Portland State University

PDXScholar

Dissertations and Theses

Dissertations and Theses

1992

Opinions about sex offenders' progress in therapy

Laren Bays

Portland State University

Follow this and additional works at: https://pdxscholar.library.pdx.edu/open_access_etds

Part of the [Psychology Commons](#), and the [Rehabilitation and Therapy Commons](#)

Let us know how access to this document benefits you.

Recommended Citation

Bays, Laren, "Opinions about sex offenders' progress in therapy" (1992). *Dissertations and Theses*. Paper 4290.

<https://doi.org/10.15760/etd.6173>

This Thesis is brought to you for free and open access. It has been accepted for inclusion in Dissertations and Theses by an authorized administrator of PDXScholar. Please contact us if we can make this document more accessible: pdxscholar@pdx.edu.

AN ABSTRACT OF THE THESIS OF Laren Bays for the Master of Science in Psychology presented November 6, 1992.

Title: Opinions About Sex Offenders' Progress in Therapy

APPROVED BY THE MEMBERS OF THE THESIS COMMITTEE:

[REDACTED]

Hugo Maynard, Chair

[REDACTED]

Robert Jones

[REDACTED]

Ross Neder

[REDACTED]

Larry Steward

Sex offenders are often required by the court to enter therapy and receive help so they can stop deviant sexual behaviors. Mental health professionals must have some means of evaluating a mandated client's progress in therapy, however, there are currently no valid criteria available. A survey form was developed containing 73 items which professionals identified as having possible utility in evaluating progress. One hundred thirty experts in treating sex offenders, 123 non-experts and 76 sex offenders were anonymously surveyed for their opinions about useful criteria. Respondents were asked to give their opinion of

each item's utility by using a Likert scale from 1 (low utility) to 5 (high Utility). There was a high degree of agreement about useful criteria but little evidence that experience, maturation or education lead to greater agreement among respondents. Offenders were much more optimistic about the usefulness of items than experts.

Experts and offenders identified 5 areas which they considered useful in evaluating progress. These were: the offender discloses full criminal history, participates in group therapy, controls his behavior outside of group, understands personal criminality and learns skills to quickly stop criminal behavior. Additionally, experts and offenders identified two areas which were not useful: the relationship between therapist and client and a personality change in the client. Offenders also regarded the penile plethysmograph as having little utility in evaluating progress. The possible relevance of these areas are discussed and recommendations for research given.

OPINIONS ABOUT SEX OFFENDERS' PROGRESS IN THERAPY

by

LAREN BAYS

A thesis submitted in partial fulfillment of
the requirements for the degree of

MASTER OF SCIENCE
IN
PSYCHOLOGY

Portland State University
1992

TO THE OFFICE OF GRADUATE STUDIES:

The members of the Committee approve the thesis of
Laren Bays presented November 6, 1992.

Hugo Maynard, Chair

Robert Jones

Ross Neder

Larry Steward

APPROVED:

Cord B. Sengstake, Chair, Department of Psychology

Roy W. Koch, Vice Provost for Graduate Studies and Research

TABLE OF CONTENTS

	PAGE
LIST OF TABLES	v
INTRODUCTION	1
METHOD	22
Introduction	22
Development of Survey Instrument	22
Respondents	33
Survey Procedure	35
RESULTS	37
Exploratory Questions	37
Respondents' Demographic Information	39
Comparison of Groups	41
Experts Compared With Offenders	42
Non-experts Compared With Offenders	45
Experts Compared With Non-experts	47
Group Comparisons on Clusters of Items	50
Areas of <i>Agreement</i> Among and Within the Three Groups on <i>Clustered</i> Items	60
Areas of <i>Disagreement</i> Among and Within the Three Groups on <i>Clustered</i> Items	61
Items Rated as Highest and Lowest Utility by Both Experts and Offenders	61
Comparisons On Items by Conditions Within the Experts Group	73
Factor Analysis of Experts and Offenders Groups	78
Experts' Highest Rated Items Factor Analyzed	79
Experts' Lowest Rated Items Factor Analyzed	81
Offenders' Highest Rated Items Factor Analyzed	83

Offenders' Lowest Rated Items Factor Analyzed . . .	86
DISCUSSION	90
Items Possibly of High Utility for Judging Progress	96
Items Experts and Offenders Groups Rated as Having High Utility	97
Items of High Utility <i>Common to Both</i> Experts and Offenders	97
Theme #1 Consistent Behavioral Control Outside of Group	99
Theme #2 Involvement in Group Therapy . . .	103
Theme #3 Fully Disclosing Criminal History .	105
Theme #4 Understanding Criminal Thinking and Behavior	107
Theme #5 Gaining Skills to Quickly Stop Criminal Behavior	108
Experts' and Offenders' Factors Compared	111
Offenders' Opinions About Progress	113
Items of Low Utility for Judging Progress	113
Theme #1 The Relationship Between the Professional and Client	114
Theme #2 Personality Change	119
Theme #3 Penile Plethysmographic Testing . .	121
Limitations of This Survey	123
Summary and Recommendations	128
REFERENCES	131
APPENDIX	140

LIST OF TABLES

TABLE		PAGE
I	Cluster Component Items and Reliability	25
II	Completed Forms Returned	35
III	Items Experts and Offenders Agreed Upon	43
IV	Items Experts and Offenders Agreed Were Most Useful	44
V	Non-experts Compared With Offenders; Items On Which Groups Disagreed	46
VI	Items Experts and Non-experts Agreed Upon	47
VII	Items Experts and Non-experts Agreed Had the Highest Utility	48
VIII	Items Experts and Non-experts Disagreed On	49
IX	Data From Group Comparisons on Clusters of Items	51
X	Experts' 25 Highest Items Ranked	62
XI	Experts' 25 Lowest Items Ranked	64
XII	Offenders' 25 Highest Items Ranked	66
XIII	Offenders' 25 Lowest Items Ranked	69
XIV	Highest Five Items Common to Both Experts and Offenders Groups	72
XV	Lowest Five Items Common to Both Experts and Offenders Groups	72
XVI	Items Female Experts Rated Higher Than Male Experts	74

TABLE	PAGE
XVII	Items on Which Experts and Non-experts Who Were Victims of Sexual Abuse Differed . . . 74
XVIII	Items on Which Experts With Doctorate Degrees Differed from Experts With Bachelor Degrees . . . 75
XIX	Items Experts with Less Experience (< 5 years) Rated More Highly than Experts with More Experience (> 5 years) 76
XX	Items The Youngest 10% of Male Experts Rated More Highly Than the Oldest 10% of Male Experts 76
XXI	Items On Which Experts From the Top and Bottom Ten Percent by Years of Experience Differed . . . 77
XXII	Factors Derived From Experts' Highest Rated Items . 79
XXIII	Factors Derived From Experts' Lowest Rated Items . 82
XXIV	Factors Derived From Offenders' Highest Rated Items 84
XXV	Factors Derived From Offenders' Lowest Rated Items 87

INTRODUCTION

Prosecution for sexual crimes is increasing and the numbers of sex offenders under the jurisdiction of the Justice Department are growing (Flanagan, T.J., & Jamieson, K.M., 1987). This growth in the numbers of identified sex offenders has increased awareness of their dangerousness. Sex offenders are viewed as dangerous because of long term consequences to victims (Browne, A. & Finkelhor, D., 1986), the large number of crimes they commit (Abel et al., 1987) and the economic impact on society. Because society has become concerned about this problem, sex offenders are being identified, prosecuted and placed under the jurisdiction of the criminal justice system.

There are three primary interventions that the criminal justice system uses to attempt to control the population of sex offenders; incarceration, supervision (probation or parole) and treatment (Galliher, 1989; Sytherland, & Cressey, 1978). The function of the first two interventions, incarceration and supervision, is to protect the public and punish the offender by using the external controls of isolation (incarceration) and supervision (probation and parole). They are both effective while the offender is under the jurisdiction of the criminal justice system (Petersilia & Turner, 1986; Sutherland & Cressey,

1978). However, incarceration and probation are only temporary solutions. As much as some segments of society would like it, it is impossible to incarcerate or keep all sex offenders on probation or parole forever. Eventually virtually all sex offenders complete their sentences and are free in the community again.

The third intervention the criminal justice system utilizes to manage sex offenders is psychological treatment. Psychological treatment emphasizes teaching the sex offender self control, avoidance of risk situations, more effective ways to solve his problems and helping him to set and achieve realistic goals in an appropriate manner (Bays & Freeman-Longo, 1989). The ultimate purpose of therapy (from society's perspective) is to eliminate an offender's criminal behavior for a longer period of time and at less cost compared to the short term solutions offered by probation and incarceration. Psychological therapies attempt to influence the offender's motivation to commit crime and encourage him to intervene in his deviant behavior (Bays, Freeman-Longo & Hildebran, 1990; Cullen & Gilbert, 1982; Salter, 1988; Sutherland & Cressey, 1978). Because of the hope for a longer lasting intervention, the justice system frequently mandates sex offenders to participate in and complete a treatment program.

A sex offender mandated to treatment, as most offenders in treatment are, is different than the usual psychotherapy

client. He often chooses therapy as the lesser of two evils; prison or treatment. Frequently mandated offenders lack real interest in what health professional and the court regard as their problems. They frequently feel that professionals are being intrusive into parts of their private lives which offenders feel are unrelated to their crimes. In fact clinicians find that most offenders say that their criminal behavior is in the past and will never happen again and so do not need treatment. Instead of examining their lives offenders will often try to figure out what the judicial system or therapist wants and then display those behaviors or mouth appropriate words so that they will be released from treatment (Freeman-Longo & Bays, 1989).

Offenders' resistance to therapy is often high, so much so that Monahan (1980) wrote a monograph for an American Psychological Association task force saying when treatment is mandated the client and the patient are often different. In this situation usually the client, who desires and pays for treatment, is the court or corrections department, while the patient, the one who is being treated, is the offender (Bohmer, 1983).

There are numerous treatment programs for mandated sex offenders in the United States (Knopp, 1988). Each of them hopes to stop or decrease future sexually deviant behavior by bringing about behavioral or psychological change in the sex offender. However, for a treatment program to be

successful there must be some objective criteria which indicate that the offender is making progress. A mandated sex offender client who would rather not be spending the money or time for treatment is not able to make an unbiased decision about whether he is making progress or not. In fact it is likely that such a offender would say that he is well and does not need any treatment. From his point of view the idea of improving his mental health or making progress in therapy is meaningless, as he would claim there is not now, nor has there ever been, anything wrong with him.

However, the community and mental health workers are very concerned about progress. To them progress means that the offender is less likely (than the baseline of probable reoffence rate) to commit a sex crime in the future. For instance, if there is a 60% chance that an offender will commit a new sexual crime, then treatment can only be considered effective if it lessens the dangerousness of the offender and lowers the probability of recidivism to less than 60%.

Throughout the course of a treatment program clinicians must make determinations about the progress or lack of progress of their clients. Such a determination is necessary to help clinicians answer such questions as: is the offender now safe to be at home with his children? If he is now allowed to drive will he expose himself again or

not? If he is permitted the freedom to stay out at night will he begin seeking another victim? These and other vital questions all depend upon an evaluation of an offender's progress. The final and hardest decision about progress that a clinician has to make is about graduation.

Graduation, or completing a treatment program, implies that the offender no longer needs treatment and supervision.

This can only happen when the offender has made enough progress in therapy that he is judged to be no longer dangerous or at least less dangerous. This decision is fraught with difficulty, for when clients have completed therapy and are no longer under supervision those who were unsuccessful in treatment are more likely to begin reoffending (Furby, Weinrott, & Blackshaw, 1989).

Clinicians must have some means of evaluating their client's progress, their dangerousness or non-dangerousness.

Because of these difficult questions, an evaluation of progress is an essential part of clinical practice and the criminal justice system. Gabor (1986) suggests three reasons why clinicians must make predictions of progress when working with criminal offenders.

First, they can help assess the potential danger an individual poses to society. Second, they can ascertain the level of custody or surveillance required in the management of an offender in the case of a correctional institution or agency. Third, they assess the therapeutic needs of an offender (p. 4).

There are at least two general elements needed to make a prediction about a sexual offender's progress, an assessment of his pretreatment functioning and an evaluation of his behavioral and cognitive change while in therapy.

For many mandated criminal clients progress can not be defined in the same way as for other mental health clients (Conklin, 1986). There are a number of reasons for this. Sex offenders are a heterogenous group made up of exhibitionists, voyeurs, pedophilics, fetishists and frotteures (DSM-III, 1985). Additionally, there are sexual sadists and rapists who often have a primary aggressive disorder which expresses itself sexually (Groth & Birnbaum, 1979). Offenders who engage in these behaviors are often very different than other less overtly violent offenders. Nor is there any personality profile which describes offenders who commit sexual crimes {Murphy & Peters, 1992}.

A second reason that usual definitions of progress do not work with sex offenders, is that mandated clients are unlikely to give a valid self-report of improvement (as previously discussed). For most mental health clients self-report is a common method of evaluating progress in therapy (Myers, 1986). The therapists' opinions are also suspect, offenders who know that they will be allowed to leave therapy if they can convince the therapist that they are doing well will very likely show the therapist the most functional parts of their personality. These clients fear

that if they show their true problems they will be regarded as sick and never get out of therapy.

For many clients a lessening of symptoms and an increase in energy are signs of progress, but for 25% of sex offenders who have a diagnosis of antisocial personality disorder these signs are not valid indicators of improvement. According to William Reid (1989), an expert in treating antisocial personality disorders, the first sign of improvement in this population is dysphoria, just the opposite of most patients. Enhanced self-esteem is often a factor used in determining progress for a mental health client (Luborsky, Crits-Christoph, Mintz & Auerbach, 1988). In many criminal clients increased self esteem may be inversely correlated with recidivism (Prentky, 1991).

Lastly, for sex offenders the sexual symptoms which caused them to be mandated to treatment are usually rare. A man who has molested children five times over a twenty year period will not have pedophilic impulses that can be counted and followed for use as criteria for progress.

If a subjective determination of improvement and the standard factors which are used for mental health clients are not valid, then what factor can be used as a criterion for evaluating progress in therapy? The crucial factor which must be used to evaluate progress in mandated clients is the evaluation of a client's possible future dangerousness or non-dangerousness. Progress is then

determined by showing that clients are less dangerous than when they started therapy. Shah (1978) has defined dangerousness for the National Institutes of Mental Health:

Dangerousness refers to a propensity (i.e., an increased likelihood when compared with others) to engage in dangerous behavior. *Dangerous behavior* refers to acts that are characterized by the application of or the overt threat of force and that are likely to result in injury to other persons (p. 226).

Thus a dangerous person is one who has a high probability of inflicting serious injury on another. It is important to note that sexual offenders may injure their victims even though they are overtly gentle and kind. A fixated pedophile who "loves" children may groom them for sexual advances by actions which appear emotionally warm or playful. These "kind" offenders are often considered even more dangerous than an overtly aggressive offender as the emotional and psychological damage to a victim is greater (Hindman, 1989).

In order to evaluate if a mandated criminal offender is making progress in therapy, the behavior which caused him to be labeled criminal must be considered less likely to reoccur. If a sexual offender is improving his mental health status but is still prone to sexual assault, then he is not making progress. Thus an evaluation of progress in therapy for a sex offender must be synonymous with a comparison of the dangerousness of the client at the time he

is apprehended with his present dangerousness and must include a prediction of his future dangerousness.

A determination of dangerousness is not easy and many factors must be taken into account (Monahan, 1981). There is a truism in forensic mental health that past behavior is the best predictor of future behavior (Black, 1977). While this is intuitively true, research indicates that predictions based on past behavior demonstrate a high rate of false positives, that is, individuals who have been predicted to be dangerous but were not shown to be dangerous at a later time (Shah, 1978). Thus prediction is not just an extrapolation from a person's past, but must also be based on their present and future behavior. Cohen, Groth, & Siegel (1978) report: "in recent years a series of federal court decisions have emphasized that past misconduct alone is not a sufficient basis for the label 'dangerous' (p. 30)."

Another complication in the prediction of dangerousness is distinguishing dangerous behavior from criminal behavior. A determination of dangerousness can not be made on the basis of possible future *criminal* conduct, but must be made on the basis of *dangerous* conduct. The U.S. Court of Appeals has ruled:

"dangerous conduct is not identical with criminal conduct. Dangerous conduct involves not merely violation of social norms enforced by criminal sanctions, but significant physical or psychological injury to persons or substantial destruction of property" (Millard V. Harris, 1968).

Thus a prediction of dangerousness in a sexual offender does not mean that the client will engage in some future frightening or socially undesirable behavior, but that he will have additional victims. Making a decision which focuses only on dangerous behavior thus becomes much more difficult, if not impossible.

The American Psychological Association (1978) and the American Psychiatric Association (1974) have both stated that clinicians cannot make accurate predictions of an individual's future violent behavior. Researchers have shown repeatedly that it is impossible to predict dangerous behavior (Greenland, 1980). Coccozza & Steadmann, (1976) after long clinical experience and a review of the research of dangerousness said:

"the findings. . . would appear to present clear and convincing evidence of the inability of psychiatrists or anyone else to predict dangerousness accurately (p. 1099)."

Chaiken, Rolph and Houches (1981) in a Rand Corporation study about crime rates of violent offenders, wrote that "...it would be extremely difficult to develop, at this time, a statistical model that could be fairly used by the courts ... to predict dangerous behavior (p. 54)."

There is good clinical support for these statements. Kozol, Boucher and Garofalo (1972) reported on a study of 335 sexual offenders, of whom 304 were found not to be sexually dangerous and 31 were found to be sexually dangerous. Of those determined not dangerous, 8.6% committed a new crime (false negatives), of those determined as dangerous 61.3% did not commit a new crime (false positives). Hodges (1971) followed up 447 dangerous delinquent offenders for three years. Of the total found dangerous only 81% committed another offense (19% false positives) while of those treated and found not dangerous, 37% committed a new crime (false negatives). Smith & Monastersky (1986) were unable to predict which of 112 juvenile sexual offenders would or would not relapse. Lastly, Monahan (1976) has summarized seven large-scale studies of attempts to identify which of those released from prisons, or from institutions for mentally abnormal offenders, would commit violent crimes, and notes that between 54% and 99% of those predicted to be dangerous did not in fact subsequently commit such crimes.

There are a number of reasons why a determination of dangerousness (hence progress in treatment) in sex offenders is difficult. The low base-rate of criterion behaviors, problems with recidivism data, the heterogeneity of sex offenders, the small population, and the major limitations imposed by evaluating offenders who are in controlled

environments (such as prisons where they are not as likely to offend), make it difficult to reach reliable conclusions (Group for the Advancement of Psychiatry, 1977).

The use of baseline data of violent behavior is considered the most useful criterion for the prediction of violent sexual behavior and the progress of an offender in therapy. This criterion is conservative and generates fewer false positives than the other predictive approaches (Blackburn, 1983). However the literature also points out considerable technical difficulties for any effort attempting to predict events with very low base-rates. Such predictions are weakened by large rates of false positive errors; that is, the great majority of the persons predicted as likely to engage in future violent behavior will *not* display such behavior (Cocozza & Steadman, 1976: Fagin, 1976: Megargee, 1976, Monahan, 1975, Shah 1978).

Unfortunately, the base-rate, or a behavior's normal frequency of occurrence, is especially difficult to determine for criminal sexual acts. Crime is typically hidden and sex offenses especially are under-reported (Abel et al, 1987; Groth, Longo, & McFadin, 1982). Thus, there is a low frequency of identifiable sex offenses. We know from well done self report studies that a sex offender may have committed hundreds of criminal sexual acts in his life but have only one or two documented deviant behaviors (Abel et al, 1987; Groth, Longo, & McFadin, 1982). Thus a 60 year

old man with homosexual pedophilic interests may have committed thousands of sexual offenses over a 50 year period but have only one documented arrest or conviction. This pattern is typical of sexual offenders as a group. The base-rate of documented behaviors is very low, while the base-rate of actual behaviors may be very high. Is it justifiable to evaluate an offender, whose liberty depends on the evaluation, using the low statistical base-rate of sexual crimes based on convictions or the high rate estimated by self report?

An additional problem in the prediction of low base-rate behaviors, is false negatives, those who are dangerous but who are predicted not to be. In prediction, the rate of false positives usually involves greater numbers, but false negatives, such as the offender judged as benign who commits a new crime, may be more of a problem to society as a whole. A criminal who has been treated as though he was not dangerous and who then commits a violent offense or a series of violent offenses elicits a very strong negative reaction on the part of the public and may do damage out of proportion to the statistics involved. It has been shown repeatedly that a small percentage of a population commits the majority of crime (Wolfgang, Figlio, & Sellin, 1972; Sutherland & Cressey, 1978a).

The only available criteria to provide feedback about the accuracy of predictions of dangerousness and the

efficacy of interventions, and therefore progress in therapy, is recidivism or the reoffence rate. Recidivism indices have serious sources of error. The difficulty comes from two sources, the definition of recidivism and the accuracy of recidivism reports.

The lack of a generally agreed upon definition for measuring recidivism in sex offenders gives rise to a great deal of confusion. Depending on the study, recidivism may be defined as a new sexual charge against the offender, another arrest for a sexual crime, a new conviction for a sexual crime, or the commission of any new crime even one that is not reported (Furby, 1989). Recidivism indices may also refer to a variable time period, from six months to 25 years after the treatment or release (Furby, 1989). This lack of standardization and consistent research methods makes it very hard to find comparable studies upon which to determine recidivism rates. Thus, clear feedback about the accuracy or inaccuracy of dangerousness predictions is lacking.

The inaccuracy of the recidivism reports is another part of the problem. Very few of a criminal's new crimes come to the attention of authorities to be counted in recidivism data. Undetected sexual crimes have a two to five times higher incidence than the rate of detected sexual crimes (Hall, 1982). Victims provide still other figures that are at variance with crime reports. The best current

estimates are that, in the United States, at least one in four females and one in seven males is the victim of some form of unwanted overt physical sexual contact (Badgley, 1984; Russell, 1984; Peters, Wyatt, & Finkelhor, 1986). This large number of victims suggests that many perpetrators are committing crimes and not being apprehended. The most optimistic estimate of the crime/arrest ratio is 3:1, while most experts consider the true figure to be several times higher (Sutherland & Cressey, 1978b). As an example of the numbers of hidden crimes, Short surveyed 65 supposedly noncriminal male college students at Washington State College. He found they admitted to committing an average of 16.5 sex offenses for which they were never apprehended (Short, 1954). To further confound recidivism data, even when crimes are reported, as few as 2% actually result in a conviction for a sexual crime (Groth & Birnbaum, 1979).

The vast number of hidden crimes adds still another complication to a prediction of dangerousness and the ability of a therapist to evaluate an offender's progress in therapy effectively. In deciding if a client is improved and less dangerous, is the clinician attempting to predict whether his client will commit another crime, even one which may go unreported, or is the clinician trying to predict if his client will commit another reported crime, that is; be arrested or convicted? It seems reasonable that clinicians should try to gauge the probability of any crime and not

just the probability of getting caught. But this may be impossible.

A last consideration, in deciding about an offender's progress in therapy by making predictions of dangerousness, is how to gauge the reliability of the prediction. As sex offenders have low base-rates of identifiable behavior, the behavior is intentionally hidden, and recidivism definitions are inconsistent, validity and reliability issues confound recidivism data and acceptable margins of error are impossible to achieve. A prediction without an estimation of error is not very useful. Thus, our ability to predict dangerousness or non-dangerousness for an individual is not well developed.

Despite this evidence, there have been a number of factors upon which different researchers have attempted to base evaluations of dangerousness. Such objective and easily quantifiable factors as increasing age (Frisbie, 1965; Pacht & Cowden, 1974; Peters, Pedigo, Steg & McKenna, 1968), nature of offense (Frisbie, 1965; Gigeroff, Mohr & Turner, 1968; Sadoff, 1975), previous sex offense history (Frisbie, 1958; Gigeroff et al., 1968; Pacht & Cowden, 1974; Sadoff, 1975), occupational level (Frisbie, 1965), education (Frisbie, 1965), and marital status (Frisbie, 1965) all play some role in determining the potential for dangerousness and the amenability for successful completion of treatment. Each of these may play some role as yet unclear in

predicting a baseline level of dangerousness. However, they do not help to accurately evaluate a client's progress from the baseline level of dangerousness. There must be some way to examine the process of therapy while it is ongoing instead of trying determine the outcome before beginning by examining past history or after ending therapy when the wisdom of hindsight is too late to be of assistance.

Clinicians who work with sex offenders daily must make decisions about a client's progress or continued dangerousness. Even though the state of science is such that accurate predictions of dangerousness are impossible, there are legislative, social, and judicial pressures that often require the professional to make such predictions about sex offenders. The Supreme Court of the United States has commented on the difficulty of such predictions. The court wrote:

"It is of course not easy to predict future behavior. The fact that such a determination is difficult, however, does not mean that it cannot be made. Indeed, prediction of future criminal conduct is an essential element in many of the decisions rendered throughout our criminal justice system...[It] is basically no different from the task performed countless times each day throughout the American system of criminal justice" (Jurek v. Texas, 1976).

Thus both the American Psychological Association (1978) and the American Psychiatric Association (1974), who both said that an accurate prediction of dangerousness is impossible, have been overruled by the legal community.

Professionals now have a statutory obligation in many jurisdictions to comment on future social dangerousness (Hall, 1984). In fact making predictions of dangerous behavior is part of the expected professional standard in many governmental agencies (Stone, 1975). Moreover, most institutions for criminal offenders are so crowded that dangerousness has emerged as the key criterion for admission, transfer, and discharge (Stone, 1975), thus further forcing mental health experts to make predictions about their clients and forcing them to determine who is benefiting from therapy and who is not. Indeed, some states require such decisions from mental health workers when a question of potential violence exists.

Significant court decisions (e.g., *MacIntosh vs Milano*, 1979; *Tarasoff vs California Board of Regents*, 1976) have, in effect, obliged the mental health professional to prognosticate future violence or non-violence in their clients in order to assess whether potential victims should be warned. Thus clinicians not only must make predictions but may be held legally responsible if they recommend a dangerous person for release or if they fail to inform a potential victim of danger (*Tarasoff vs California Board of Regents*, 1976). It is apparent that in mental health services there exist strong social and political pressures which demand not only that the clinician make predictions

but he or she must do it in a way which calls for them to be "better safe than sorry" (Scheff, 1963; Shah, 1969).

Therapists must frequently decide if the client is benefiting from therapy and is less dangerous or is not benefiting and remains a danger to society. These clinicians are caught between being scientifically unable to predict dangerousness while being required to make such a prediction. They must simultaneously try to balance, "the patient's right not to be a false positive and the victim's right not to be set upon by a false negative" (Monahan, 1981, p. 169).

A clinician cannot forego a decision about what effect his or her therapy may be having on a client. Not to make such a decision means that the mandated client is (by default) not changing, continues to be dangerous and must remain in therapy indefinitely under the same sanctions as when first mandated. To require a client to remain in a mandated program without the ability to be released is a violation of personal freedom and incompatible with ethical practice. To make a determination that therapy is positively affecting a client means that the clinician must predict dangerousness and risk being wrong. Clinicians are in the unenviable position of being required to perform a function which can not be done or at least not done accurately. It seems reasonable that clinicians have a moral duty to attempt to protect potential victims by making

predictions. And in this difficult task it is more important that they do their best, rather than not do it at all because they can not be perfectly accurate. It is essential to determine how clinicians can make the most accurate judgements about their client's progress or lack of progress.

Given all of the difficulties cited above, it may be useful to work backwards, that is, to accept that clinicians are constantly evaluating their clients' progress in therapy and then to investigate what criteria they use for these evaluations. These criteria could then be used heuristically to develop new research on sex offenders. Such investigation could help in developing a formative evaluation, (one which provides ongoing feedback to clinicians, allowing them to adjust their approach to the problem while they are actively involved with solving it) (Suchman E. A., 1967) and ultimately, a summative evaluation (one done at the end of a program to evaluate the overall efficacy of the criteria used) (Hudson, J., 1977).

As the field of treating sex offenders is a relatively new field, most clinicians are not experienced or sophisticated in this area. However, experts may have the most sophisticated understanding of the issue. Also, experts have been shown to have a narrower range of opinion about their area of specialty than non-experts (Tversky, A. & Kahneman, D., 1974). A survey which asks experts'

opinions of criteria useful in evaluating sex offenders' progress in therapy could give more useful information than a survey of non-experts. Information from experts could also be used to recommend tentative criteria with which to evaluate the progress of sex offenders in therapy. Such criteria would assist working clinicians and would provide structure for future formative evaluations. With additional research such criteria could be validated and used in preparing summative evaluations.

METHOD

INTRODUCTION

This is an exploratory study to find out if there is any agreement on criteria with which to gauge the improvement of sex offenders in therapy. Data were collected using an instrument, developed for this study, which asked mental health professionals and sex offender clients for their opinions about what criteria are useful in evaluating the progress of sex offenders in therapy. As this was an exploratory study, there was no hypothesis about possible results, rather there was a series of questions posed to help demonstrate possible agreement or difference in evaluation criteria. (For specific questions see page 32.)

DEVELOPMENT OF SURVEY INSTRUMENT

Six therapists who are professionals in the field of sexual offender treatment were interviewed and asked about the criteria that they use to evaluate the progress of sexual offenders in therapy. Unstructured, open-ended interviews were conducted with specialists in treating sex offenders including: Barry Maletzky, M.D., psychiatrist and director of the Sexual Abuse Clinic, Portland, Oregon; John Prilloud, Ph.D., chief psychologist of Correctional

Treatment Programs at the Oregon State Hospital; Ron Wall, M.A., Chief Behavioral Technician, Sex offender Unit, Ward 41B, Oregon State Hospital; Rob Freeman-Longo, M.R.C., Director of the Sex Offenders Unit, Ward 41B, Oregon State Hospital; Greg Barish, M.A., Director of the Forensic Unit, Ward 47B, of the Oregon State Hospital; and Steve Jensen, M.A., Director of the Center for Behavioral Intervention and President of the Association for the Treatment of Sex Abusers (ATSA). To provide additional breadth four interviews were conducted with sexual offenders in treatment (two in prison, a rapist and a sadistic offender and two in outpatient settings, an incest offender and an exhibitionist).

Each interview was begun by asking, "In your opinion what criteria can be used to evaluate an offender's progress in therapy, that is, his decreasing dangerousness?" Each interview was then open for any opinion, recommendation or suggestion about progress in therapy and dangerousness. Interviews lasted from 45 minutes to 2 hours. Each was recorded.

The interviews were then analyzed. Each item mentioned (no matter how unusual) was noted. Redundant items were removed. Items which could be misinterpreted were clarified and ambiguity was eliminated. Each item was considered for simplicity, clarity, specificity and intelligibility. Items were shortened to one line to reduce the complexity of the

questionnaire and make it less taxing on subjects (Converse & Presser, 1986). The resulting list was then presented to the same individuals and also to Robert Jones, Ph.D. Hugo Maynard, Ph.D., Ross Neder, Ph.D. and Jan Bays, M.D.. Each of these individuals was asked to comment on the content and text of the items and make any recommendation to clarify or simplify them. The recommendations from these individuals were then incorporated into the survey form. The resulting list included 73 items. Though analysis would be easier if there were fewer items, presenting the entire list to the study groups was judged realistic for a preliminary study. At this stage any one item could be judged as having great utility.

Additionally, to investigate respondents' opinions about the utility of specific components common to sex offender therapy, 9 clusters composed of theoretically related items were formed from the 73 items. These clusters were identified and presented to the above individuals for comment. The clusters were: Disclose, 5 items related to disclosure about sexual behavior; Penile, 3 items relating to the use of the penile plethysmograph; Relate, 5 items related directly to the therapist/client relationship; MMPI, 1 item related to the Minnesota Multiphasic Personality Inventory; Concrete, 13 items related to observable behaviors (other than verbal); Social, 12 items related to social skills acquisition; Aware, 10 items

related to new awarenesses of the offender; Verbal, 17 items related to what the offender says while in therapy; Ability, 7 items that relate to new abilities the client has learned in therapy (see Table I). Adjustments were made in the clusters based on the consultants' opinions. These clusters were not identified for the respondents on the final survey form and were used during the analysis to demonstrate possible discriminations among the groups' opinions.

TABLE I

CLUSTER COMPONENT ITEMS AND RELIABILITY

1) Items That Are Related to Awareness, Insight and Understanding ($\alpha = .85$).

Q2	New awareness of personal and social
deficits/inadequacies
Q3	New awareness of personality strengths or
competency
Q8	Awareness of personal potential for harming self
or others
Q12	Spontaneous use of intervention skills for deviant
cycle
Q13	Thinking in advance about negative consequences of
behavior

TABLE I
CLUSTER COMPONENT ITEMS AND RELIABILITY
(continued)

- Q32 Understanding of deviant cycle
- Q36 Understanding of his criminal behavior and
thinking
- Q39 New insights about the causes of his criminality
- Q41 Awareness that he has life long personality
problems
- Q44 Appreciation of the harm and costs of his
criminality
- Q54 A socially acceptable understanding about right
and wrong
- Q70 Understanding and acceptance of how ordinary he is

2) Items That Are Related to the Verbal Expressions of the
Client ($\alpha = .90$).

- Q6 Honest expression of a range of good and bad
feelings
- Q11 Regret about his criminal activity
- Q16 Initiative to make restitution for the damage of
crime
- Q20 Initiation of therapy ie; spontaneously bringing
up issues
- Q21 Assertion of needs consistent with therapeutic
goals

TABLE I
CLUSTER COMPONENT ITEMS AND RELIABILITY
(continued)

Q29	Desires to improve the quality of his social support system
Q46	Willingness to ask for help with personal problems
Q47	Willingness to make commitments and assume responsibility
Q48	Desire to eliminate his deviant sexual arousal
Q49	Client expresses guilt over criminal behaviors
Q57	Client feels that therapy has been effective for him
Q64	Client expresses hope and optimism about the future
Q65	Less self centered speech, more concern/interest in others.
Q69	Willingness to be afraid, able to express fear
Q73	Client expresses gratitude about his arrest and therapy
3)	<u>Items That Are Directly Related to Disclosure</u> ($\alpha = .75$).
Q72	Reveals old crimes, that no one knew of before
Q42	Ongoing disclosure of daily problems and solutions

TABLE I
CLUSTER COMPONENT ITEMS AND RELIABILITY
(continued)

- Q33 No denial or minimization of crime
- Q34 Full agreement with victim's statement
- Q35 Greater disclosure about crime than victim's
statement

4) Items That Directly Relate to the Therapists

Relationship with the Client ($\alpha = .84$).

- Q68 Therapist feels optimistic about client's future
- Q61 Therapist's subjective judgement of the clients
sincerity
- Q62 Therapist feels personally successful about client
- Q58 That the therapist enjoys the interaction with the
client
- Q56 Client has a good relationship with his therapist

5) Items That Relate to the Direct Observation of the

Client's Concrete Behaviors While in Group or
Individual Sessions ($\alpha = .83$).

- Q1 Control of alcohol and drugs, ie; clean and sober
- Q9 Reduction of demanding behavior
- Q10 No indications of (either overt or covert) lying
- Q15 Consistent completion of assigned homework
- Q17 Congruent: observed behavior, speech and 3d party
reports

TABLE I
CLUSTER COMPONENT ITEMS AND RELIABILITY
(continued)

- Q18 Regular attendance at individual or group therapy sessions.
- Q19 Consistency of noncriminal behaviors (while observed).
- Q22 Regular payment of bills or no accumulation of prison debts.
- Q26 Positive peer evaluations about his progress
- Q40 Open and active participation in group therapy
- Q45 "Significant other" reports improvement of behavior
- Q50 Participation in six months of continuous therapy
- Q63 A reduction in complaints about his life and his troubles

6) Items That Relate to the Penile Plethysmograph

($\alpha = .80$).

- Q23 No deviant arousal on plethysmographic testing
- Q24 No evidence of supression on plethysmographic testing
- Q25 Appropriate arousal on plethysmographic testing

TABLE I
CLUSTER COMPONENT ITEMS AND RELIABILITY
(continued)

7)	<u>Items That Relate to Specific <i>Social</i> Skills That Have Been Effected During Therapy ($\alpha = .87$).</u>
Q4	Willingness to try out new ideas or procedures
Q5	That the client has learned a new skill and practices it
Q7	More introverted behavior (if an extroverted client)
Q30	That he involves intimates to support nondeviant behavior
Q37	Appropriate development of self confidence
Q43	Evidence that he is complying with group recommendations
Q51	An increased ability to handle stress
Q52	A new ability to generate options for problem solving
Q53	A reduction in concrete thinking, fewer fixed ideas
Q59	A spontaneous display of emotion (in a closed client)
Q60	Reduction of attention-seeking behavior (in an extrovert)
Q67	More extroverted behavior in an introverted client

TABLE I
CLUSTER COMPONENT ITEMS AND RELIABILITY
(continued)

8) Items That Relate to the Current Ability of the Client
($\alpha = .85$).

- Q14 Ability to make realistic plans for the future
- Q27 Ability to identify and articulate his feelings
- Q28 Ability to accurately listen to others
- Q31 Ability to develop and maintain friends
- Q38 Ability to solve or manage complex social problems
- Q55 The ability to empathize, especially with his
victims
- Q66 Able to laugh at himself, humor about his
situation

9) ITEMS RELATED TO PSYCHOLOGICAL TESTING, e.g., *MMPI*.

- Q71 Demonstrates improvement on *MMPI* or Millon testing

(Note: Cluster names and Alphas are in italics)

The final survey instrument was composed of 73 items, which respondents were asked to rate on a Likert scale with a range from; 1 (little utility) to 5 (great utility). It was estimated that most respondents would take from 5 to 10 minutes to fill out the survey form. During this time respondents were asked to make 73 difficult judgements. Because of the time and difficulty involved, some respondents were likely to think more carefully about the first items then the last. To minimize possible fatigue effects the 73 items were counterbalanced: on half of the

survey forms items were listed forwards (0-73) and on the other half items were listed backwards (73-0) (see Appendix B, Forms #4 & #5). An introduction explaining the procedures and rationale for the survey was written to supplement information on the form (see Appendix B, Form #1).

All respondents received the same survey form but with a different demographic data sheet depending on whether they were a mental health professional or sex offender. Each form indicated clearly that responses were anonymous, that no identifying marks were to be used and that respondents were not to place their names on the form. On the mental health workers demographic form respondents were asked to indicate if they felt they were a professional mental health worker and an expert in treating sex offenders and/or their victims. Professionals were asked how long, how many hours per week and under what conditions they worked with these populations. They were also asked to provide general information about their: age, sex, education, location and whether they were a victim of sexual abuse or not. Lastly, they were asked how long they believed the average sex offender and victim should remain in weekly therapy (see Appendix B, Form #2).

Offenders were asked about age, sex, state of residence, criminal history and personal victimization.

They too were questioned about how long offenders should remain in weekly therapy (see Appendix B, Form #3).

RESPONDENTS

Three groups of respondents were surveyed. First, mental health professionals who were most likely to be expert in treating sex offenders. Second, mental health professionals who specialized in treating victims of sex offenders. Lastly, sex offenders themselves.

Respondents who were expert in treating sex offenders were drawn from the ATSA. It is an international professional organization founded to encourage research and to provide a forum for information about the assessment and treatment of sex offenders. As an example of their expertise in this area the members of the ATSA board of directors and advisory board include most of the internationally known researchers and authors concerned with the treatment of sex offenders. Members of the ATSA who were present at the national conventions in 1987, 1988, 1989 and 1991 were chosen as the main subjects for this survey.

To provide contrast to the ATSA member's opinions, two other groups were surveyed: participants in the 1988 national Adults Molested as Children (AMAC) conference and sex offenders themselves. The AMAC conference was chosen to survey as it was a national conference of mental health professionals not expert in treating sex offenders. The

attendants at the AMAC conference would have professional experience in treating victims of sex abuse and be familiar with the process of evaluating their clients' progress. Furthermore, it was likely that those professionals would have some understanding of the complexities of sex offender treatment, understand the terminology included in the form and be aware of how dangerous this population is. Thus professionals who dealt with the effects of childhood molestation but did not treat offenders provided a relevant and important contrast. Lastly, sex offenders in therapy were included for comparison. These men did not have experience in evaluating progress in treatment but did have pertinent first-hand information and relevant opinions.

Based on the information in the demographic data form respondents were divided into 3 groups: *Experts* (130 mental health professionals who were expert in treating sex offenders), *Non-experts* (123 mental health professionals who were not expert in treating sex offenders) and *Offenders* (76 men who had committed sex crimes). For this analysis an expert in treating sexual offenders was defined as a mental health professional with a Masters or Doctoral degree and at least 1.5 years of clinical experience with sex offenders or a Bachelors degree with 2.5 years of experience or anyone who had worked as a therapist with offenders for more than 5 years. Approximately 1300 survey forms were distributed to the three groups; 329 or about one third of the forms were

returned. The ATSA attendants had a lower rate of return (19%) when compared with AMAC attendants (50%) and sex offenders (97%) (see Table II).

TABLE II
COMPLETED FORMS RETURNED

	Number of forms distributed	Number of forms returned
ATSA participants	800+/-	154
AMAC participants	200+/-	99
Offenders	78	76
Total	1078 +/-	329

SURVEY PROCEDURE

Professional groups were contacted during conferences. Survey forms were placed at each individual's seat and an announcement was made asking for participation and indicating who the researcher was in case anyone had questions. There were no questions about the procedure for filling out the forms. Conference attendants were told that participation was voluntary and all opinions would be confidential. They were requested to fill out the survey form during the following 24 hours. Most forms were collected by the end of each conference, although a few were returned by mail in subsequent weeks.

Additionally, 75 sex offenders enrolled in therapy programs were asked to complete survey forms. One week before the survey was distributed group members were told about it and questions about it answered. Sex offenders were assured that their participation was voluntary, their opinions would be anonymous and answers they gave would in no way effect their treatment or evaluations. The following week, at the end of a group therapy session, forms were distributed to the sex offenders. Offenders were told that to avoid being identified as not wanting to participate they should take a form and mark it meaninglessly and indicate that it was not to be used in the analysis. All but two sex offenders filled out survey forms. To insure a common understanding, items were read aloud, explained and questions answered. Questions were generally about the vocabulary used in the survey form. When all men had ceased writing, forms were collected by a group member, were shuffled and placed into an envelope which was then given to the researcher.

RESULTS

EXPLORATORY QUESTIONS

In this survey 3 groups, Experts, Non-experts and Offenders, were asked to give their opinions about criteria that are useful for evaluating sex offenders' progress while in therapy. To evaluate their responses and to help identify criteria on which the groups agreed or disagreed, a series of questions were posed:

- 1) In what ways do the 3 groups agree or disagree about the utility of each of the 73 items? In what ways do they agree or disagree about the utility of clusters of items based on like content?
- 2) When the Experts and Offenders groups are considered separately, which items does each group rank as having the highest and lowest utility?
- 3) Which items do *BOTH* the Experts and Offenders groups agree have the greatest and least utility?
- 4) In what ways do subgroups (by gender, age, etc.) of the Experts group agree or disagree about the utility of criteria for evaluating progress?
 - a) Within the Experts group is there agreement or disagreement about the utility of specific components common to sex offender therapy

such as: penile plethysmography, disclosure, therapist/client relationship, MMPI and behavioral changes?

b) Does experience, amount of education, age, sex or whether an expert has him or her self been a victim of sexual abuse make any difference in their opinions of utility of these items?

5) Can other as yet unidentified factors be found that are useful for the evaluation of progress?

To examine these questions the following general procedures were used. First, the opinion ratings of three primary groups, Offenders, Experts and Non-experts were compared on each of the 73 (Q1 to Q73) rated items. The same three group's opinions were then compared on content-related clusters of items, e.g., 3 items relating to the penile plethysmograph or 5 items about disclosure. Items were then ranked for each group of respondents by the mean opinion rating that group gave each item. Specific items which had high and low utility ratings were identified for each group of respondents. The identified items were then compared to see which were common among groups.

Second, subsets of Experts were compared for meaningful contrasts within groups. For example, the opinions of men were compared with those of women and opinions of older men were compared with those of younger men.

Third, opinion ratings for each group were ranked and subjected to factor analysis to allow for the emergence of as yet unidentified factors present.

RESPONDENTS' DEMOGRAPHIC INFORMATION

There were 329 returned forms. The respondents comprised: 206 men, including 76 male sex offenders, and 117 women. The mean age of respondents was 40.5 years, with a range of 19 to 74 years. Professionals included 241 individuals who stated that they worked in mental health, and an additional 10 others who reported job tasks that were consistent with a mental health professional. For example, one individual did not designate him or her self as a professional but reported treating offenders 30 hours a week. Of 241 professionals, 91 judged themselves expert in working with victims and 161 professionals judged themselves expert working with offenders. There was overlap between the two groups. Interestingly, some professionals who had many years of experience did not rate themselves as expert and a few professionals with only a few months experience rated themselves experts. Among all professionals degree frequencies were:

- 2 individuals who had no degree,
- 42 with bachelor degrees,
- 139 with masters degrees,
- 70 with doctoral degrees.

Among Experts there were:

- 14 individuals with bachelor degrees,
- 72 with masters degrees,
- 70 with doctorate degrees.

Among Non-experts there were:

- 28 individuals with bachelor degrees,
- 67 with masters degrees,
- 28 with doctorate degrees.

Among Offenders no respondent had a degree.

Both Experts and Non-experts groups had a mean education level equivalent to a masters degree. The Experts had an average of about 6 months more education than Non-experts. Professionals were asked about sexual victimization. Sixty-two reported being a victim, 133 reported not being a victim and the rest did not respond to this question.

Sex offenders surveyed were all male and in group therapy either in prison or in an outpatient clinic. The average age was 32.5. Of the 76 sex offenders, 34 reported being a victim of sexual abuse, 37 reported being a victim of physical abuse and 50 reported being a victim of emotional abuse. These reported levels of abuse are not independent, several men reported one or more kinds of abuse. Virtually all those in the Offenders group reported abuse. Six of the men had never been incarcerated. The rest reported a range of incarceration from .5 to 15 years

with an average of 4.5 years. Final groups contained 130 Experts, 123 Non-experts and 76 Offenders.

Lastly, all those surveyed were asked about the length of time a victim of sexual abuse and a sexual offender should remain in therapy. The average recommendations of each group were as follows:

- Experts group recommended 2.2 years ($sd \pm 1.0$).
- Non-experts group recommended 2.6 years ($sd \pm 1.2$).
- Offenders group recommended 2.9 years ($sd \pm 1.8$).

COMPARISON OF GROUPS

There were 73 items (labeled Q1 to Q73) judged for possible utility in evaluating the progress of sex offenders in therapy. These items were judged on a 5 point Likert scale by the three groups; Experts, Non-experts and Offenders. The first question posed was whether the 3 groups agreed or disagreed about the utility of each of the 73 items. Groups were paired (Experts/Non-experts, Experts/Offenders, Non-experts/Offenders). Then the opinions of each pair were tested for agreement on each individual item (Q1 to Q73). Thus there were 73 tests run for each of the 3 pairs.

To test if two groups agreed or disagreed on an item the Mann-Whitney signed rank test was used for analysis. The Mann-Whitney test can be useful if samples are

independent, not normally distributed and the data are ordinal. For this test, the null hypothesis was that there is no difference between the distributions of the group's ratings of each item. For the ratings had the same distribution in each group, the means of their ranks should be similar. Mean ranks are the sum of the ranks divided by the number of cases. If the mean ranks are dissimilar there is reason to suspect that the groups' opinions are different (Norušis, 1986). All statistics were run on a 386 personal computer using SPSS/PC+.

Experts Compared with Offenders

Comparing the opinions of Experts and Offenders for each item, Offenders rated 66 out of 73 items higher than Experts. A mean opinion including all items (Q1 - Q73) was determined for each group. The mean of Offenders' opinions was 2.97, while the mean of Experts' opinions was 2.05, almost a full point of difference.

Using the Mann-Whitney test, the opinions of Experts and Offenders differed ($p \leq .05$) on 53 of the 73 items. The two groups agreed (the null hypothesis was not rejected) on the utility of 20 of 73 items: Q1, Q8, Q10, Q12, Q13, Q19, Q20, Q22, Q23, Q24, Q25, Q30, Q32, Q33, Q35, Q36, Q42, Q44, Q45, Q54 (see Table III).

TABLE III

ITEMS EXPERTS AND OFFENDERS AGREED UPON

- Q1. Control of alcohol and drugs, ie; clean and sober.
- Q8. Awareness of personal potential for harming self or others.
- Q10. No indications of overt or covert lying.
- Q12. Spontaneous use of intervention skills for deviant cycle.
- Q13. Thinking in advance about negative consequences of behavior.
- Q19. Consistency of noncriminal behaviors (while observed).
- Q20. Initiation of therapy ie; spontaneously bringing up issues.
- Q22. Regular payment of bills or no accumulation of prison debts.
- Q23. No deviant arousal on plethysmographic testing.
- Q24. No evidence of suppression on plethysmographic testing.
- Q25. Appropriate arousal on plethysmographic testing.
- Q30. That he involves intimates to support nondeviant behavior.
- Q32. Understanding of deviant cycle.
- Q33. No denial or minimization of crime.
- Q35. Greater disclosure about crime than victims statement.
- Q36. Understanding of his criminal behavior and thinking.
- Q42. Ongoing disclosure of daily problems and solutions.

TABLE III
ITEMS EXPERTS AND OFFENDERS AGREED UPON
(continued)

- Q44. Appreciation of the harm and costs of his criminality.
Q45. "Significant other" reports improvement of behavior.
Q54. A socially acceptable understanding about right and wrong.

Agreement meant only that Experts and Offenders were in accord about a particular item. It did not mean that the item was judged of relatively greater or lesser utility. The groups could have agreed that an item was of average utility. To ascertain which items out of the 20 were judged of higher utility, opinions of Experts and Offenders on each item (e.g., Q1), were combined and the mean opinion for that item computed. This was done for each of the 20 items. The 20 items were then ranked by means. Items that were judged above one standard deviation from the mean were considered of high utility. Items that were within one standard deviation from the mean were considered of average utility. For these two groups the mean rank of all variables (Q1 to Q73) was 3.60 ($sd \pm .57$). Of the items Experts and Offenders agreed upon, there were 7 which had mean ranks more than one standard deviation above the mean. Listed by mean rank score from higher to lower utility these items were: Q12, Q1, Q33, Q13, Q8, Q32, Q36 (see Table IV).

TABLE IV

ITEMS EXPERTS AND OFFENDERS AGREED WERE MOST USEFUL

Item Mean

- Q12.(4.41) Spontaneous use of intervention skills for
deviant cycle.
- Q1. (4.37) Control of alcohol and drugs, ie; clean and
sober.
- Q33 (4.32) No denial or minimization of crime.
- Q13 (4.31) Thinking in advance about negative consequences
of behavior.
- Q8. (4.23) Awareness of personal potential for harming self
or others.
- Q32 (4.11) Understanding of deviant cycle.
- Q36 (4.08) Understanding of his criminal behavior and
thinking.

There were no items of agreement more than one standard deviation below the mean.

Non-experts Compared With Offenders

The Non-experts and Offenders groups disagreed on 58 out of 73 items ($p < .05$). They agreed on the following 15 items: Q1, Q6, Q10, Q12, Q13, Q16, Q19, Q20, Q23, Q24, Q25, Q30, Q33, Q35, Q53, (see Table V).

TABLE V

NON-EXPERTS COMPARED WITH OFFENDERS:
ITEMS ON WHICH GROUPS DISAGREED

- Q1. Control of alcohol and drugs, ie; clean and sober.
- Q6. Honest expression of a range of good and bad feelings.
- Q10. No indications of overt or covert lying.
- Q12. Spontaneous use of intervention skills for deviant cycle.
- Q13. Thinking in advance about negative consequences of behavior.
- Q16. Initiative to make restitution for the damage of crime.
- Q19. Consistency of noncriminal behaviors (while observed).
- Q20. Initiation of therapy ie; spontaneously bringing up issues.
- Q23. No deviant arousal on plethysmographic testing.
- Q24. No evidence of suppression on plethysmographic testing.
- Q25. Appropriate arousal on plethysmographic testing.
- Q30. That he involves intimates to support nondeviant behavior.
- Q33. No denial or minimization of crime.
- Q35. Greater disclosure about crime than victims statement.
- Q53. A reduction in concrete thinking, fewer fixed ideas.

When the opinions of the Non-experts and Offenders groups were combined and the overall mean of their combined Q-variables was calculated, it was found to be

3.64 ($sd \pm .55$). The following items with means above 4.19 are more than one standard deviation from the mean and are judged of greater utility: Q1, Q13, Q33.

Experts Compared With Non-experts

The Experts and Non-experts groups had a greater degree of agreement with one another than Offenders did with either group. They agreed on 64 out of 73 items. The following are the 10 items of agreement (ranked by means from highest to lowest) which were judged to be of highest utility: Q12, Q1, Q33, Q13, Q55, Q48, Q17, Q18, Q35, Q10 (see Table VI).

TABLE VI

ITEMS EXPERTS AND NON-EXPERTS AGREED UPON

- 1) Q12. Spontaneous use of intervention skills for deviant cycle.
- 2) Q1. Control of alcohol and drugs, ie; clean and sober.
- 3) Q33. No denial or minimization of crime.
- 4) Q13. Thinking in advance about negative consequences of behavior.
- 5) Q55. The ability to empathize, especially with his victims.
- 6) Q48. Desire to eliminate his deviant sexual arousal.
- 7) Q17. Congruent: observed behavior, speech and 3d party reports.

TABLE VI
ITEMS EXPERTS AND NON-EXPERTS AGREED UPON
(continued)

- 8) Q18. Regular attendance at individual or group therapy sessions.
- 9) Q35. Greater disclosure about crime than victim's statement.
- 10) Q10. No indications of overt or covert lying.

The mean of all the Experts and Non-experts opinions on all items was 3.64 ($sd \pm .55$). When comparing this with the means of the individual Q-variables there were 5 items which were rated more than one standard deviation above the mean (≥ 4.19). By this calculation the members of the Experts and Non-experts groups agreed that the following items had greater utility in predicting progress: Q12, Q1, Q33, Q13, Q55 (see Table VII).

TABLE VII
ITEMS EXPERTS AND NON-EXPERTS AGREED
HAD THE HIGHEST UTILITY

- Q12. Spontaneous use of intervention skills for deviant cycle.
- Q1. Control of alcohol and drugs, ie; clean and sober.
- Q33. No denial or minimization of crime.
- Q13. Thinking in advance about negative consequences of behavior.
- Q55. The ability to empathize, especially with his victims.

The Experts and Non-experts groups *disagreed* on 9 items at ($p < .05$). These items were: Q8, Q15, Q22, Q32, Q36, Q42, Q43, Q45, Q48 (see Table VIII).

TABLE VIII

ITEMS EXPERTS AND NON-EXPERTS DISAGREED ON

- Q8. Awareness of personal potential for harming self or others.
- Q15. Consistent completion of assigned homework.
- Q22. Regular payment of bills or no accumulation of prison debts.
- Q32. Understanding of deviant cycle.
- Q36. Understanding of his criminal behavior and thinking.
- Q42. Ongoing disclosure of daily problems and solutions.
- Q43. Evidence that he is complying with group recommendations.
- Q45. "Significant other" reports improvement of behavior.
- Q48. Desire to eliminate his deviant sexual arousal.

Experts rated all 9 items higher than Non-experts. Of the 9 items Experts rated only 4 items (Q8, Q32, Q36, Q48) more than one standard deviation from the mean. Non-experts rated no item that high.

Group Comparisons on Clusters of Items

The second question considered was whether groups Experts, Non-experts and Offenders agreed or disagreed about particular aspects of sex offender treatment. The 73 items were grouped into clusters that were alike in content. The groups' opinions were then compared on the following clusters (see Table I).

- Disclose, 5 items related to disclosure of sexual crimes,
- Penile, 3 items related to utility of the penile plethysmograph,
- Relate, 5 items related to client therapist relationship,
- MMPI, 1 item about the MMPI and the MCMI,
- Concrete, 13 items related to observable behaviors
- Social, 12 items related to social skills acquisition.
- Aware, 10 items related to new awareness of the offender,
- Verbal, 17 items related to what the offender says,
- Ability, 7 items related to new skills.

The above clusters were tested for reliability by calculating Chronbach's Alpha. The results indicated an alpha between .81 and .90 for most clusters (see Table I). This result suggests there is internal consistency within each cluster and that these are reliable clusters. The one

exception to this was the cluster Disclose. Disclose's alpha was .75, suggesting that it is an adequate factor but not as robust as the others. An alternative explanation for the high reliability of these clusters is that the ratings of the items within the clusters are simply a reflection of the narrow range of opinion found in much of the data. For example, when comparing opinions on the cluster Concrete older male Experts and younger male Experts were almost in total agreement (see Table IX). This extremely high level of agreement is found within much of the non-offender data.

When comparing two groups the Mann-Whitney test was used. When the opinions of three groups were compared for agreement a Kruskal-Wallis one-way analysis of variance was used. This test is an extension of the Mann-Whitney test (Norušis, 1986).

TABLE IX

DATA FROM GROUP COMPARISONS ON CLUSTERS OF ITEMS

<u>Cluster #1</u>	<u>Disclosure of Sexual Crimes</u> (5 items: Q33, Q34, Q35, Q42, Q72)	PROBABILITY THAT THE TWO GROUPS ARE SIMILAR
Experts combined with Non-experts vs Offenders . . .		<.001
Experts who were victims of abuse vs Experts who were not victims of abuse		>.74
Expert males vs Expert females		<.02

TABLE IX

DATA FROM GROUP COMPARISONS ON CLUSTERS OF ITEMS
(continued)

Experts who have had at least five years of experience vs Experts who have had less than five years of experience	>.45
Experts from the top ten percent by years of experience vs Experts from the bottom ten percent by years of experience	>.62
Experts from the top ten percent by age vs Experts from the bottom ten percent by age	<.03
Experts from the top ten percent of men by age and experience vs Experts from the bottom ten percent of men by age and experience	>.20
Experts from the top ten percent of women by age and experience vs Experts from the bottom ten percent of women by age and experience	>.93
Experts with doctoral degrees vs Experts with bachelor degrees	>.41

Cluster #2 Penile Plethysmograph
(3 items: Q23, Q24, Q25)

PROBABILITY THAT THE
TWO GROUPS ARE SIMILAR

Experts combined with Non-experts vs Offenders	>.52
Experts who were victims of abuse vs Experts who were not victims of abuse	>.66
Expert males vs Expert females	>.38

TABLE IX

DATA FROM GROUP COMPARISONS ON CLUSTERS OF ITEMS
(continued)

Experts who have had at least five years of experience vs Experts who have had less than five years of experience	>.39
Experts from the top ten percent by years of experience vs Experts from the bottom ten percent by years of experience	>.45
Experts from the top ten percent by age vs Experts from the bottom ten percent by age	>.86
Experts with doctoral degrees vs Experts with bachelor degrees	>.10

Cluster #3 Relationship Between Client and Therapist
(5 items: Q33,Q34,Q35,Q42,Q72)

PROBABILITY THAT THE
TWO GROUPS ARE SIMILAR

Experts combined with Non-experts vs Offenders . . .	<.001
Experts who were victims of abuse vs Experts who were not victims of abuse	>.93
Expert males vs Expert females	>.73
Experts who have had at least five years of experience vs Experts who have had less than five years of experience	>.95

TABLE IX

DATA FROM GROUP COMPARISONS ON CLUSTERS OF ITEMS
(continued)

Experts from the top ten percent by years of experience vs Experts from the bottom ten percent by years of experience	>.61
Experts from the top ten percent by age vs Experts from the bottom ten percent by age	<.41
Experts with doctoral degrees vs Experts with bachelor degrees	>.38

Cluster #4 Psychological testing, e.g., MMPI
(1 item: Q71)

PROBABILITY THAT THE
TWO GROUPS ARE SIMILAR

Experts combined with Non-experts vs Offenders . . .	<.001
Experts who were victims of abuse vs Experts who were not victims of abuse	>.12
Expert males vs Expert females	>.53
Experts who have had at least five years of experience vs Experts who have had less than five years of experience	>.52
Experts from the top ten percent by years of experience vs Experts from the bottom ten percent by years of experience	>.12
Experts from the top ten percent by age vs Experts from the bottom ten percent by age	>.95

TABLE IX

DATA FROM GROUP COMPARISONS ON CLUSTERS OF ITEMS
(continued)

Experts with doctoral degrees vs Experts with bachelor degrees		>.64
<u>Cluster #5</u>	<u>AWARE Items Relating to New Awarenesses of the Offender.</u> (10 items: Q2, Q3, Q8, Q12, Q13, Q32, Q36, Q39, Q42, Q44, Q54, Q70)	
		PROBABILITY THAT THE TWO GROUPS ARE SIMILAR
Experts combined with Non-experts vs Offenders . . .		<.001
Experts who were victims of abuse vs Experts who were not victims of abuse		>.48
Expert males vs Expert females		>.05
Experts from the top ten percent by years of experience vs Experts from the bottom ten percent by years of experience		>.18
Experts from the top ten percent by age vs Experts from the bottom ten percent by age		>.65
Oldest ten percent of male Experts vs youngest ten percent of male Experts		>.69
Oldest ten percent of female Experts vs youngest ten percent of female Experts		>.88
Experts with doctoral degrees vs Experts with bachelor degrees		<.03

TABLE IX
DATA FROM GROUP COMPARISONS ON CLUSTERS OF ITEMS
(continued)

<u>Cluster #6</u>	<u>Verbal Items Relating to What the Offender Says About His Progress.</u> (17 items: Q6, Q11, Q16, Q20, Q21, Q29, Q46, Q47, Q48, Q49, Q57, Q64, Q65, Q69, Q73)	PROBABILITY THAT THE TWO GROUPS ARE SIMILAR
Experts combined with Non-experts vs Offenders . . .		<.001
Experts who were victims of abuse vs Experts who were not victims of abuse		>.49
Expert males vs Expert females		>.14
Experts from the top ten percent by years of experience vs Experts from the bottom ten percent by years of experience		>.47
Experts from the top ten percent by age vs Experts from the bottom ten percent by age		>.84
Oldest ten percent of male Experts vs youngest ten percent of male Experts		>.25
Oldest ten percent of female Experts vs youngest ten percent of female Experts		>.21
Experts with doctoral degrees vs Experts with bachelor degrees		>.27

TABLE IX
DATA FROM GROUP COMPARISONS ON CLUSTERS OF ITEMS
(continued)

<u>Cluster #7</u>	<u>Concrete Items Relating to the Offender's Observable Behaviors</u> (13 items: Q1, Q9, Q10, Q15, Q17, Q18, Q19, Q22, Q26, Q40, Q45, Q50, Q63).	PROBABILITY THAT THE TWO GROUPS ARE SIMILAR
Experts combined with Non-experts vs Offenders . . .		<.001
Experts who were victims of abuse vs Experts who were not victims of abuse		>.93
Expert males vs Expert females		>.32
Experts from the top ten percent by years of experience vs Experts from the bottom ten percent by years of experience		>.29
Experts from the top ten percent by age vs Experts from the bottom ten percent by age		>.23
Oldest ten percent of male Experts vs youngest ten percent of male Experts		>.90
Oldest ten percent of female Experts vs youngest ten percent of female Experts		>.60
Experts with doctoral degrees vs Experts with bachelor degrees		>.45

TABLE IX

DATA FROM GROUP COMPARISONS ON CLUSTERS OF ITEMS
(continued)

<u>Cluster #8</u>	<u>Social Items Relating Social Skills the Offender Has Learned in Therapy (Q4, Q5, Q7, Q30, Q37, Q43, Q51, Q52, Q53, Q59, Q60, Q67)</u>	PROBABILITY THAT THE TWO GROUPS ARE SIMILAR
Experts combined with Non-experts vs Offenders . . .		<.001
Experts who were victims of abuse vs Experts who were not victims of abuse		>.29
Expert males vs Expert females		>.13
Experts from the top ten percent by years of experience vs Experts from the bottom ten percent by years of experience		>.52
Experts from the top ten percent by age vs Experts from the bottom ten percent by age		>.52
Oldest ten percent of male Experts vs youngest ten percent of male Experts		>.25
Oldest ten percent of female Experts vs youngest ten percent of female Experts		>.69
Experts with doctoral degrees vs Experts with bachelor degrees		<.01

TABLE IX

DATA FROM GROUP COMPARISONS ON CLUSTERS OF ITEMS
(continued)

<u>Cluster #9</u>	<u>AWARE Items Relating to New Awarenesses of the Offender</u> (10 items: Q2, Q3, Q8, Q12, Q13, Q32, Q36, Q39, Q42, Q44, Q54, Q70)	PROBABILITY THAT THE TWO GROUPS ARE SIMILAR
Experts combined with Non-experts vs Offenders . . .		<.001
Experts who were victims of abuse vs Experts who were not victims of abuse		>.48
Expert males vs Expert females		>.05
Experts from the top ten percent by years of experience vs Experts from the bottom ten percent by years of experience		>.18
Experts from the top ten percent by age vs Experts from the bottom ten percent by age		>.65
Oldest ten percent of male Experts vs youngest ten percent of male Experts		>.69
Oldest ten percent of female Experts vs youngest ten percent of female Experts		>.88
Experts with doctoral degrees vs Experts with bachelor degrees		<.03

Areas of Agreement Among and Within
the Three Groups on Clustered Items

Areas of agreement are found in the following comparisons:

- 1) Experts and Non-experts groups were in agreement about all clusters.
- 2) Offenders, Experts and Non-experts agreed only on the cluster *Penile*. Experts and Non-experts rated this cluster slightly but not significantly higher than Offenders.
- 3) The opinions of subgroups within the Experts group were compared on the clustered items and essentially showed no differences of opinion (see Table IX). The following subgroups were compared:
 - Those who were victims with those who were not victims.
 - The top 10% by age with the bottom 10% by age.
 - Those who were men with those who were women.
 - By age, the top 10% of men with the bottom 10% of men.
 - By age, the top 10% of women with the bottom 10% of women
 - Those with doctorate degrees with those with bachelor degrees.

- Experts from the top ten percent by years of experience with Experts from the bottom ten percent by years of experience.

Areas of Disagreement Among and Within the Three Groups on Clustered Items

Areas of disagreement are found in the following comparisons:

- 1) Those in the Expert group with bachelor degrees and those with doctorate degrees disagreed on the utility of clusters *Aware* ($p < .03$), *Social* ($p < .01$), *Ability* ($p < .03$). In all three cases, those with bachelor degrees rated these clusters higher than those with doctorate degrees. They agreed on all other clusters.
- 2) Consistent with the results of the item-by-item comparisons (with the exception of cluster *Penile*) Offenders' opinions disagreed with those of both other groups. Offenders rated every cluster significantly more highly than the other groups (see Table IX).

ITEMS RATED AS HIGHEST AND LOWEST UTILITY
BY BOTH EXPERTS AND OFFENDERS

The third question was which items do both Experts and Offenders rate as having the highest and lowest utility and are there any common items in these ratings? The 25 highest and 25 lowest items were ranked by the opinion scores given

by the Experts group (see Table X and Table XI) and Offenders group (see Table XII and Table XIII).

TABLE X
EXPERTS' 25 HIGHEST ITEMS RANKED

Rank Mean Item

- 1)[4.50] Q12. Spontaneous use of intervention skills for deviant cycle.
- 2)[4.47] Q1. Control of alcohol and drugs, ie; clean and sober.
- 3)[4.44] Q33. No denial or minimization of crime.
- 4)[4.38] Q13. Thinking in advance about negative consequences of behavior.
- 5)[4.37] Q55. The ability to empathize, especially with his victims.
- 6)[4.35] Q8. Awareness of personal potential for harming self or others.
- 7)[4.23] Q48. Desire to eliminate his deviant sexual arousal.
- 8)[4.18] Q32. Understanding of deviant cycle.
- 9)[4.15] Q36. Understanding of his criminal behavior and thinking.
- 10)[4.12] Q17. Congruent: observed behavior, speech and 3d party reports.

TABLE X
EXPERTS' 25 HIGHEST ITEMS RANKED
(continued)

Rank Mean Item

11)	[4.08]	Q18. Regular attendance at individual or group therapy sessions.
12)	[4.03]	Q35. Greater disclosure about crime than victim's statement.
13)	[4.03]	Q47. Willingness to make commitments and assume responsibility.
14)	[3.99]	Q44. Appreciation of the harm and costs of his criminality.
15)	[3.97]	Q10. No indications of overt or covert lying.
16)	[3.97]	Q30. That he involves intimates to support nondeviant behavior.
17)	[3.85]	Q5. That the client has learned a new skill and practices it.
18)	[3.83]	Q2. New awareness of personal and social deficits/inadequacies.
19)	[3.83]	Q40. Open and active participation in group therapy.
20)	[3.81]	Q43. Evidence that he is complying with group recommendations.
21)	[3.81]	Q46. Willingness to ask for help with personal problems.
22)	[3.80]	Q72. Reveals old crimes, that no one knew of before.

TABLE X
EXPERTS' 25 HIGHEST ITEMS RANKED
(continued)

Rank Mean Item

- 23)[3.78] Q20. Initiation of therapy ie; spontaneously
bringing up issues.
- 24)[3.78] Q65. Less self centered speech, more
concern/interest in others.
- 25)[3.76] Q6. Honest expression of a range of good and bad
feelings.

TABLE XI
EXPERTS' 25 LOWEST ITEMS RANKED

Rank Mean Item

- 1)[2.05] Q58. That the therapist enjoys the interaction
with the client.
- 2)[2.32] Q62. Therapist feels personally successful about
client.
- 3)[2.49] Q7. More introverted behavior (in an extroverted
client).
- 4)[2.54] Q68. Therapist feels optimistic about client's
future.
- 5)[2.57] Q71. Demonstrates improvement on MMPI or Millon
testing.

TABLE XI
EXPERTS' 25 LOWEST ITEMS RANKED
(continued)

<u>Rank</u>	<u>Mean</u>	<u>Item</u>
6)	[2.67]	Q63. A reduction in complaints about his life and his troubles.
7)	[2.74]	Q61. Therapist's subjective judgement of the clients sincerity.
8)	[2.97]	Q64. Client expresses hope and optimism about the future.
9)	[2.92]	Q56. Client has a good relationship with his therapist.
10)	[2.93]	Q70. Understanding and acceptance of how ordinary he is.
11)	[2.95]	Q73. Client expresses gratitude about his arrest and therapy.
12)	[2.97]	Q67. More extroverted behavior in an introverted client.
13)	[3.08]	Q59. A spontaneous display of emotion (in a closed client).
14)	[3.10]	Q60. Reduction of attention-seeking behavior (in an extrovert).
15)	[3.13]	Q57. Client feels that therapy has been effective for him.
16)	[3.18]	Q66. Able to laugh at himself, humor about his situation.

TABLE XI
EXPERTS' 25 LOWEST ITEMS RANKED
(continued)

Rank Mean Item

- 17) [3.19] Q50. Participation in six months of continuous therapy.
- 18) [3.28] Q38. Ability to solve or manage complex social problems.
- 19) [3.29] Q39. New insights about the causes of his criminality.
- 20) [3.30] Q26. Positive peer evaluations about his progress.
- 21) [3.36] Q22. Regular payment of bills or no accumulation of prison debts.
- 22) [3.40] Q21. Assertion of needs consistent with therapeutic goals.
- 23) [3.47] Q23. No deviant arousal on plethysmographic testing.
- 24) [3.47] Q16. Initiative to make restitution for the damage of crime.
- 25) [3.48] Q37. Appropriate development of self confidence.

TABLE XII
OFFENDERS' 25 HIGHEST ITEMS RANKED

<u>Rank</u>	<u>Mean</u>	<u>Item</u>
1)	[4.53]	Q48. Desire to eliminate his deviant sexual arousal.
2)	[4.46]	Q46. Willingness to ask for help with personal problems.
3)	[4.43]	Q47. Willingness to make commitments and assume responsibility.
4)	[4.42]	Q13. Thinking in advance about negative consequences of behavior.
5)	[4.40]	Q18. Regular attendance at individual or group therapy sessions.
6)	[4.36]	Q11. Regret about his criminal activity.
7)	[4.35]	Q55. The ability to empathize, especially with his victims.
8)	[4.32]	Q36. Understanding of his criminal behavior and thinking.
9)	[4.31]	Q8. Awareness of personal potential for harming self or others.
10)	[4.29]	Q4. Willingness to try out new ideas or procedures.
11)	[4.28]	Q41. Awareness that he has life long personality
12)	[4.28]	Q32. Understanding of deviant cycle.
13)	[4.28]	Q54. A socially acceptable understanding about right and wrong.

TABLE XII
OFFENDERS' 25 HIGHEST ITEMS RANKED
(continued)

Rank Mean Item

- 14)[4.26] Q40. Open and active participation in group therapy.
- 15)[4.26] Q29. Desires to improve the quality of his social support system.
- 16)[4.25] Q33. No denial or minimization of crime.
- 17)[4.25] Q3. New awareness of personality strengths or competency.
- 18)[4.24] Q12. Spontaneous use of intervention skills for deviant cycle.
- 19)[4.23] Q5. That the client has learned a new skill and practices it.
- 20)[4.21] Q39. New insights about the causes of his criminality.
- 21)[4.19] Q1. Control of alcohol and drugs, ie; clean and sober.
- 22)[4.15] Q51. An increased ability to handle stress.
- 23)[4.14] Q28. Ability to accurately listen to others.
- 24)[4.12] Q37. Appropriate development of self confidence.
- 25)[4.11] Q52. A new ability to generate options for problem solving.

TABLE XIII
OFFENDERS' 25 LOWEST ITEMS RANKED

<u>Rank</u>	<u>Mean</u>	<u>Item</u>
1)[2.97]		Q58. That the therapist enjoys the interaction with the client.
2)[3.15]		Q7. More introverted behavior (in an extroverted client).
3)[3.15]		Q23. No deviant arousal on plethysmographic testing.
4)[3.15]		Q62. Therapist feels personally successful about client.
5)[3.17]		Q34. Full agreement with victims statement.
6)[3.31]		Q24. No evidence of suppression on plethysmographic testing.
7)[3.31]		Q71. Demonstrates improvement on MMPI or Millon testing.
8)[3.34]		Q68. Therapist feels optimistic about client's future.
9)[3.44]		Q66. Able to laugh at himself, humor about his situation.
10)[3.45]		Q22 No accumulation of prison debts.
11)[3.45]		Q63. A reduction in complaints about his life and his troubles.
12)[3.45]		Q61. Therapist's subjective judgement of the clients sincerity.

TABLE XIII
OFFENDERS' 25 LOWEST ITEMS RANKED
(continued)

<u>Rank</u>	<u>Mean</u>	<u>Item</u>
13)	[3.46]	Q60. Reduction of attention-seeking behavior (in an extrovert).
14)	[3.53]	Q67. More extroverted behavior in an introverted client.
15)	[3.55]	Q59. A spontaneous display of emotion (in a closed client).
16)	[3.58]	Q17. Congruent: observed behavior, speech and 3d party reports.
17)	[3.63]	Q25. Appropriate arousal on plethysmographic testing.
18)	[3.67]	Q53. A reduction in concrete thinking, fewer fixed ideas.
19)	[3.71]	Q70. Understanding and acceptance of how ordinary he is.
20)	[3.74]	Q26. Positive peer evaluations about his progress.
21)	[3.76]	Q16. Initiative to make restitution for the damage of crime.
22)	[3.77]	Q45. "Significant other" reports improvement of behavior.
23)	[3.80]	Q19. Consistency of noncriminal behaviors (while observed).

TABLE XIII
OFFENDERS' 25 LOWEST ITEMS RANKED
(continued)

Rank Mean Item

24)[3.81] Q73. Client expresses gratitude about his arrest
and therapy.

25)[3.83] Q42. Ongoing disclosure of daily problems and
solutions.

Considering the order of item ranks, Experts group ranked item #12 (spontaneous use of intervention skills for deviant cycle) as the single highest ranked item. Offenders group ranked item #48 (desire to eliminate his deviant sexual arousal) as the highest item. Item #58 (that the therapist enjoys the interaction with the client) was given the lowest rank by both professionals and offenders.

When comparing the ten highest ranked and the ten lowest ranked items of Experts and Offenders there are 5 common items, Q13, Q55, Q8, Q48, Q36 in the top ten (see Table XIV) and another 5 common items, Q58, Q62, Q7, Q68, Q71, in the bottom ten (see Table XV).

TABLE XIV
HIGHEST FIVE ITEMS COMMON TO EXPERTS
AND OFFENDERS GROUPS

<u>Rank</u>	<u>Item</u>
1)	Q13. Thinking in advance about negative consequences of behavior.
2)	Q55. The ability to empathize, especially with his victims.
3)	Q8. Awareness of personal potential for harming self or others.
4)	Q48. Desire to eliminate his deviant sexual arousal.
5)	Q36. Understanding of his criminal behavior and thinking.

TABLE XV
LOWEST FIVE ITEMS COMMON TO BOTH
EXPERTS AND OFFENDERS GROUPS

<u>Rank</u>	<u>Item</u>
1)	Q58. That the therapist enjoys the interaction with the client.
2)	Q62. Therapist feels personally successful about client.
3)	Q7. More introverted behavior (in an extroverted client).
4)	Q68. Therapist feels optimistic about client's future.
5)	Q71. Demonstrates improvement on MMPI or Millon testing.

COMPARISONS ON ITEMS BY CONDITIONS
WITHIN THE EXPERTS GROUP

The fourth question was; do subgroups of the Expert group agree or disagree about the utility of items? The following sub-groups were compared for similarity using a Mann-Whitney test. Each of these 8 pairs was tested on items Q1 to Q73. Thus 584 separate tests were run.

- 1) Male Experts vs Female Experts,
- 2) Victims vs Non-victims,
- 3) Those with Doctorate degrees vs those with Bachelor degrees,
- 4) Those with more than 5 years experience vs those with less experience,
- 5) The most experienced (by years of practice) 10% vs the least experienced 10%,
- 6) The oldest 10% vs the youngest 10%,
- 7) The oldest 10% of males vs the youngest 10% of males,
- 8) The oldest 10% of females vs the youngest 10% of females.

The following items are items on which these groups disagreed (probability of undetected difference on all the following comparisons was $<.05$):

- 1) Female Experts rated these items significantly higher than Male Experts: Q20, Q36, Q57, Q60 (see Table XVI).

TABLE XVI

ITEMS FEMALE EXPERTS RATED
HIGHER THAN MALE EXPERTS

Q20. Initiation of therapy ie; spontaneously bringing up issues.

Q36. Understanding of his criminal behavior and thinking.

Q57. Client feels that therapy has been effective for him.

Q60. Reduction of attention-seeking behavior (in an extrovert).

- 2) Experts who were victims of sexual abuse differed from Experts who were non-victims on the following items:
Q13, Q19 (see Table XVII).

TABLE XVII

ITEMS ON WHICH EXPERTS AND NON-EXPERTS WHO
WERE VICTIMS OF SEXUAL ABUSE DIFFERED

Q13. Thinking in advance about negative consequences of behavior. (Victims rated this item more highly.)

Q19. Consistency of noncriminal behaviors (while observed). (Non-victims rated this item more highly.)

- 3) Experts with doctorate degrees differed from Experts with bachelor degrees on: Q1, Q6, Q13, Q17, Q23, Q37, Q41, Q55, Q73 (see Table XVIII). Experts with doctorates rated all items more highly except Q41.

TABLE XVIII

ITEMS ON WHICH EXPERTS WITH DOCTORATE DEGREES
DIFFERED FROM EXPERTS WITH BACHELOR DEGREES

- Q1. Control of alcohol and drugs, ie; clean and sober.
- Q6. Honest expression of a range of good and bad
feelings.
- Q13. Thinking in advance about negative consequences of
behavior.
- Q17. Congruent: observed behavior, speech and 3d party
reports.
- Q23. No deviant arousal on plethysmographic testing.
- Q37. Appropriate development of self confidence.
- Q41. Awareness that he has life long personality
problems.
- Q55. The ability to empathize, especially with his
victims.
- Q73. Client expresses gratitude about his arrest and
therapy
- 4) Experts with less experience (< 5 years) rated the
following items significantly more highly than Experts
with more experience (> 5 years): Q8, Q12, Q47, Q72
(see Table XIX).

TABLE XIX

ITEMS EXPERTS WITH LESS EXPERIENCE (< 5 YEARS)
 RATED THE MORE HIGHLY THAN EXPERTS WITH
 MORE EXPERIENCE (> 5 YEARS).

- Q8. Awareness of personal potential for harming self or others.
- Q12. Spontaneous use of intervention skills for deviant cycle.
- Q47. Willingness to make commitments and assume responsibility.
- Q72. Reveals old crimes, that no one knew of before.
- 5) The oldest 10% of Experts rated this item more highly than the youngest 10% of Experts:
- Q10 No indications of overt or covert lying.
- 6) The youngest 10% of male Experts rated the following items more highly than the oldest 10% of male Experts:
- Q12, Q21, Q27, Q61, Q65 (see Table XX).

TABLE XX

ITEMS THE YOUNGEST 10% OF MALE EXPERTS RATED MORE
 HIGHLY THAN THE OLDEST 10% OF MALE EXPERTS

- Q12. Spontaneous use of intervention skills for deviant cycle.
- Q21. Assertion of needs consistent with therapeutic goals.
- Q27. Ability to identify and articulate his feelings.

TABLE XX

ITEMS THE YOUNGEST 10% OF MALE EXPERTS RATED MORE
HIGHLY THAN THE OLDEST 10% OF MALE EXPERTS
(continued)

Q61. Therapist's subjective judgement of the clients
sincerity.

Q65. Less self centered speech, more concern/interest in
others.

7) The oldest 10% of female Experts rated this item more
highly than the youngest 10% of women:

Q10 No indications of overt or covert lying.

8) The top 10% by years of experience was compared with
the bottom 10% by experience. They differed on: Q18,
Q31, Q50, Q59, Q66 (see Table XXI). Those with more
experience rated Q18 and Q50 more highly. Those with
less experience rated Q31, Q59 and Q66 more highly.

TABLE XXI

ITEMS ON WHICH EXPERTS FROM THE TOP AND BOTTOM
TEN PERCENT BY YEARS OF EXPERIENCE DIFFERED

Q18. Regular attendance at individual or group therapy
sessions.

Q31. Ability to develop and maintain friends.

Q50. Participation in six months of continuous therapy.

Q59. A spontaneous display of emotion (in a closed client).

Q66. Able to laugh at himself, humor about his situation.

FACTOR ANALYSIS OF EXPERTS AND OFFENDERS GROUPS

The last question posed was: are there as yet unidentified factors which could be identified? A principle components factor analysis with equamax rotation was used on the 25 highest (see Tables X and XI) and lowest (see Tables XII and XIII) rated items to examine this question. Equamax rotation was chosen as it gave a number of clear factors on analysis. This type of rotation was used for all subsequent factor analyses. Kim and Mueller in Introduction to Factor Analysis (1978) state, "If identification of the basic structuring of variables into theoretically meaningful subdimensions is the primary concern of the researcher, ... any readily available rotation method will do the job." Additionally, each factor determined was tested for reliability by determining Chronbach's Alpha.

As the Experts and Offenders groups rated items differently, their opinions were considered separately. Thus there were four possible types of factors, factors each of the Experts and Offenders groups felt were useful and factors that each of the two groups felt were not useful. Though the opinions of the Experts and Non-experts were similar on some of the previous comparisons, the Experts and Non-experts groups differed on over 8 percent of the items. Of the two groups, only the Experts group had direct

experience with sex offenders. As the purpose of the survey was to determine items that are useful in predicting the progress of sex offenders in therapy the data from the Non-experts group was not used for further analysis.

Experts' Highest Rated Items Factor Analyzed

The 25 items receiving the highest mean ratings from the Experts group were analyzed (see Table X). The following factors are derived from Experts' highest 25 items (see Table XXII):

Factor #1	13.0% of variance accounted for (alpha .83)
Factor #2	9.5% of variance accounted for (alpha .64)
Factor #3	10.0% of variance accounted for (alpha .67)
Factor #4	11.7% of variance accounted for (alpha .80)
Factor #5	11.4% of variance accounted for (alpha .83)

TABLE XXII

FACTORS DERIVED FROM EXPERTS' HIGHEST RATED ITEMS

Factor #1 13.0% of variance accounted for (alpha .83)

Q46. Willingness to ask for help with personal problems.

Q20. Initiation of therapy ie; spontaneously bringing up
issues.

Q47. Willingness to make commitments and assume
responsibility.

TABLE XIX

FACTORS DERIVED FROM EXPERTS'
HIGHEST RATED ITEMS
(continued)

Q5. That the client has learned a new skill and practices it.

Q6. Honest expression of a range of good and bad feelings.

Factor #2 11.7% of variance accounted for (alpha .80)

Q48. Desire to eliminate his deviant sexual arousal.

Q18. Regular attendance at individual or group therapy sessions.

Q43. Evidence that he is complying with group recommendations.

Q40. Open and active participation in group therapy.

Factor #3 9.5% of variance accounted for (alpha .64)

Q17. Congruent: observed behavior, speech and 3d party reports.

Q30 That he involves intimates to support nondeviant behavior.

Q33. No denial or minimization of crime.

Q35. Greater disclosure about crime than victim's statement.

Factor #4 11.4% of variance accounted for (alpha .83)

Q55. The ability to empathize, especially with his victims.

TABLE XIX

FACTORS DERIVED FROM EXPERTS'
HIGHEST RATED ITEMS

Q12. Spontaneous use of intervention skills for deviant cycle.

Q13. Thinking in advance about negative consequences of behavior.

Q36. Understanding of his criminal behavior and thinking.

Q32. Understanding of deviant cycle.

Factor #5 10.0% of variance accounted for (alpha .67)

Q2. New awareness of personal and social deficits/inadequacies.

Q1. Control of alcohol and drugs, ie; clean and sober.

Q8. Awareness of personal potential for harming self or others.

Q10. No indications of overt or covert lying.

Experts' Lowest Rated Items Factor Analyzed

The 25 items receiving the lowest mean ratings (see Table XI) from the Experts group were analyzed. The following factors were derived from Experts' lowest 25 items (see Table XXIII):

Factor #1 15.9% of variance accounted for (alpha .88)

Factor #2 11.6% Of variance accounted for (alpha .82)

Factor #3 8.9% Of variance accounted for (alpha .51)

Factor #4 11.4% Of variance accounted for (alpha .79)

Factor #5 9.8% Of variance accounted for (alpha .62)

TABLE XXIII

FACTORS DERIVED FROM EXPERTS'
LOWEST RATED ITEMS

Factor #1 15.9% Of variance accounted for (alpha .88)

Q68. Therapist feels optimistic about client's future.

Q57. Client feels that therapy has been effective for
him.

Q62. Therapist feels personally successful about client.

Q56. Client has a good relationship with his therapist.

Q61. Therapist's subjective judgement of the clients
sincerity.

Q73. Client expresses gratitude about his arrest and
therapy.

Q64. Client expresses hope and optimism about the future.

Q58. That the therapist enjoys the interaction with the
client.

Factor #2 11.6% Of variance accounted for (alpha .82)

Q38. Ability to solve or manage complex social problems.

Q37. Appropriate development of self confidence.

Q39. New insights about the causes of his criminality.

Q59. A spontaneous display of emotion (in a closed
client).

Q21. Assertion of needs consistent with therapeutic
goals.

TABLE XXIII

FACTORS DERIVED FROM EXPERTS'
LOWEST RATED ITEMS
(continued)

Factor #3 8.9% Of variance accounted for (alpha .51)

Q23. No deviant arousal on plethysmographic testing.

Q22. Regular payment of bills or no accumulation of
prison debts.

Q16. Initiative to make restitution for the damage of
crime.

Factor #4 11.4% Of variance accounted for (alpha .79)

Q66. Able to laugh at himself, humor about his situation.

Q60. Reduction of attention-seeking behavior (in an
extrovert).

Q67. More extroverted behavior in an introverted client.

Q59. A spontaneous display of emotion (in a closed
client).

Factor #5 9.8% Of variance accounted for (alpha .62)

Q71. Demonstrates improvement on MMPI or Millon testing.

Q50. Participation in six months of continuous therapy.

Q70. Understanding and acceptance of how ordinary he is.

Q7. More introverted behavior (in an extroverted
client).

Offenders' Highest Rated Items Factor Analyzed

The 25 items receiving the highest mean ratings from the Offenders group were analyzed (see Table XII). The

following factors were derived from Offenders' highest 25 items (see Table XXIV):

Factor #1 12% of variance accounted for (alpha .78)
 Factor #2 12% of variance accounted for (alpha .74)
 Factor #3 12% of variance accounted for (alpha .79)
 Factor #4 15% of variance accounted for (alpha .87)
 Factor #5 15% of variance accounted for (alpha .89)

TABLE XXIV

FACTORS DERIVED FROM OFFENDER'S
 HIGHEST RATED ITEMS

Factor #1 12% of variance accounted for (alpha .78)

Q55. The ability to empathize, especially with his
 victims.

Q12. Spontaneous use of intervention skills for deviant
 cycle.

Q54. A socially acceptable understanding about right and
 wrong.

Q13. Thinking in advance about negative consequences of
 behavior.

Q11. Regret about his criminal activity.

Factor #2 12% of variance accounted for (alpha .74)

Q8. Awareness of personal potential for harming self or
 others.

TABLE XXIV

FACTORS DERIVED FROM OFFENDER'S
HIGHEST RATED ITEMS
(continued)

- Q3. New awareness of personality strengths or competency.
- Q4. Willingness to try out new ideas or procedures.
- Q1. Control of alcohol and drugs, ie; clean and sober.
- Q5. That the client has learned a new skill and practices it.

Factor #3 12% of variance accounted for (alpha .79)

- Q18. Regular attendance at individual or group therapy sessions.
- Q39. New insights about the causes of his criminality.
- Q11. Regret about his criminal activity.
- Q48. Desire to eliminate his deviant sexual arousal.
- Q41. Awareness that he has life long personality problems.

Factor #4 15% of variance accounted for (alpha .87)

- Q29. Desires to improve the quality of his social support system.
- Q33. No denial or minimization of crime.
- Q32. Understanding of deviant cycle.
- Q46. Willingness to ask for help with personal problems.
- Q47. Willingness to make commitments and assume responsibility.
- Q51. An increased ability to handle stress.

TABLE XXIV
FACTORS DERIVED FROM OFFENDER'S
HIGHEST RATED ITEMS
(continued)

Q48. Desire to eliminate his deviant sexual arousal.

Q41. Awareness that he has life long personality
problems.

Factor #5 15% of variance accounted for (alpha .89)

Q36. Understanding of his criminal behavior and thinking.

Q28. Ability to accurately listen to others.

Q37. Appropriate development of self confidence.

Q52. A new ability to generate options for problem
solving.

Q40. Open and active participation in group therapy.

Q41. Awareness that he has life long personality
problems.

Q46. Willingness to ask for help with personal problems.

Q5. That the client has learned a new skill and
practices it.

Q51. An increased ability to handle stress.

Offenders' Lowest Rated Items Factor Analyzed

The 25 items receiving the lowest mean ratings from the Offenders group were analyzed (see Table XIII). The following factors were derived from Offenders' lowest 25 items (see Table XXV):

Factor #1, 14% of variance accounted for (alpha .72)

Factor #2, 14% of variance accounted for (alpha .77)

Factor #3, 9% of variance accounted for (alpha .43)

Factor #4, 11% of variance accounted for (alpha .72)

Factor #5, 14% of variance accounted for (alpha .82)

TABLE XXV

FACTORS DERIVED FROM OFFENDERS' LOWEST RATED ITEMS

Factor #1 (14% of variance accounted for (alpha .72)

Q61. Therapist's subjective judgement of the clients
sincerity.

Q58. That the therapist enjoys the interaction with the
client.

Q26. Positive peer evaluations about his progress.

Q73. Client expresses gratitude about his arrest and
therapy.

Q71. Demonstrates improvement on MMPI or Millon testing.

Factor #2 (14% of variance accounted for (alpha .77)

Q73. Client expresses gratitude about his arrest and
therapy.

Q63. A reduction in complaints about his life and his
troubles.

Q19. Consistency of noncriminal behaviors (while
observed).

Q68. Therapist feels optimistic about client's future.

Q45. "Significant other" reports improvement of behavior.

Q62. Therapist feels personally successful about client.

TABLE XXV

FACTORS DERIVED FROM OFFENDER'S
HIGHEST RATED ITEMS
(continued)

Q34. Full agreement with victim's statement.

Factor #3 (9% of variance accounted for (alpha .43)

Q17 Congruent: observed behavior, speech and 3d party reports.

Q7. More introverted behavior (in an extroverted client).

Q70 Understanding and acceptance of how ordinary he is.

Q34 Full agreement with victims statement.

Factor #4 (11% of variance accounted for (alpha .72)

Q24. No evidence of suppression on plethysmographic testing.

Q25. Appropriate arousal on plethysmographic testing.

Q22. Regular payment of bills or no accumulation of prison debts.

Q23. No deviant arousal on plethysmographic testing.

TABLE XXV

FACTORS DERIVED FROM OFFENDERS'
LOWEST RATED ITEMS
(continued)

Factor #5 (14% of variance accounted for (alpha .82)

Q53. A reduction in concrete thinking, fewer fixed ideas.

Q60. Reduction of attention-seeking behavior (in an
extrovert).

Q66. Able to laugh at himself, humor about his situation.

Q67. More extroverted behavior in an introverted client.

Q59. A spontaneous display of emotion (in a closed
client).

Q42. Ongoing disclosure of daily problems and solutions.

DISCUSSION

These survey data were analyzed for criteria used by mental health professionals in evaluating the progress of sex offenders in therapy. Mental health professionals must have some means of determining their clients' progress. Theoretically in the course of training, work experience or maturation, professionals develop skill in appraising this. If so, then sex offender treatment specialists who had more experience, were older and were better educated would have more understanding about how to evaluate progress than those who had less experience, were younger and less educated. If the opinions of those who are regarded as experts and those who are regarded as neophytes in the field do not differ is there then any development of expertise in offender treatment?

In this survey the Experts' group contained many members of the Association for the Treatment of Sex Abusers (ATSA). Members of this organization are leaders in the treatment and evaluation of sex abusers. The level of education of ATSA members is high. The Experts group contained 70 professionals with doctorate degrees and 72 with masters degrees. These sex offender specialists are knowledgeable about issues specific to sex offender evaluation and treatment. Unfortunately however, the data

from this survey strongly suggest that specialized mental health training alone may not result in expertise in assessing progress.

Members of the Experts group appeared largely in agreement with one another. Within this group, opinions of men over age 47 differed on only 5 items out of 73 from men under age 36. Women over age 46 differed from women under age 33 on only 1 item. Women rated only 4 items differently than men. Experts who were victims of sexual abuse and Experts who were not victims of sexual abuse differed on only 2 out of 73 items. None of the items of difference in the above comparisons appeared to have any common pattern or theme.

The small differences of opinion between the subgroups of the Experts group were significant at a probability level of .05. A probability of .05 means that the possibility of making a type I error (rejecting the null hypothesis when it is true) is 5 out of 100 trials or 3.87 out of 73 trials. Which also means that the decision that the null hypothesis (groups are not different) is likely to be inaccurate 3.87 times out of 73 tests. The 8 subgroups of the Experts group which were compared (e.g. men vs women, victims vs non-victims, see Tables XVI, XVII, XVIII, XIX, XX, XXI) on the 73 Q variables averaged 3.75 differences of opinion per comparison. Given that there appeared no discernable pattern in the items of difference, which could suggest why

there was disagreement over particular items, the minor differences found within this group could easily be attributed to type I error.

One exception to these findings is that professionals with doctorate degrees differed from those with bachelor degrees on 9 items (see Table XVIII). Those with doctorates rated all items more highly than those with bachelor degrees. A possible explanation is that those with doctorates were less likely to work directly with offenders and were more likely to know the literature that discusses long-term efficacy, while those with bachelor degrees were more likely to work directly with offenders and see their day-to-day problems and failures. If those with bachelor degrees had more experience with offenders' failures then they may have been less optimistic about progress. Of these nine items there were four items rated above one standard deviation from the mean, Q1, Q13, Q17, Q55. There does not appear to be any overt pattern to these items. However, these items do reoccur in other analyses and will be considered below.

Overall, the mental health professionals specializing in sex offender treatment opinions about progress were similar to the opinions of mental health professionals who did not treat sex offenders. Members of the Experts and Non-experts groups agreed on 64 of the 73 items and disagreed on 9 (see Table VI). (There was no overlap

between the 9 items discussed in the previous doctorate/bachelor comparison and the 9 items from this comparison.) Of the 9 items of disagreement, only 4 items (Q8, Q32, Q36, Q48) were rated as highly useful by the Experts group. All other ratings by the Experts and Non-experts groups fell within one standard deviation of the mean and were considered of average utility. The items the Experts rated as having high utility have to do with the offender: accepting his potential to commit another crime, learning his deviant cycle, understanding his criminal thinking and behavior, and eliminating his deviant sexual arousal. That these themes dealing with criminality were emphasized by the professionals is not surprising. It is likely that professionals who are specialists in criminology would rate items relating to criminality more highly than those are not. However, the offender's understanding of his criminality is a theme frequently identified for the evaluation of progress in this survey.

The above comparisons suggest that professionals who treat sex offenders opinions are largely in agreement about the criteria for evaluating progress. Unfortunately, none of the comparisons suggest that mental health professionals base their judgments of sex offenders' progress on knowledge gained through personal experience, maturation, sexual socialization or education. This was a surprising and disappointing finding.

Though the members of the Experts group were largely in agreement with one another, they clearly thought differently about progress than the members of the Offenders group. Experts and Offenders groups differed in their opinions about 53 out of 73 items (see Table III). Overall, professionals were much less optimistic about the utility of most factors than were offenders. The members of the Experts group rated only 6 out of 73 items higher than those in the Offenders group. The items which group members agreed or disagreed on did not seem to have any organizing theme which suggested the reason for the agreement or disagreement.

One way of accounting for the Experts group's overall lower ratings compared to the Offenders group would be to consider each group's situation. Offenders in therapy often find that their freedom is dependent upon their making progress. They wish to have as many opportunities to succeed as possible and want criteria which are clearly distinguished and can be readily determined. From the offender's point of view, there are no aversive consequences to having an evaluation that says they are making progress. They would have no reason to downgrade any item, as they desire a positive evaluation and would want as many items as possible used to their advantage. An offender carries no responsibility for an incorrect evaluation of progress. He

may in fact be rewarded by being freed inappropriately from a therapy which he does not want.

Mental health professionals' circumstances and considerations are very different from those of sex offenders. When evaluating the utility of each item as a criterion of progress, professionals consider their experience with many offenders. In most clinical settings a professional rarely gets feedback on accurate evaluations of progress. Clients who genuinely do well are likely to be released and are not heard of again. However, a professional may get negative feedback on an inaccurate evaluation of progress after an offender brings attention to himself through some kind of illegal behavior. When the therapist later reviews his or her evaluation, items which were used for identifying progress are likely to be down graded for utility. Thus when a professional is asked about specific criteria he or she is more likely to remember contraindications for many of the items, that is, instances when an item used as a criterion for progress was subsequently negated by an offender's behavior (Glass & Holyoak, 1986). This pattern is likely to lead to opinions which view all items more conservatively.

Professionals would also be cautious about saying an offender is making progress as progress implies decreasing danger. Professionals know that if a client reoffends after they stated that he is less dangerous, the professional

could be held accountable, their ability to make competent judgements questioned and the offender will have created another victim. Given the broad negative effects of an inaccurate evaluation of progress, professionals would be likely to rate all items more cautiously than offenders.

ITEMS POSSIBLY OF HIGH UTILITY FOR JUDGING PROGRESS

One way of determining items of high utility for judging sex offenders' progress in therapy would be to look at items rated most highly by Experts and Offenders groups. (Non-experts are not considered here as they do not do evaluations and responded somewhat differently than Experts.) To do this the mean value of each Q-variable was ranked and the top 10 items from each group were combined resulting in a total of 20 items. Of these items which the two groups judged most useful, 15 had means less than one standard deviation from the mean. Five items were rated more than one standard deviation above the mean, implying high utility for evaluating the progress of sex offenders in therapy. (Note: these items differ from those in Table IV as items in that table were *agreed upon* by Experts and Offenders, while in this comparison the highest items of each group were considered independent of the other group's opinion. For example, for item Q33 to be included in Table IV both Offenders and Experts had to agree about its

utility, to be included in the following items either group could have rated it highly).

ITEMS EXPERTS AND OFFENDERS GROUPS
RATED AS HAVING HIGH UTILITY

- Q1. Control of alcohol and drugs, ie; clean and sober.
- Q8. Awareness of personal potential for harming self or others.
- Q12. Spontaneous use of intervention skills for deviant cycle.
- Q13. Thinking in advance about negative consequences of behavior.
- Q33. No denial or minimization of crime.

Another way items of high utility for evaluating progress were demonstrated was to consider which items were *common* (but not necessarily statistically agreed upon) to both the Experts and Offenders groups' highest rated items. The following items were common to the 10 most highly rated items of both groups:

ITEMS OF HIGH UTILITY *COMMON TO BOTH*
EXPERTS AND OFFENDERS

- Q8. Awareness of personal potential for harming self or others.
- Q13. Thinking in advance about negative consequences of behavior.

Q18. Regular attendance at individual or group therapy sessions.

Q48. Desire to eliminate his deviant sexual arousal.

Q55. The ability to empathize, especially with his victims.

The 5 items judged most highly by the Experts and Offenders groups and the 5 highest common items of both groups could be accounted for by 5 themes:

- 1) Consistent Behavioral Control Outside of Group (Q48, Q18, Q13, Q1).
- 2) Involvement in Group Therapy (Q18).
- 3) Fully Disclosing Criminal History (Q33).
- 4) Understanding Criminal Thinking and Behaviors (Q8, Q48).
- 5) Gaining Skills to Quickly Stop Criminal Behavior (Q13, Q55, Q12).

These 5 themes, which suggest possible criteria for judging progress, were not clearly delineated by either of the groups. However the 5 factors which resulted from the factor analysis of the Experts group's 25 most useful items (see Table XXII) do support many of these themes. Analysis of the Offenders group's highest 25 items did not result in factors corresponding to any of the 5 themes (see Table XXIV). One theme which is least supported is Fully Disclosing Criminal History. Out of the 6 possible items related to the disclosure of criminal history only 2 were ranked among the highest 10 items by Experts group members.

Three of the 6 possible items about disclosure were found in Factor #3 from the Experts group. Only one of the 6 items about disclosure was in the Offenders group's highest 25 items. However, 5 out of 6 of these items were in the Experts group's highest 25 items and this theme does account for one item which both the members of the Experts and Offenders groups agreed had some utility. Therefore the theme about disclosure was included with the other 4 themes.

These 5 themes are congruent with current theories about sex offender therapy and provide the beginnings of a guideline for the evaluation of sex offenders in therapy. The factor analysis of the Experts highest 25 items in part supported these themes. The factor analysis will be referred to as supporting information, the themes were not developed from the factor analysis. Each theme will be discussed in detail.

Theme #1 Consistent Behavioral Control Outside of Group

This theme includes items such as: refraining from abusing alcohol or drugs, coming to group therapy regularly (as compared with behavior in group), spontaneously using intervention skills, asking others for support and having a consistency of behavior that is confirmed by others. This theme was not supported by a single factor from the factor analysis.

Alcohol and drug use or abuse are correlated with inappropriate sexuality and criminal behavior (National Institute on Alcohol Abuse and Alcoholism, (1992); Biglan, et al., (1990); Taylor, (1983); Rosewicz, (1983); Berry & Borland, (1977)). Additionally, alcohol has been shown to increase non-specific sexual arousal. That is, an individual who may have a narrow range of sexually attractive stimuli can, under the influence of alcohol, become more easily aroused to stimuli that are outside of his norm (Langevin, 1985). Thus in a family with children an adult male, whose sexual preference is adult females, may more easily become sexually aroused to the children while under the influence of alcohol. The consistent control of alcohol and drug use reduces the likelihood of all criminal behavior. For a substance-abusing offender consistent control of his alcohol and drug use would be a reasonable indicator that he is progressing in therapy.

Leaving his work, family and recreational activities and coming to group therapy for at least 6 months is another criterion for evaluating an offender's control of his behavior. Treatment, progress or evaluation are not possible without the participation and presence of the offender. Erratic attendance is an indication that a client does not have serious motivation for treatment. On indicator of the importance which respondents gave this item was their responses to the question, "How long do think a

sex offender should remain in therapy?" the Experts, Non-expert and Offenders groups each recommended remaining in therapy for over two years (see page 41). It is likely that if mental health professionals had been presented with an item such as "progress requires over two years of regular attendance," many would have rated it highly.

The recommended time for sex offenders to remain in therapy may eventually parallel the recommendations for the treatment of alcoholics. One common component in the treatment of alcoholism is attending Alcoholics Anonymous (AA). A basic principle of AA is the tenet, "once an alcoholic always an alcoholic," (Bootzin & Acocella, 1988). Because AA does not consider alcoholism a curable problem, it recommends that recovering alcoholics attend AA meetings from the time of their recovery through the rest of their lifetime. Recovery from criminal sexuality may also be a lifetime process. Carnes (1991), when speaking of sexually compulsive behaviors, says that only after 5 years of sexual sobriety and treatment does the sex offender begin to reach the advanced stages of recovery. He recommends that people with sexually compulsive problems never stop working on themselves and their problems.

Simply coming to group or individual therapy sessions for 6 months can not by itself be adequate. An offender may attend with his body but not with his mind. An offender may not personalize any of the information that he is given.

Gaining benefit from any kind of therapy requires the active participation of the client this need is addressed in Theme #2. Based upon the opinions in this survey, regular attendance at group therapy for 6 months is probably a necessary but not sufficient component for evaluating progress.

The behavior of, "asking others for help," is another component in the theme of Consistent Behavioral Control. Twelve step programs such as Sexaholics Anonymous or Alcoholics Anonymous strongly recommend developing a healthy support system (Yoder, 1990) so that he will have someone to talk to about problems. For sexual offenders, withdrawal, isolation and depression are common indications that they are at higher risk to reoffend. These negative states often intensify as the offender moves closer toward offending behavior. Most offenders do not have good support systems, friends or family who can help them to get perspective on their negative states of mind and change their behavior. Developing a support system is often very difficult for these men. In order to do this they have to learn about themselves, about communication, assertiveness and trust. Thus an indication of progress in treatment could be the ability of an offender consistently to ask his intimate family and friends to participate in his support system.

Theme #2 Involvement In Group Therapy

There were a number of items about group therapy that clustered together in the factor analysis of the Experts group's highest rated items. Three out of the 4 items in Factor #2 were about some aspect of active participation in therapy (see Factor #2, Table XXII). There were 4 possible items about group therapy included in the survey. They were: asking group members for help, bringing up personal issues in group, attending group regularly and utilizing group therapy recommendations in daily life. Note also that most of the items in Factor #1 could be associated with an offender's behavior in group (see Factor #1, Table XXII).

In many ways Theme #2 is similar to Theme #1, Consistent Behavioral Control, but Theme #1 is about behavior outside of group while Theme #2 is about behavior within group.

Group therapy is now considered to be the core of all sex offender treatment programs (Schwartz, 1988). It is an effective way of getting sex offenders together in a cooperative and supportive environment. In a group each offender's experience of criminal sexuality can be evaluated and the negative consequences of the deviant behavior can be learned from the other group member's experience. One of the many ways that group therapy works is helping offenders learn how their thinking was distorted before their crime. In group work, offenders try to give and receive feedback

about their thinking and behavior from other group members. This allows them to become aware of and correct personal distortions of thinking and behavior.

Group therapy is one arena where an offender can be observed while interacting with others. It can become a microcosm of daily life. Watching an offender interact with group members can help a therapist understand the offender's interpersonal strengths or deficits (Yalom, 1975a). This is different from what occurs in individual therapy.

Individual therapy is often shaped by the personality of the mental health professional. A strong and flexible therapist with good social skills can make most interactions with clients harmonious. But in group therapy an offender relates to peers and reveals behaviors which could be hidden in individual sessions (Yalom, 1975b).

Initially, sex offenders often resist group therapy. Typically, offenders feel that they personally are fine people, but they do not want to be involved with those, "other nasty sex offenders." They often worry that group therapy is expensive, time consuming, and will require painful introspection and difficult confrontations. Though there are numerous benefits to be achieved from group therapy, offenders are not usually aware of them when they first begin therapy. Seeing an offender consistently attend group therapy, learn to gain benefit from it and change how

he interacts with others in the group could be regarded as a sign of progress.

Additionally, having a support group in place will provide both therapist and offender with an alert network. This network can help indicate potential behavior problems and reinforce appropriate behavior. Often deviant behavior has its antecedents in actions that are close to normal. For example, one of the early signs that an offender may reoffend is his choosing to be alone. Initially, isolation may not be a problem, but the longer an offender remains isolated the harder it is to reconnect with others. When an offender first begins to enter a distorted state of mind or unsafe environment, his support group can alert him, remind him of interventions and assist him in quickly taking corrective action. Likewise, when the support group knows what healthy behavior for an offender is, they can encourage him and provide corroborative evidence that the offender is doing well. This independent evidence can be a sign that the offender is making progress (Hindman, 1989)

Theme #3 Fully Disclosing Criminal History

This theme includes: not denying or minimizing crimes, telling the full details of current and past crimes, revealing details that victims may have not noticed or blanked out and that his report of what happened is consistent with those of others.

While not strongly supported in the development of the 5 themes it is supported in the factor analysis (see Factor #3, Table XIX). This theme is a commonly accepted principle in the treatment of sex offenders. Just as a doctor cannot treat a disease without knowing its signs and symptoms, a therapist cannot help a client without first knowing his problems. If anamnesis is the key to medical or psychological diagnosis, a client who is open and honest about his past will allow himself to be correctly diagnosed. When the offenders' true behaviors are known, specific interventions can be prepared to help him stop them in the future. For example, an offender may initially present with a report of molesting female children, but if further history reveals that he has also molested male children interventions can be developed for both situations.

However, sex offenders tend to deny their crimes, lie about their actions and attempt to deceive therapists about their motivations (Abel et al, 1987; Salter, 1988). According to Salter (1988) there are three main types of denial: denial of the criminal behaviors, denial of a crime's seriousness and denial of responsibility for crime. Additionally, criminals sometimes deny their intentions, the frequency of criminal behaviors, their planning of the crime and the methods they used to try to avoid detection. All sex offenders begin therapy with some degree of denial. As they participate more fully in therapy, begin to trust the

therapist and start to feel that there is help for them, they frequently open up about past criminal behavior. This kind of information often shows that they increased their investment in therapy and are interested in getting something useful out of it.

Lastly, disclosure is one way that hidden victims of sexual crime can be helped. When an offender reveals that he has molested other children it can be reported to the authorities and those children can then enter therapy. Revealing names of victims puts the offender in jeopardy of more criminal charges. When, despite this threat, he reveals names of past victims, it is a clear indication that he is thinking more of others than of himself. Crime usually is associated with extreme selfishness, wanting something without caring what the cost is to others. Helping others is the antithesis of this and a sign that the offender is making progress.

Theme #4 Understanding Criminal Thinking and Behavior

This theme includes such items as not denying criminality and understanding criminal thinking, behavior and the deviant cycle (see Factor #4, Table XIX). As a theme useful in the evaluation of progress it is readily explained. One of the common models of sex offender treatment is Relapse Prevention (RP). RP is designed to teach offenders self control and to enable them to continue

their recovery from criminal sexuality beyond the period of formal or mandated therapy (George & Marlatt, 1989). In learning RP the offender must first admit that he has committed crimes (Theme #3). Second, he must understand the step-by-step process (frequently called the deviant cycle) he repeatedly used to create a mind state, emotional state and environmental situation that was conducive to a sex offense. Learning about his criminal thoughts, feelings and actions during his cycle is a necessary first step in learning how to intervene to stop future criminal behavior. Knowing about the deviant cycle and the thoughts, feelings and behaviors which comprise it does not in itself make an offender better able to stop himself from reoffending. However, an offender who understands his criminal thought and behavior thoroughly also can better identify what is not criminal behavior. Knowing what is and what is not criminal behavior puts him in a better position to lead a non-criminal life. He can recognize when any sign of deviant behavior first appears and interrupt this deviant behavior quickly. Thus, professionals feel that learning about criminality shows that an offender is making progress towards stopping criminality.

Theme #5 Gaining Skills to Quickly Stop Criminal Behavior

This theme includes such items as thinking in advance about problems which could result from his deviant behavior,

asking family and friends to support him in using intervention skills, not lying, and honoring his commitments (doing what he says he will).

This theme builds on the skills identified in Themes #3 and #4 (Fully Disclosing Criminal Behavior and Understanding Criminal Thinking and Behavior). Once the offender admits what he has done and understands his criminal behaviors then he may be able to learn skills to stop himself from committing future crimes. Learning interventions to stop criminal behavior is a consistent component of the majority of well-designed treatment programs in the United States and Canada. These programs usually require the offender to learn to identify situations in which he would be at risk to reoffend and then teach him specific cognitive and behavioral interventions for each situation (Knopp, 1988; Salter, 1988; Laws, 1989; Pithers, 1990). It is inevitable that offenders encounter risky situations. A risk situation or risk factor includes anything which could lead the offender closer to a reoffence. A risk factor could be an internal state such as anger or depression, or it could be an external situation such as seeing a prostitute, or being asked to babysit. Encountering risk factors while having the skills to recognize them, respond to them and prevent them from becoming situations leading to reoffence, shows progress over encountering and trying to deal with these situations without such skills.

Techniques for controlling sexual arousal are also important for stopping future deviant behavior. "The modification of inappropriate sexual preferences is of central concern in many treatment programs for sex offenders" (Quinsey & Earls, 1990). Every sex crime has some degree of sexual arousal in it. If there were no sexual arousal then a crime might still be committed but the sexual component of it would be missing. For example, if a criminal without sexual arousal were to encounter a potential victim during burglary of a home, the criminal might tie up and/or intimidate the victim, but would be unlikely to rape them. If a criminal has deviant sexual arousal and encounters a vulnerable victim, it is more likely that a sexual crime will be committed (Abel, Rouleau & Cunningham-Rathner, 1986; Earls, 1988). If the presence of deviant sexual arousal is related to sex crimes, then decreasing deviant sexual arousal is a sign of progress. Treatment programs teach an offender several skills including minimal arousal conditioning, aversive behavioral rehearsal and offence-specific aversive conditioning. Learning these skills provides the offender with concrete ways to stop deviant sexual arousal.

The above 5 themes can be useful in explaining the results of this survey. They can also provide a structure for further investigation.

EXPERTS' AND OFFENDERS' FACTORS COMPARED

One interesting finding was the difference between the factors derived from the Experts and Offenders groups highest 25 items. The structure of the factors appeared different for the two groups. Offenders' opinions about therapy and progress appeared less well organized and did not show meaningful patterns when compared with those of the Experts group (see Tables XXII & XXIV).

The lack of overt pattern in the Offenders group's opinions and the presence of pattern in the Experts group's opinions is not likely to be due to education or maturation. The average mental health professional in this survey had a masters degree, while no offender had a degree. This is consistent with other groups of offenders, as 99% of all criminals have not completed college (Sutherland & Creassey, 1978a). However, if education was a discriminating factor it is likely that the experts with more education would differ from the experts with less. They did not. Neither did the Experts group's age, sex, victimization nor experience appear to be discriminating factors (see Tables XI - XXI). One possibility, to explain the differences in meaningful pattern in the factors from the 2 groups, is that mental health professionals, in their early education, socialization and relationships, learned to think differently than offenders. Professionals may have acquired

a mental structure that is an inherent part of a non-criminal's world view. This sort of internal patterning could be developed through socialization by the time a young man or woman has graduated from high school. Criminals, however, often have severely disrupted social relationships (Sutherland & Cressey, 1978b). This disruption often begins in childhood. In this survey virtually 100% of offenders reported some form of childhood physical, emotional or sexual abuse, while only 62 out of 250 professionals (or about 25%) reported sexual abuse (see page 40). This disruption of the socialization process could account for part of the lack of order in the Offenders group's opinions. The antisocial personality disorder, which is often regarded as the most criminal of the personality disorders, does indicate a pattern of emotional, financial and behavioral immaturity (DSM-III, 1985).

If an offender has sociopathic elements to his personality, immature social interactions are likely. An example of immature thinking is a criminal who, despite all evidence to the contrary, thinks that he will never commit another crime or get caught if he does. This social immaturity is present in all offenders. If they are still offending they are socially immature. Social immaturity could account for an offender's inability to make ordered judgements about social behaviors.

The last option is that the structure found in the Experts group is apocryphal and not the result of any cognitive order.

OFFENDERS' OPINIONS ABOUT PROGRESS

Offenders' ratings of the items were ranked by means. This group's single highest item was a desire to eliminate deviant sexual arousal, an aspect of Theme #1, Consistent Behavioral Control. The second highest item was a willingness to ask for help, a component of Theme #5, Gaining Skills to Quickly Stop Criminal Behavior. In general, Offenders seemed to regard themselves as making progress if they identified themselves as criminals who have harmed, have the potential to harm again but who are willing to try to do better.

ITEMS OF LOW UTILITY FOR JUDGING PROGRESS

Though the Experts and Offenders groups have discrepancies of opinion about what is useful, both groups appear to concur about what is not useful. There are five common items found in the 8 items rated least useful by both groups:

Q58. That the therapist enjoys the interaction with the client.

Q62. Therapist feels personally successful about client.

Q68. Therapist feels optimistic about client's future.

Q71. Demonstrates improvement on MMPI or Millon testing.

Q7. More introverted behavior (in an extroverted client).

These items may be roughly divided into two themes, (a) the mental health professional and client relationship and (b) personality change. These themes were well supported by the factor analysis of the 25 items rated least useful by both Experts and Offenders groups (see Tables XXIII and XXV). Additionally, Offenders identified a third theme which they felt was not useful, the use of the penile plethysmograph.

The first theme that both groups identified and rated not useful for evaluating progress has to do with transference and counter-transference between the mental health professional and client.

Theme #1 The Relationship Between the Professional and Client

Both the Experts and Offenders groups judged that it was not useful as a criterion for progress if the mental health professional felt successful about his work with the client, felt optimistic about the client's future, thought the client was sincere, or enjoyed the interaction with the client. Likewise, they suggested that progress is not to be gauged by the client's gratitude for therapy, having a good relationship with the therapist or thinking that therapy has been effective.

The presence of this theme may be explained differently for Offenders and Experts. In the area of their crime, offenders typically do not conform to societal mores for behavior. They wish to get what they want when they want it. This behavior is so common that those who use the Relapse Prevention model with offenders call this, "the Problem of Immediate Gratification, (PIG)" (Pithers, 1989). Thus when there is someone with authority over an offender, someone who can limit what the offender can or cannot have or do, the offender is likely to respond with resentment and resistance. It is very unlikely the offender would value anyone else having control over him and interfering with his desires. This would be especially true when a therapist's judgement about his progress or lack of it could lead to aversive consequences, more time in therapy, additional costs or an extended probation or parole.

Offenders may feel that being dependent on a therapist's good opinion may be very unfair. Often offenders do not have good social skills or are angry and defensive. Not being well liked may be a lifelong pattern and unrelated to dangerousness or progress. When judgements of progress are based on the therapist's opinion, an offender who is polite but devious is likely to get a higher rating than the offender who is angry and open about it.

Mandated clients tend to have little trust in authority. If the mental health professional has the

ability to put an offender in jail, the offender will carefully monitor everything he does or says to avoid being reincarcerated. If an offender ends up in therapy with a critical or unsympathetic therapist his trust in the professional's opinion would be even lower. When offenders lack trust in a therapist they are unlikely to value his or her criticism or feedback. Thus offenders would devalue items relating to the therapist's judgement. Interestingly, the Offender's group did not exclude items relating to their judgement about progress. They seemed to regard their own opinions as more valuable than those of experts, a finding consistent with low trust in therapists. An additional reason could be that being aware of their own history of duplicity they imagine that others do the same thing.

For different reasons, mental health professionals who work with criminals are unlikely to trust positive reactions to their clients. Professionals are likely to have been deceived by their clients at one time or another. Clients whom the therapist had high hopes for often reoffend. Criminals may manipulate the therapist. Frequently they present a warm, friendly and cooperative front to a therapist, hoping that the therapist will relax his or her guard and trust them. This trust can then be used to the criminal's advantage. Most mental health professionals who work with criminals are aware of this dynamic and thus would

rate items related to transference low (Allen & Bosta, 1988).

Decisions of progress are difficult and require the professional to consider all of the evidence before coming to a judgement. Objective criteria should be the foundation for evaluation. However, objectivity means something that is "uninfluenced by emotion or personal prejudice" (Davies, 1981). This may be an impossible criterion upon which to base judgement as each act of perception and volition will involve subjective influences. If the subjective feelings of the mental health professional and client about their relationship are irrelevant, difficult therapeutic work with criminals becomes even more difficult. A professional who cannot trust his or her own judgement about a relationship is handicapped because relationship is an integral part of most psychological therapies. At this time there are no objective criteria available for the evaluation of progress. This inevitably leads mental health professionals to rely on subjective criteria which they know are often untrustworthy.

If, based on a relationship with a client, a therapist cannot reasonably predict if he is to be trusted or not, then doubt and mistrust may generalize to all clients. The following (taken from personal experience) is a clinical example of this problem:

Dr. George worked in a state correctional facility. He evaluated, did individual therapy and

group therapy for inmates. An inmate Jerry H. volunteered to participate in sex offender treatment. Jerry was apparently open, appeared remorseful, confronted group members about distorted thinking (thus demonstrating that he knew what distorted thinking was), completed homework assignments and gave Dr. George positive feedback about his skill. Jerry would also frequently tell Dr. George about how grateful he was for Dr. George's work and how much benefit he was receiving from it.

Dr. George dutifully noted his observations of Jerry's behavior in his clinical record. After several months of working with Jerry. Dr. George trusted his observations of Jerry's sincerity and believed some of his positive feedback. Dr. George began to feel that Jerry was making progress and interested in turning his life around. Periodically, Jerry would ask Dr. George for letters about his progress to be placed in his prison file. Dr. George feeling that this was a reasonable request cautiously did this.

A few months later Dr. George lost contact with Jerry after he was transferred to a pre-release center. About a year after seeing Jerry,

Dr. George got a subpoena from Jerry's lawyer requiring him to come to court as a positive witness for Jerry who had been caught running a drug ring in the release center. Dr. George suddenly found himself in court caught between the positive things he said about Jerry's progress in his clinical assessments and the obvious criminality of his client.

Only one incident like this will make a mental health professional extremely cautious about trusting reactions to criminal clients.

Theme #2 Personality Change

The opinions of both the Experts and Offenders groups suggest that they do not regard personality change as a valid criterion for progress. However, this was less clearly defined than the previous theme. Items included in this theme were: the offender's personality changes by moving toward more balance: if he is overly outgoing he becomes more introspective; or if he is overly introverted he becomes more open and spontaneous. These changes are accompanied by increased confidence and can be demonstrated on MMPI or MCMI testing.

There are many different definitions of personality (Chaplin, 1985). Attempting to evaluate progress by looking at personality implies that there is a deviant sexual

personality pattern and that changing it is the equivalent of progress. At this time there is no known sex offender personality. There have been numerous topologies developed to attempt to understand sex offenders and the traits that identify them. To date there is no agreement among professionals about what is or is not a criminal personality (Schwartz & Cellini, 1988a). Offenders have many different types of personalities and personality disorders (Salter, 1988a).

However, if there were a personality that was associated with sex offenses the most likely choice would be the Diagnostic and Statistical Manual of the American Psychiatric Association's (1985) antisocial personality disorder (ASPD). This personality disorder by definition includes a history of criminal behavior. An individual with ASPD may have criminal behavior that is not sexual. In fact, only about one out of five sexual offenders has ASPD. Thus even the most commonly accepted criminal personality disorder does not include most sex offenders.

An additional fact that supports the difficulty of using personality as a criterion for progress, is that criminals may make apparent changes in personality in response to learning what behavioral changes the therapist is looking for. Offenders in therapy can look like they are making progress by acting friendly and motivated. They can learn to participate actively in group, ask intelligent

questions, talk about successes or risk situations and confront other group members. They can perform these tasks and still continue to harbor deviant sexual fantasies and desires. In this case the Experts and Offenders groups appear to agree with the mental health community's assessment that personality is a poor criterion for evaluating progress.

Theme #3 Penile Plethysmographic Testing

Experts did not concur about the utility or lack of utility of the plethysmograph. Unfortunately, this survey did not ask if the members of the Experts group used the plethysmograph or only had opinions about it. It is possible that only a portion of the population of experts had actual experience with the technology, while the rest were answering this question based upon preconceived notions or second-hand information.

The Offenders group identified items relating to the penile plethysmograph as having little utility in the evaluation of progress. There were 3 items relating to the plethysmograph in this survey. After factor analysis of offenders' lowest items these three items formed a discrete cluster. The items rated as not useful included no plethysmographic evidence that deviant sexual arousal was present and the absence of evidence of suppression of

deviant sexual arousal. Nor was the presence of sexual arousal to appropriate adult stimuli considered useful.

For offenders, their low opinion of the usefulness of the plethysmograph is understandable. An offender in therapy is likely to deny that he has deviant sexual arousal because he does not want to appear more deviant than he is. For example, an incest offender who gets reported for molesting children usually tries to make professionals believe that the molestation was a rare event. If an evaluation shows that he has very high deviant arousal to children it suggests that the offender is more dangerous than the reported few incidents might indicate. If a plethysmographic evaluation detects arousal different than that evinced in the reported crime, the offender's denial or lies may be unmasked. An example is an offender convicted for rape of an adult who on plethysmograph shows deviant sexual arousal to children. If an offender has additional deviant sexual arousal discovered during a plethysmographic evaluation, he is likely to deny that the findings are valid.

Additionally, the basic sexual orientation of mature adults is not very amenable to change (Money, 1990). Even after treatment the potential for deviant sexual arousal reasserting itself is present. If basic sexual orientation is stable over time then progress should not be measured by plethysmographic findings of changed sexual arousal

patterns. If progress were evaluated by plethysmographic findings it would probably be measuring some degree of suppression of arousal rather a fundamental change in sexual interest. Often offenders are treated for deviant arousal using aversive conditioning monitored with the plethysmograph. They may be aware that their arousal is lowered while observed but unaffected in private. If this were the case they would rate the plethysmograph as having little utility in the evaluation of progress.

Respondents appeared to consider the penile plethysmograph, personality change and the relationship between the mental health professional and client as having little utility in the evaluation of progress. Though there were a number of positive factors for evaluating progress identified in order to get some idea of the strength or weaknesses of these findings some limitations of this survey must be considered.

LIMITATIONS OF THIS SURVEY

The findings of this survey are based on the opinions of Experts and Offenders. "Opinion usually lies somewhere between faith and knowledge" (Chaplin, 1985a). It is generally not a reliable factor upon which to base difficult judgements.

There are several issues which must be considered when evaluating outcome: limitations of the data set, problems

inherent in the survey method, the effect of judgement heuristics, problems with respondents ignoring true base-rates and the effect of self-interest on respondent's observations. Each of these factors may influence the outcome of this survey.

This analysis was based on a data set which included 73 items on which respondents were asked to give opinions. The high number of items was indicative of the complexity of assessing progress. A conscientious mental health professional who must make many decisions on a daily basis will inevitably take many factors into his decision. Though it is unlikely that a professional would ask him or her self about 73 factors each time they made an evaluation, it is likely that all of these factors play some part in the evaluation of progress. The number of items on this form probably required the average clinician to consider more factors than usual in practice. Hopefully, this led to more comprehensive and reasoned judgements, but it could lead to more confusion. When a respondent tries to make difficult choices on many items there is a tendency to regress to the mean and use an average judgement for many items. With fewer, more discrete items this effect could be reduced.

The three judgement heuristics (representativeness, causality and availability), ignoring the true base-rates and self-interest, may exert the most significant influence on the results. The representativeness heuristic refers to

a tendency in individuals to disregard information that is contrary to their ideas. For example, in a predictive decision, mental health professionals may have a belief that a client making progress will agree with them and give them positive feedback. When a therapist interviews a antisocial client, who is charming and ingratiating, the therapist may misinterpret this behavior and ignore other more valid information. Another example would be a professional who thinks that dangerous people exhibit overtly aggressive behavior. When he or she interviews a polite and relaxed offender, who does not fit the internal image of dangerousness, they may tend to disregard how dangerous the person has been in the past. Thus the representative picture which an evaluator has in his or her mind may take precedence over more valid and factual information. The representativeness heuristic is likely to encourage an evaluator to ignore other factors which were known earlier and have higher influence. This shift often leads to gross departures from the prior probabilities and from accurate judgements. (Kahneman & Tversky 1973, Glass & Holyoak, 1986).

The second judgmental heuristic which influences evaluators is the availability heuristic. This heuristic influences evaluators by the ease with which relevant information can be brought to mind. In judging progress therapists are likely to think of their most dramatic or

spectacular cases most easily. A spectacular case may become a basis for judgement even though it may be an idiosyncratic example (Tversky and Kahneman, 1974, Glass & Holyoak, 1986). For example, an evaluator who is thinking of progress may think of a case where an offender had a religious experience and was transformed into a law abiding and moral person. This example may easily come to mind when thinking of progress and yet in reality may be a rare event. The relative ease with which the more dramatic example comes to mind makes it easier to give other similar-appearing behavior more importance than it should have.

The third judgement heuristic is the causality heuristic. In the case of judgements concerning human behavior and its effects, Ajzen (1977) suggests that, "people often rely on their intuitive understanding of factors that seem to cause the event in question. Such a judgmental strategy has been termed the *causality* heuristic." Thus an evaluator may have a preconceived notion about what causes progress and base his judgement on this rather than weighing the facts. For example, developing social skills is frequently pointed to as a sign of progress, as poor social functioning seems to precede criminal behavior and thus may appear to cause it. In reality poor social skills may be only incidentally related to subsequent problems and not be the cause of them. Another example would be an evaluator who believes that

pornography causes sexual violence. In evaluating, he is likely to judge an individual more or less dangerous based upon use of pornography. In fact the evaluator would be ignoring objective studies showing that violent behavior is not correlated with use of pornography (Attorney General's Commission on Pornography, 1986). The causality heuristic is likely to cause judgements to reflect personal, historical or social beliefs rather than scientific knowledge.

A fourth factor which influences evaluators is neglect of base-rate information (Nisbett and Borgida, 1975). Evaluating progress in therapy for sex offenders is not an easy task. The base-rate of recidivism in sex offenders is at least 60% over a 10 year period (Furby, 1987) but the annual incidence of overt sexual behaviors which lead to recidivism is low. Clinicians virtually never see sexual behavior in their offices from even the most disturbed sex offender. Thus clinicians who feel optimistic about their client's long-term recovery are ignoring the base-rate data. Likewise, violent behavior is a rare phenomenon, even in men who have been violent. Most of the time these men are not acting violently. They are engaged in the routine tasks which occupy us all: eating, sleeping, working, etc.. The base-rate of violent behavior in an individual's life is low. On the other hand, a clinician who becomes apprehensive about a dangerous offender may ignore the low

base-rate of violent behavior and judge him overly dangerous.

Lastly, there is the concern that each client has his or her vested interests at stake. Ziskin (1981) says that the influence of all of the judgement heuristics is "exceeded only by not accounting for the deliberate distortion of many examined forensic subjects in the direction of their vested interests." Every individual who is being evaluated for progress attempts to present himself in the most favorable light. If incarceration, therapy, removal from home and family, driving restrictions, curfews, etc. are the negative consequences of a judgement of no progress in therapy then offenders are likely not to reveal self-damaging information however relevant it may be to an accurate prediction.

SUMMARY AND RECOMMENDATIONS

The results of this survey suggest that mental health professionals who work with sex offenders believe that there are five themes which could be used and two themes which should be avoided when evaluating sex offender's progress in therapy. However, this survey also demonstrates the need for continued research. The themes about what not to base evaluations on seemed clear. But, the themes about what to base evaluations on were less clear. However, these are only themes and not specific criteria for evaluating

progress. To refine our ability to evaluate progress there must be some clearly identifiable and reliable criteria which mental health professionals could learn and utilize. When this is the case the professional's maturation, education and level of expertise all will reflect an increasing understanding of a body of knowledge with which to evaluate sex offenders progress. Such criteria can only be determined with much further research.

The largest problem in research about evaluating progress is determining validity. For this population recidivism is the only criterion that could be used to validate hypotheses and research findings. To do a study of recidivism is an expensive and long term task. However, such an evaluation is currently being undertaken at Atascadero State Hospital in California (Marques, Day, Nelson & Miner, 1989). It is expected that by the year 2000 this study will have been completed and its findings published. On a much smaller scale it might be possible to work backwards and review old case histories of offenders who are elderly or deceased. Doing this would allow the researcher to investigate the backgrounds of those who did not return to the criminal justice system. This could enable researchers to identify underlying common denominators that could be used to predict progress. State agencies such as prisons or corrections departments have such data.

Research in the evaluation of progress of sex offenders in therapy should continue. Despite their questionable validity evaluations will inevitably continue to be made. It is important for ethical reasons to make them as accurate as possible while acknowledging their limitations. Analysis of these survey data produced five theoretical factors which mental health professionals who work with sex offenders think might be useful in evaluating progress in therapy: Consistent behavioral control outside of group; involvement in group therapy; fully disclosing criminal history; understanding criminal thinking and behaviors; gaining skills to quickly stop criminal behavior. These five factors could be used as a basis for formative evaluations. However as these factors are not validated, their use and the subsequent evaluations of their efficacy should be used primarily to provide feedback about useful directions for further research on sex offenders' progress in therapy.

REFERENCES

- Abel, G. G., Becker, J. V., Mittelman, M., Cunningham-Rathner, J., Gouleau, J. L., & Murphy, W. D. (1987). Self-reported sex crimes of nonincarcerated paraphiliacs. Journal of Interpersonal Violence, 2(1), (pp. 3-25).
- Abel, G. C., Rouleau, J. L., & Cunningham-Rathner, J., (1986). Sexually aggressive behavior. In W. J. Curran, A. L. McGary, & S. A. Shah (Eds.), Forensic Psychiatry and Psychology: Perspectives and standards for interdisciplinary practice (pp. 289-313). Philadelphia: Davis.
- Ajzen, I., (1977). Intuitive theories of events and the effects of base-rate information on prediction. Journal of Personality and Social Psychology, 35, (pp. 303-314).
- Allen, B., & Bosta, D. (1988). Games Criminals Play: How you can profit by knowing them. Sacramento: Rae John Publishers.
- American Psychiatric Association, (1974). Clinical aspects of the violent individual. Washington, D. C.: American Psychiatric Association [Task Force Report].
- American Psychological Association, (1978). Report of the task force on the role of psychology in the criminal justice system. American Psychologist, 33, (pp. 1099-1113).
- Attorney General's Commission on Pornography, (1986). Final Report. Washington D.C.: U.S. Department of Justice.
- Badgley, R. (1984). Sexual offenses against children: Report of the Committee on Sexual Offenses Against Children and Youths. Ottawa: Government of Canada.
- Biglan, A., Metzler, C. W.; Wirt, R.; Ary, D.; Noell, J.; Ochs, L.; French, C.; & Hood, D. (1990). Social and behavioral factors associated with high-risk sexual behavior among adolescents. Journal of Behavioral Medicine, 13(3), (pp. 245-261).

- Bays, L., & Freeman-Longo, R. (1989). Why did I do it again? Understanding my cycle of problem behaviors: a guided workbook for clients in treatment. Vermont: Safer Society Press.
- Bays, L., Freeman-Longo, R. & Hildebran, D. (1990). How can I stop? Breaking my deviant cycle: a guided workbook for clients in treatment. Vermont: Safer Society Press.
- Berry, R. E., & Boland, J. P. (1977). The economic cost of alcohol abuse. New York, Free Press.
- Blackburn, R., (1983). Psychometrics and personality theory in relation to dangerousness. In J. W. Hinton (Ed.), Dangerousness: Problems of Assessment and Prediction (pp. 57-70). London: George Allen & Unwin.
- Bohmer, C., (1983). Legal and ethical issues in mandatory treatment: The patient's rights versus society's rights. In J. G. Greer, & I. R. Stuart (Eds.), The Sexual Aggressor: Current Perspectives on Treatment (pp. 3-21). New York: Van Nostrand Reinhold.
- Bootzin, R. R., & Acocella, J. R. (1988). Abnormal Psychology: Current Perspectives. New York: Random House.
- Browne, A., & Finkelhor, D., (1986). Impact of child sexual abuse: A review of the research. Psychological Bulletin, 99(1), (pp. 66-77).
- Carnes, P. J., (1991). Don't Call It Love (pp. 299-349). New York: Bantam.
- Chaiken, J., Rolph, J., and Houches, R. L., (1981). Methods for estimating crime rates of individuals, executive summary (p. 54). Santa Monica: Rand Corporation.
- Chaplin, J. P., (1988). Dictionary of Psychology (p. 333). New York: Laurel.
- Chaplin, J. P., (1988a). Dictionary of Psychology (p. 315). New York: Laurel.
- Cocozza, J. J., & Steadman, H. J. (1976). The failure of psychiatric predictions of dangerousness: Clear and convincing evidence. Rutgers Law Review, 29, (pp. 1084-1101).

- Cohen, M. L., Groth, A. N. & Siegel, R., (1978). The clinical prediction of dangerousness. Crime & Delinquency, 1, (pp. 28-39).
- Conklin, J. E., (1986). Criminology (p. 155). New York: McMillian.
- Cullen, F. T. & Gilbert, K. (1982). Reaffirming Rehabilitation. Cincinnati: Anderson.
- Converse, J. M. & Presser, S., (1986). Survey Questions: Handcrafting the Standardized Questionnaire. Beverly Hills: Sage.
- Davies, P., (1981), The American Heritage Dictionary of the English Language (p. 491). Boston: Houghton Mifflin.
- Diagnostic and Statistical Manual of Mental Disorders, (1985). Washington D. C.: American Psychiatric Association.
- Diagnostic and Statistical Manual of Mental Disorders, (1985a) (p. 317). Washington D. C.: American Psychiatric Association.
- Earls, C. M. (1988). Deviant sexual arousal in sexual offender. In R. Prentky & V. L. Quinsey (Eds.), Human Sexual Aggression: Current Perspectives (pp. 41-48). Annals of the New York Academy of Sciences, Vol. 528.
- Fagin, A., (1976). The policy implications of predictive decision-making: "Likelihood" and "dangerousness" in civil commitment proceedings. Public Policy, 24, (pp. 491-528).
- Flanagan, T. J., & Jamieson, K. M. (Eds). (1987). Sourcebook of Criminal Justice Statistics-1987. Washington: U.S. Department of Justice, Bureau of Justice Statistics.
- Ferguson, G. A., (1981). Statistical Analysis in Psychology and Education. New York: McGraw-Hill.
- Freeman-Longo, R. & Bays, L., (1989). Who am I and why am I in treatment? A guided workbook for clients in evaluation and beginning treatment. Vermont: Safer Society Press.
- Frisbie, L. V., (1965). Treated sex offenders who reverted to sexually deviant behavior. Federal Probation, 24(2), (pp. 52-57).

- Furby, L., Weinrott, M. R., & Blackshaw, L., (1989). Sex offender recidivism: A review. Psychological Bulletin, 105(1), (pp. 3-30).
- Gabor, T., (1986). The Predictability of Criminal Behavior. Toronto: University of Toronto Press.
- Gigeroff, A. K., Mohr, J. W. & Turner, R. E., (1968). Sex offenders on probation: Heterosexual pedophiles. Federal Probation, 32(4), (pp. 17-21).
- Glass, A & Holyoak, K., (1986). Cognition (pp. 333-363). New York: Random House.
- George, W. A., & Marlatt, G. A., (1989) Introduction. In D. R. Laws (Ed.), Relapse Prevention with Sex Offenders (pp. 1-34). New York: Guilford Press.
- Greenland, C., (1980). Psychiatry and the prediction of dangerousness. Journal of Psychiatric Treatment and Evaluation, 2, (pp. 97-103).
- Groth, A. N. & Birnbaum, H. J., (1979). Men Who Rape: The Psychology of the Offender (p. 222). New York: Plenum Press.
- Groth, A. N., Longo, R. E., & McFadin, J., (1982). Undetected recidivism among rapists and child molesters. Crime & Delinquency, 28(3), (pp. 450-458).
- Group for the Advancement of Psychiatry, (1977). Methodological problems in evaluating treatment of sex psychopaths. In: Psychiatry and sex psychopath legislation: the 30's to the 80's, Vol. 9, (pp. 869-874).
- Hall, H., (1982). Dangerousness predictions and the maligned forensic professional: Suggestions for detecting distortion of true basal violence. Criminal Justice and Behavior, 9, (pp. 3-12).
- Hall, H., (1984). A proposed plan for forensic reporting and court testimony: Predicting dangerousness for the courts. American Journal of Forensic Psychology, 2(1).
- Hindman, J. (1989). Just Before Dawn (pp. 78-88). Boise: Northwest.
- Hodges, E. F. (1971). Crime prevention by the indeterminate sentence law. American Journal of Psychiatry. (pp. 291-295).

- Hudson, J., (1977). Problems of measurement in criminal justice. In L. Rutman (Ed.), Evaluation Research Methods: A Basic Guide. (pp. 75-101). Beverly Hills: Sage Publications.
- Jurek Vs Texas 1976. 96 S.Ct. 2950.
- Kahneman, D., & Tversky, A., (1973). On the psychology of prediction. Psychological Review, 80, 237-251.
- Kelly, C., (1976). Crime in the United States: Uniform crime reports. Washington, D. C.: U. S. Government Printing Office.
- Kim, J. O., Mueller, C. W., (1978). Introduction to Factor Analysis: What it is and how to do it. (p. 50). Beverly Hills: Sage Publications.
- Kozol, H. L., Boucher, J. R. & Garofalo, R. F., (1972). The diagnosis and treatment of dangerousness. Crime and Delinquency, 10, (pp. 371-392).
- Knopp, F. H., (1988). Nationwide Survey of Juvenile & Adult Sex-Offender Treatment Programs & Models. Vermont: Safer Society Press, Orwell, Vermont.
- Laws, D. R., (1989). Relapse Prevention with Sex Offenders, (pp. 153-244). New York: Guilford Press.
- Langevin, R., Ben-Aron, M. H., Coulthard, R., Hucker, S. J., Purins, J. E., Russon, A. E., Day, D., Roper, V. & Webster, C. D. (1985). The effect of alcohol on penile erection. In; Langevin, R., Erotic Preference, Gender Identity, and Aggression in Men: New Research Studies. Lawrence Erlbaum Associates, London.
- Luborsky, L., Crits-Christoph, P., Mintz, J. & Auerbach, A., (1988). Who Will Benefit from Psychotherapy? Predicting Therapeutic Outcomes. Basic Books, New York.
- McCrocklin, M. T. (1991, November). Value-Based Behavior Therapy and Covert Errors of Sex Offenders. Paper presented at the Association for the Treatment of Sexual Abusers Tenth Annual Research and Data Conference, Fort Worth, Texas.
- MacIntosh Versus Milano, 168 N. J. Super 466, (1979). Megargee, E. I., (1976). The prediction of dangerous behavior. Criminal Justice and Behavior, 3, (pp. 3-22).

- Marques, J. K., Day, M. D., Nelson, C. & Miner, M. H. (1989). The Sex Offender Treatment and Evaluation Project: California's Relapse Prevention Program. In D. R. Laws (Ed.), Relapse Prevention with Sex Offenders, (pp. 247-267). New York: Guilford Press.
- Millard Versus Harris, 406 F2d 964, (1968).
- Monahan, J., (1975). The prediction of violence. In I D. Chappell & J. Monahan (Eds.), Violence and Criminal Justice. Lexington, Massachusetts: Lexington Books.
- Monahan, J. (Ed.), (1980). Who is the client? The ethics of psychological intervention in the criminal justice system. Washington D.C.: American Psychological Association.
- Monahan, J., (1981). The Clinical Prediction of Violent Behavior. Rockville: U.S.Department of Health and Human Services.
- Monahan, J., (1981). Predicting Violent Behavior: An Assessment of Clinical Techniques. Beverly Hills: Sage.
- Money, J., (1990). Pedophilia: A specific instance of new phylism theory as applied to paraphiliac lovemaps. In J. R. Feierman (Ed.), Pedophilia: Biosocial Dimensions (p.460). New York: Springer-Verlag.
- Murphy, W. D., & Peters, J. M. (1992). Profiling Child Sexual Abusers: Legal Considerations. Criminal Justice and Behavior, 19 (1), pp 24-37.
- Myers, D. G., (1986). Psychology (p. 479). New York: Worth Publishers.
- National Institute on Alcohol Abuse and Alcoholism, (1992). Alcohol and Sexual Behavior. In Alcohol Alert no. 15, (p. 311), January 1992. United States Department of Health and Human Services: Alcohol, Drug Abuse and Mental Health Administration, Rockville, Maryland.
- Nisbett, R. E., & Borgida, E., (1975). Attribution and the psychology of prediction. Journal of Personality and Social Psychology, 32, (pp. 932-943).
- Norušis, M. J., (1986). SPSS/PC+ for the IBM PC/XT/AT (pp. B-177, B-178). Chicago: SPSS Inc..
- Norušis, M. J., (1986a). SPSS/PC+ for the IBM PC/XT/AT (p. B-186). Chicago: SPSS Inc..

- Quinsey, V. L. & Earls, C. M., (1990). The modification of sexual preferences. In W. L. Marshall, D. R. Laws & H. E. Barbaree (eds), Handbook of Sexual Assault: issues, theories and the treatment of the offender. (pp. 279-295). New York: Plenum Press.
- Reid, W. H. (1989). The Treatment of Psychiatric Disorders: Revised for the DSM-III-R (p. 335). New York: Brunner/Mazel.
- Pacht, A. R. & Cowden, J. E., (1974). An exploratory study of five hundred sex offenders. Criminal Justice and Behavior, 1(1), (pp. 13-20).
- Peters, S. D., Wyatt, G. E., & Finkelhor, D., (1986). Prevalence. In D. Finkelhor (Ed.), A Sourcebook on Child Sexual Abuse, (pp. 15-54). Beverly Hills: Sage.
- Petersilia, J. & Turner, S. (1986). Prison Versus Probation in California: Implications for Crime and Offender Recidivism. Rand Corporation Study for National Institutes of Justice.
- Peters, J. J., Pedigo, J. M., Steg, J. & McKenna, J. J., (1968). Group psychotherapy of the sex offender. Federal Probation, 32(3), (pp. 41-45).
- Pithers, W. D. (1990). Relapse Prevention with Sexual Aggressors: A Method for Maintaining Therapeutic Gain and Enhancing External Supervision. In Marshall, W. L., Laws, D. R. and Barbaree, H. E., Handbook of Sexual Assault: Issues Theories and Treatment of the Offender. (pp. 343-362). Plenum Press: New York.
- Pithers, W. D., Beal, L. S., Armstrong, J., Petty, J., (1989). Identification of risk factors through clinical interviews and analysis of records. In D. R. Laws, (1989). Relapse Prevention with Sex Offenders, (pp. 77-87). New York: Guilford Press.
- Prentky, R. (1991). Sexual Violence. A.T.S.A. Professional Forum, 5 (1), (pp. 8-12).
- PROMIS Research Project, (1977). Highlights of Interim Findings and Implications. Washington, D.C.: Institute for Law and Social Research.
- Quinsey, V., (1986). Introduction: The prediction and control of violent behavior. Journal of Interpersonal Violence, 2, (pp. 139-142).

- Rosewicz, B. (1983, January 31). Study finds grim link between liquor and crime: figures far worse than officials expected. Detroit Free Press, (pp. 1A, 4A).
- Russell, D. (1984). Sexual Exploitation: Rape, Child Sexual Abuse, and Workplace Harassment. Beverly Hills: Sage.
- Sadoff, R. L., (1975). Treatment of violent sex offenders. International Journal of Offender Therapy and Comparative Criminology, 19(1), (pp. 75-80).
- Salter, A. C., (1988). Treating Child Sex Offenders and Victims (pp. 96-110). Beverly Hills: Sage.
- Salter, A. C., (1988a). Treating Child Sex Offenders and Victims (p. 184). Beverly Hills: Sage.
- Scheff, T. J., (1963). Decision rules, types of error and their consequences in medical diagnosis. Behavioral Science, 8, (pp. 97-107).
- Schwartz, B. K., (1988). Interpersonal Techniques in Treating Sex Offenders. In B. K. Schwartz & H. R. Cellini (Eds.), A Practitioner's Guide to Treating the Incarcerated Male Sex Offender: Breaking the Cycle of Abuse (p. 101). U.S. Department of Justice: National Institute of Corrections: Washington, D. C..
- Schwartz, B. K., & Cellini, H. R., (1988). Characteristics and topologies of sex offenders. In B. K. Schwartz & H. R. Cellini (Eds.), A Practitioner's Guide to Treating the Incarcerated Male Sex Offender: Breaking the Cycle of Abuse (pp. 15-26). U.S. Department of Justice: National Institute of Corrections: Washington, D. C..
- Shah, S. A., (1969). Crime and mental illness: Some problems in defining and labeling deviant behavior. Mental Hygiene, 53, (pp. 21-33).
- Shah, S. A., (1978). Dangerousness: A paradigm for exploring some issues in law and psychology. American Psychologist, 3, (pp. 224-238).
- Short, J. F., (1954). A report on the incidence of criminal behavior, arrests and convictions in selected groups. Research Studies of the State College of Washington, 22, (pp. 110-18).

- Smith, W. R. & Monastersky, C., (1986). Assessing juveniles sexual offenders' risk for reoffending. Criminal Justice and Behavior, 13(2), (pp. 115-140).
- Stone, A., (1975). Mental health and the law: A system in transition. (DHEW Publication Number (ADM) 76-176). Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office.
- Suchman E. A., (1967). Evaluative Research. New York: Russell Sage Foundation, (pp. 77-79).
- Sutherland, E. H., & Cressey, D. H. (1978a). Criminology (p. 44). Philadelphia: Lippincott.
- Sutherland, E. H., & Cressey, D. H. (1978b). Criminology (p. 31). Philadelphia: Lippincott.
- Sutherland, E. H., & Cressey, D. H. (1978c). Criminology (p. 246). Philadelphia: Lippincott.
- Sutherland, E. H., & Cressey, D. H. (1978d). Criminology (p. 169-174). Philadelphia: Lippincott.
- Tarasoff versus Regents of the University of California. 17 CAL 3d 551 P 2d 334 (1976).
- Taylor, S. P. (1983). Alcohol and human physical aggression. Aggression, 2, (pp. 77-101).
- Tversky, A., & Kahneman, D., (1974). Judgement under uncertainty: Heuristics and biases. Science, 185, (pp. 1124-1131).
- Wolfgang, M., Figlio, R. M. & Sellin, T., (1972). Delinquency in a Birth Cohort. Chicago: University of Chicago Press.
- Yoder, B., (1990). The Recovery Resource Book, (p. 11). New York: Simon & Schuster.
- Yalom, I. D., (1975a). The Theory and Practice of Group Psychotherapy (pp. 3-17). New York: Basic Books.
- Yalom, I. D., (1975b). The Theory and Practice of Group Psychotherapy (p. 16). New York: Basic Books.
- Ziskin, J., (1981). Coping with Psychiatric and Psychological Testimony, Second Edition. Beverly Hills: Law and Psychology Press.

APPENDIX

VALUES OF Q-VARIABLES FOR ALL RESPONDENTS

Variable	Mean	sd		Variable	Mean	sd
Q1	4.47	.80		Q21	3.40	.87
Q2	3.83	.92		Q22	3.36	.99
Q3	3.66	.93		Q23	3.47	1.18
Q4	3.75	.98		Q24	3.52	1.07
Q5	3.85	.97		Q25	3.64	1.89
Q6	3.76	1.01		Q26	3.30	1.02
Q7	2.49	1.04		Q27	3.68	.90
Q8	4.35	.81		Q28	3.82	.81
Q9	3.49	.98		Q29	3.63	.95
Q10	3.97	.97		Q30	3.97	.92
Q11	3.69	1.12		Q31	3.60	.93
Q12	4.50	.73		Q32	4.18	.86
Q13	4.38	.71		Q33	4.44	.76
Q14	3.61	.79		Q34	3.65	1.08
Q15	3.69	.91		Q35	4.03	.96
Q16	3.47	1.05		Q36	4.15	.85
Q17	4.12	.91		Q37	3.48	.87
Q18	4.08	1.07		Q38	3.28	1.02
Q19	3.76	1.07		Q39	3.29	1.08
Q20	3.78	.92		Q40	3.83	.88

VALUES OF Q-VARIABLES
(continued)

Variable	Mean	sd		Variable	Mean	sd
Q41	3.83	1.08		Q61	2.84	1.08
Q42	3.82	.95		Q62	2.32	1.04
Q43	3.81	.86		Q63	2.67	.93
Q44	3.99	.88		Q64	2.97	1.06
Q45	3.56	.95		Q65	3.78	.80
Q46	3.81	.84		Q66	3.18	1.00
Q47	4.03	.88		Q67	2.97	.83
Q48	4.23	1.00		Q68	2.54	1.87
Q49	3.80	1.19		Q69	3.40	.89
Q50	3.19	1.41		Q70	2.93	1.18
Q51	3.65	.83		Q71	2.57	1.06
Q52	3.71	.84		Q72	3.80	.93
Q53	3.53	.84		Q73	2.95	1.23
Q54	3.55	1.11				
Q55	4.37	.75				
Q56	2.92	.99				
Q57	3.13	1.19				
Q58	2.05	.99				
Q59	3.08	.94				
Q60	3.10	.83				

FORM #1, INTRODUCTION FORM

CRITERIA OF PROGRESS FOR SEXUAL OFFENDERS

It is very difficult to know if a sex offender has made any progress in therapy and is less dangerous to his family and the community. That is, has he made changes from his baseline condition of behaviors which contribute or lead to his acts of sexual abuse? As a professional involved in the treatment of sexual offenders, you are aware of the constant needs that society, the justice system and professionals have to evaluate an offender's progress in therapy. Unfortunately, the criteria for making these evaluations are neither standardized nor well researched. The purpose of this questionnaire is to gather data on the OPINIONS of professionals in the field of sexual offender treatment about what factors are important in order to evaluate an offenders progress. After collection these opinions will be analyzed to determine if there are clusters of factors that professionals feel are more or less useful. One note; we recognize that it is extremely difficult to point to an item in isolation and determine if it indicates progress or not. Therefore, it may be useful to bring to mind both a client that you felt gained a great deal of benefit from therapy and a client that you felt did not benefit from therapy and to then score the items. It is inevitable that there are many criteria that could be considered when evaluating progress. The criteria listed on this questionnaire came from interviews with: psychiatrists, psychologists, an administrator, masters level therapists and offenders, all of whom are experienced in the field of sexual abuse. I appreciate your help in making this survey. In exchange for your time and effort, I will be happy to send you a copy of the results. If you wish a copy please fill out the following address form, detach this sheet from the survey form and return it separately. This is necessary to preserve the anonymity of the persons answering. Thanks for your help.

IF YOU WOULD LIKE A COPY OF THE RESULTS OF THIS SURVEY THEN PLEASE FILL IN THE FOLLOWING INFORMATION AND RETURN THIS SHEET SEPARATELY FROM THE SURVEY FORM:

NAME: _____

EMPLOYER OR GROUP NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FORM #2: PROFESSIONAL'S DEMOGRAPHIC DATA FORM

BACKGROUND INFORMATION

*****please do not put your name on this form *****

- 1) What is your age? _____
- 2) What is your sex? _____
- 3) In which state or province do you currently work? . . . _____
- 4) Are you a professional mental health worker? _____
- 5) What is your most advanced degree? _____
- 6) Were you a victim of sexual abuse? _____
- 7) Do you treat offenders or victims of sexual crime? . . . _____
 If yes, what percentage of current practice is:
 a. Victims _____
 b. Offenders _____
- 8) How many years have you treated victims? _____
- 9) How many years have you treated offenders? _____
 a. How many years treating incarcerated offenders? . . . _____
 b. How many years treating outpatient offenders? . . . _____
- 10) Do you consider yourself an expert?
 a. Working with Victims? _____
 b. Working with Offenders? _____
- 11) How many hours per week of direct therapy do you currently do ...
 a. Therapy with Victims _____
 b. Therapy with Offenders _____
- 12) How long do you feel that the average sexual
 offender should remain in weekly therapy? _____
- 13) How long do you feel that the average victim
 should remain in weekly therapy? _____

FORM #3: OFFENDER'S DEMOGRAPHIC DATA FORM

*****PLEASE DO NOT PUT YOUR NAME ON THIS FORM*****

- 1) What is your age? _____
 - 2) What is your sex? _____
 - 3) What state do you currently reside in? . . . _____
 - 4) Have you ever been a victim of sexual abuse? _____
 - 5) Have you ever been a victim of physical abuse? _____
 - 6) Have you been a victim of emotional/mental abuse? _____
 - 7) What is the total number of years that you
have spent in jail or prison? _____
 - 8) IF sexual offenders were required to be in
treatment, how long do you think that treatment should
last?
-
-
-
-

>>>>PLEASE DO NOT PUT ANY IDENTIFYING MARKS ON THIS
SHEET<<<<<>>>>>>>>>>DO NOT PUT YOUR NAME ON THIS SHEET<<<<<<<<<

FORM #4: OPINION FORM (forward)

**FACTORS USED FOR DECISIONS ABOUT SEXUAL OFFENDERS
PROGRESS IN THE FIRST SIX MONTHS OF THERAPY**

Please score each item for it's utility as an indicator of progress using the following scale:

1 -----2----- 3 ----- 4----- 5
(Little utility) (Moderate utility) (Great utility)

IF YOU DO NOT KNOW HOW TO SCORE AN ITEM PLEASE LEAVE BLANK

- 1.(AA) Control of alcohol and drugs, ie; clean and sober.
- 2.(BA) New awareness of personal and social deficits/inadequacies. . .
- 3.(CA) New awareness of personality strengths or competency. . .
- 4.(DA) Willingness to try out new ideas or procedures.
- 5.(EA) That the client has learned a new skill and practices it. . . .
- 6.(FA) Honest expression of a range of good and bad feelings.
- 7.(GB) More introverted behavior (if an extroverted client).
- 8.(HB) Awareness of personal potential for harming self or others. . .
- 9.(IB) Reduction of demanding behavior.
- 10.(JB) No indications of (either overt or covert) lying.
- 11.(KB) Regret about his criminal activity.
- 12.(LB) Spontaneous use of intervention skills for deviant cycle. . . .
- 13.(MC) Thinking in advance about negative consequences of behavior. .
- 14.(NC) Ability to make realistic plans for the future.
- 15.(OC) Consistent completion of assigned homework.
- 16.(PC) Initiative to make restitution for the damage of crime.
- 17.(QC) Congruent: observed behavior, speech and 3d party reports. . .
- 18.(RC) Regular attendance at individual or group therapy sessions. .
- 19.(SD) Consistency of noncriminal behaviors (while observed).
- 20.(TD) Initiation of therapy ie; spontaneously bringing up issues. .
- 21.(UD) Assertion of needs consistent with therapeutic goals.
- 22.(VD) Regular payment of bills or no accumulation of prison debts. .
- 23.(WD) No deviant arousal on plethysmographic testing.

FORM #4: OPINION FORM (forward)

**FACTORS USED FOR DECISIONS ABOUT SEXUAL OFFENDERS
PROGRESS IN THE FIRST SIX MONTHS OF THERAPY
(continued)**

- 24.(XD) No evidence of suppression on plethysmographic testing.
- 25.(YE) Appropriate arousal on plethysmographic testing.
- 26.(ZE) Positive peer evaluations about his progress.
- 27.(AE) Ability to identify and articulate his feelings.
- 28.(BE) Ability to accurately listen to others.
- 29.(CE) Desires to improve the quality of his social support system.
- 30.(DE) That he involves intimates to support nondeviant behavior. . .
- 31.(EF) Ability to develop and maintain friends.
- 32.(FF) Understanding of deviant cycle.
- 33.(GF) No denial or minimization of crime.
- 34.(HF) Full agreement with victims statement.
- 35.(IF) Greater disclosure about crime than victims statement.
- 36.(JF) Understanding of his criminal behavior and thinking.
- 37.(KG) Appropriate development of self confidence.
- 38.(LG) Ability to solve or manage complex social problems.
- 39.(MG) New insights about the causes of his criminality.
- 40.(NG) Open and active participation in group therapy.
- 41.(OG) Awareness that he has life long personality problems.
- 42.(PG) Ongoing disclosure of daily problems and solutions.
- 43.(QH) Evidence that he is complying with group recommendations. . . .
- 44.(RH) Appreciation of the harm and costs of his criminality.
- 45.(SH) "Significant other" reports improvement of behavior.
- 46.(TH) Willingness to ask for help with personal problems.
- 47.(UH) Willingness to make commitments and assume responsibility. . .
- 48.(VH) Desire to eliminate his deviant sexual arousal.
- 49.(WI) Client expresses guilt over criminal behaviors.
- 50.(XI) Participation in six months of continuous therapy.

FORM #4: OPINION FORM (forward)

**FACTORS USED FOR DECISIONS ABOUT SEXUAL OFFENDERS
PROGRESS IN THE FIRST SIX MONTHS OF THERAPY
(continued)**

- 51.(YI) An increased ability to handle stress.
- 52.(ZI) A new ability to generate options for problem solving.
- 53.(AI) A reduction in concrete thinking, fewer fixed ideas.
- 54.(BI) A socially acceptable understanding about right and wrong.
- 55.(CJ) The ability to empathize, especially with his victims.
- 56.(DJ) Client has a good relationship with his therapist.
- 57.(EJ) Client feels that therapy has been effective for him.
- 58.(FJ) That the therapist enjoys the interaction with the client.
- 59.(GJ) A spontaneous display of emotion (in a closed client).
- 60.(HJ) Reduction of attention-seeking behavior (in an extrovert).
- 61.(IK) Therapist's subjective judgement of the clients sincerity.
- 62.(JK) Therapist feels personally successful about client.
- 63.(KK) A reduction in complaints about his life and his troubles.
- 64.(LK) Client expresses hope and optimism about the future.
- 65.(MK) Less self centered speech, more concern/interest in others.
- 66.(NK) Able to laugh at himself, humor about his situation.
- 67.(OL) More extroverted behavior in an introverted client.
- 68.(PL) Therapist feels optimistic about client's future.
- 69.(QL) Willingness to be afraid, able to express fear.
- 70.(RL) Understanding and acceptance of how ordinary he is.
- 71.(SL) Demonstrates improvement on MMPI or Millon testing.
- 72.(TL) Reveals old crimes, that no one knew of before.
- 73.(UM) Client expresses gratitude about his arrest and therapy.

FORM #5: OPINION FORM (reversed)

**FACTORS USED FOR DECISIONS ABOUT SEXUAL OFFENDERS
PROGRESS IN THE FIRST SIX MONTHS OF THERAPY**

Please score each item for it's utility as an indicator of progress using the following scale:

1	-----2-----	3	-----4-----	5
(Little utility)		(Moderate utility)		(Great utility)
- *****IF YOU DO NOT KNOW HOW TO SCORE AN ITEM PLEASE LEAVE BLANK*****
- 1.(UM) Client expresses gratitude about his arrest and therapy.
 - 2.(TL) Reveals old crimes, that no one knew of before.
 - 3.(SL) Demonstrates improvement on MMPI or Millon testing.
 - 4.(RL) Understanding and acceptance of how ordinary he is.
 - 5.(QL) Willingness to be afraid, able to express fear.
 - 6.(PL) Therapist feels optimistic about client's future.
 - 7.(OL) More extroverted behavior in an introverted client.
 - 8.(NK) Able to laugh at himself, humor about his situation.
 - 9.(MK) Less self centered speech, more concern/interest in others.
 - 10.(LK) Client expresses hope and optimism about the future.
 - 11.(KK) A reduction in complaints about his life and his troubles.
 - 12.(JK) Therapist feels personally successful about client.
 - 13.(IK) Therapist's subjective judgement of the clients sincerity.
 - 14.(HJ) Reduction of attention-seeking behavior (in an extrovert).
 - 15.(GJ) A spontaneous display of emotion (in a closed client).
 - 16.(FJ) That the therapist enjoys the interaction with the client.
 - 17.(EJ) Client feels that therapy has been effective for him.
 - 18.(DJ) Client has a good relationship with his therapist.
 - 19.(CJ) The ability to empathize, especially with his victims
 - 21.(AI) A reduction in concrete thinking, fewer fixed ideas.
 - 22.(ZI) A new ability to generate options for problem solving.
 - 23.(YI) An increased ability to handle stress.
 - 24.(XI) Participation in six months of continuous therapy.
 - 25.(WI) Client expresses guilt over criminal behaviors.

FORM #5: OPINION FORM (reversed)

**FACTORS USED FOR DECISIONS ABOUT SEXUAL OFFENDERS
PROGRESS IN THE FIRST SIX MONTHS OF THERAPY
(continued)**

- 26.(VH) Desire to eliminate his deviant sexual arousal.
- 27.(UH) Willingness to make commitments and assume responsibility. . .
- 28.(TH) Willingness to ask for help with personal problems.
- 29.(SH) "Significant other" reports improvement of behavior.
- 30.(RH) Appreciation of the harm and costs of his criminality.
- 31.(QH) Evidence that he is complying with group recommendations. . .
- 32.(PG) Ongoing disclosure of daily problems and solutions.
- 33.(OG) Awareness that he has life long personality problems.
- 34.(NG) Open and active participation in group therapy.
- 35.(MG) New insights about the causes of his criminality.
- 36.(LG) Ability to solve or manage complex social problems.
- 37.(KG) Appropriate development of self confidence.
- 38.(JF) Understanding of his criminal behavior and thinking.
- 39.(IF) Greater disclosure about crime than victims statement. . . .
- 40.(HF) Full agreement with victim's statement.
- 41.(GF) No denial or minimization of crime.
- 42.(FF) Understanding of deviant cycle.
- 43.(EF) Ability to develop and maintain friends.
- 44.(DE) That he involves intimates to support nondeviant behavior. .
- 45.(CE) Desires to improve the quality of his social support system.
- 46.(BE) Ability to accurately listen to others.
- 47.(AE) Ability to identify and articulate his feelings.
- 48.(ZE) Positive peer evaluations about his progress.
- 49.(YE) Appropriate arousal on plethysmographic testing.
- 50.(XD) No evidence of supression on plethysmographic testing. . . .
- 51.(WD) No deviant arousal on plethysmographic testing.
- 52.(VD) Regular payment of bills or no accumulation of prison debts. .

FORM #5: OPINION FORM (reversed)

**FACTORS USED FOR DECISIONS ABOUT SEXUAL OFFENDERS
PROGRESS IN THE FIRST SIX MONTHS OF THERAPY
(continued)**

- 53.(UD) Assertion of needs consistent with therapeutic goals.
- 54.(TD) Initiation of therapy ie; spontaneously bringing up issues. . .
- 55.(SD) Consistency of noncriminal behaviors (while observed).
- 56.(RC) Regular attendance at individual or group therapy sessions. . .
- 57.(QC) Congruent: observed behavior, speech and 3d party reports. . .
- 58.(PC) Initiative to make restitution for the damage of crime.
- 59.(OC) Consistent completion of assigned homework.
- 60.(NC) Ability to make realistic plans for the future.
- 61.(MC) Thinking in advance about negative consequences of behavior. .
- 62.(LB) Spontaneous use of intervention skills for deviant cycle. . .
- 63.(KB) Regret about his criminal activity.
- 64.(JB) No indications of (either overt or covert) lying.
- 65.(IB) Reduction of demanding behavior.
- 66.(HB) Awareness of personal potential for harming self or others. .
- 67.(GB) More introverted behavior (if an extroverted client).
- 68.(FA) Honest expression of a range of good and bad feelings.
- 69.(EA) That the client has learned a new skill and practices it. . .
- 70.(DA) Willingness to try out new ideas or procedures.
- 71.(CA) New awareness of personality strengths or competency. .
- 72.(BA) New awareness of personal and social deficits/inadequacies. .
- 73.(AA) Control of alcohol and drugs, ie; clean and sober.