism prediction power than either the Groth (1978) or the Howell (1981) dichotomies. They noted that nearly one third of the "high paraphilia" subjects in their study would have been classified as "regressed" or as "situational" on assessment instruments designed respectively to operationalize Groth's (1978) and Howell's (1981) typologies. Beech et.al. concluded that it is unlikely that all offenders are equally treatable or that all those who have been had therapy actually benefited" (p.156), with the "high paraphilia" molesters being far less amenable to treatment than "low paraphilia" child sex offenders and much more likely to recidivate following treatment.

In addition to their pedophilic fantasies, a substantial proportion of child sex offenders engage in other types of paraphilias. Using the same populace of non-incarcerated child molesters as Abel et.al. (1987), Abel, Becker, Cunningham-Rathner, Mittelman and Rouleau (1988) reported that among the non-familiar child molesters in

their sample, more than half engaged in three or more additional paraphilias. This was true of offenders against boys, against girls, and among those with both male and female victims.

More recently, Raymond and colleagues (Raymond, Coleman, Ohlerking, Christenson, and Miner (1999) reported an extremely high incidence of Axis I psychiatric disorders other than pedophilia in a group of 45 convicted male pedophiles. Using the Structured Clinical Interview for the DSM IV, Raymond et.al. found that 93 percent of their sample (N = 42) met the criteria for at least one other Axis I disorder. The most common pathology among these molesters was mood disorder (with lifetime incidence rate of 67 percent), followed by an anxiety disorder (64 percent), psychoactive substance abuse disorder (60 percent), while 53 percent of the subjects qualified for another paraphilia diagnosis. Given the co-morbidity rates observed among the pedophiles assessed, Raymond and associates (1999) argued that while some of low responsiveness to therapy reported in the literature on treating pedophiles may be due to poor motivation, pro-offending attitudes supporting denial/minimization of harm, victim empathy deficits and the like, "it seems likely that unrecognized psychiatric conditions contribute to the

difficulties individuals face when they try to engage in the process of therapy and in completing therapeutic tasks" (p.787). At the very least, they asserted, the likely presence of co-morbid psychiatric disorders should be taken into account when designing individualized treatment plans for pedophiles.

Lastly, while it is by now evident that child sex offenders differ from general offender populations and that treatment focusing upon broad criminogenic variables is not likely to be effective in reducing sex offense recidivism among the former, it is also clear that released child sex offenders are at high risk for committing non-sexual crimes. Parkinson, Shrimpton, Oates, Swanston, and O'Toole (2004) reported that at a mean of 10 years after an index event of child sex abuse, 73 percent of the child molesters that they followed had been convicted of some type of non-sexual crime. Indeed, within this sample, it was more likely that a subject would be convicted of a property crime (theft, for example) than would be convicted of another sexual offense of any type. Based on these findings, Parkinson et.al. (2004) asserted that "any theory concerning the dynamics of sex offending against children needs to account for the level of nonsexual offences committed by child molesters" (p.28). In addition to

therapy directed explicitly to their paraphilic sexuality, treatment programs for child molesters should address the likelihood that several psychiatric and social competency factors associated with child sex offenses are also implicated in their inordinately high propensity to commit non-sexual crimes.

The development and testing of child sex offender typologies over the past two decades has clearly enhanced our capacity to assess individual recidivism risk with greater accuracy than reliance upon static variables alone. Concurrently, the progress that has been registered in the refinement of categorical systems for the classification of child molesters, notably through the inclusion of dynamic factors, furnishes a much stronger basis for designing therapeutic regimens addressed to variable treatment needs and variable responsiveness to interventions. In their overview of CBT with sexual offenders at large, Marshall, Anderson and Fernandez (1999) wrote that "on almost all measures that have been used with these men, the variability of their responses is more evident than their conformity" (p.32). Marshall et.al. then added that "this heterogeneity presents problems for research, theory, and for some aspects of clinical practice, not the least of which concerns fitting such a variable group within the

same treatment program" (1999, p.32). From what has been learned about the diversity of child sex offenders, it is very unlikely that exposure to a "standardized" CBT/RP can reduce recidivism risk for all, or even a majority, of identified child molesters. What is required, as Becker and Murphy (1998) have argued, is comprehensive assessment of individual offenders and the tailoring of treatment to those risk factors and offense precursors identified through such assessments.

VI. Treatment Efficacy Studies

Although most scholars would concur that exposure to treatment does reduce recidivism risk for at least some child sex offenders, the salient issue of whether "treatment works" in the bottom-line sense of lowering rates of re-offense, resists definitive resolution. As Becker and Murphy (1998) have put it, "there are a number of methodological, legal, and ethical issues clinical researchers face when trying to establish the effectiveness of sex offender treatment programs" (p.127). In virtually every review or meta-analysis of the existing research data there are encounter extended discussions of the problems entailed in attempting to gauge the influence of treatment effects. *Inter alia*, Prentky, Lee, Knight, and Cerce (1997)

noted in their critique of sex offender recidivism studies that many of these investigations lack a randomly assigned and/or carefully-matched control group as well as precise descriptions of the study populace under investigation, and that these studies encompass a wide variety of outcome measures that purportedly reflect "recidivism." In addition, sex offender recidivism studies vary substantially in their temporal scope; many investigations are limited to a one-year (or less) follow-up period. Investigations that have attempted to measure the influence of treatment upon recidivism rates evince all of these problems. They also suffer from inadequate descriptions of the treatment methods employed with study subjects, most failing to go beyond the currently standard "comprehensive CBT within an RP framework" designation.

Space does not permit a comprehensive exposition of all of the issues common to sex offender treatment effect investigations, but two generic types of problems warrant our attention. First, to date, only a small number of sex offender treatment efficacy studies have included a randomly-selected or carefully-matched control group within their designs. Under most circumstances, the inclusion of an untreated control group entails denying or delaying treatment (or comparable treatment) to a substantial number

of identified offenders. To partially circumvent this problem, researchers have constructed control groups through an array of incidental procedures. These methods include the use of subjects that have agreed to treatment but who remain on waiting lists, of subjects who have refused treatment, and/or of subjects who have withdrawn from treatment. Each of these study group construction procedures embodies substantial methodological deficiencies, but the paramount issue here is ethical in nature. As Marshall and Pithers (1994) have declared, "we cannot see how any ethically concerned researcher would suggest a random design treatment outcome study for sex offenders" (p.24). Randomly with-holding (or even delaying) treatment of sex offenders for the purposes of constructing a control group is ethically suspect since it carries with it a potential for harm to both the untreated offenders and to their prospective victims.

The second problem revolves around the length of the temporal span between treatment exposure and the measurement of recidivism/re-offense. As noted in passing above, many studies purporting to demonstrate the influence of treatment on recidivism rates have very limited follow-up periods, often less than a year. Longitudinal studies have demonstrated that sex offenders, and especially child

molesters, may recidivate many years or even several decades following treatment/ release (Hanson, Steffy & Gautier, 1993; Prentky, Lee, Knight, & Cerce, 1997). In addition to difficulties in locating current records for offenders who are no longer under supervision, a major consequence of this time lag quandary is that much of the long-term research on treatment efficacy actually measures the effect of out-dated treatment programs. Indeed, as will be brought forth in this section, conclusions presented in several of the more pessimistic reviews/meta-analyses of treatment effects upon child molester recidivism rates have been biased by their heavy dependence on studies from programs that have been discontinued or significantly improved during the intervals between treatment exposure and the time of outcome measurement.

Some of the earlier longitudinal studies of treatment effects with child sex offenders reported significantly positive outcomes. Thus, for example, Barbaree and Marshall (1988) followed re-offense records in a sample of 68 treated and 58 untreated child molesters for a period of between 1 to 11 years. The former had been exposed to a "strict behavior" intervention featuring electric shock aversion, masturbatory reconditioning, self-administration of smelling salts contingent upon paraphilic thoughts or

urges, and general social skills training. At a mean follow-up of four years, 13 percent of the treated subjects had re-offended, while during a comparable period, 34 percent of the untreated group had been charged with another sex offense against minors.

In 1989, Furby, Weinrott, and Blackshaw published the first narrative review of studies concerning the effects of treatment on recidivism by sex offenders. Based upon findings from twenty investigations (all of which included populations comprised chiefly or exclusively of child molesters), Furby et.al. (1989) came to the disheartening conclusion that "there is no evidence that clinical treatment reduces rates of sex offenses in general and no appropriate data for assessing whether it may be differentially effective for different types of offenders" (p.27). This statement remains the most frequently cited generalization about the absence of efficacy for treatment programs with sex offenders at-large, and interventions for child molesters in particular. In addition to severe limitations cited by Marshall and Pithers (1994) in their critique of the review's methods, Furby et.al. did not conclude that treatment has no effect on recidivism. Instead, the authors merely observed that the extant body

of research did not permit any firm conclusions (positive or negative) about such effects.

During the early 1990s, some researchers published studies which appeared to support the pessimistic view of sex offender treatment efficacy. Rice, Quinsey and Harris (1991), for example, studied 136 extrafamilial child molesters who had received phallometric assessment at a maximum-security psychiatric institution for a mean period of 6.3 years. The experimental group in Rice et.al.'s investigation was comprised of 50 subjects who had received a behavioral treatment designed to reduce paraphilic arousal and to re-direct their sexual preferences toward appropriate (adult) relationships. The remainder of the subjects in the sample were released without treatment despite having comparable PPG measured levels of paraphilic sexual arousal. Rice et.al. (1991) found very high rates of re-offense within both the treated and untreated groups, and they reported no significant difference in recidivism rates between the groups.

Some of the research studies on the treatment of child molesters that appeared during the early 1990s were very narrowly focused and yielded highly questionable findings. Thus, for example, O'Donohue and Letourneau (1993) investigated the efficacy of an author-designed

intervention intended to reduce denial among child molesters who had been sentenced to probation. Their sample consisted of 17 convicted molesters, all of whom were exposed to a seven-session intervention aimed at breaking down denial through challenges to cognitive distortion, at enhancing victim empathy, and at the delivery of a sex education curriculum. Among the 12 subjects for whom follow-up data were obtained, the "denial status" of nine subjects was upgraded to "admitted status" by probation officers after their completion of this seven-session program. On that basis, O'Donohue and Letoureneau declared that their program had helped participants to overcome offense-related denial. Not only were the findings of this investigation limited by the size of the sample, at outset of the program, participants were advised that if they continued to deny their offenses against children, they would be charged with a probation violation and imprisoned. In light of this aspect of the program, the authenticity of subjects' admissions is clearly problematic.

In a 1994 essay, Marshall and Pithers reconsidered Furby et.al.'s study and issued a critique of Rice et.al.'s (1991) research findings. Marshall and Pithers observed that several of the treatment programs included in Furby et.al.'s review were no longer in operation. In one such

program (accounting for more than 30 percent of the total subject populace in the review), treatment was limited to behavior conditioning directed toward the reduction of paraphilic sexual arousal without any effort to alter cognitive distortions, notably the persistence of pro-offending attitudes. Marshall and Pithers also observed that some of the efficacy studies examined by Furby and his co-authors were single-component treatment interventions. With regard to Rice et.al.'s (1991) failure to find treatment effects among child molesters incarcerated at the Penetanguishene maximum security prison in Ontario, Canada, Marshall and Pithers noted that the reconditioning intervention had been designed by Rice et.al., had been described by them as being "very brief" in duration, and had not been accompanied by any type of aftercare/RP component. Based upon their examination of recent studies using comprehensive CBT/RP approach, Marshall and Pithers concluded that their findings "simultaneously demonstrate the efficacy of treatment and the need to modify these approaches with some offender groups" (1994, p.20). As it turns out, most of the investigations cited by Marshall and Pithers in support of this more optimistic conclusion were, in fact, small-scale studies that lacked control groups and

that had measured outcomes (notably re-offense rates) over a comparatively short time span.

In 1994, Marques, Day, Nelson, and West published preliminary findings from the "best designed" investigation of the effects of CBT/RP treatment on recidivism rates among 299 convicted sex offenders (240 child molesters and 59 rapists). Marques et.al.'s study design included three groups: (1) an experimental group that completed a "comprehensive CBT/RP" treatment program; (2) a group of offenders who had volunteered for that program but who did not receive treatment owing to resource limitations; and, (3) a second control group comprised of offenders who refused to participate in treatment. At a mean of 34 months of risk time from release, among the child molesters in the study, the recidivism rate for subjects in the treatment group was "significantly lower" than that of both the untreated volunteers and the "treatment refusers." Marques et.al. (1994) cautiously characterized this finding as "promising" but withheld conclusion concerning treatment efficacy for additional follow-up. Subsequent longer-term recidivism results reported by Marques (1999) and by Marques, Nelson, Alarcon, and Day (2000) failed to affirm the impact of treatment upon child molester re-offense.

Hall (1995) conducted the first meta-analysis of sex offender treatment effects, integrating data drawn from a dozen studies published after Furby et.al's review appeared in print. Indicative of the methodological difficulties entailed in this research domain, Hall discarded 80 investigations from his initial universe owing to their lack of a control group and/or the small size of their study samples. Meta-analysis of results from the twelve remaining investigations (encompassing a total of 1,313 sex offenders) yielded modestly positive findings: the composite recidivism rate among treated sex offenders was 19 percent compared to a 27 percent rate among untreated control group subjects. Hall noted that the size of this effect increased substantially when data were limited to CBT programs; on the other hand, studies of programs that followed a "strict" behavioral regimen had no effect upon recidivism. In addition, the efficacy of CBT for recidivism reduction was relatively uniform across the studies that Hall included in his analysis.

In one of the few investigations to compare the effects of different treatment approaches, McGrath, Hoke, and Vojtsek (1998) divided 122 convicted sex offenders into three groups: (1) a large (N =71) group that completed what the researchers characterized as a "highly specialized"

CBT/RP program; (2) a smaller group that received "less specialized" treatment; and (3) a still smaller group that received no treatment. The CBT group was exposed to masturbatory reconditioning, peer group challenges to cognitive distortions, and relapse prevention training, while the less specialized treatment group received cognitive treatment, sex education instruction and relapse prevention training without a reconditioning component. As hypothesized, over a mean 5-year time span, the participants in CBT group had significantly lower rates of sex crime re-offense and probation violations than the subjects in the non-specialized treatment and no-treatment groups.

In a mixed sample that included both child molesters and rapists, Nicholaichuk, Gordon, Gu, and Wong (2000) compared recidivism rates at a mean of 6 years after release. The study was comprised of 296 subjects who completed a CBT/RP-type program and 283 untreated subjects from the same institution. The re-offense rates of the former were less than half those recorded among the untreated offenders (14.5 percent versus 33.2 percent), leading Nicholaichuk et.al. (2000) to assert that treatment had reduced recidivism risk for both the child molesters and the rapists.

By the time that Nicholaichuk et.al's findings were published, several large-scale investigations and research reviews of sex offender treatment program effects had reported cautiously optimistic conclusions. After examining over 100 studies published between 1970 and 1998, Grossman et.al (1999), for example, reckoned that:

(1) over a mean time span of seven years, treatment reduced recidivism by approximately 30 percent;

(2) CBT/RP programs were more effective than "strict behavioral" approaches;

(3) hormonal treatment was a useful adjunct to treatment; and concluded that,

(4) "effective programs involve components that reduce paraphilic arousal while increasing appropriate arousal and should include cognitive restructuring, social skills training, victim empathy awareness, and relapse prevention" (p.358).

Concurrent, meta-analyses performed by Gallagher, Wilson, Hirschfield, Coggeshall & Mackenzie (1999) and by Alexander (1999) found some evidence that treatment reduces recidivism among sex offenders. Integrating data from 79 investigations with a total population of over 11,000 sex offenders, Alexander calculated that subjects who completed CBT programs with a relapse prevention component had a sexual offense re-arrest rate of 7.2 percent as compared to a 17.6 percent rate among untreated offenders. It is noteworthy that most of the investigations included in

Alexander's exercise had comparatively short recidivism measurement intervals.

Following Hanson's (2000) preliminary meta-analysis of 42 sex offender treatment studies, Hanson, Gordon, Harris, Marques, Murphy, Quinsey, and Seto (2002) conducted an in-depth meta-analysis of 43 investigations covering a total of 9,454 subjects. While the main finding derived from study data in the analysis were fairly modest, with the re-offense rate for treated sex offenders coming in at 12.3 percent as opposed to 16.8 percent among untreated controls, the most significant finding was that the more recent investigations showed substantially stronger positive effects. On the one hand, investigations published between 1995 and 2000 using "improved" CBT/RP treatment approaches indicated that 9.9 percent subjects receiving treatment re-offended as compared to 17.4 percent recidivism rate for untreated participants. On the other hand, meta-analysis of data limited to investigations published before 1980 indicated that these older treatment programs had no impact on recidivism outcomes. "The balance of the available evidence," Hanson and associates wrote, "suggests that current treatment reduces recidivism, but that firm conclusions await more and better research" (2002, p.186). Subsequently, Hanson, Morton, and Harris

(2003) conducted a meta-analysis covering 4,724 sex offenders, which indicated that while recidivism rates for sex offenders cumulate, instances of "new" offending tend to decline substantially across time. This implies that the positive treatment effects for "current" CBT/RP therapies reported in Hanson et.al. (2002), while based on near-term (less than five years) outcome data, should persist across time.

In their 5-year and 25-year follow-up study of 7,275 sexual offenders, Maletzky and Steinhauser (2002) provided robust evidence that newer CBT/RP programs are significantly more effective than prior treatment approaches. Their study sample included six offender classes: (1) child molesters (female victims), (2) child molesters (male victims), (3) heterosexual pedophiles, (4) homosexual pedophiles, (5) exhibitionists, and (6) rapists (adult victims). All of the subjects in the study had been treated at a single clinic, and the authors recounted that sex offender treatment at this facility underwent a progressive shift over the past three decades from primary reliance upon aversive conditioning to aversive behavior rehearsal, relapse prevention, and group-based cognitive therapy. Maletzky and Steinhauser's study included four outcome measures: (1) self-report of any paraphilic sexual

behavior, (2) paraphilic sexual arousal greater than 20 percent on PPG, (3) deceit on any sexually related question (polygraph-tested), and (4) charge with a sexual crime at time of follow-up. An indication that any of these criteria were met led to the researcher to classify the subject as a treatment "failure." Follow-up data were obtained at five-year and twenty-five year intervals after release. Maletzky and Steinhauser (2002) found substantial differences in failure rates across offender categories. Thus, for example, "offenders classified as predatory or preferential, including pedophiles and rapists, had 2 to 2 1/2 times the overall failure rate of child molesters" (Maletzky & Steinhauser, 2002, p.138). The most important finding in this study, however, was that five-year failure rates for all except the rapists in the sample declined across treatment cohorts: that is, in five of the six offender categories examined, the failure rates for subjects treated during a more recent five-year interval (1990 to 1995, for example) were significantly lower than failure rates for subjects treated at an earlier five-year interval (1985 to 1990, for example). With the exception of the rapists and with due note of significant variations across the other five offender categories, the results of this study strongly imply that treatment "failure" rates

had declined across time and that at least a portion of these declines could be attributed to improved program efficacy.

More recently, Marques, Wiederanders, Day, Nelson, and van Ommeren (2005) investigated the influence of a CBT/RP treatment program on re-offense rates measured at a mean of 8 years following release in a sample comprised of 704 sex offenders (child molesters and rapists). As in Marques et.al. (1994), this investigation's design used an experimental "RP" treatment group, a "volunteer" control group and a "non-volunteer" control group. The participants in the experimental study group completed an intensive CBT program with a one-year RP aftercare component akin to the program reported in Marques et.al. (1994, 1999, 2000). The main finding of this study was, again, disappointing. There were no statistically significant differences in the re-offense rates for the three study groups at a mean of eight years after discharge. However, through an examination of individual treatment records, Marques and colleagues determined that among the child molesters (but not the rapists) in the "RP" group, those patients who "got it" (as reflected in good post-treatment scores, primarily on measures of sexual interest in children) were much less likely to re-offend than treated child molesters who "did

not get it." Marques et.al. elaborated on what they retrospectively identified as the shortcomings of California's SOTEP program. Chief among these was the use of the virtually identical group-based cognitive therapies for molesters and rapists; the inclusion of molesters and rapists in the same therapy groups; and the RP component's failure to distinguish between child molesters who saw their offending behavior as a problem and those who continued to hold positive attitudes toward molesting. Taking these (and some additional deficiencies) into account, Marques and colleagues asserted that the SOTEP program "clearly fell short of the interdisciplinary, individualized case management model of aftercare that is now recommended" (p.101).

Taken collectively, studies, reviews and meta-analyses of sex offender treatment programs published during the past decade suggest that their efficacy in reducing re-offense rates, including recidivism/re-offense rates for child molesters, has, in fact, improved substantially. Indeed, some of the disappointing results reported in the late 1980s and early 1990s (including those from Marques and colleagues) *may* be ascribed to treatment programs that were not comprehensive and that did not adequately accommodate diversity across and within offender

categories, most notably differences in identified dynamic risk variables.

Nevertheless, some researchers have continued to question whether the treatment of sex offenders as a group (and child sex offenders within that populace) is worthwhile. Rice and Harris (2003), for example, issued a forceful critique of Hanson et.al.'s (2002) meta-analysis based in large part on its inclusion of studies lacking random assignment of subjects to control groups. They observed while positive treatment effects have been attributed to "comprehensive" CBT/RP programs, "there is no information about what aspects of treatment (teaching social skills versus exploring the offense chain versus practicing relapse prevention) might produce reductions in recidivism" (Rice & Harris, 2003, p.437). The dilemma here is that it would be exceedingly difficult to isolate the impact of variance in a single program component upon sex offender recidivism. Indeed, the researcher standards presented by critics of sex offender treatment comprise nearly insurmountable barriers to a demonstration their effects upon recidivism risk.

The current status of sex offender treatment research is asynchronous with reported changes in clinical practice. The current empirical base has firmly established what does

not work well with sex offenders at large and with child molesters in particular, but it does not yet furnish a strong basis for identifying methods that are effective in lowering re-offense risks. At this juncture, consistent with Marques et.al.'s (2005) most recent report on SOTEP, scholars may refocus their efforts away from long-term treatment outcomes such as re-offense rates measured years or decades after program discharge and toward the analysis of how program modules affect near-term treatment objectives, such as reductions in paraphilic arousal and changes in pro-offending attitudes, within offender categories defined by both static and dynamic risk factors.

VII. Conclusion

Although the cautious optimism that currently prevails within sex offender treatment research stands in sharp contrast to both the negative outlook of the late 1980s and the popular perception that since "nothing works" with child molesters they must be permanently institutionalized, the empirical data does not yet provide a reliable guide to practice. In fact, as reflected in the development of more refined typologies of child sex offenders, clinicians must presume that the responsiveness of patients to any given program will vary dramatically with offender attributes.

The influences of some of these attributes---paraphilic sexual arousal, interest in children, offender motivation--are clear-cut, while that of other offender variables---denial, victim empathy deficits, readiness for change, and the like---while certainly plausible, do not enjoy consistent empirical support. At the same time, it is reasonably apparent that some program components effectively enhance treatment outcomes with some offender types, but it is exceedingly difficult to disaggregate their impact.

METHOD

I. Statement of the Research Question

The primary research question addressed in this study is stated as follows: Does the treatment of incarcerated child sex offenders through a program that is differentiated by variations in subject paraphilic attraction/offense pathway attributes increase capacity to control paraphilic arousal to a greater extent than treatment through a program that is not differentiated by such attributes?

II. Study Hypotheses

The study's primary research question is formulated as a null hypothesis for testing.

Hypothesis #1: There will be *no* difference in the degree of change in capacity to control paraphilic arousal (as measured through penile plethysmography) between subjects in an experimental program in which therapy is differentiated according to variations in paraphilic attraction/offense pathway attributes and the degree of change in capacity to control paraphilic arousal among subjects in a control group receiving standard cognitive-behavioral/relapse prevention treatment program that is not differentiated by such attributes.

Although penile plethysmography (PPG) is widely recognized as a reliable means for measuring paraphilic arousal (Seto & Lalumiere, 2001) it is nonetheless vulnerable to false readings. Both the analysis and the interpretation of PPG

results for the two study groups were enhanced in this investigation through the administration of a polygraph measuring deception on items embodied within a Sexual History Disclosure (SHD) questionnaire to both experimental and control group subjects. Toward that end, the study will test a second hypothesis that states:

Hypothesis #2: There will be no difference in the incidence of deceptive responses (as measured by a standard polygraph instrument) to items formulated on the basis of individual answers to a Sexual History Disclosure (SHD) questionnaire between subjects in the experimental and control groups.

The findings generated through the testing of Hypothesis #2 will be presented separately, but they will be used primarily to determine for the presence of a confounding influence upon the results for Hypothesis #1 stemming from any significant variance in incidence of deception between the experimental and control groups.

III. Description of the Research Setting

The original field research for this study was conducted exclusively at the Lansing Correctional Facility (LCF). Located in Lansing, Kansas. LCF is the oldest and the largest prison operating under the administration of the Kansas Department of Corrections. It has been in continuous operation since 1868 and has the capacity to house a maximum of 2,489 inmates, amounting to

approximately 27.3 percent of all adults held in state prisons within Kansas. LCF encompasses maximum, medium and minimum-security compounds, and while it has accommodated female prisoners in the past, all of the inmates at LCF at the time of this study were adult males.

IV. Researcher Access to and Professional Role within the Research Setting

The researcher gained access to the research setting and permission to collect both original and archival data used in this study through a position as a clinical therapist employed by the Douglas County Community Coalition on Alcoholism (DCCCA). DCCCA is a non-profit organization that administers the Kansas Sexual Abuse Treatment Program (SATP) under contract to the Kansas Department of Corrections. It is the sole provider of evaluation and treatment services to incarcerated sex offenders held at LCF. In addition, to LCF, DCCCA administers the SATP at correctional facilities for male prisoners at the Norton and Hutchison Correctional Facilities and for females prisoners held at the Topeka Women's Facility. Under its current contract with the Kansas Department of Corrections, DCCCA is obligated to

provide sex offender treatment service for a maximum of 312 inmates incarcerated within these four penal institutions.

V. Description of Treatment Programs

Until 2003, all inmates within the SATP as administered and operated by DCCCA within the Lansing facility were enrolled in a relatively standardized program grounded in a cognitive-behavioral treatment model with a relapse prevention component. Participation in the SATP was (and is) mandatory for all convicted sex offenders housed at LCF, and the program was designed as an eighteen-month intervention. Although this "standard" program takes into account individual offense histories and variations in static offender risk factors, treatment is delivered primarily through a therapist-led group modality to stable groups that included inmates convicted of sexual crimes against adults, against children, and against both adults and children. Consistent with the assumptions of the CBT model, participants in the "standard" program are exposed to components that are intended to reduce denial and/or minimization of harm done and to increase their empathy towards victims of sex crimes. Consistent with its RP framework, participants in this program are also taught to recognize cognitive and behavior precursors to the

initiation of a sexual offense chain sequence, ways to avoid and/or counter-act the influence of those precursors, and techniques for disrupting the offense chain before it reaches the actual commission of a crime.

In 2003, DCCCA initiated a specialized child specific sex offender program at LCF. This program was established as a remedial response to the inordinately high proportion of child specific offenders who were failing to progress in the evaluation and treatment phases of the SATP program while they were grouped together with other types of sexual offenders. Designed as an 11-month to 12-month intervention, this "specialized" program incorporated several of the components of the standard program. Based in part and utilizing materials obtained from the Canadian Ministry of Corrections in Ontario, however, the "specialized" therapy was restricted to inmates who had committed offenses against children. Moreover, the specialized treatment program classified participants according to child sex offender profiles. The latter were differentiated from each other on the basis of preferred victim age/gender and prior victim's relation to the offender, the object, intensity and nature of offenders' pedophilic interest/arousal, the level of offender social and stress- coping skills and other variables. The focus of

the specialized therapy was the offender's specific paraphilic attraction template. In both individual therapy and group sessions with other child-specific sex offenders, participants in this program were instructed in the mechanisms of their particular offense pathway (or, in some instances, pathways).

Neither the "standard" nor the "specialized" treatment program employed any type of aversive conditioning, covert sensitization, or a pharmacological regimen addressed to the sexual offense propensities of their respective participants.

VI. Delineation of Treatment

A. Standard Treatment

The Standard treatment program lasts eighteen months in duration and consists of a three month Evaluation phase, twelve month Intensive phase and a three month Transition phase. New participants receive Evaluation four days a week, for one hour each day after completing all entry testing. Participants begin evaluation by learning specific treatment language, completing daily journals about events, thoughts and feelings related to treatment and working towards owning culpability for their sexual offense(s). Participants complete the first in a series of four Safer Society workbooks entitled "Who am I and why am I in

treatment?" as well as an autobiography which is presented in the small group setting. Instruction is provided in lecture format as well as through a series of videotapes outlining offense precursors, a chain of events leading to cycles of sexually offending behavior and relapse prevention components. Participants are placed in small groups of approximately ten to twelve offenders with one facilitator per group upon entry into the program. Groups consist of participants in the Evaluation, Intensive and Transition phases of treatment. Groups are held four days a week for approximately one and one-half hours a day. It is in the small group setting where participants present their autobiographies and take responsibility for their sexually offending behavior before advancing to the Intensive phase of treatment. Participants also present their sexual histories, victim sheets, results of Penile Plethysmograph (PPG), Sexual History Disclosure Polygraphs (SHDP), Deviant (Although paraphilic is the proper term, the SATP program used this word) Cycles and Personal Maintenance Program Contracts (PMPC).

The Intensive phase of standard treatment lasts twelve months in duration. Psychoeducation is conducted in a classroom setting of approximately thirty to forty-five participants. Instruction is provided through lecture

format, video presentations and individual lesson handouts. Instruction is received for one hour daily, four days a week with three to four facilitators alternating instructor duties between the morning and afternoon classes. The Psychoeducation component covers the following subject areas; Relapse Prevention, Life Skills, Communication, Feelings, Empathy, Values and Decisions, Self-Esteem, Sexuality, Parenting and Relationships and Conflict, Anger and Stress Management. The Empathy and Sexuality modules last two months in duration whereas all other modules last one month in duration.

Participants receive learning objectives for each module on the first day as well as a pre test. Testing is conducted by means of pre and post tests with each participant being required to score eighty per cent on the module for completion of the module. Participants failing to score eighty per cent on the module post test receive individual assistance from one of the facilitators and retest until a passing score is achieved.

During the Intensive phase of Standard treatment, participants process sexual histories, victim sheets, victim empathy letters, deviant cycles (program designation for paraphilic sexual cycle), entry PPG and SHDP results in small group settings.

Participants learn the build up, act out, justification and pretend normal components of their individual cycles.

Participants begin to recognize precursors to their offense chain to include seemingly unimportant decisions (SUDS), problems of immediate gratification (PIGS), and abstinence violation effect (AVE). Internal and external triggers are explored and appropriately targeted interventions are developed for identified stressors and triggers.

Participants complete the remaining three workbooks in the Safer Society series which are; "Why did I do it again," "How can I stop," and "Empathy and Compassionate Action" as well as complete all Psychoeducation and process their deviant cycles in small groups prior to advancing to the Transition phase of Standard Treatment. During the Intensive phase, participants learn to identify arousal patterns, recognize and replace cognitive distortions with healthier thinking, identify and clarify offending behaviors, recognize progressive patterns of sexually offending and develop interventions for identified stressors and triggers.

Participants in the Transition phase of standard treatment work independently on developing their PMPCs apart from the psychoeducation and evaluation classes for one hour daily, four days a week. The Transition phase is

the culmination of all that is learned in the prior fifteen months and is specifically for the development of the PMPC which details how each participant plans to maintain individual safety and reduce individual risk to community safety.

Standard treatment does not specifically target attraction/offense pathway attributes. The standard treatment model was based primarily on relapse prevention and assumes that all offenders have substance abuse issues that trigger a sexual offense cycle. Standard treatment also assumes that all participants experience remorse for their offending behaviors. Lastly, standard treatment does not address specific impulse-urge pathways to offending or offense pathways of those who do not suffer from social skills deficits, substance abuse issues or previously diagnosed mental health concerns but tend to operate from scripted fantasies, ritualistic planning and precisely executed offenses of a recurring nature for the purpose of ongoing sexual gratification most accurately defined as sadistic in nature.

B. Specialized Treatment.

The Specialized treatment program lasts twelve months in duration consisting of a three month Evaluation phase, six month Intensive phase and a three month Transition

phase. Specialized Evaluation is conducted similar to the standard evaluation in terms of entry and exit testing, number of days held, amount of time spent in small groups and education daily as well as instruction format. Participants receive early instruction on attraction template recognition and defining offense types according to the specialized matrix. The matrix displays four quadrants of offending behavior; Focused (exclusive child template), Nonfocused (child and adult template), Incestor (intrafamilial and/or extrafamilial) and Atypical (encompasses multiple paraphilia clusters). Participants are required to complete an adult attraction template and a child attraction template outlining physical and emotional characteristics the participant finds desirable. The level of victim attraction is a Likert scale (1-10) in which participants assign a number to their level of attraction towards their sexual offense victim(s) based on how attractive the participant found the victim at the time of offense. Specialized Evaluation participants receive a brief overview of the standard treatment cycle and complete "Who am I and why am I in Treatment." Participants learn specific treatment language, process daily journals involving events, thoughts and feelings relative to treatment, autobiographies and take responsibility for

their sexually offending behavior in the small group setting. Everyone in the Specialized Evaluation has an offense against a child sixteen or under and/or identified paraphilic clusters unlike the standard treatment and evaluation groups. Due to security concerns, specialized participants do not usually work on written assignments outside of the treatment environment or in the cell houses. This is often the primary reason specialized group participants often fail to progress in standard treatment groups.

Upon completion of evaluation, specialized participants attend psychoeducation with the standard treatment participants as specific details of offending behavior is not addressed in this arena. Psychoeducation is conducted in the same manner for standard and specialized participants relative to time spent daily, number of days and method of instruction. Specialized participants often test out of certain modules at the discretion of the facilitator under uniform guidance of the clinical director and complete psychoeducation in nine months or less.

The Intensive phase of specialized treatment lasts nine months. Participants are required to complete sexual histories with greater detail than the standard treatment groups as patterns of offending behaviors, cognitive

distortions that give permission to offend, proximity, opportunity, grooming behaviors and emotional bond issues are explored and processed within the small group setting. Specialized participants process victim sheets, empathy letters, PPG and SHDP results as well as all four Safer Society workbooks in the same manner as the standard treatment participants. Prior to completion of the Specialized Intensive phase, participants will have also presented their paraphilic sexual template in group and finished any remaining psychoeducation modules.

The Transition phase of specialized treatment lasts three months and is the culmination of everything learned in the last nine months. This is reflected in the specialized PMPC which is processed in the small group setting along with exit Multiphasic Sexual Inventory (MSI) testing and results of the exit PPG, which is the facilitator's best indicator of whether the participant can control paraphilic arousal previously indicated on entry PPG and written actuarial assessments. The specialized PMPC clearly outlines the participant's attraction template(s), pathways to offending, level of victim attraction and matrix identifier. The Core attraction, Critical elements and Contributing factors involved in the participant's sexual offense(s) are also clearly outlined in the

specialized PMPC. Participants must be able to identify arousal patterns, cognitive distortions, offending behaviors, progressive patterns of sexually offending, grooming behaviors and erotic motivations in their individual PMPC.

VII. Study Design

A. Overview

This investigation was designed as a pre-treatment/post-treatment study comparing changes in subjects' ability to control paraphilic arousal following exposure to a specialized treatment program with changes in subjects' ability to control paraphilic arousal following exposure to a standard treatment program. Subjects participating the specialized program (or DCCCA model) who are included in the study constitute its "experimental" group while those participating in the standard program (or CBT/RP model) comprise its "control" group.

Change in the study principal outcome variable (paraphilic arousal control) was determined for both study groups by calculating the difference between control measured at two sampling junctures. All subjects underwent PPG testing at an "entry" point following a preliminary phase that did not include group therapy. For the

experimental group subjects, initial PPG testing took place approximately four months after their enrollment in the specialized program. For the control group subjects, the first round of PPG testing occurred approximately six months after their enrollment in the standard program. The second round of PPG administration for subjects in the experimental group was conducted near their "graduation" from the specialized program, that is, between 7 to 8 months after their initial PPG testing. The subjects in the control group received their second PPG test upon their completion of the standard program, that is, approximately 12 months after their initial PPG tests. In addition, subjects in both the experimental and control groups received a single round of polygraph testing at a mean of 6 months after their entrance into either the specialized or the standard treatment programs.

B. Study Variables

The study's sole independent variable is binomial variance in subject exposure to one of two treatment conditions: (a) treatment through the specialized program for child sex offenders at LCF; and, (b) treatment through the standardized program for sex offenders at that same facility. The study's sole dependent variable is change in subjects' capacity to control paraphilic arousal.

Variations in polygraph deception findings for the two groups are construed as a potential inter-mediating variable that may indicate the presence of a confounding factor, which, in turn, might affect the validity of findings for study's main principal hypothesis.

C. Data-Gathering Methods

The researcher collected the data for this study over a two-year time span with the knowledge and approval of the Clinical Director of SATP and LCF's Deputy Warden for Programs. An initial round of testing was conducted for the subjects in the experimental group at a mean of four months after their entry into the specialized child sex offender program at LCF. A professional penile plethysmograph technician used an eight-channel Behavioral Technologies Monarch 20 PPG to conduct testing. Subjects were exposed to a set of 42 digitized slides depicting prospective sexual offense victims. The images displayed on these slides included those of males and females ranging in development stage from infancy to geriatric and varied according to characteristics of the sexual contact scenario depicted, that is, as involving either "coercion" or "persuasion." If during a particular segment of the slide presentation measured subject arousal displayed an upswing greater than 10 points from a basal reading without detumescence or a

decline in response, the arousal was considered to be significant and the response was noted accordingly. Excluding two individuals who were medically disqualified from participation in the PPG, scores for the experimental group subjects were classified under four headings: (1) control, (2) marginal control, (3) no control, and (4) flatlined. This procedure was replicated with the subjects in the experimental group 7 or 8 months later, that is, around the time of completion of the specialized treatment program.

An initial round of testing was conducted with subjects in the control group at a mean of six months after their entry into the standard sex offender program at LCF. The procedures, measurement instrumentation, and categorical ratings used with this group were identical to those employed with the experimental group subjects. One of the subjects in the control group was excluded from PPG testing due to a medical condition. An identical exercise was conducted with the same subjects around the time of their completion of the standard treatment program, that is, at a mean of 12 months after the first sampling juncture with this group.

Subjects in both the experimental and control groups were subjected to a polygraph at a mean of approximately

six months after their respective entrance into the specialized and standard treatment programs. Prior to the administration of this test, all subjects completed a Sexual History Disclosure polygraph package. The completion of this package entailed an extensive "In Your Own Words" account of subjects' sex crime offending history, a closely related questionnaire, as well as presentations in both therapy group sessions and in one-on-one sessions with a trained clinician (the researcher). From the information obtained through these means, the researcher constructed polygraph questionnaires for each inmate that was subsequently administered to each subject by a professional polygrapher. Two subjects (one from the experimental and one from the control group) were disqualified from this exercise on medical grounds. Response patterns for the remainder of the subjects were classified under one of three categorical headings: (1) deception indicated, (2) non-deceptive, or (3) inconclusive. The researchers aggregated data from both rounds of the PPG and from the SHD polygraph exercises.

D. Statistical Analysis Procedures

Statistical analysis took the form of a standard Chi Square regression. The criteria for statistical significance was set at $r = 0.5$

VIII. Study Populace

A. Description of the Study Sample

The total study sample was comprised of 85 (N = 85) inmates incarcerated at the Lansing Correctional Facility after sentencing for a sexual crime involving an individual under the age of 16 years old. All study subjects were adult males who met the SATP's criteria as specialized child sex offenders at the time of their entrance into treatment. They ranged in age from 20 years old to 80 years old at the time of the second round of PPG testing. All study subjects completed treatment in one of the two programs under investigation between April, 2003 and April, 2005. A total of 50 inmates (N = 50) entered and completed the specialized treatment program; 35 subjects entered and completed the standard treatment program. (See Table I).

B. Recruitment of the Study Populace and Study Group Formation

While all inmates entering LCF who meet the DCCCA/SATP's criteria as sexual offenders must undergo some form of sex offender treatment or face significant institutional sanctions (such as loss of privileges), all of the subjects in this investigation voluntarily consented to participate in the study. Upon their arrival at LCF, inmates were evaluated and assigned to either the

specialized or the standard treatment program by the DCCCA/SATP's Clinical Supervisor/Program Director on the basis of their individual treatment needs. However, because the number of available "slots" in the specialized program was limited, some of the individuals who would otherwise have been assigned to the study's experimental group were placed in the study's control group.

C. Ethical Considerations

Unlike the majority of sex offender treatment effect studies, "control" group subjects in this investigation were *not* assigned to a "no treatment" condition: they received standard CBT/RP therapy. Moreover, assignment to the specialized treatment program was determined by a professional clinical psychologist on a needs basis under available resource constraints that could not be relaxed.

As noted in passing above, all subjects volunteered to participate in the study and signed an authorization release attesting to that fact. The release form (see Appendix A) stipulated that the prospective participant could withdraw *from the study* at any time without penalty and without furnishing a reason for withdrawal. The form also stated that participants in the study would receive no form of compensation or other type of incentive beyond taking part in a research study that might lead to an

improvement in the quality of treatment available to themselves and to other child sex offenders.

The researcher did not record the identities of the study participants. Nevertheless, all study data was treated as confidential. To the best of the researcher's understanding, the study conformed to all of ethical standards for conducting research with human subjects.

IX. Limitations and Significance of Study Findings

Both the validity and the reliability of study findings are substantially limited by the relatively small size of the study sample, by the use of non-probabilistic means to identify prospective participants for recruitment into the study, by the use of non-probabilistic means to assign subjects to experimental/control groups, and by the likely influence of confounding variables. The latter include, but are not restricted to, the possibility that one or more subjects intentionally "faked" or otherwise manipulated PPG measurement outcomes and that uncontrolled treatment process variables (such as differences in therapy group cohesion or therapist skill) influenced study results.

The study's findings are significant for both the development of the existing empirical base on child sex offender treatment effects and for the enhancement of

treatment program efficacy. Very few published investigations have compared the effects of different treatment models in samples of child sex offenders. To the best of the researcher's knowledge, no studies have compared the treatment effects of a "standard" CBT/RP-type therapy with those of "specialized" program for child sex offenders based upon the DCCCA model. A finding of superior effects on the control of paraphilic arousal for the DCCCA program in comparison to those of the CBT/RP-based program could conceivably facilitate the dissemination and implementation of more effective treatment program designs for use with incarcerated child sex offenders. Given the United States Department of Justice's estimate that 25 percent of the imprisoned population in the United States has committed some type of sexual offense and that a substantial portion of this populace has committed an offense against children, improvements in treatment program efficacy are plainly of considerable significance. By the same token, a contrary finding (of no significance or of stronger direct effects for the control group) would also be relevant in the ongoing effort to enhance treatment efficacy. It would either argue against differentiation of treatment or indicate an as yet unrecognized need to revise the DCCCA model.

X. Additional Treatment Considerations

Ultimately, what is being measured is recognition and control of paraphilic arousals with interventions specifically designed to target the attraction/offense pathway. Specialized treatment addresses criminogenic thinking and erotic motivation in terms of areas of risk, needs and responsivity. Specialized treatment was designed to encourage participants to build on the healthy adult attraction template and assumes that all but focused (exclusive) pedophiles have more than one attraction template. Specialized treatment addresses offense pathways of the Approach-Automatic and Approach-Explicit participants as defined by Ward and Hudson (1998). Specialized treatment does not address many of the issues focused (exclusive) pedophiles bring to treatment at this time due to the limited body of available literature relative to the specific needs of this target populace and even fewer studies designed to address these needs at this time.

XI. Sample Size

Under ideal clinical research conditions, the relatively small sample size could have negatively affected the study's outcome. One must keep in mind that because of

the limited amount of available research relative to the target populace and ethical considerations about the availability of treatment for incarcerated child sexual offenders, this study was a preliminary effort to address issues of heterogeneity amongst the aforementioned, test what is known, discover new data, call for additional studies to improve research design and attempt to provide increased treatment efficacy to an underserved population through streamlined service delivery.

XIII. Clinician Training

All clinicians participating in this research study had postgraduate specialist licenses in clinical social work or psychology. All clinicians had a minimum of three years of experience with a heterogeneous population of sexual offenders in community and institutional settings. All clinicians were certified at the clinical level by the Association for Treatment of Sexual Abusers (ATSA). Continued training in specialty areas was provided through in-service trainings on a monthly basis, continuing education credit courses and additional doctoral coursework in forensic psychology, clinical sexuality and counseling psychology.

XIII. Description of Study Participants

Demographics, sexual and offense histories, Axis I and Axis II diagnoses as well as additional delineating information comparing and contrasting the standard versus the specialized treatment populations can clearly be seen in tables one through ten and corresponding graphs located in the appendices.

RESULTS

The study involved eighty-five incarcerated child specific sexual offenders, all of whom met the criteria for specialized treatment. Fifty received specialized treatment and thirty-five received standard treatment although there were more offenders not meeting the criteria in standard treatment. The study became weighted when this researcher originally sought to compare fifty offenders receiving standard treatment with fifty offenders receiving specialized treatment. Adjustments were made so all eighty-five participants met criteria for specialized treatment prior to commencement of the study.

The primary research question addressed in this study was stated as follows: Does the treatment of incarcerated child sex offenders through a program that is differentiated by variations in subject paraphilic attraction / offense pathway attributes increase capacity to control paraphilic arousal to a greater extent than treatment through a program that is not differentiated by such attributes? The answer is no.

*The study's primary research question was formulated as the following null hypothesis for testing.
Hypothesis #1: There will be no difference in the degree of change in capacity to control paraphilic arousal (as measured through penile plethysmography) between subjects in an experimental program in which therapy is differentiated according to variations in paraphilic*

attraction / offense pathway attributes and the degree of change in capacity to control paraphilic arousal among subjects in a control group receiving standard cognitive-behavioral / relapse prevention treatment program that is not differentiated by such attributes.

There was not a significant relationship between penile plethysmograph (PPG) control and treatment (Standard versus Specialized). This was established by conducting a Chi Square after weighing the number of subjects achieving control in each group utilizing the following formula:

$$\chi^2 = \frac{(f_o - f_e)^2}{f_e}$$

The Chi square revealed a non-significant relationship, $\chi^2 (1) = 0.57, NS$. The critical value for significance needed to be 3.84 or greater. There is no relationship between control and treatment.

Table 1.

Frequency of PPG Control by Treatment (Standard versus Specialized).

	Treatment	
Standard		Specialized
Control	21	18

Hypothesis #2: There will be no difference in the incidence of deceptive responses (as measured by a standard polygraph instrument) to items formulated on the basis of individual answers to a Sexual History Disclosure (SHD) questionnaire between subjects in the experimental and control groups.

The results from the findings of hypothesis #2 were used primarily to determine for the presence of a confounding influence upon the results for Hypothesis #1 stemming from any significant variance in incidence of deception between the experimental and control groups.

A nonsignificant relationship was found between the Sexual History Disclosure (SHD) Questionnaire and treatment (Standard versus Specialized). This was established by conducting a Chi Square after weighting the participants in each group.

$\chi^2 (1) = 0.04$, NS. A number equal to or greater than 3.84 is the critical value to be significant. There is no significant relationship between a Nondeceptive Sexual History Disclosure Polygraph and treatment.

Table 2.

Frequency of Nondeceptive SHDP by Treatment (Standard versus Specialized).

	Treatment	
	Standard	Specialized
ND	14	18
(Nondeceptive)		

Neither form of treatment increased the capacity to control paraphilic arousal to a greater extent. There was a difference in the degree of change in capacity to control paraphilic arousal measured through penile plethysmography between subjects in the experimental program and subjects in the control group. There was also a difference in the incidence of deceptive responses measured by a standard polygraph instrument to Sexual History Disclosure Questionnaire answers between subjects in both groups.

Tables and graphs are located in the appendices. Table 1 and the corresponding graph indicates 60% of the Standard participants demonstrated control on the PPG whereas, only 36% of the Specialized participants demonstrated control of paraphilic arousals. When marginal control results are examined, only 8% of the Standard group demonstrated marginal control as opposed to 24% of the Specialized participants. It would appear that the Standard participants demonstrated better control of paraphilic arousals.

Due to concerns over the possibility of one or more participants could have intentionally "faked" or otherwise manipulated PPG Measurement results, the Sexual History Disclosure Polygraph (SHDP) results were also examined. As Table 2 and corresponding graph indicate 40% of the

Standard participants scored nondeception as compared to 36% of Specialized participants. 34% of the Standard participants scored inconclusive as opposed to 22% of the Specialized participants. Lastly, 23% of the Standard group participants scored deception as opposed to 40% of the Specialized group participants.

It would appear that the Specialized participants were less likely to effectively manage their paraphilic arousals as well as less likely to honestly and accurately disclose prior sexually offending behavior. It would also appear more likely that the Specialized participants were more likely to endorse attitudes favorable to offending and remain entrenched in those attitudes at the conclusion of treatment.

In terms of demographics, Lansing Correctional Facility and the DCCCA SOTP programs examined were predominantly populated with Caucasians as Table 3 and corresponding graph depict. Caucasians comprised 69% of Standard participants as well as 88% of the Specialized participants. There were no African-Americans in the Specialized group at the time of this study and only 17% in the Standard group. Hispanics comprised 11% of the Standard group population and 8% of the specialized group. Lastly, Native Americans comprised a mere 2% of the Standard

participants and 4% of the Specialized group. It would appear that Caucasians in the SATP program commit child specific sexual offenses at a ratio of four to five times higher than other ethnicities participating in the program.

Table 4 and the corresponding graph indicate that age twenty was the youngest for Standard group participants and age sixty-eight was the oldest. The age ranged from twenty-one to eighty for Specialized participants. It would appear that Specialized participants in the program begin offending at approximately the same age as Standard participants but continue to offend for approximately eleven to twelve more years.

In terms of Intelligence Quotient (IQ) range of participants, Table 5 and corresponding graph indicate Standard group participants ranged from sixty-five or mild cognitively challenged to One hundred eighteen or high average intelligence. Specialized participants ranged from a low of seventy-four or borderline intellectual functioning to a high of one hundred twenty nine or high average intelligence. One can clearly see that Specialized participants were often more intelligent than their Standard group counterparts however, it would appear that the Specialized participants had more paraphilic interests, were more skilled at sexually offending and were less

likely to be fully disclosive about extent, duration, level of intrusiveness and number of victims.

When comparing frequency of paraphilic arousals of both treatment groups as depicted in Table 6 and corresponding graphs, Specialized participants were three times as likely to offend male and female infants as their Standard group counterparts. Specialized participants were twice as likely to coerce preschool females and equally as likely to groom grammar school females. Standard participants were twice as likely to coerce grammar school females. Specialized participants were twice as likely to groom or coerce grammar school males. Standard participants were twice as likely to groom or coerce adolescent females with the numbers suggesting a 6% greater preference for coercion. The Specialized participants were twice as likely to groom or coerce an adolescent male. 57% of the Standard participants demonstrated a preference for grooming teen females with 51% also demonstrating a preference for coercion of teen females. Specialized participants demonstrated a 14% greater preference for coercion as opposed to grooming a teen female. Standard participants were 6% less likely to groom a teen male than their Specialized counterparts but equally as likely to coerce a teen male. Standard participants had a 6% greater

preference for grooming an adult female than coercing an adult female. Specialized participants demonstrated no significant arousal to adult females or adult males in the challenge section however; Standard participants demonstrated an 8% arousal to the female challenge and 5% arousal to the male challenge. Standard participants were 12% more likely to be aroused to violence against children than their Specialized counterparts. Both groups were almost equally aroused to violence against women. Standard participants were 22% more likely to be aroused to violence against men. Standard participants were 28% more likely to be aroused to a female adult exhibitionist than their Specialized counterparts. This may indicate a greater preference for visual stimulation as opposed to other modalities and could also indicate that Specialized participants have a wider range of paraphilic interests. It is also of interest to add that pedophiles who are interfamilial incestors do not usually get aroused to the children of others. 8% of Standard participants demonstrated an arousal to male adult exhibitionists whereas no Specialized participants demonstrated arousal to the same stimuli.

Based on the aforementioned frequency of paraphilic arousal results, it would appear that the three main areas

of arousal for specialized participants were pedophilic in nature including grooming grammar school females and males as well as coercing adolescent males. Standard participants three main areas of arousal centered on grooming teen females, coercing teen females and viewing adult female exhibitionists. Of noteworthy interest, Standard participants were almost equally as likely to be aroused to coercing female adolescents, grooming grammar school females and grooming female adolescents. Specialized participants demonstrated 38% arousal to coercing teen females, 36% arousal to violence against females and 34% arousal to male and female infants equally.

Axis I diagnosis frequency of both treatment groups is documented in Table 7 and both corresponding graphs. Results indicate that 20% of Standard participants had no Axis I diagnosis, 43% had Sexual Abuse of a Child, 11% were diagnosed with Major Depressive Disorder, 11% had Alcohol Dependence as a primary diagnosis with Alcohol and Cannabis Abuse following at 9% each. Lastly, Adjustment Disorder with Mixed Emotional Features topped off the primary diagnoses at 9%.

Specialized participants received an equal percentage of Sexual Abuse of a Child and Pedophilia, nonexclusive type, limited to females as an Axis I diagnosis with each

being 18%. Paraphilia Not Otherwise Specified (NOS) with Hebophilic Features, Pedophilia, Females, Limited to Incest, (Intrafamilial), Major Depression and Alcohol Dependence occurred equally at 12% each. Alcohol abuse and No Diagnosis occurred in the specialized participant group as well with a frequency of 10%.

Table 8 and both corresponding graphs depict most frequently occurring Axis II diagnoses for both treatment groups. Axis II Diagnoses for Standard participants included; No Diagnosis 26%, Personality Disorder NOS with Antisocial Features and Personality Disorder NOS with Narcissistic Features, both at 20%. Antisocial Personality Disorder was the most common personality disorder with a frequency of 9%, followed by Avoidant Personality Disorder, Obsessive-Compulsive Personality Disorder and Schizoid Personality Disorder each occurring with a frequency of 6% in the Standard Treatment Population.

Specialized Participants received No Diagnosis on Axis II 20% of the time. 28% received Personality Disorder NOS with Narcissistic Features, 12% received Personality Disorder NOS with Antisocial Features, Personality Disorder NOS with Avoidant Features and Personality Disorder NOS with Dependent Features. 8% had Personality Disorder NOS with Histrionic or Borderline Features. In terms of Axis II

Personality Disorders, 6% of Specialized participants were Avoidant Personality Disorder, 4% were Antisocial Personality Disorder and 2% were Borderline Personality Disorder.

It would appear that Specialized participants have more limited socialization skills and are less likely to be outwardly noncompliant with statutes, societal norms and authority figures. Narcissistic features appear to be 5% more prevalent with the Specialized group whereas antisocial features are 8% more prevalent with the Standard participants. 3% of Standard participants in this study also carried a diagnosis of Psychopathy.

Table 9 and corresponding graph document the frequency of offense types for both treatment groups. For the Standard participants, Aggravated Indecent Liberties with a Child under Sixteen occurred most frequently at 29%. Indecent Liberties with a Child under Sixteen occurred next with a frequency of 17%. Adult Rape and Aggravated Indecent Liberties with a Child under Fourteen occurred equally with a frequency of 11%.

Offense types for Specialized participants occurred most frequently as follows; Aggravated Indecent Liberties with a Child under Fourteen at 60%, Indecent Liberties with a Child under Fourteen occurred at 24%, Aggravated Criminal

Sodomy with a Child under Fourteen occurred at 18%, Clergy abuse and Attempted Aggravated Indecent Liberties with a Child under Fourteen occurred with equal frequency at 12%. Lastly, Lewd Conduct and Aggravated Indecent Solicitation of a Child occurred with equal frequency at 10%. The results clearly indicate strong paraphilic interest from Specialized participants with Adult Rape and Hebophilic interests most frequently occurring with the Standard Participants. Of Noteworthy interest, 10% of specialized participants committed Internet Child Pornography offenses and 4% used alcohol to groom minors for sexual purposes. 12% of specialized participants committed acts of Indecent Exposure on their victims. One can clearly see that Specialized participants have clusters of paraphilic interests.

Table 10 and corresponding Pie Graph clearly focuses on the frequency of Specialized Sexual Offenses by Categorical Nomenclature strongly influenced by Dr. William Granzig and further explained in the Discussion section of this dissertation. Pedophilic offenses against females occurred with 53% frequency amongst Specialized participants. Hebophilic offenses against post pubescent females occurred with 19% frequency amongst Specialized participants. Pedophilic offenses against males occurred

with 16% frequency amongst Specialized participants.

Ephebophilic offenses against post pubescent males occurred amongst Specialized participants with 8% frequency.

Gynephilic offenses (offending was not primarily due to attraction template preference but revenge motives or Post Traumatic Stress Syndrome) occurred with 2% frequency amongst Specialized Participants. Nephophilic (sexual assaults on infants from birth to age 3) offenses occurred with 1% frequency amongst Specialized participants. A plus or minus 1% margin of error was factored into this table.

Of primary importance is the fact that 69% of Specialized participants committed sexual offenses against females from the age of three to the age of lawful voluntary sexual consent, which is age 16 in the State of Kansas.

DISCUSSION

I. Study Implications

The study's findings are significant for the ongoing development of the existing empirical research on child sex offender treatment effects and for the development of improved research design in order to enhance treatment program efficacy. The research indicates that neither form of treatment has a significant effect on the issues that child specific sex offenders bring to treatment.

Furthermore, child sex offenders are homogenous only in that they are all child sex offenders. Current forms of treatment do not begin to recognize or address the heterogeneity of child sex offenders. Lastly, because even less is known about pedophilia, researchers have yet to discover the issues that pedophiles bring to treatment and to find improved means of addressing treatment needs of this specific sub group of child sex offenders.

The scholarly literature and this researcher's first hand observations indicate that there is significant evidence to substantiate the heterogeneity of child sex offenders based on differences in paraphilic attraction templates, social skill competence, criminogenic thinking patterns, erotic motivations, offense pathways, core

emotional issues and cognitive distortions that give permission to offend.

II. Study Limitations

Both the validity and the reliability of study findings are substantially limited by the relatively small size of the study sample, by the use of non-probabilistic means to identify prospective participants for recruitment into the study, by the use of non-probabilistic means to assign subjects to experimental/control groups, and by the likely influence of confounding variables. The latter include, but are not restricted to, the possibility that one or more subjects intentionally "faked" or otherwise manipulated PPG measurement outcomes and that uncontrolled treatment process variables (such as differences in therapy group cohesion or therapist skill) influenced study results.

III. Applicability

A significant number of child sex offenders do not meet the Diagnostic and Statistical Manual's (DSM IV TR) for pedophilia. A substantial proportion has additional paraphilic interests besides their attraction to children. There is also a higher incidence of co-morbidity with other Axis I and Axis II mental disorders.

At this time, a pressing need exists for expanded typologies of child sex offenders and the development of specifically tailored treatment plans that address differences in categories of child sex offenders in order to improve program development as well as increase the therapeutic value of current treatment approaches.

This researcher and colleague, Mike Boniello, propose the following classification of sexual offenders with a child specific sub classification strongly influenced by Dr. William Granzig;

- A) Sexually Reactive (Post traumatic Stress Syndrome) - emotional-sexual connection to PTSD.
- B) Psychosocially challenged (Mentally Challenged /Developmentally Disabled).
- c) Impulse and Urge Group (Specialized / Paraphilic). Tend to have a higher incidence of Bipolar, OCD, Impulsivity, ADHD, Sexual Compulsivity.
- D) Romeo & Juliet (Unlawful Voluntary Sexual Relations).
- E) Co-morbid Severe and Persistent Mental Illness (SPMI).
- F) Substance Abusers (Relapse Prevention Group).
- G) Antisocial Personality Disorder (principle diagnosis). This group tends to be chronic rule breakers and appear to be better served by focusing on their mental health needs as opposed to specific sexual behaviors.
- H) Sadists tend to have the most disturbed boundaries and experience significant difficulty with the physiological aspects of sexual functioning.
- I) Psychopathy / Criminal Genius

Sub classifications of child sexual offenders as follows;

Nephiophiles - sexually act on infants from birth to age 3.

Pedophiles - find children desirable between the ages of 3 and the development of secondary sexual characteristics between ages 11 and 13.

Hebophiles- attracted to girls between pubescence and the age of lawful sexual consent.

Ephhebophiles - attracted to males between pubescence and The age of lawful sexual consent.

Gynephiles - tied in with PTSD and do not offend based on sexual attraction template. Most often, for revenge or an attempt to punish someone other than the victim.

Factors to consider when developing future programs for nephiophiles would include co-morbid Axis I and II diagnoses, specific treatment for post traumatic stress disorder, addressing prior sexual victimization of the perpetrator, cognitive distortions that give permission to offend, social skills deficits, paraphilic fantasy and conjoint pharmacological interventions.

Factors to consider when developing future programs for pedophiles include; level of attraction, gender and age of the child(ren), prior sexual offenses, offense pathways, responsivity to covert sensitization and anti androgen medications, emotional needs, social skill competency, emotional self-regulation and overall willingness / ability

to effectively manage the paraphilic attraction template as well as attitudes favorable to sexual offending.

Factors to consider when developing future treatment programs for hebophiles would include; attraction template recognition, building on a healthier adult attraction template, addressing social skills deficits, recognition and effective management of paraphilic fantasy as well as other erotic motivations (impulses, urges, obsessions and compulsions), targeting cognitive distortions that give permission to offend, addressing emotional bond and codependent core issue concerns, assessing the offender's willingness to change attitudes favorable towards offending and lastly, overall motivation for treatment.

Factors to consider when developing future treatment programs for ephebophiles would include; addressing issues surrounding the sexual identity of the offender and related self-image concerns, paraphilic fantasy, attitudes favorable to offending, building on a healthy adult attraction template, addressing additional cognitive distortions and erotic motivations, effective management of impulses / urges, dangerous places, emotional bond, codependent core issues, prior sexual victimization (if applicable) and Lastly, conjoint pharmacological

interventions, if and when deemed necessary by the treatment team.

Factors to consider when developing future programs for gynephiles would include; (in most cases) identifying the motivation behind the offense and whom the offender was trying to affect both directly and vicariously. Most often, these offenses are not attraction template driven and are not primarily focused on the actual victim of the sexually offending behavior. Often, the sexual acting out is designed to vicariously punish a spouse, lover, ex or other by engaging in sexual activity with their child. There are times when the sexual acting out is an attempt by the offender to regain their power when the victim physically resembles the individual who victimized the offender at an earlier age. Oftentimes, the victim is within five years of the age of the offender when they were victimized. These offenses can be driven by anger, hatred or a subconscious attempt at payback and are often deeply rooted in the post traumatic stress disorder issues of the offender.

Gynephiles often have; cognitive distortions which give permission to offend, paraphilic fantasy, emotional bond issues, co-morbid Axis I and II diagnoses, unrecognized offense pathway concerns and desires for secondary gain which become further exacerbated by the disinhibiting

effects of drugs / alcohol. Gynephiles are often well into treatment before a link is established between their own victimization and their sexually offending behavior. Some gynephilic offenses have no link to prior sexual victimization and are primarily motivated by attempts to vicariously punish someone other than the actual victim for a variety of reasons later discovered in treatment.

IV. Future Research Considerations

Available scholarly literature indicates that little is known about successful treatment interventions with pedophiles. Factors to consider when developing future programs for pedophiles include; level of attraction, gender and age of the child(ren), prior sexual offenses, offense pathways, responsivity to covert sensitization and anti-androgen medications, attitudes favorable to offending, emotional needs, social skill competency, emotional self regulation and overall willingness / ability to manage the paraphilic attraction. When individualized treatment and pharmacological approaches fail to reduce pedophiles risk to public safety, stiffer laws and increased efforts towards containment are warranted with civil commitment being the last resort when other treatment options have failed.

Future treatment programs should tailor treatment to aforementioned sub classifications of sexual offenders differentiated by victim age and gender, attraction / arousal, attitudes favorable to offending, pathways to offending, mental health diagnosis, evidence of PTSD from sexual trauma and psychosocially challenged while continuing to address areas of risk, need and responsivity.

Since neither form of tested treatment significantly improved the child specific offender's ability to control paraphilic arousal whether the attraction / offense pathway attributes were targeted or not, further testing of specialized treatment and improved research design is needed to develop improved programs for the sub categories of child specific offenders. Additional actuarial assessments should measure sexual interests, paraphilic fantasy, attitudes favorable towards offending, level of motivation for treatment, capacity to change and responsivity to clinical recommendations.

In retrospect, if nothing else was accomplished, this study further established the heterogeneity of child sexual offenders and called for significant changes in the way that they are categorized as well as the way in which treatment services are currently delivered.

References

- Abel, G., Becker, J., Cunningham-Rathner, J. Mittelman, M.S. & Rouleau, J.L. (1988), Multiple paraphilic diagnoses among sex offenders. *Bulletin of the American Academy of Psychiatry and the Law*, 16(2), 153-168.
- Abel, G.G., Becker, J.V., Mittelman, M.S., Cunningham-Rathner, J., Rouleau, J.L. & Murphy, W.D. (1987). Self-reported sex crimes of nonincarcerated paraphiliacs. *Journal of Interpersonal Violence*, 2(1), 3-25.
- Alexander, M.A. (1999). Sex offender treatment efficacy revisited. *Sexual Abuse*, 11(2), 101-117/
- Alexander, R. (2004). The United States Supreme Court and The civil commitment of sex offenders. *Prison Journal*, 84(3). 361-378.
- Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Barbaree, H. & Marshall, W. (1988). Deviant sexual arousal, offense history, and variables as predictors of reoffense among child molesters. *Behavioral Sciences and the Law*, 6, 267-280.
- Becker, J.V. (1994). Offenders: Characteristics and treatment. *The Future of Children*, 4(2), 176- 197.
- Becker, J.V. & Murphy, W.D. (1998). What we know and do not know about assessing and treating sex offenders. *Psychology, Public Policy and Law*, 4(1/2), 116-137.
- Beckett, A.R., Beech, D., Fisher, D. & Fordham, A.S. (1994). *Community-based treatment for sex offenders: An evaluation of seven treatment programmes*. London: Home Office.
- Beech, A.R. (1998). A psychometric typology of child abusers. *International Journal of Offender Therapy and Comparative Criminology*, 42(4), 319-339.

- Beech, A.R. & Fordham, A. (1997). Therapeutic climate of sexual offender treatment programs. *Sexual Abuse, 9*, 219-237.
- Beech, A., Friendship, C., Erikson, M. & Hanson, R.K. (2002). The relationship between static and dynamic risk factors and reconviction in a sample of U.K. child molesters. *Sexual Abuse, 14*(2), 155-167.
- Bumby, K.M. (1996). Assessing the cognitive distortions of child molesters and rapists: Development and validation of the MOLEST and RAPE scales. *Sexual Abuse, 8*(1), 37-54.
- Craissati, J. (1998). *Child sexual abusers: A community approach*. Psychology Press.
- Finkelhor, D. (1984). *Child sexual abuse: New theory and research*. New York: Free Press.
- Fisher, D., Beech, A. & Browne, K. (1999). Comparison of sex offenders and nonoffenders on selected psychological measures. *International Journal of Offender Therapy and Comparative Criminology, 43*(4), 473-491.
- Furby, L. Weinrott, M. & Blackshaw, K. (1989). Sex offender recidivism. *Psychological Bulletin, 105*(1), 3-30.
- Gallagher, C.A., Wilson, D.V., Hirschfield, P., Coggeshall, M.B., & Mackenzie, D.L. (1999). A quantitative review of the effects of sex offender treatment on sexual reoffending. *Corrections Management Quarterly, 3*, 19-29.
- Glasser, M., Kovlin, I., Campbell, D. Leitch, I. & Farrelly, S. (2001). Cycle of child sexual abuse: Links between being a victim and becoming a perpetrator. *British Journal of Psychiatry, 179*, 482-494.
- Grossman, L.S., Martis, B. & Fichtner, C.G. (1999). Are sex offenders treatable? A research overview. *Psychiatric Services, 50*(3), 349-361.

- Groth, A.N. (1978). Patterns of sexual assault against children and adolescents. In A.W. Burgess, L.L. Holstrom, & S.M. Groi (Eds.), *Sexual assault of children and adolescents*. (pp.3-24). Boston: D.C. Heath.
- Hall, G.C.N. (1995). Sexual offender recidivism revisited: A meta-analysis of recent treatment studies. *Journal of Consulting and Clinical Psychology, 63*(5), 802-809.
- Hanson, R.K. & Bussiere, M.T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66*(2), 348-362.
- Hanson, R.K. Gizzarelli, R. & Scott, H. (1994). The attitudes of incest offenders: Sexual entitlement and the acceptance of sex with children. *Criminal Justice and Behavior, 27*, 6-35.
- Hanson, R.K., Gordon, A., Harris, A.J.R., Marques, J.K., Murphy, W., Quinsey, V.L. & Seto, M.C. (2002). First report of the Collaborative Outcome Data Project on the effectiveness of psychological treatment of sex offenders. *Sexual Abuse, 14*(2), 169-194.
- Hanson, R.K., Morton, K.E., & Harris, A.J.R. (2003). Sexual offender recidivism risk: What we know and what we need to know. *Annals of the New York Academy of Sciences, 989*, 154-166.
- Hanson, R.K., Steffy, R.A. & Gauthier, R. (1993). Long-term recidivism of child molesters. *Journal of Consulting and Clinical Psychology, 61*(4), 646-652.
- Harris, G.T., Rice, M.E. & Quinsey, V.L. (1998). Appraisal and management of risk in sexual aggressors: Implications for criminal justice policy. *Psychology, Public Policy and Law, 4*, 73-115.
- Hood, J. Shute, S., Feilzer M. & Wilcox, A. (2002). Sex offenders emerging from long-term imprisonment. *British Journal of Criminology, 42*, 371-394.

- Howells, K. (1981). Adult sexual interest in children: Considerations relevant to theories of etiology. In M. Cook & K. Howells (Eds.), *Adult sexual interest in children* (pp.55-94). London: Academic Press.
- Johnston, H. & Ronken, C. (2005). *The management and treatment of child sex offenders*. Sydney, AU: Bravehearts Inc.
- Knight, R. Carter, D. & Prentky, R. (1989). A system for the classification of child molesters. *Journal of Interpersonal Violence*, 4 (1), 3-23.
- Knight, R.A. & Prentky, R.A. (1990). Classifying sexual offenders: The development and corroboration of taxonomic models. In W.L. Marshall, D.R. Laws & H.E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories, and treatment of the offender* (pp.25-53). New York: Plenum Press.
- Launay, G. (2001). Relapse prevention with sex offenders: Practice, theory and research. *Criminal Behavior and Mental Health*, 11, 38-54.
- Lussier, P. (2005). The criminal activity of sexual offenders in adulthood: Revisiting the specialization debate. *Sexual Abuse*, 17(3). 269-292.
- Maletzky, B.M. (1998). *Treatment outcome, technique Efficacy and assessment of risk: A five to twenty-Five year follow up of 7,200 sexual offenders*. Vancouver: Association for the Treatment of Sexual Abusers.
- _____. (1998). Editorial: Defining our field: Cycles, chains, and other assorted misnomers. *Sexual Abuse*, 10, 1-3.
- Maletzky, B.M. & Steinhauser, C. (2002). A 25-year follow-up of cognitive/behavioral therapy with 7,275 sexual offenders. *Behavior Modification*, 26(1), 123-147.
- Mann, J., Stenning, W. & Borman, C. (1992). The utility of the MMPI-2 with pedophiles. *Journal of Offender Rehabilitation*, 18(3/4), 59-74.

- Mann, R.E. (2004). Innovations in sex offender treatment. *Journal of Sexual Aggression, 10*(2), 141-152.
- Mann, R.E. & Beech, A.R. (2003). Cognitive distortions, schemas and implicit theories. In T. Ward, D.R. Laws & S. Hudson (Eds.), *Sexual deviance: Issues and controversies* (pp.135-153). London: Sage.
- Marques, J.K. (1999). How to answer the question: "Does sex offender treatment work?" *Journal of Interpersonal Violence, 14*(4), 437-451.
- Marques, J.K., Day, D.M., Nelson, C. & West, M.A. (1994). Effects of cognitive-behavioral treatment on sex offender recidivism: Preliminary results of a longitudinal study. *Criminal Justice and Behavior, 21*(1), 28-54.
- Marques, J.K. Nelson, C., Alarcon, J.M. & Day, D.M. (2000). Preventing relapse in sex offenders: What we learned from SOTEP's experimental treatment program. In D.R. Laws, S.M. Hudson & T. Ward (Eds.), *Remaking relapse prevention with sex offenders: A sourcebook* (pp.321-240). London: Sage.
- Marques, J.K., Wiederanders, M., Day, D.A., Nelson, C. & van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Results from California's Sex Offender Treatment and Evaluation Project (SOTEP). *Sexual Abuse, 17*(1), 79-107.
- Marshall, W.L. (1979). Satiation therapy: A procedure for reducing sexual arousal. *Journal of Applied Behavioral Analysis, 12*, 10-22.
- _____. (1989). Invited essay: Intimacy, loneliness and sexual offenders. *Behavior Research and Therapy, 27*, 491-503.
- _____. (1997). Pedophilia: Psychopathology and theory. In D. Laws and W. O'Donohue (Eds.), *Sexual deviance* (pp.152-174). New York: Guilford Press.
- Marshall, W.L., Anderson, D. & Fernandez, Y. (1999). *Cognitive-behavioural treatment of sexual offenders*. Chichester, UK: John Wiley.

- Marshall, W.L. & Fernandez, Y.M. (2003). *Phallometric testing with sexual offenders*. Vermont: Safe Society Press.
- Marshall, W.L., Hamilton, K. & Fernandez, Y. (2001). Empathy deficits and cognitive distortions in child molesters. *Sexual Abuse, 13*(2), 123-130.
- Marshall, W.L. & Laws, D.R. (2003). A brief history of behavioral and cognitive behavioral approaches to sexual offender treatment: Part 2, the modern era. *Sexual Abuse, 15*(2), 93-120.
- Marshall, W.L. & Pithers, W.D. (1994). A reconsideration of treatment outcome with sex offenders. *Criminal Justice and Behavior, 21*(1), 10-27.
- Marshall, W.L., Serran, G.A., Fernandez, Y.M., Mann, R. & Thornton D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behavior change. *Journal of Sexual Aggression, 9*, 395-405.
- Marshall, W.L., Serran, G.A., Mouldeon, H., Mulloy, R., Fernandez, Y.M., Mann, R.E. & Thornton, D. (2002). Therapist features in sexual offender treatment: Their reliable identification and influence on behavior change. *Journal of Sexual Aggression, 9*, 25-30.
- McConaghy, N. (1998). Neglect of evidence that relapse prevention is ineffective in the treatment of incarcerated sexual offenders. *Sexual Abuse, 10*, 159-162.
- McGrath, R.J. (1991). Sex offender risk assessment and disposition planning: A review of the empirical and clinical findings. *International Journal of Offender Therapy and Comparative Criminology, 35*, 328-350.
- McGrath, R.J., Hoke, S.E., & Vojtsek, J.E. (1998). Cognitive-behavioral treatment of sex offenders: A treatment comparison and long-term follow-up study. *Criminal Justice and Behavior, 25*(2), 203-225.

- Nicholaichuk, T., Gordon, A., Gu, D. & Wong, S. (2000). Outcome of an institutional sexual offender treatment program: A comparison between treated and untreated offenders. *Sexual Abuse, 12*(2), 139-153.
- O'Donohue, W. & Letourneau, E. (1993). A brief group treatment for the modification of denial in child sexual abusers: Outcome and follow-up. *Child Neglect and Abuse, 17*, 299-304.
- O'Donohue, W., Regev, L.G. & Hagstrom, A. (2000). Problems with the DSM-IV diagnosis of pedophilia. *Sexual Abuse, 12*(2), 95-105.
- Parkinson, P.N., Shrimpton, S., Oates, R.K., Swanston, H.Y. & O'Toole, B.I. (2004). Nonsex offences committed by child molesters: Findings from a longitudinal study. *International Journal of Offender Therapy and Comparative Criminology, 48*(1), 28-39.
- Pithers, W.D., Marques, J.K. Gibat, C.C., & Marlatt, G.A. (1983). Relapse prevention with sexual aggressors: A self-control model of treatment and maintenance of change. In J.G. Greer & J.R. Stuart (Eds.), *The sexual aggressor: Current perspectives on treatment* (pp.214-239). New York: Van Nostrand Reinhold.
- Prentky, R.A., Knight, R.A. & Lee, A.F.S. (1997). Risk factors associated with recidivism in extrafamilial child molesters. *Journal of Consulting and Clinical Psychology, 65*(1), 141-149.
- Prentky, R.A., Lee, A.E.S., Knight, R.A. & Cerce, D. (1997). Recidivism rates among child molesters and rapists: A methodological analysis. *Law and human behavior, 21*(4), 631-659.
- Quinsey, V.L. (1998). Treatment of sex offenders. In M. Tonry (Ed.), *The handbook of crime and punishment*. New York: Oxford Press.
- Raymond, N.C., Coleman, E., Ohlerking, F., Christenson, G.A. & Miner, M. (1999). Psychiatric comorbidity in pedophilic sex offenders. *American Journal of Psychiatry, 156*, 768-788.

- Rice, M.E. & Harris, G.T. (2003). The size and sign of treatment effects in sex offender therapy. *Annals of the New York Academy of Sciences*, 989, 428-440.
- Rice, M.E., Quinsey, V.L., & Harris, G.T. (1991). Sexual recidivism among child molesters released from a maximum security psychiatric institution. *Journal of Consulting and Clinical Psychology*, 59(3), 381-386.
- Seto, C. & Barbaree, H.E. (1999). Psychopathy, treatment behavior, and sex offender recidivism. *Journal of Interpersonal Violence*, 14, 1235-1248.
- Seto, M.C. & Lalumiere, M.I. (2001). A brief screening scale to identify pedophilic interests among child molesters. *Sexual Abuse*, 13(1), 15-25.
- Tierney, D.A. & McCabe, M.P. (2004). The assessment of motivation for behaviour change among sex offenders against children: An investigation of the utility of the Stages of Change Questionnaire. *Journal of Sexual Aggression*, 10(2), 237-249.
- Vivian-Byrne, S. (2004). Changing people's minds. *Journal of Sexual Aggression*, 10(2), 181-192.
- Ward, T., Fon, C., Hudson, S.M. & McCormack, J. (1998). A descriptive model of dysfunctional cognitions in child molesters. *Journal of Interpersonal Violence*, 13, 129-155.
- Ward, T. & Hudson, S.M. (1998). A model of the relapse process in sex offenders. *Journal of Interpersonal Violence*, 13, 700-725.
- Ward, T. & Stewart, R.A. (2003). Good lives and the rehabilitation of sex offenders: A positive approach to treatment. In T. Ward, D.R. Laws, & S.M. Hudson (Eds.), *Sexual Deviance: Issues and controversies* (pp.21-44), Thousand Oaks, CA: Sage Publications.

Case and Statute Citations:

Kansas Statute Annotated 59-29a 01 (1994)

Kansas v. Crane, 122 S.Ct. 867 (2002)

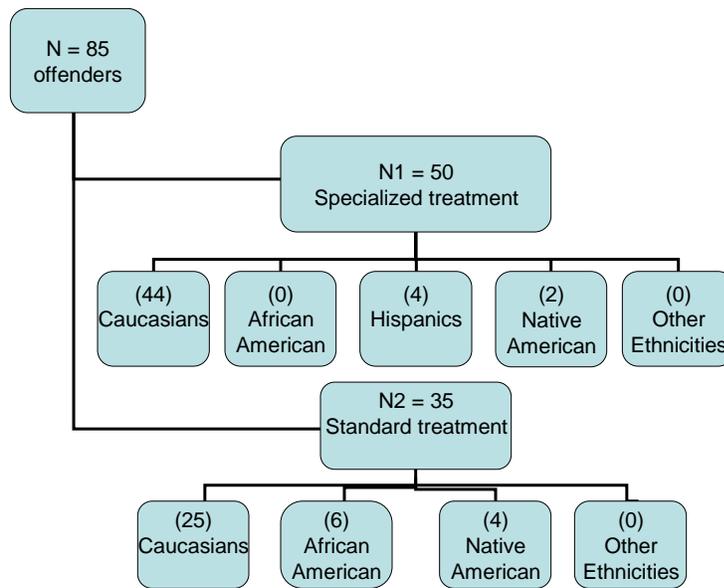
Kansas v. Hendricks, 521 U.S. 346 (1997)

Minnesota ex rel. Pearson v. Probate Court of Ramsey County, 309 U.S. 270 (1940).

Seling v. Young, 531 U.S. 250 (2001).

APPENDICES

Tables and Graphs



This table depicts eighty five incarcerated child specific sexual offenders, all of whom met eligibility criteria for specialized treatment. The study became weighted when this researcher originally sought to compare fifty offenders receiving standard treatment with fifty offenders receiving specialized treatment. Adjustments were made to the sample study so all eighty five offenders met criteria for specialized treatment although more participants actually received standard treatment.

Table 1 Frequency of PPG Control by Treatment (Standard versus Specialized)

	Standard (N = 35)	Specialized (N = 50)	Standard (%)	Specialized (%)
Medically disqualified	1	2	2%	4%
Control	21	18	60%	36%
Marginal control	3	12	8%	24%
No control	8	12	23%	24%
Flatlined	2	6	6%	12%

PPG

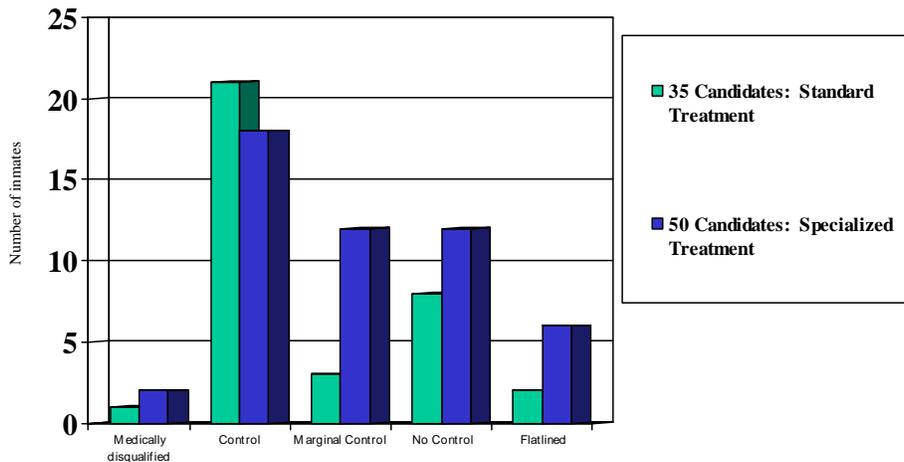


Table 1 and the corresponding graph depict both the frequency of PPG control for both groups as well as the percentage achieving control.

Table 2 Frequency of Nondeceptive SHDP by Treatment (Standard versus Specialized)

	Standard (N = 35)	Specialized (N = 50)	Standard (%)	Specialized (%)
Medically disqualified	1	1	2%	2%
Deception indicated	8	20	23%	40%
Inconclusive	12	11	34%	22%
Nondeceptive	14	18	40%	36%

Sexual History disclosure Polygraph (SHDP)

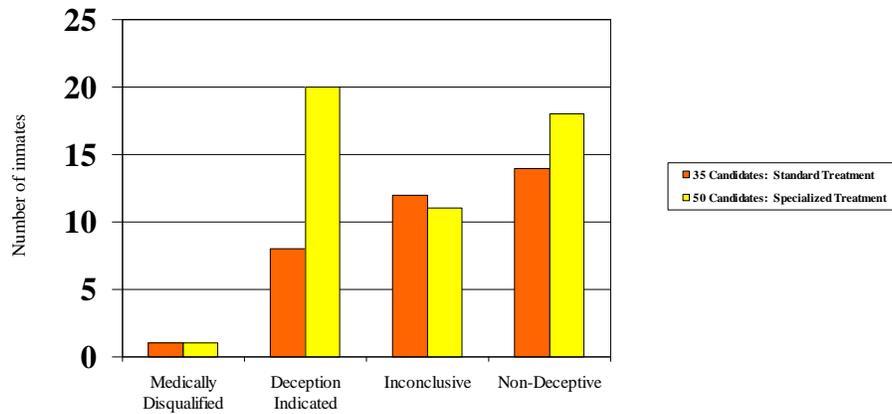


Table 2 and the corresponding graph depict the number of offenders who received nondeceptive SHDP and what percentage was nondeceptive by treatment groupings.

Table 3

Demographics

	Standard Treatment	Specialized Treatment	Standard (%)	Specialized (%)
Caucasian	24	44	69%	88%
African-American	6	0	17%	0%
Hispanic	4	4	11%	8%
Native American	1	2	2%	4%
Other	0	0	0%	0%

Demographics

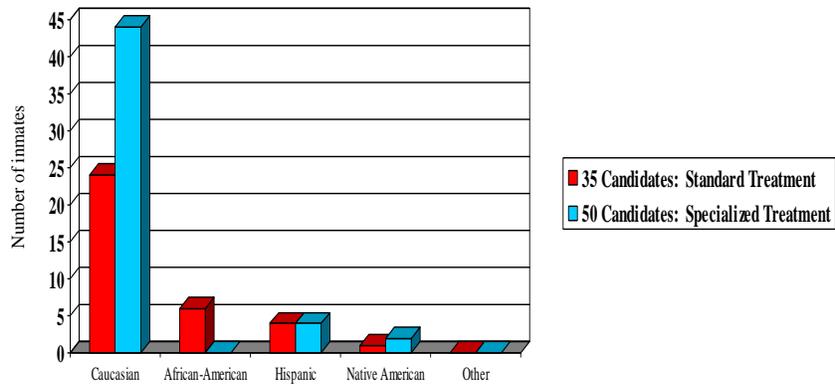


Table 3 and the corresponding graph highlights the Demographics of both treatment groups and lists what ethnic percentage is represented in each group.

Table 4 Age Range of Participants (Standard versus Specialized)

	Standard Treatment	Specialized Treatment
Oldest	68	80
Youngest	20	21

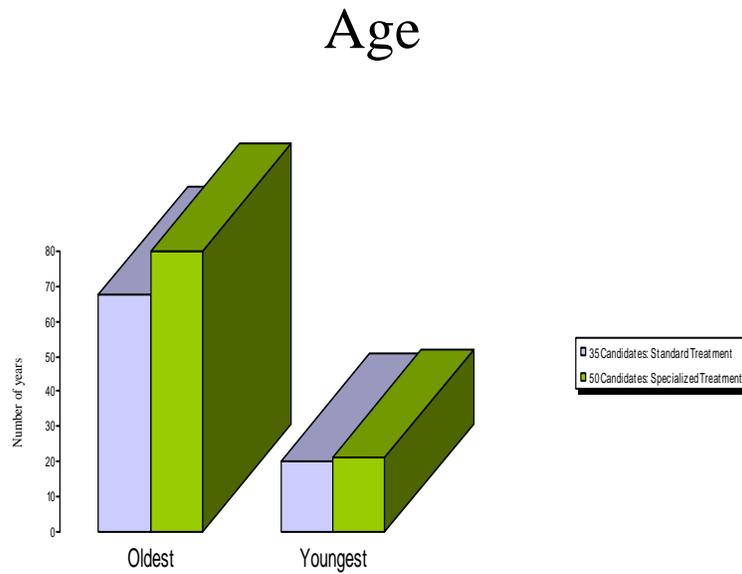


Table 4 highlights differences in age range from oldest to youngest in both treatment groups.

Table 5 IQ Range of Participants (Standard versus Specialized)

	Standard Treatment	Specialized Treatment
Lowest	65	74
Highest	118	129

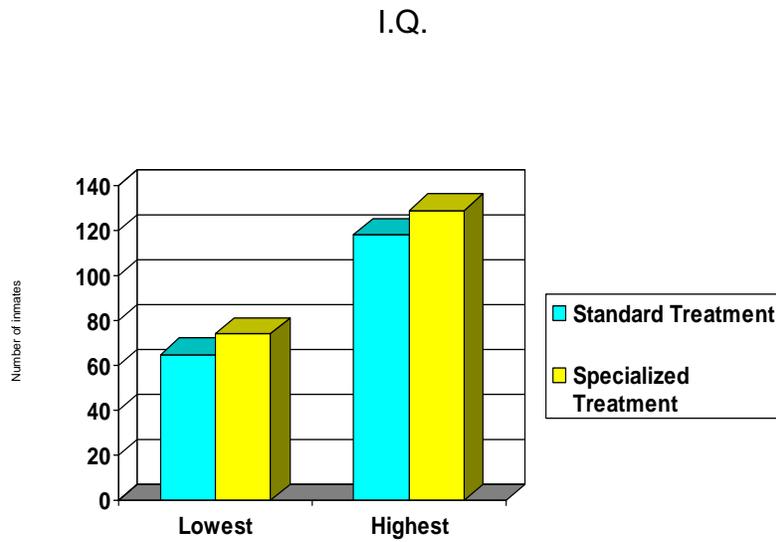


Table 5 and the corresponding graph compare and contrast Intelligence Quotient scores of both treatment groups.

Table 6 Frequency of Paraphilic Arousals (Standard versus Specialized)

	Standard Treatment	Specialized Treatment	Standard (%)	Specialized (%)
Male Infant	3	17	1%	34%
Female Infant	4	17	1%	34%
Female Preschool Persuasive	5	9	14%	18%
Female Preschool Coercive	6	17	17%	34%
Male Preschool Persuasive	6	23	17%	46%
Male Preschool Coercive	7	12	20%	24%
Female Grammar Persuasive	16	24	46%	48%
Female Grammar Coercive	15	14	43%	28%
Male Grammar Persuasive	5	17	14%	34%
Male Grammar Coercive	5	15	14%	30%
Female Adolescent Persuasive	15	15	43%	30%
Female Adolescent Coercive	17	17	49%	34%
Male Adolescent Persuasive	6	13	17%	26%
Male Adolescent Coercive	6	21	17%	42%
Female Teen Persuasive	20	12	57%	24%
Female Teen Coercive	18	19	51%	38%
Male Teen Persuasive	9	16	26%	32%
Male Teen Coercive	9	13	26%	26%
Adult Female Persuasive	14	0	40%	0%
Adult Female Coercive	12	0	34%	0%
Adult Male Persuasive	4	0	11%	0%
Adult Male Coercive	4	0	11%	0%
Female Challenge	3	0	8%	0%
Male Challenge	2	0	5%	0%
Violence Against Children	7	4	20%	8%
Violence Against Females	13	18	37%	36%
Violence Against Men	9	2	26%	4%
Female Adult Exhibitionist	21	16	60%	32%
Male Adult Exhibitionist	3	0	8%	0%
Low Level Arousals	3	1	8%	2%

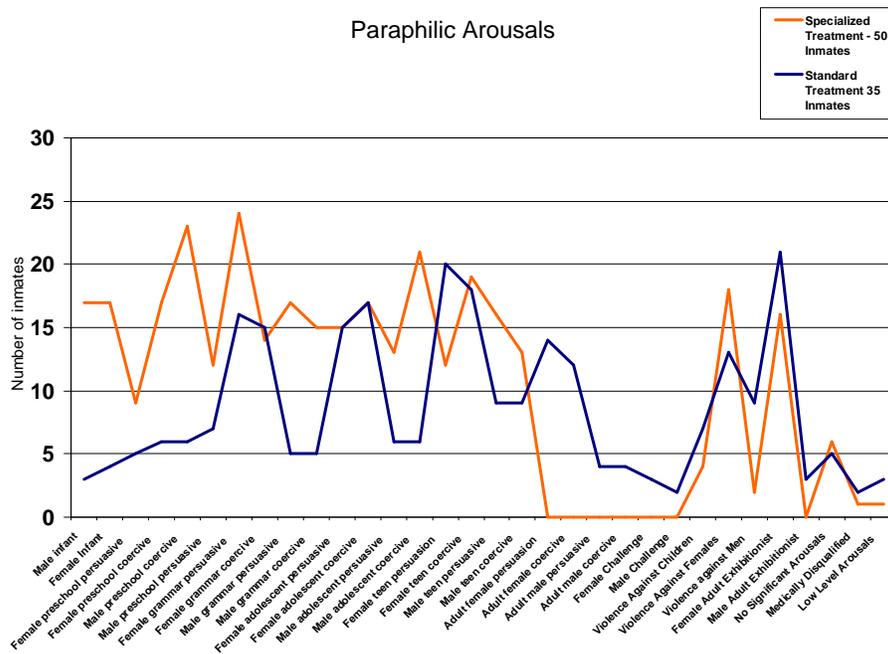
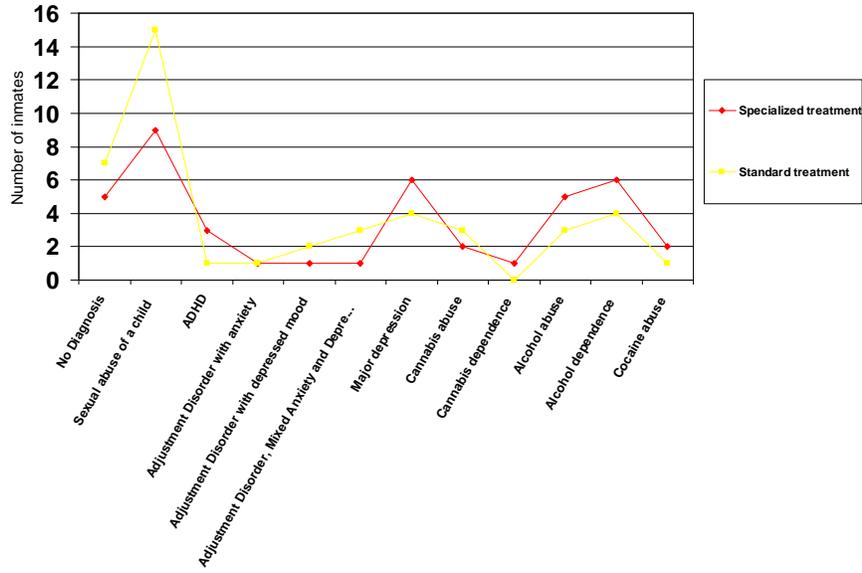


Table 6 and the corresponding line graph depict frequency and percentage of paraphilic arousal occurrences in both treatment groups.

Table 7 Axis I Diagnosis (Standard versus Specialized).

	Standard Treatment	Specialized Treatment	Standard (%)	Specialized (%)
No Diagnosis	7	5	20%	10%
Sexual Abuse of a Child	15	9	43%	18%
Paraphilia, NOS	1	0	3%	0%
Sexual Disorder, NOS	1	1	3%	2%
Learning Disability, NOS	0	1	0%	2%
Cognitive Disorder, NOS	0	2	0%	4%
Exhibitionism	0	1	0%	2%
Paraphilia NOS, Ehebophilic Features	0	2	0%	4%
Paraphilia Nos, Hebophilic Features	0	6	0%	12%
Pedophilia, Nonexclusive, r Males	0	3	0%	6%
Pedophilia, Exclusive, Males	0	0	0%	0%
Pedophilia, Nonexclusive, Females	0	9	0%	18%
Pedophilia, females, Limited to Incest	0	6	0%	12%
Pedophilia, Nonexclusive, Both	0	3	0%	6%
Attention Deficit Hyperactivity Disorder	1	3	3%	6%
Dysthymia	0	1	0%	2%
Bipolar I, Rapid Cycling	0	1	0%	2%
Adjustment Disorder, Anxiety	1	1	3%	2%
Adjustment Disorder, Depressed Mood	2	1	6%	2%
Adjustment Disorder, Mixed Features	3	1	9%	2%
Obsessive Compulsive Disorder	0	1	0%	2%
Major Depression	4	6	11%	12%
Social Phobia, NOS	1	0	3%	0%
D.O. Adolescence, NOS	1	0	3%	0%
Impulse Control Disorder	1	0	3%	0%
Post Traumatic Stress Disorder	1	0	3%	0%
Generalized Anxiety Disorder	1	0	3%	0%
Panic Disorder	1	0	3%	0%
Alcohol Abuse	3	5	9%	10%
Alcohol Dependence	4	6	11%	12%
Cannabis Abuse	3	2	9%	4%
Cannabis Dependence	1	1	3%	2%
Cocaine Abuse	1	2	3%	4%
Cocaine Dependence	0	0	0%	0%
Methamphetamine Abuse	1	1	3%	2%

Axis I Diagnosis



Axis I Diagnosis

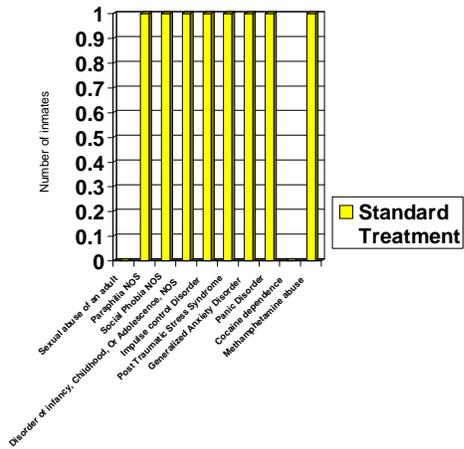
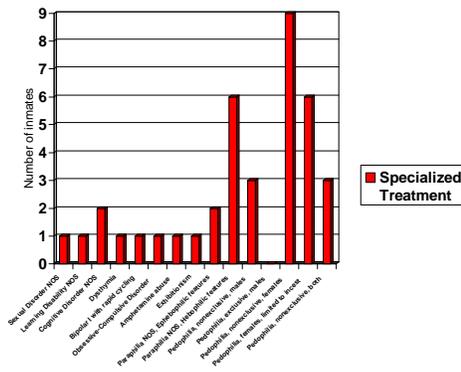
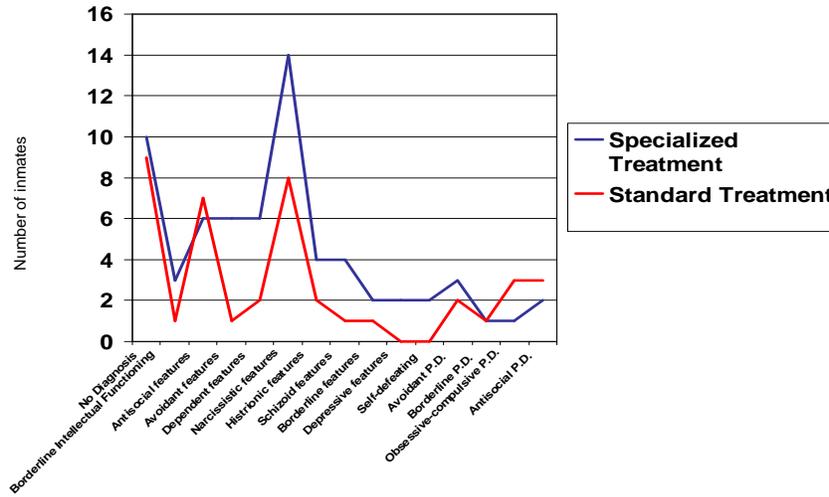


Table 7 and both corresponding graphs depict frequency and percentage of Axis I Diagnosis occurrence in both treatment groups.

Table 8 Axis II Diagnosis by Frequency (Standard Versus Specialized).

	Standard Treatment	Specialized Treatment	Standard (%)	Specialized (%)
No Diagnosis	9	10	26%	20%
Borderline Intellectual Functioning	1	3	3%	6%
Psychopathy	1	0	3%	0%
Personality Disorder NOS				
Antisocial Features	7	6	20%	12%
Avoidant Features	1	6	3%	12%
Sadistic Features	2	0	6%	0%
Dependent Features	2	6	6%	12%
Narcissistic Features	8	14	23%	28%
Histrionic Features	2	4	6%	8%
Borderline Features	2	2	6%	4%
Schizoid Features	1	4	3%	8%
Passive Aggressive Features	0	3	0%	6%
Depressive Features	0	2	0%	4%
Self Defeating Features	0	2	0%	2%
Personality Disorders				
Antisocial Personality Disorder	3	2	9%	4%
Avoidant Personality Disorder	2	3	6%	6%
Borderline Personality Disorder	1	1	3%	2%
Obsessive Compulsive P.D.	3	1	6%	2%
Schizoid Personality Disorder	2	0	6%	0%
Schizotypal Personality Disorder	0	2	0%	4%
Paranoid Personality Disorder	0	1	0%	2%

Axis II Diagnosis



Axis II Diagnosis

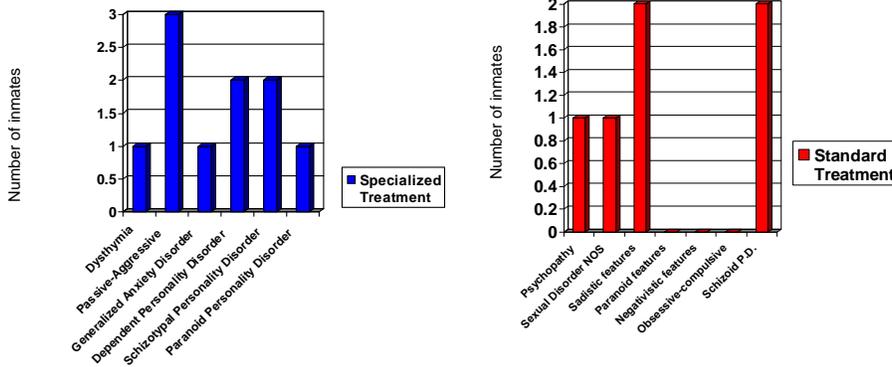


Table 8 and corresponding graphs depict frequency and percentage of occurrence of Axis II Diagnoses for both treatment groups.

Table 9

Frequency of Offense Types (Standard Versus Specialized Treatment)

	Standard Treatment	Specialized Treatment	Standard (%)	Specialized (%)
Agg Ind Libs with Child < 14	5	30	14%	60%
Att Agg Ind Libs with Child < 14	4	6	11%	12%
Indecent Liberties with Child < 14	1	12	3%	24%
Agg Ind Libs \ with Child < 16	10	3	29%	6%
Att Agg Ind Libs with Child < 16	2	2	6%	4%
Ind Libs with Child < 16	6	2	17%	4%
Unlawful Voluntary Sexual Relations with Child < 16	1	1	3%	2%
Lewd Conduct	1	1	3%	2%
Sexual Exploitation of Child (Internet)	3	5	9%	10%
Agg Kidnapping	2	0	6%	0%
Att Kidnapping	2	0	6%	0%
Kidnapping	1	1	3%	2%
1st degree Murder	1	0	3%	0%
Manslaughter	1	0	3%	0%
Robbery	2	0	6%	0%
Criminal Threat	2	1	6%	2%
Agg Escape From Custody	0	1	0%	2%
Criminal Damage to Property	0	1	0%	2%
Assault and Battery	1	1	3%	2%
Agg Sexual Battery	1	2	3%	4%
Sexual Battery	1	3	3%	6%
Battery	0	1	0%	2%
Misdemeanor Battery	1	0	3%	0%
Agg Ind Solicitation of Child < 14	0	5	0%	10%
Indecent Solcitation of a Child < 14	1	0	3%	0%
Agg Ind Solicitation of Child < 16	0	1	0%	2%
Indecent Solcitiatiion of Child < 16	2	0	6%	0%
Att Agg Criminal Sodomy	1	0	3%	0%
Aggravated Criminal Sodomy	3	0	9%	0%
Agg Criminal Sodomy with Child < 14	0	9	0%	18%
Att Agg Criminal Sod with Child < 14	0	2	0%	4%
Att Rape of Child < 14	0	2	0%	4%
Att Rape of Child < 16	0	1	0%	2%
Rape of Child < 14	0	3	0%	6%
Adult Rape	5	0	14%	0%
Att Adult Rape	4	0	11%	0%
Furnishing Alcohol to a Minor	0	2	0%	4%
Lewd Fondling	0	4	0%	8%
Clergy Abuse	0	2	0%	4%
Indecent Exposure	0	6	0%	12%
Aggravated Incest	0	2	0%	4%
Agg Intimidation of a witness	0	2	0%	4%

Types of Offenses

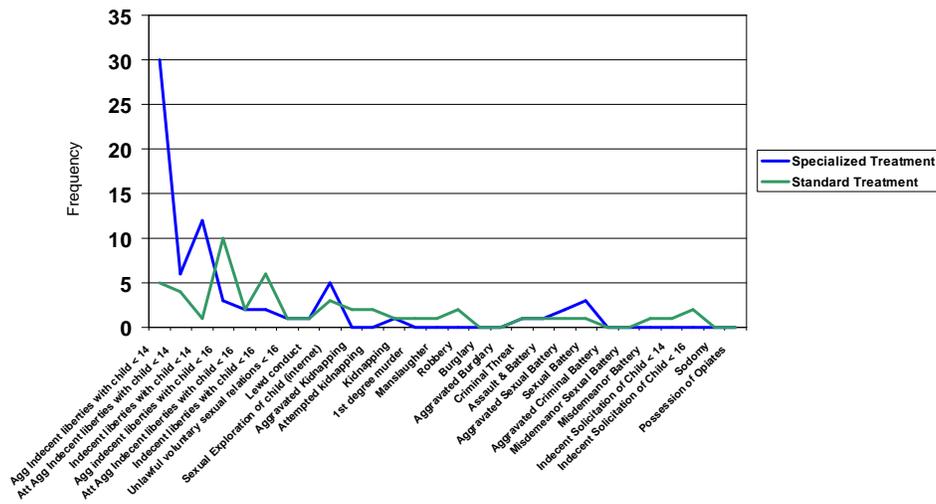


Table 9 and corresponding graphs displays frequency and percentage of offense types for both treatment groups.

Table 10 Frequency of Specialized Offenses by Categorical Nomenclature

Type	Number of Offenses	Specialized Treatment (%)
Nephiophilic	1	1%
Gynephilic	2	2%
Pedophilic, Males	14	16%
Pedophilic, Females	46	53%
Hebophilic	16	19%
Ephebophilic	7	8%

Categories of Offenses

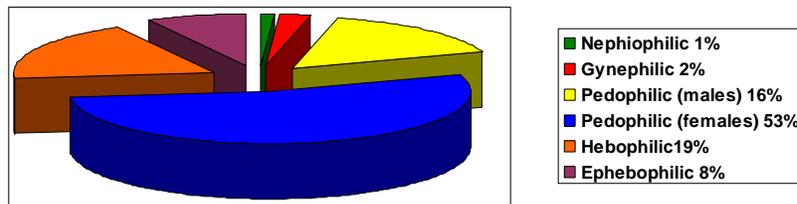


Table 10 displays the frequency and percentage of specialized offense occurrence.

APPENDICES

1. Study Release Authorization
2. Standard Treatment Timeline
3. Specialized Treatment Timeline
4. SATP Intake Packet
5. In Your Own Words 1-3
6. Autobiography Outline
7. Sexual History Worksheet (Both Groups)
8. Victim Sheets
9. Yes / No Sexual History Disclosure Questionnaire
10. 1:1 Sexual History Disclosure Questionnaire
11. Additional Questions for Polygraph Examiner
12. Specialized Treatment Packet
13. Penile Plethysmograph Charting Sheet
14. Deviant Cycle from Standard Treatment
15. Paraphilic Sexual Template from Specialized Treatment
16. Evaluation Progress Report
17. Intensive 3, 6 & 9 Month Progress Reports
18. Intensive 12 Month Progress Report
19. Standard Treatment PMPC
20. Specialized Treatment PMPC
21. DCCCA SATP Discharge Summary Outline

ACTUARIAL ASSESSMENT APPENDICES

1. Multiphasic Sexual Inventory
2. Shipley Institute of Living Scale
3. Static 99
4. Minnesota Sexual Offender Screening Test (MnSOST).
5. Level of Service Inventory Revised (LSI-R).