THE EVALUATION OF TREATMENT NEEDS OF SEXUAL OFFENDERS

In order to determine the treatment needs of an individual, an exhaustive assessment must first take place. During the assessment, clinicians will examine a broad range of variables in order to identify the factors that place an individual at risk of committing sexual abuse. While there is no universally accepted assessment paradigm, mental health professionals are likely to assess risk through actuarial and clinical means.

Actuarial assessments seek to evaluate an individual through interpretation of standardized scores on various risk assessment instruments whereas clinical assessments are based upon the mental health professional's personal judgment and knowledge. Grubin (1997) argues that actuarial instruments provide little information pertaining to the causation and management of sexual offending and say nothing about the individual. While clinical assessments can provide greater detail, Grubin provides evidence that it is a paradigm essentially based upon "untested and unsound theoretical foundations." The available literature suggests that one possible solution to the shortcomings of these models is to utilize a hybrid of the two in order to render a comprehensive report.

When interpreting risk factors, it is imperative that the mental health professional specifies both the static and dynamic factors applicable to the individual. Static factors involve variables that are stable over time whereas dynamic variables are subject to change. While numerous studies have evaluated static risk factors, the literature is practically void of studies devoted to the evaluation of dynamic factors (Hanson, 1998). Hanson and Harris (2000) addressed this issue by providing evidence that dynamic factors can be broken down further into stable dynamic risk factors (those expected to remain unchanged for a substantial period of time) and acute dynamic risk factors (factors that change rapidly). In their study of 208 sexual offense recidivists and 201 non-recidivist sex offenders, the authors concluded that stable dynamic risk factors showed the greatest potential in differentiating the recidivists from the non-recidivists. Criminal lifestyle variables were found to be the strongest predictors of recidivism. However, these results must be interpreted with caution due to methodological limitations.

Once the differentiation has been made between static and dynamic factors, research has illustrated that specific factors contribute to offending behavior. Browne et al. (1998) found that in a sample of 98 sex offenders, treatment drop out was best predicted by having spent time in prison, having committed a violence-related index offense, having committed non-contact offenses, unemployment, substance abuse and delinquent/disruptive behavior during treatment. Hanson and Harris (2000) concluded that recidivists had poor social support, attitudes tolerant of sexual assault, antisocial lifestyles, poor self-management strategies and difficulties complying with supervision. The recidivists showed similarities with the non-recidivists concerning general mood, but the recidivists displayed more anger and subjective distress before reoffending. Prentky et al. (1997) provided evidence illustrating that the strongest predictors of sexual offense recidivism include the degree of sexual preoccupation with children, presence of paraphilias and the number of prior sexual offenses. The meta-analysis conducted by Hanson and Bussière (1998) illustrated that the best predictors of recidivism were sexual deviancy as measured by PPG, history of sex crimes, psychological characteristics, negative relationship with mother, failure to complete treatment and the presence of depression and anxiety.

In recent years, a variety of evaluative instruments have been developed in order to assess the risk of sex offender recidivism. Some of these instruments include the Sex Offender Risk Appraisal Guide (SORAG), Rapid Risk Assessment of Sexual Offense Recidivism (RRASOR), Static-99 and the Minnesota Sex Offender Screening Tool-Revised (MnSOSTR). General recidivism tools such as the Violence Risk Appraisal Guide (VRAG) and the Psychopathy Checklist-Revised (PCL-R) have also

shown promise in determining sex offender recidivism. Barbaree et al. (2001) concluded that when these instruments were cross-validated on a sample of 215 sex offenders, the VRAG, SORAG, RRASOR and Static-99 were capable of predicting general, violent and sexual recidivism. MNSOST-R scores and guided clinical interviews were able to indicate general recidivism, but showed little sensitivity in discerning between serious or sexual reoffending. Out of all of these measures, the PCL-R, when used alone, was sensitive in predicting general and serious recidivism but was unable to predict sexual recidivism.

According to Abel et al. (1994), screening tests for pedophilia have existed in various forms for a number of years. These screening tools have included interviews, questionnaires, home visits and police reports. Institutional policies have also been developed in the hopes of managing child molestation (education/training, elimination of individual staff-child interactions), yet all of these methods suffer from various limitations. The Abel Screening Tool (1994) entails a questionnaire and slides depicting children, adolescents and adults. The individual then rates these images based upon on how sexually arousing they are. A psychophysiological hand monitor then records physiological responses. The efficacy of the instrument was established by comparing the responses of a self-selecting sample of "normal" participants to that of pedophiles that had molested pubescent males and prepubescent males/females. The Abel Screen displays high specificity (77%-98%), sensitivity (76%-91%) and efficiency (77.5%-96.9%) when applied in a setting that assumes a 5% prevalence rate of child molestation. The volumetric phallometer (sensitivity 86.7%; specificity 95%; and efficiency 94.6%) and circumferential plethysmograph (sensitivity 47.5%; specificity 100%; efficiency 97.4%) also display respectable sensitivity, specificity and efficiency, but evidence suggests that these instruments are much more intrusive, expensive and problematic than the Abel Screen.

The Violence Risk Appraisal Guide (VRAG) and the Sex Offender Risk Appraisal Guide (SORAG) are very similar in their content. Rice and Harris (1997) utilized the VRAG on a sample of 159 sex offenders in order to determine its predictive accuracy in assessing sexual recidivism. The results support use of the VRAG in predicting violence among high-risk offenders, and it performed well upon cross-validation and follow-up when the two samples were combined. The authors claim that from a practical standpoint, the focus should be placed upon predictions of future violence, not necessarily a differentiation between sexual and nonsexual violence. Nunes et al. (2002) compared the predictive accuracy of the SORAG to the revised Static-99. When the instruments were evaluated independently of one another, evidence suggests that they did not provide any unique contributions and may be redundant. However, when phallometric scores were computed in conjunction with Static-99 scores, accuracy increased. The authors propose that this effect was not observed in the use of the SORAG because it targets only general deviant arousal.

Static-99, one of the most recent and promising risk assessment instruments, consists of only static risk factors taken from the RRASOR and the Structured Anchored Clinical Judgment (SACJ). Hanson and Thornton (2000) combined the two scales in order to determine whether or not a hybrid would display greater predictive accuracy than the individual scales. These instruments were applied across four data sets, and it was concluded that while the RRASOR and the SACJ were nearly equivalent in their predictive accuracy of sexual recidivism, Static-99 showed the greatest accuracy. However, Sjöestedt and Långström (2001) provide evidence illustrating that the RRASOR and Static-99 should not be used as the only determinants of risk. Cross-validation of these two instruments on a sample of 1,400 Swedish sex offenders illustrated that both instruments displayed moderate predictive accuracy regarding short-term sexual recidivism. However, Static-99 was found to have greater predictive accuracy when it came to assessing violent recidivism, not sexual recidivism.

Social scientists have undertaken the task of developing a risk assessment instrument to screen for the presence of ephebophiles within the clergy. Musser et al. (1995) found that the Millon Clinical Multiaxial Inventory (MCMI-II) was incapable of differentiating cleric sex offenders from mentally ill

clerics. Cimbolic et al. (1999) attempted to create an ephebophile scale by combining 11 items from the MCMI-II with 16 items from the MMPI-2. When tested on a sample of 165 Catholic priests undergoing treatment, the authors concluded that a combination of the two scales displayed greater accuracy and increased the internal consistency of the MCMI-II items. However, the combined scale failed to identify many of the ephebophiles in the sample. The individual scales were capable of differentiating sexually abusive clerics from mentally ill clerics, but the authors urge that a multidimensional approach be utilized when evaluating sex offenders.