

### ASSESSMENT AND TREATMENT OF MEN WHO SEXUALLY OFFEND AGAINST WOMEN OR AGAINST CHILDREN

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Over the past 20 years, there have been great advances in what we know about men who sexually offend, their risk of recidivism and what works to reduce the likelihood that they will commit further sexual crimes. These advances have established that: 1) sexual offenders are not all the same; and 2) the risk of sexual recidivism (the risk that a new sexual crime will occur) and the effectiveness of treatment of sexual offenders to reduce this risk are indissolubly tied. This paper provides a brief review of these issues.

#### I. CLASSIFICATIONS OF MEN WHO SEXUALLY OFFEND

There are two broad categories of sexual offences: contact and non-contact. By definition, a *contact* sexual offence is when the offender has engaged, or attempted to engage, in actual sexual contact with a person without their consent (i.e., the victim – who can be of any age or sex). *Non-contact* offences have traditionally been those that primarily involved exhibitionism (exposing one's own genitals to a non-consenting person) or voyeurism (observing without consent, and usually without their knowledge, a person engaged in intimate behaviour such as sexual activity or while using the bathroom). With the advent of the internet, the use of Child Sexual Exploitation Material (CSEM – often described as “child pornography”) has become a predominant non-contact offence, while child luring (using the internet to attempt to obtain sexual contact with a child) is frequently classified as an attempted contact offence.

There are also two broad categories of men who sexually offend: those who sexually assault adults, typically women (referred to as “rapists”), and those who sexually assault children (referred to as “child molesters”). Within the rapist category, there are four general subtypes of offenders (Knight & Sims-Knight, 2017), although they are not mutually exclusive:

1. The *opportunistic* type is impulsive and there is no planning; the offence occurs when the situational and contextual factors present an opportunity to sexually assault. In this type, non-sexual violence is usually limited to what is necessary to attain victim's compliance.
2. The *vindictive* type is a man who is specifically angry at women; his offending is characterized by high levels of expressed anger at women and the offence aims to humiliate and degrade the victim. Severe non-sexual violence is frequent with this type of offender.
3. The *pervasively angry* type is a man who is consistently angry at everyone. He engages in non-sexual violence against other men, and uses sexual violence toward women. This is someone who typically has a history, starting at a young age, of problematic impulse and anger controls.
4. The *sexually motivated* type is someone who is highly preoccupied with sex. Sexual fantasies play a large role in his life, and his offences are driven by his need for sexual gratification. Non-sexual violence is usually no more than that needed to obtain compliance from the victim, except for the *sadistic* subtype. In this sub-category, the individual experiences sexual pleasure by inflicting physical pain and humiliation to the victim. Further, in the *sadistic* subtype, the sexual and the non-sexual violence are typically highly ritualized, and the offence is planned in detail.

In contrast to men who assault adults, men who sexually offend children (child molesters) can generally be classified into two main categories (Knight & Prentky, 1990):

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- 1) The *fixated* (or *preferential*) type describes a man who is sexually attracted to prepubescent (i.e., ≤ 10 years) male or female children and who meets the diagnostic criteria for paedophilia (APA, 2013). His lifestyle is typically organized so he can have easy access to children, for example through work, church, or volunteer activities). This type of offender tends to have a large number of victims.
- 2) The second category is the *regressed* type. This offender demonstrates adult sexual interest and lifestyle, but he turns to children for sexual and other emotional gratification when experiencing life difficulties. Incest offenders usually fall in this category.

## II. THEORIES THAT EXPLAIN SEXUAL OFFENDING

Early explanations tended to focus on single factors to explain sexual offending behaviour. In particular, sexual aggression was viewed as a 'sexual' problem and therefore, attention tended to be devoted to the sexual arousal patterns of offenders (e.g., Abel, Barlow, Blanchard, & Guild, 1977; Barbaree, Marshall, & Lanthier, 1979; Freund, Sedlack, & Knob, 1965). For example, the sexual preference hypothesis states that a man will engage in sexual behaviour with a child because he sexually prefers children to adults. Similarly, rape was considered to be due to a preference for violence over consenting sexual relationships. However, these early theories failed to fully explain why many men without such deviant sexual interests sexually assault children or rape women, and why many men with such deviant sexual interests never sexually offend.

Beginning in the late 1970s in North America, the impact of feminist theory broadened the understanding of sexual aggression by placing it in the context of a male-dominated society with sexual aggression being described as an expression of power and control over women and children (Brownmiller, 1975). The contribution of feminist theory to the understanding of sexual assault led to a broadening of the research concerning this problem. It is now well established that sexual aggression is a multifaceted problem that results from an interaction of problems among relational, sexual, cognitive, and emotional factors (see Beech & Ward, 2017). The following section examines in detail these factors in relation to risk assessment and treatment needs.

## III. THE ASSESSMENT OF RISK OF RECIDIVISM AND TREATMENT NEEDS

The assessment and treatment of sexual offenders is essentially driven by the need to reduce the likelihood of future occurrences of sexual offending behaviour (i.e., reducing the risk of recidivism). The assessment of risk of sexual recidivism informs treatment strategies. This assessment considers the individual characteristics of the offender that increase or decrease the probability of recidivism while treatment focuses on those that are amenable to change. These characteristics, referred to as *risk factors*, are divided into two categories: *static* and *dynamic* factors.

### A. Static Risk Factors

*Static risk factors* are aspects in the offender's history that are related to recidivism but that cannot be changed by an intervention. There are static risk factors common to *all* offenders, whether sexual or not, that are associated with general and violent (non-sexual) recidivism. These common risk factors include:

- being at a younger age;
- being single;
- having a history of lifestyle instability;
- have a history of rule violations;
- prior criminal offences (Bonta & Andrews, 2017; Hanson & Morton-Bourgon, 2005).

Generally, these characteristics demonstrate the presence of antisocial traits and personality, traits that have a consistent and strong relationship with recidivism (Bonta & Andrews, 2017).

Besides those common risk factors, there are also static factors that are uniquely related to sexual recidivism (Hanson & Thornton, 1999):

- history of sexual offending: the higher the number of offences and the more varied the history of

- sexual offending, the more likely the offender is to continue in his offending behaviour.
- type of victim: offenders who strictly engage in father-daughter incest tend to show the lowest rates of recidivism, while offenders who have male victims, or victims unrelated to them tend to show the highest rates.
  - presence of contact *and* non-contact sexual offences.

The details related to the offending history may simply reflect an enduring interest in deviant sexual activity. However, not all men who engage in sexual offending demonstrate deviant sexual preferences (Marshall, 1997). Rather, an enduring propensity for sexual offending additionally requires, among other factors, a willingness to disregard the rights of others, which is a characteristic of antisociality. Taken together, the combination of an interest in sexual deviancy and antisociality are the best predictors of sexual recidivism (Hanson & Morton-Bourgon, 2005; Roberts, Doren, & Thornton, 2002). Instruments designed to assess risk of sexual recidivism include those two categories of predictors.

## **B. Assessing Static Risk Factors**

Several instruments have been developed to specifically assess the static factors related to sexual recidivism. The best-known instrument, and the most translated and used around the world, is the STATIC-99 (now STATIC-99R; Hanson & Thornton, 2000; Helmus, Thornton, Hanson, & Babshichin, 2012). This scale includes 10 items that take into account the antisocial and sexual deviance domains to predict both violent and sexual recidivism. Scales such as the STATIC-99 provide superior predictive utility than simple clinical judgment based on traditional models of psychopathology or clinical experience (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2009; Harris, Rice, Quinsey, & Cormier, 2015).

## **C. Dynamic Risk Factors**

Risk assessments based strictly on static risk factors, however, do not provide information on the areas that would benefit from intervention to reduce sexual recidivism. Given that risk of reoffending is not a static state, dynamic factors add an important dimension to the evaluation of risk: they improve the accuracy of risk prediction and identify the factors to address in the treatment and management of sexual offenders (Bonta & Andrews, 2017).

*Dynamic risk factors* are those aspects of the offender that are amenable to change and help identify when an offender may be most at risk (Hanson, 2006). They are therefore the targets of treatment. Dynamic risk factors can be stable or acute. *Stable factors* are relatively enduring characteristics that are related to the potential for recidivism. *Acute factors* can be viewed as short-term states that create conditions for sexual offending. Three converging bodies of research from Canada, the United States, and the United Kingdom have demonstrated that dynamic risk factors predict sexual reoffending independently from static factors, providing evidence of the importance of not only assessing these factors but also addressing them in treatment (Hanson, Harris, Scott, & Helmus, 2007; Hanson & Morton-Bourgon, 2005; Thornton, 2002). The main changeable dynamic risk factors associated with sexual offending are: 1) problematic sexual interests and sexual preoccupation; 2) cognitions supportive of sexual offending; 3) problematic socio-affective functioning; and 4) poor general self-regulation.

### 1. Problematic Sexual Interests and Sexual Preoccupation

A sexual interest and arousal to children or violence has long been established as a powerful predictor of sexual recidivism, particularly when combined with high levels of antisociality. Typically, a physiological assessment, such as penile plethysmography, is the best method to establish sexual deviance, although such tests are not without their limitations: many offenders fail to demonstrate arousal under assessment conditions, and this lack of arousal does not mean that an individual has no deviant sexual interests. Many factors influence whether sexual deviancy can be detected during a physiological assessment, including the ability by the offender to suppress his arousal. When a physiological assessment of arousal is not possible, sexual deviance can be inferred from an examination of the history of sexual offending, or through the use of various psychometric instruments (e.g., the *Revised Screening Scale for Pedophilic Interests*; Seto, Stephens, Lalumière, & Sandler, 2017).

The extent to which an offender is generally pre-occupied with sex is also related to sexual reoffending (Hanson et al., 2007). Sexual offenders tend to give sex an exaggerated importance in their lives and tend to believe they have stronger sexual urges and needs than most people. Further, these men utilize both

consenting and deviant sex to cope with life's difficulties and manage negative emotional states, and this particular tendency is strongly related to sexual recidivism (Cortoni & Marshall, 2001; Hanson et al., 2007). The examination of the sexual self-regulation patterns of sexual offenders are therefore an important component of their assessment. Indicators of sexual pre-occupation include the frequency in which offenders engage in any type of sexual activity such as masturbation, and the use of pornography or other similar sex-related activities, such as attending strip bars or prostitutes. The presence of paraphilias, such as fetishism, particularly if they are related to the offending behaviour, provides another indication of sexual pre-occupation.

## 2. Cognitions That Support Sexual Offending

Cognitions supportive of sexual offending refers to a general cognitive disposition that facilitates sexual offending behaviour (Thornton, 2002). Sexual aggressors typically hold cognitions (attitudes and beliefs) that excuse, permit, or condone sexual offending and that indicate a sense of entitlement to sex. Further, men who sexually offend adhere to beliefs about relationships, gender roles, and children to stereotypical, hostile, or distorted views of women, children, and sex that facilitate and excuse sexual offending (Hanson & Harris, 2001). These attitudes and beliefs are related to sexual recidivism (Helmus, Hanson, Babchishin, & Mann, 2013).

## 3. Problematic Socio-Affective Functioning

Another difficulty exhibited by male sexual offenders is a lack of emotional intimacy in relationships. Both a lack of romantic/conjugal partners and the presence of conflicts within an existing conjugal relationship are predictive of sexual reoffending. For men who sexually assault women, difficulties in intimate relationships may be related to their pattern of adversarial or impersonal relationships with women. Difficulties with family and others may also be linked to a general lack of concerns for people in general. For men who sexually assault children (i.e., child molesters), socio-affective difficulties may also include an emotional identification with children, which interferes with their ability to establish healthy relationships with adults. The presence of emotional identification with children is also a powerful predictor of sexual recidivism among child molesters.

## 4. Poor General Self-Regulation

Poor self-regulation, also known as poor self-management abilities, is marked by a poor ability to self-monitor and to inhibit impulsive, irresponsible, and rule-breaking decisions (Thornton, 2002). Among sexual offenders, evidence of lifestyle instability and low levels of self-control are indicative of difficulties in anticipating consequences of one's actions and in establishing and working towards long-term goals. Within the context of supervision, poor self-regulation is evidenced by a tendency to break conditions of community supervision and failure to meet other commitments such as work or treatment demands. Offenders with poor self-regulation also typically minimize their risk and fail to engage in identified strategies to prevent a return to offending behaviour, including dropping out of treatment (Hanson & Morton-Bourgon, 2005). Poor general self-regulation is not unique to sexual offenders; it is found among all types of offenders and is related to *all* types of criminal recidivism (Bonta & Andrews, 2017).

## **D. Assessing Dynamic Risk Factors**

A number of tools are available to assess stable dynamic risk factors. In Canada, the most widely used are the STABLE-2007 and the ACUTE-2007 (Hanson et al., 2007). The STABLE-2007 contains 13 items that assess various aspects of the following dimensions: significant social influences, intimacy deficits, attitudes supportive of sexual assault, cooperation with supervision, sexual self-regulation, and general self-regulation. The ACUTE 2007 (Hanson et al., 2007) assesses the following acute risk factors: victim access; emotional collapse (i.e., evidence of severe emotional disturbance / emotional crisis), collapse of social support; hostility; substance abuse; sexual preoccupations; and rejection of supervision. The items assessing victim access, sexual preoccupations, hostility, and rejection of supervision, taken together, are particularly predictive of new sexual or violent offences (Hanson et al., 2007). An understanding of the literature on risk assessment and risk factors and training in the scoring methods of these risk assessment tools is recommended prior to their utilization.

## **E. Treatment**

The goal of treatment for sexual offenders is to reduce their risk of sexual recidivism. As discussed above, dynamic risk factors are changeable characteristics of the offender that have a demonstrated empirical relationship with sexual offending behaviour and that, when reduced, lead to reductions in recidivism.

Consequently, these dynamic factors are the elements that are addressed in contemporary treatment of sexual offenders. The main goals of treatment are therefore:

- decreasing sexual deviancy,
- increasing healthy sexuality,
- modifying problematic cognitions and related negative emotional states,
- developing healthy sexual and general self-management skills.

As part of treatment, offenders are required to address the factors that led to their sexually offending behaviour, understand the behavioural progression to their offences, and develop a self-management plan to be implemented upon their release into the community. In essence, these offenders need to learn to manage their lives in prosocial ways (Marshall, Marshall, Serran, & O'Brien, 2011; Marshall et Ward, 2004). Concurrently, they need to maintain an awareness of the factors that facilitated their sexual offending and engage in appropriate strategies to manage their risk.

Cognitive-behavioural therapy (CBT) that targets criminogenic needs of offenders is currently the most effective way to help offenders prevent a return to offending behaviour (Bonta & Andrews, 2017; Jung, 2017; Hanson, Bourgon, Helmus, et Hodgson, 2009). With sexual offenders, cognitive-behavioural therapy is employed to challenge beliefs that underlie sexual and non-sexual violence and to teach the offender behavioural competencies to behave in more pro-social ways. Hence, treatment is based on behavioural strategies, social learning, modelling, and skill building. It also includes strategies to address the cognition (thoughts, attitudes, beliefs) that support the offending behaviour, and their associated emotional states that impact on sexual recidivism. Therapy therefore aims to help the offender think differently about events, thus giving rise to different emotions and behaviour. The use of self-instruction and self-monitoring—and the development of an awareness of how one thinks affects how one feels and behaves—are vital components in cognitive-behavioural therapy (see Table 1). Finally, treatment needs to motivate the offender, and provide optimal conditions for learning pro-social behaviours. The combination of CBT and motivational approaches that targets dynamic risk factors at an intensity that matches the risk of recidivism presented by the offender has been shown to reduce sexual offending (Hanson et al., 2009).

Group, rather than individual, work is the usual method of delivery of CBT. The group work approach is seen as being suitable for all types of sexual offenders. There are many benefits to doing group treatment. Specifically, groups provide an environment that can offer both support and challenge to the sexual offender; group work provides the opportunity for discussion with peers; and provides a forum for support and sharing of problems which may be a completely new experience for sexual offenders who are generally isolated individuals, often with interpersonal deficits and feelings of inadequacy. Given that feelings of rejection and lack of appropriate relationships are important vulnerability factors for many sexual offenders, improvement in these areas is an important element in reducing reoffending.

**Table 1: Concepts of Cognitive-Behavioural Therapy with Sexual Offenders**

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**In treatment, the offender needs to:**

- Learn to monitor his negative automatic thoughts.
  - Recognize the connection between cognition, affect and behaviour.
  - Examine the evidence for and against his distorted automatic thoughts and learn to substitute his distortions with more reality-based interpretations.
  - Learn to identify and alter the dysfunctional patterns which pre-dispose him to distort his experiences, and lead him to offending.
  - Develop a broader and more effective coping repertoire to deal with problematic issues in his life.
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**The work is based on the following tenets:**

- A person's emotions and behaviour are in large part determined by how he/she thinks about or interprets the world. No two persons interpret the event in exactly the same way.
  - People have habitual ways of thinking about things called attitudes, assumptions, beliefs or schemas that are based on previous experiences (e.g., individuals who have been mistreated throughout their life may carry the expectation that all people intend to harm them, even when this is clearly not the case).
  - Therapy is designed to identify, reality test, and correct distorted ways of thinking and the problematic attitudes and beliefs that underlie them. Concurrently, the client learns to master situations that were previously beyond his ability. Thus, the therapist helps the client think and act more realistically.
  - Clients are challenged to try out new behaviours in addition to challenging their own negative thoughts.
  - When the required behavioural competencies are lacking, they are directly taught through discussion, role playing, modelling, and repeated practice.
  - Increasing self-esteem is not the focus of treatment. Most clients, however, will feel better emotionally as they become able to master situations which they could not previously tolerate. In turn, their ability to employ more effective strategies to deal with problematic situations will improve. The reliance on old coping patterns will concurrently decrease.
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#### IV. CONCLUSION

The accurate assessment of treatment need and recidivism risk in sexual offenders is the cornerstone of effective practice in treating and managing of adult male sexual offenders both in prisons and in the community. It is important to note that the information reviewed here applies to adult male perpetrators of sexual abuse. This information does not necessarily apply to special populations of sexual offenders such as internet offenders, juveniles, adult female offenders, sexual offenders with intellectual disabilities or those with severe mental health problems. While the treatment of these subgroups of sexual offenders may be guided by our knowledge on male sexual offenders, there is a growing body of knowledge that indicates the need for unique assessment and treatment procedures for many of these special populations (e.g., Cortoni, 2018; Craig, Lindsay, & Browne, 2010; Harrison, 2010; Righthand & Murphy, 2017; Seto, 2013). That information should be reviewed when assessment and treatment services are offered to those special subgroups of sexual offenders.

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