Child Sex Offender Treatment:

The Effects of Voluntary Exclusion.

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Abstract

Despite the rarity of child sexual abuse in relation to other reported criminal offences, high sentencing rates have resulted in an accumulation of child sex offenders within New Zealand's correctional facilities. Acknowledging that incarceration alone does not deter, let alone prevent, sexual recidivism, contemporary treatment programs are seen to dramatically reduce recidivism among child sex offenders. New Zealand's adoption of a broad-based cognitive/ behavioural framework for treating the child sex offender has not only proven successful in reducing recidivism, but, as the present research has demonstrated, it has also shown to be a financially cost effective way of dealing with this incarcerated population.

In light of the success of New Zealand's treatment programs, the extensive heterogeneity evidenced in the child sex offender population has proven problematic, especially when treatment is voluntary. Given such heterogeneity, treatment programs like Kia Marama, which adopt a voluntary intake criterion, allow for the more dysfunctional offender to avoid treatment.

The present research postulated that the voluntary nature of the Kia Marama treatment program is resulting in the more deviant offender, who presents with a more dysfunctional cognitive and affective disposition, not volunteering for treatment. Furthermore, because of the inherent distorted beliefs, these individuals are also the ones for whom the potential for recidivism is greatest. Hence it was postulated that those who do not volunteer for treatment, despite being eligible, will display more of the characteristics reported to predict recidivism among incarcerated child sex offenders.

Results showed that, contrary to expectation, the cognitive and affective aspects of those who do not volunteer for treatment, are no more dysfunctional than the child sex offenders who volunteer for the Kia Marama program. However, non-volunteers were seen to present a greater risk of reoffence, when they displayed more of the recidivism predictor characteristics.

It was concluded that the most distinctive features discriminating treated and untreated child sex offenders are, their degree of denial and motivation for treatment. Thus, given that the Kia Marama treatment unit is capturing a representative cross-section of New Zealand's child sex offender population, coupled with the extensive repercussions of such aberrant sexual behaviour, something must be done to reduce the recidivism potential among those who do not volunteer for child sex offender treatment. Whether this necessities the call for mandatory treatment, or just greater powers for those within corrections facilities to coax the offender into treatment, is a question which must be addressed by New Zealand's governmental legislators.

Introduction

For over a decade growing public and professional awareness, coupled with increased media coverage, has resulted in the proliferation of reported child sexual abuse. Billed by Sgroi as "the last frontier of child abuse" (1975, p. 19), the sexual victimisation of children has reached epidemic proportion world-wide (Prentky, 1994). Research in Western societies has been consolidated by findings in non-western settings (Western and Southern Africa: Russell, 1990; China: Ho and Kwok, 1991; Yuan, 1990; Japan: Ikeda and Satoh, 1992), with child sexual abuse now recognised as a serious and significant societal problem. The costs can no longer be ignored.

Despite its rarity in relation to other reported criminal offences, the impacts of child sexual abuse are strong enough to instil hatred and severe public condemnation on those who chose to violate the moral and legal sentiments set in place by society to protect children. The extensive burden placed on these societies, both financially and otherwise, as a result of such acts, is becoming increasingly apparent. Current medical and psychological services, which aid victim recovery, are under immense pressure. So to are the already limited resources required for the investigation, prosecution and incarceration of child sex offenders.

Acknowledging the extensive physical, psychological and emotional repercussions faced by the victims of child sexual abuse (Browne & Finkelhor, 1990; Finkelhor, 1979, 1984, 1986, 1990; Gomes-Schwartz, Horowitz, & Cardarelli, 1990; Peters, 1976; Shand & Milford, 1993) the current review focuses predominantly on the perpetrator. Not because they are deemed more important, but because it is here where the most direct root to reducing child sexual abuse is to be found. Hence a reduction in the incidence of child sexual abuse will stem from early intervention and adequate treatment, aimed at reducing the number of potential offenders, together with the recidivism of those

offenders already incarcerated.

This thesis has two parts. Part one consists of a literature review, divided into seven chapters focusing on the individuals who commit acts of child sexual abuse. After reviewing contemporary definitions of child sexual abuse and recent prevalence data in chapter one, the focus is shifted to the perpetrator. Chapter two reviews the child sex offender's demographic characteristics, together with a closer look at three of the most researched aspects of the perpetrators affective and cognitive functioning. That is, the child sex offender's distorted cognitions, the often reported deficits in empathy and their extensive use of denial.

Chapter three examines the historic and contemporary approaches to child sex offender treatment. Specific emphasis is placed on institutional and correctional based treatment, where a review of the most widely implemented approaches to child sex offender treatment is carried out (i.e., cognitive/behavioural and relapse prevention). In chapter four a brief look at New Zealand's two correctional based treatment programs is undertaken. Chapter five reviews the efficacy of child sex offender treatment programs and presents the characteristics of the recidivist offender.

The final section of the literature review investigates the cost effectiveness of New Zealand's child sex offender treatment programs. A cost benefit analysis is carried out on the Kia Marama child sex offender treatment program (Rolleston prison) incorporating a similar methodology to that advanced by Prentky and Burgess, (1990).

Chapter seven contains a brief recap of the literature review, before providing the rationale, justification and hypothesis for the current research.

Part two of the thesis comprises of an exploratory study into the characteristics of the New Zealand child sex offender population. More specifically, the research firstly documents the demographic and personality characteristic of those child sex offenders

who do not volunteer, although eligible, for the Kia Marama sex offender treatment program. Secondly, the current research will compare the cognitive and affective disposition of these individuals with child sex offenders who volunteer for the Kia Marama program. Finally, using the often reported characteristics and predictors of sexual recidivism, the research assesses the potential for recidivism between those who volunteer for the Kia Marama program and those child sex offenders who do not volunteer, although eligible, for treatment while incarcerated.

PART I

LITERATURE REVIEW:

CHAPTER I

The Act:

"...accusations of sexual misconduct that little girls often lodge against men are... *one of the gravest scandals of our present penal system"*(Moll, 1912).

The sexual molestation of children encompasses a diverse array of sexual misconduct. Such behaviours include touching of the genitals, forced masturbation, penetration with a finger or foreign object, oral-genital contact, and vaginal/anal penetration. Furthermore, when dealing with children, inappropriate touching, voyeurism, exhibitionism, and involvement in photography or filming for pornographic purposes, are also deemed abusive. In general, any behaviour, whether a single event or a series of incidences over a number of years, that exploits a child sexually can be conceived as child sexual abuse.

One of the most cited definitions (Kempe & Kempe, 1978; New Zealand Law Society, 1992; Police Training and Development Section, 1992; Shand & Milford, 1993) of child sexual abuse within contemporary literature is that of Schechter and Roberge (1976). That is;

> "The involvement of dependent, developmentally immature children and adolescents in sexual activities which they do not fully comprehend, are unable to give consent to, and that violate social taboos of family roles" (p.129).

1.1.1 Statutory Definition

Due to the nature of the present research an alternative definition to that advanced by Schechter and Roberge seems more applicable. Currently within New Zealand there is no legal or statutory definition of what best constitutes child sexual abuse. What is evident, is that within the criminal context a range of sexual offences involving minors exist. Each offence has a distinct set of ingredients (e.g., age of victim, relationship between offender and victim, and the type of sexual activity involved) and results in differing penalties for the perpetrator. Table 1 displays these offences, the maximum penalty for each and the respective section of the Crimes Act (1961) from which each was drawn.

TABLE 1: Sexual Offences Against Children.

Age Bracket of Victim	*Offence*	*Maximum Penalty*	*Crimes Act*
Women over 21 and girl under age 16		7 years	Section 139
Girl under 20 in offenders care or protection	Sexual intercourse with girl under care or protection	7 years	Section 131
Girl aged 12-16	Sexual intercourse, attempt intercourse or indecency	7 years	Section 134
Girl under 12	Sexual Intercourse	14 years	Section 132
	Attempted Intercourse	10 years	Section 133
	Indecency	10 years	Section 133
Boy under 12	Indecency - Indecent Assault	10 years	Section 140
Boy aged 12-16	Indecency	7 years	Section 140A
Boy under 12	Anal Intercourse	14 years	Section 142
Boy aged 12-16	Anal Intercourse	7 years	Section 142
Parent/Child contact (Birth/Adopted)	Incest	10 years	Section 130

Source: Crimes Act, (1961).

The statutory definition, or more specifically that which is adopted by the legal profession and dictated by New Zealand criminal law, is better suited to the present context for two reasons. Firstly, it makes no assumptions about the underlying aetiology of child sexual abuse. Second, and what is of more importance, it is the statutory criteria which results in a perpetrator being charged, convicted and incarcerated of child sexual abuse within New Zealand.

1.2. Extent of Child Sexual Abuse

As Sgroi (1975) suggests, the recognition of child sexual abuse is entirely dependent on an individual's inherent willingness to accept that the phenomenon actually exists.

Thus the recent upsurge in the estimated incidence of child sexual abuse may have as much to do, if not more, with the increased publicity, awareness and reporting, as it does an actual increase in sexual victimisation.

1.2.1 International statistics

International research (Abel, Gore, Holland, Camp, & Becker, 1989; Ho & Kwok, 1991; Ikeda & Satoh, 1992; Russell, 1990; Yuan, 1990) places the incidence (i.e., "the number of cases of sexual abuse that come to the attention of professionals during a year" [Finkelhor, 1994, p. 36]) of child sexual abuse between 5 and 20 per cent of those under the age of 18. While a prevalence study by Grauerholz and Koralewski (1991) concluded that 21/1000 American children experience unwanted sexual contact, with an average age of onset being 10.5 years.

In what has become the most comprehensive and culturally expansive study of child sexual abuse prevalence rates (i.e., the proportion of the adult population that have been victims of sexual abuse at some time in their childhood), Finkelhor (1994a) reviewed 34 epidemiological studies from 21 countries. He concluded that a history of sexual abuse was evident in at least 7 per cent of the female and 3 per cent of the male population. Finkelhor's research also highlighted the extensive variability in child sexual abuse prevalence rates across cultures. Peak rates for women were found in Austria, where up to 36 per cent of the female population had experienced sexual abuse. While for men, rates of up to 29 per cent were reported in the South African sample.

In light of the extensive variation of child sexual abuse prevalence rates across countries, a cautionary note must accompany any direct comparison. As noted by Finkelhor, similar variation can be found within the United States (Peters, Wyatt, & Finkelhor, 1986) as a consequence of differing methodologies. Therefore, because of the acknowledged methodological variability within Finkelhor's study, the reported

prevalence rates may not be a true reflection of the actual prevalence rates, nor of their variability. In fact it may be the case that, as Finkelhor suggests, a lack of methodological rigour has lead to the inflated prevalence rates of child sexual abuse in some countries, while underestimating the true prevalence rates in others.

1.2.2 New Zealand statistics

New Zealand prevalence rates are seen to parallel those found in international research. Two studies which address the extent of sexual victimisation in New Zealand are those by Anderson et al. (1991) and Gavey (1991). In Anderson et al.'s research, 32 per cent of the female participants reported having unwanted sexual experiences before the age of 16, while 20 per cent of the sample reported unwanted sexual contact before the age of 12. Similarly, Gavey's study provided support for the widespread sexual victimisation of children within New Zealand when 51.6 per cent of her female sample (347 undergraduate psychology students) reported having experienced some form of sexual victimisation. Acknowledging that the sample was by no means representative of the greater New Zealand society, Gavey's research also revealed that 13.6 per cent of her male sample (176 psychology undergraduates) had reported perpetrating some form of sexual victimisation.

More recent postal surveys (Martin, Anderson, Romans, Mullen, & O'Shea, 1993; Mullen, Martin, Anderson, Romans, & Herbison, 1993), which utilised a narrowly defined abuse criteria, provided further support for the high rates of sexual victimisation within New Zealand, when they to reported prevalence rates of 20 per cent. These later findings were consistent with previous surveys which reported prevalence estimates of 19 per cent for child sexual abuse involving genital contact (Mullen, Romans-Clarkson, Walton, & Herbison, 1988) and 13 per cent for intrafamilial sexual abuse (Bushnell, Wells, & Oakley-Browne, 1992).

In light of the aforementioned research an important point must be made with respect to the legitimacy of sexual victimisation claims. The early conclusions of Freud (1905: cited in Sulloway, 1979) which asserted that the majority of sexual abuse complaints were false accusations rooted in hysteria, have since been contested. More recent figures advance that not more than 4 - 8 per cent of child sexual abuse allegations made by children are exaggerated or invented (Collings, 1991; Everson & Boat, 1989; Summit, 1983). However, in her New Zealand based study Rawls (Rawls, 1996; The Dominion, 1996) reported that nearly one-quarter (24%) of the 30 five-year-old children in her sample reported inappropriate adult-child touching when no such activity had taken place.

Despite the contemporary uncertainty with respect to the overall legitimacy of child sex abuse accusations, it is generally accepted that a substantial proportion of sex abuse allegations, if not the majority, are legitimate. Combining such a conclusion with the increasing body of literature which advances that child sexual victimisation is in the order of 13-52 percent (depending on where and how sexual abuse is measured), it can be concluded that child sexual abuse is a problem in both New Zealand and on a broader international scale.

CHAPTER II

The Child Sex Offender:

Historically the predominating stereotype of a child sex offender has been that of 'the dirty old man'. A small group of socially incompetent individuals whose inability to conform to societal norms sees them socially alienated and incapable of forming adult relationships. As a result, this 'sick' and 'perverted' individual turns to children in an effort to gain the sexual gratification that is denied him by his peers.

Such a stereotypic belief is only now being debunked. In the face of extensive research the myth of a homogeneous group of individuals is giving way to a more heterogeneous population (Ballard, Blair, Devereaux, Valentine, Horton, & Johnson, 1990; Barbaree & Marshall, 1989; Holmes, 1991; Kalichman, 1991; Marshall & Hall, 1995) whose most distinctive characteristic is their share lack of homogeneity. Thus, child sex offending is no longer seen as culturally or economically bound, nor is it restricted to a single gender or religious affiliation. Indeed in a number of child sex abuse cases the offender is a respectable, otherwise law-abiding person, who escapes detection for this very reason. Fontaine (1990) went as far as to say, the main thing child sex offenders have in common is the opportunity to be alone with a child or children.

2.1 Incidence of Incarceration

The extensive divergence between the occurrence of child sexual abuse and the incarceration of the perpetrator is one of the most problematic features of this population. Shand and Milford (1993) noted that only 6 per cent of all child sexual abuse cases are ever reported, with the offender seldomly apprehended, and even more infrequently processed through the courts and imprisoned. Despite this low reporting rate, society's call for protection against the child sex offender has resulted in the increased criminal and family court proceedings involving allegations of child sexual abuse (Bonta & Hanson, 1994; New Zealand Law Society, 1992). As a consequence of

such proceedings, correctional facilities are witnessing a dramatic upsurge in sex offender numbers (Bureau of Justice Statistics & Office of Juvenile Justice and Delinquency Prevention, 1996; Gordon, Holden, & Leis, 1991; Grubin & Thornton, 1994).

2.1.1 International Statistics

Although accounting for only one per cent of reported crime in England and Wales, the proportion of adult men incarcerated between 1980 and 1990, as a direct result of child sex offence convictions, rose by almost 60 per cent (Grubin & Thornton, 1994). Increasing from 4.7 per cent in 1980, to 7.9 per cent in 1990 (Thornton & Hogue, 1993), the most recent figure (Grubin & Thornton, 1994) sees child sex offenders accounting for approximately 10 per cent of the adult male prison population in England and Wales.

Studies in Canadian federal institutions demonstrate a similar growth in the number of child sex offenders. As a percentage of the total inmate population, the proportion of adult men incarcerated for sex offences rose from 7.4 per cent (871) to 11.4 per cent (1385) in 1988. While in 1990 there were over 3,000 child sex offenders under the jurisdiction of Canadian correctional services (Gordon, Holden, & Leis, 1991).

While these figures represent an increase in the proportion of child sex offenders within the Canadian prison system, other statistics indicate that this growth is a result of an overall increase in convicted child sexual offenders and not just a change in population demographics. In 1978 child sex offenders constituted 6.5 per cent of the overall admissions into correctional facilities. This figure rose by 1980 to 8.5 per cent, and by 1989 adult male sex offenders accounted for 12.9 per cent of the prison system's new admissions. Gordon, Holden and Leis (1991) concluded that in 1990 the figure was still on the rise but had reached 13.2 per cent.

In the United States the inmate population is at an all time high, whilst the proportion of sexually deviant individuals is higher than at any time in history (Bureau of Justice Statistics & Office of Juvenile Justice and Delinquency Prevention, 1996; Sapp & Vaughn, 1991). In a representative sample of over 14,000 American prisoners incarcerated for violent crimes against children (<18 years old), Greenfeld (personal communication, August 1996) reported that over two-thirds were imprisoned for sexually abusive acts. This figure equates to 13 per cent of all State prisoners incarcerated for violent crime, and approximately 6 per cent of the entire US penal population.

Although these figures exclude inmates held in Federal prisons, it must be noted that less than 1 per cent of the convictions for violent offences, and only .08 per cent of convictions for sexually abusive acts against children, result in a Federal prison sentence (Greenfeld, personal communication, February 1997).

A joint publication by the Bureau of Justice Statistics and the Office of Juvenile Justice and Delinquency Prevention (1996) reported similar numbers of incarcerated child sex offenders when, it found that 7 in 10 offenders incarcerated for crimes against children had committed acts of rape (4 in 10 for forcible rape) or sexual assault (8 in 10 for forcible sodomy). This study also revealed that 66.8 per cent (43,552) of all prisoners convicted of rape or sexual assault within the United States had committed offences against children (<18 years old), whilst 58.4 per cent had victimised a child aged 12 years old or younger.

2.1.2 New Zealand Statistics

Currently within New Zealand the format for recording child sex offences, together with recent legislative changes, makes it difficult to obtain an accurate estimate of the total number of child sex offenders currently within correctional facilities. The 1993

amendments to the Criminal Justice Act (1985) invoked changes to the release provisions for incarcerated individuals, which now stipulate that inmates are eligible for parole after serving one third of their sentence, provided the Parole Board or a District Prison Board deem it appropriate. These changes resulted in a dramatic and immediate drop in both the overall numbers of incarcerated individuals, as well as the number of child sex offenders.

Since 1992 the number of convictions for child sexual abuse has steadily increased to a high of 1,870 in 1994 (see Table 2). Figures for 1995 revealed a slight reduction in number, with 1,783 individuals being convicted. Over the four year period since 1992 there have been 7,013 individuals convicted of child sexual abuse.

As a percentage of the total (annual) convicted sex offender population, convictions for child sexual abuse continue to account for over 75 percent of all sexual offences. While as a percentage of the total annual convictions, child sex offence convictions increased from 1.38 percent in 1992 to a high of 1.42 per cent in 1994. The latest figure (1995) places the number of child sex offence convictions as a percentage of the total annual convictions at 1.38 per cent.

These data also show that the number of child sex offenders who received a custodial sentence, as a percentage of the total number of custodial sentences, increased from 15.2 per cent in 1992 to 18.3 per cent in 1994. In 1995 child sex offenders accounted for 17.7 per cent of all offenders who receive a custodial sentence in New Zealand. One final point of interest illustrated by these data is that the average custodial sentence length for sexual offences increased from 40.3 months in 1992 to 47.3 months in 1995.

TABLE 2: Convictions for Sexual Offences Against Children

			1992[6]	1993[7]	1994[8]	1995[9]	TOTAL
Total Number of Convictions [1]			114215	126629	131901	129017	501762
Total Number of Sex Offence Convictions [2]			1962	2304	2371	2313	8950
Convictions for Child Sexual Abuse Committed Against:							
	Male	< 12 Years	165	191	208	165	729
		12 - 16 Years	168	108	146	150	572
	Female	< 12 Years	766	892	919	784	3361
		12 - 16 Years	421	527	529	634	2111
	Unknown		52	70	68	50	240
Total Number of Child Sexual Abuse Convictions[3]			1572	1788	1870	1783	7013
Child Sexual Abuse Convictions as a % of Total Sex Offence Convictions			80.12	77.60	78.89	76.13	78.19
Total Convictions which resulted in Custodial Sentence			8432	9020	8332	8231	34015
% of Total Sex Offence Convictions which resulted in a Custodial Sentence			77.50	75.83	73.00	71.00	74.33
% of Child Sexual Abuse Convictions which resulted in a Custodial Sentence[4]			81.60	--	--	--	--
Child Sex Offence Sentences as a % of total Sentences[5]			15.2	16.2	18.3	17.7	16.8
Average Custodial Sentence Length (in Months) for All Offences			12.2	12.5	13.6	14.0	13.1
Average Custodial Sentence Length (in Months) for Sexual Offences			40.3	38.3	45.9	47.3	43.0

Notes:

(1) Convictions for all offences except traffic offences.

(2) Sexual Offences include, rape, unlawful sexual connection, attempted sexual violation, indecent assault, incest, unlawful sexual intercourse attempted unlawful sexual connection, anal intercourse and doing indecent acts with or upon another person.

(3) Each charge that resulted in a conviction is counted separately, therefore offenders convicted of multiple offenders may inflate the actual number of convicted individuals.

(4) This figure could only be calculated for 1992 due to the change in the way data is recorded.

(5) Given that figures have changed little in the past four years (Spier, 1996) figures were based on the 1992 figure for % of Child Sex Abuse convictions which resulted in custodial sentence.

(6) Adapted from Spier and Norris, (1993).

(7) - (9) Adapted from Spier, (1994), (1995), (1996) respectively.

What the foregoing review demonstrates, is that despite the claim that only 6 per cent of child sex abuse cases are ever reported, child sex offenders account for a large proportion of the individuals convicted of sex crimes, both in New Zealand and abroad. Furthermore, within New Zealand a substantial percentage of child sex offence convictions result in a custodial sentence. As a consequence of this high sentencing rate, New Zealand's correctional service has a large number of child sex offenders under its jurisdiction. In fact within New Zealand, child sex offenders account for a higher percentage of incarcerated individuals than is evidenced in American, Canadian, or Great Britain's prisons.

2.2. Classification

To date, the majority of research with respect to child sex offenders has been conducted on institutionalised or convicted individuals. As a result, it is plausible that contemporary research is not truly representative of the broader child sex offender population. Despite such limitations, and in light of the heterogeneity witnessed in this population, extensive theorising and empirical investigation has been directed toward developing a classification system for child sex offenders.

Early research saw Karpman, (1954) distinguishing between child sex offenders who exhibited a stable erotic preference for children, and those who saw children as substitutes for peer sexual partners. Incorporating this postulate into his theoretical works, Groth (1978) advanced a psychoanalytic theory of child sex offending which held two offender types at its core. Later work saw Groth and his colleagues (Groth & Birnbaum, 1978; Groth, Hobson, & Gray, 1982) take the theory further by postulating two dichotomous groups of offender (fixated and regressed), each of which presented with a distinct set of characteristics.

To quote Groth and Birnbaum (1978);

> ""Fixation" is defined as a temporary or permanent arrestment of psychological maturation resulting from unresolved formative issues which persist and underlie the organisation of subsequent phases of development. A fixated offender has from adolescence been sexually attracted primarily or exclusively to significantly younger persons. Sexual involvement with peer-age or older persons, where this has occurred, has been situational in nature and has never replaced the primary sexual attraction to and preference for underage persons" (p.176).
>
> ""Regression" is defined as a temporary or permanent appearance of primary behaviour after more mature forms of expression had been attained, regardless of whether the immature behaviour was actually manifested earlier in the individual's development. A regressed offender has not exhibited any permanent sexual attraction to significantly younger persons during his sexual development - if any such involvement did occur during adolescence, it was situational or experimental in nature. Instead, this individual's sociosexual interests have focused on peer-age or adult persons primarily or exclusively" (p.177).

The main problem with respect to a regressed/fixated classification of child sex offenders stems from its underlying assumption of two dichotomous groups. Simon, Sales, Kaszniak, and Kahn's (1992) research revealed that the criteria for defining fixated and regressed offenders produced a unimodal and continuous distribution rather than the bimodal, discrete distribution advanced by Groth's theory.

Other traditional classifications utilised a variety of offence related variables to categorise offenders. Langevin (1983) contended that child sex offenders could be categorised by the gender of their victim. With the underlying assumption that male child sex offenders who abuse boys are basically homosexual in orientation, a homosexual/ heterosexual classification system was advanced. This classification system also proved limited in application when it firstly failed to account for the large proportion of offenders who, although abusers of boys, did not hold adult homosexual preferences. Secondly, it proved inadequate in the categorisation of those offenders who presented with an indiscriminate sexual preference for children in general.

A more contemporary approach to child sex offender classification is that adopted by the American Psychiatric Association. The latest edition of the Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV) advances a diagnosis of pedophilia. Used to define a specific type of sexual disorder, a classification of pedophilia is also accompanied by several sub-classifications with respect to the nature of the sex offences. (see American Psychiatric Association, 1994).

The most often cited of the contemporary classification systems for child sex offending is that postulated by Howells (1981). Acknowledging the complexity and importance of classification, Howells advanced the atheoretical terms of 'Situational' and 'Preferential' offender. Stressing the inevitable oversimplification and inaccuracy of a bimodially dichotomous approach, the two types (or more accurately 'prototypes') of child sex offender are better viewed as extremes on a single continuum, than as discrete categories.

2.2.1 Preferential Child Sex Offenders

The preferential sex offender is characterised by a primary sexual orientation toward children, and is relatively disinterested in adult partners for either sexual or emotional gratification. Deviant fantasies and sexual behaviour begin early in life and persist across the life-span. The target of this deviant behaviour is usually male children, whose role is as a substitute for a peer female partner. Offender's are usually unmarried, with marriage, and/or other heterosexual relationship, often being a front for access to potential child victims.

The preferential offender is seen to carry with him a set of ingrained offence supportive beliefs, viewing sexual contact with children as not only appropriate (Johnston & Ward, 1996), but also desired by children. Furthermore, the offender often

feels they are being unfairly persecuted by a society which is disallowing them to meet their needs (Barbaree, 1990; Howells, 1981).

With their deviant behaviour not violating personal morals or rules of conduct, performing the often premeditated sexual acts becomes less of an obstacle. Ward, Hudson and Marshall (1995) contended that because of these ingrained beliefs the offender is less likely to show signs of remorse, guilt, or embarrassment both during and after the offence. Hence, they are more likely to admit to the offensive behaviour and continue future offending.

2.2.2 Situational Child Sex Offenders

In contrast to the preferential offender, the situational child sex offender usually begins offending later in life and has a vested sexual and emotional interest which is unmistakably peer related. Situational offenders are generally seen to have a more-or-less normal history of heterosexual and heterosocial development. Victimisation is believed to constitute an impulsive, non premeditated act that is often associated with instances of life stress or situational convenience (Howells, 1981; Marshall & Barbaree, 1990; Simon, Sales, Kaszniak, & Kahn, 1992).

Cognitive factors are seen to play a facilitative role in the situational offenders aberrant behaviour. The loss of cognitive control, coupled with conflict arising from thoughts and behaviours which are inconsistent with their belief system, results in deviant sexual behaviours that are viewed as both abnormal and problematic by the offender (Barbaree, 1990; Howells, 1981).

Furthermore, as suggested by Johnston and Ward (1996), the situational child sex offender often experiences difficulty coming to terms with committing an act they previously deemed repugnant. As a consequence, this group of child sex offender

usually suffers high levels of guilt and contrition, thus resulting in a greater likelihood of offence denial.

Although early attempts to classify child sex offenders proved limited in their application, what the above research suggests, is that more contemporary classification systems do provide a means to categorise this heterogeneous population. However, within such a framework, it is also important to accept the potential for diversity, with respect to an offender's personal disposition.

2.3. Characteristics of the Perpetrator

The demographic characteristics of the child sex offender have been extensively documented (Ballard, Blair, Devereaux, Valentine, Horton, & Johnson, 1990; Bureau of Criminal Justice Statistics, 1996; Drugge, 1992; Finkelhor, 1986, 1991, 1994; Finkelhor, Hotaling, Lewis, & Smith, 1990; Freund & Watson, 1992; Gomes-Schwartz, Horowitz, & Cardarelli, 1990; Harry, Pierson, & Kuznetsov, 1993; Holmes, 1991; Martens & Daily, 1988; Williams & Finkelhor, 1990). It is generally accepted that the majority of perpetrators are male (90-96%), many are or have been married, and most (85-90%) are known to their victim. Furthermore, a substantial proportion of convicted offenders are of average or below average intelligence, in their 20's or 30's, and are predominantly white.

These aforementioned variables, although useful in offender classification, are superficial and reveal little of the underlying causes of such behaviour. Researchers have posited numerous other features shared by child sex offenders, many of which (e.g., denial, minimisation, passivity and victim blaming) constitute psychological processes involving the displacement of, and the avoidance of negative affect.

Valliant and Antonowicz (1992) noted, that the child sex offender is a socially alienated individual with low self-esteem and an anxious, insecure personality. Bownes (1993), Marshall (1989) and Meyer (1989) have all suggested that these individuals show significant difficulties in developing interpersonal relationships resulting in emotional loneliness. Research by Garlick (1991) and Seidman, Marshall, Hudson and Robertson (1994) not only confirmed the lack of intimacy among child sex offenders, but also demonstrated that they blamed women for such intimacy and loneliness problems. Studies by Abel and Rouleau, (1990) and Briggs, (1993) have also shown that the child sex offender often participates in multiple paraphilic behaviours including, bestiality, exhibitionism, voyeurism and child pornography.

Coupled with the former, numerous other variables, such as attachment problems, (Marshall, 1993; Marshall, Hudson, & Hodkinson, 1993; Ward, Hudson, & Marshall, 1996; Ward, Hudson, Marshall, & Siegert, 1995) assertiveness problems, (Marshall, Barbaree & Fernandez, 1995) low self confidence, (Marshall & Mazzucco,1995), varying degrees of psychopathy, (Kalichman, 1991; Serin, Malcolm, Khanna, & Barbaree, 1994; Shealy, Kalichman, Henderson, Szymanowski, & McKee, 1991) and a range of personality deficits (Brad & Knight, 1987; Carpenter, 1995; Kalichman, Dwyer, Henderson, & Hoffman, 1992; Panton, 1978; Schlank, 1995) not only characterise the sex offender, but may facilitate their deviant behaviour. In general, the child sex offender is seen as deficient in the psychological and psycho-social skills needed to function adequately in contemporary society.

Three of the most documented factors, and those characteristics which are most applicable within the present context, are the child sex offenders dysfunctional cognitions or distortions, their extensive use of denial, and their often reported empathy deficits. Acknowledging that these variables are by no means independent, for convenience, each

will be discussed separately. What follows is a review of the literature pertaining to each, and how each impinges on, and influences, the child sex offenders deviant sexual behaviours.

2.3.1. Cognitive Dysfunction's/Distortions

The most researched aspect of child sex offender functioning are the cognitive distortions and dysfunctional attitudes and beliefs evidenced in their personality, (Alaska State Department of Corrections and Charter North Hospital, 1994; Bumby, 1996; Hanson, Gizzarelli, & Scott, 1994; Howells, 1981; Johnston & Ward, 1996; Marshall & Eccles, 1991; Murphy, 1990; Neidigh & Krop, 1992; Robinson, 1989; Segal & Stermac, 1990; Stermac & Segal, 1989; Valliant & Antonowicz, 1992; Wakefield & Underwager, 1991; Ward, Hudson, Johnston, & Marshall, in press). Numerous researchers have noted the importance of such factors in the initiation, maintenance, and justification of sexual offending. Johnston and Ward (1996) have also argued that understanding the dynamics of such maladaptive behaviours plays a pivotal role in developing effective programs for treating the child sex offender.

If one is to fully comprehend the cognitive distortions which manifest in the child sex offender, one requires insight into the various levels on which such cognitive processes operate. At the most fundamental level, *cognitive structures* (e.g., schemata) represent the organisation of memory content and the various associations between stored features of memory. *Cognitive propositions* are the actual information that is stored in the various cognitive structures, while *cognitive operations* are the processes (e.g., attention allocation, encoding, control processes) by which the components of the information processing system operate. The final variable is that of the *cognitive product.* Cognitive products are the actual thoughts, attributions and self-statements which result from information input and cognitive structure, proposition and operation interaction. In

light of the focus of contemporary research on the latter of the four variables (i.e., cognitive product), Johnston and Ward (1996) raised the important point that sex offenders may differ from non-offending populations in one, some, or all, of these components.

Within the present context, cognitive products refer to the pre- and post-offence self-statements, (that is, offence-supportive attitudes or beliefs) which allow the offender to deny, minimise, justify, and rationalise their deviant sexual behaviour. Seen not as a direct causal mechanism, but instead as an integral maintenance component, these distortions serve in the avoidance of self-reproach, (anxiety, guilt and loss of self esteem) which stems from conflicting norms and societies disapproval of the offenders' behaviour. Consequently, through the avoidance of self condemnation, an offender's behaviour goes uninhibited and its significance minimised, hence the chance of continued offending is increased.

Stermac and Segal (1989) postulated that in order to fully understand the role cognitions play in adult sexual contact with children, it is necessary to systematically investigate and compare the beliefs and attitudes of the child sex offender with those of other groups. Some of the most frequently identified beliefs include;

a) Children not only enjoy sexual encounters with adults but eagerly seek, and in some cases initiate such contact.

b) When a child does not tell about sex with an adult, its because they want it to continue.

c) If a child asks about sex it means they want to have sex with the person they ask.

d) When a child wears little or no clothing around an adult male, and when they sit in a manner that exposes their underwear it is indicating that they want to have sex with him.

e) Children are both sexually seductive and provocative.

f) Having sex with a child is not a betrayal of my wife.

g) When engaging in sexual acts, passivity on the part of the child is an active agreement to participate in the behaviours.

h) Children frequently falsely accuse men of sexual assault.

i) If a man is gentle, affectionate and does not use force, sexual contact between adults and children does not cause any real harm, unless the authorities or parents make a fuss about it.

j) Sex with children is legally wrong but it is really morally 'OK'.

Together with the above beliefs, child sex offenders are seen to endorse a number of other abuse supportive attitudes and beliefs. Potentially the most destructive of which, is the belief that children are not only informed about and can consent or refuse sex with adults, but also, that the child is under no external pressure when making such judgements. Secondly, because sexual abuse is deemed consensual by the perpetrator, the social sanctions against such contact are viewed as arbitrary, and therefore, they view their behaviour as not requiring punishment.

One final belief that reinforces a sex offender's behaviour, especially the pedophile, is the notion that early sexual experiences for children are not only a healthy component of development, but they are educationally beneficial. Hence, because the child sex offender sees himself as providing a service, either by teaching the child about sex, or providing physical affection to a deprived child, he is less likely to discontinue his offending.

2.3.1.1 Comparing Cognition's

To gain a more complete understanding of the dysfunctional cognitions held by child sex offender requires a comparison between this group and other offending and non offending populations. Working toward this goal, several attempts have been made to design psychometric tools for evaluating the nature of the child sex offenders

dysfunctional attitudes and behaviours (Wilson Sexual Fantasy Questionnaire: Wilson, 1978, 1978a; Cognitions Scale: Abel, Becker, Cunningham-Rathner, Rouleau, Kaplan, & Reich, 1984; Hanson Sex Attitudes Questionnaire: Hanson, Gizzarelli, & Scott, 1994; The Molest Scale: Bumby, 1996; Multiphasic Sex Inventory and Multiphasic Sex Inventory II: Nichols & Molinder, 1984, 1996).

Using the Cognitions Scale, Gore (1988) found that child sex offenders were significantly more likely to view children as seductive, wanting adult sexual contact and being able to consent to such activities, than were other groups of sex offenders and 'normals'. This finding was mirrored in Wakefield and Underwager's (1991) research when, they to reported, that the Cognitions Scale distinguish between incest offenders and comparison groups who had no identified history of sexually abusive behaviour.

Abel, Gore, Holland, Camp, Becker, and Rathner's (1989) research, added weight to the aforementioned findings, when they investigated whether child molester paraphiliacs could be distinguished from non-child molesting paraphiliacs, and non-paraphiliacs. The results of the study verified the utility of the Cognitions Scale in discriminating child sex offenders, when it uncovered significant differences in deviancy levels between the molester sample and the other groups. Despite the positive findings, Abel et al. (1989) cautioned against drawing to stronger conclusions, as they believed the scale was in need of refinement. Specifically, the Cognitions Scale was deemed too long, too transparent, and in need of reverse keyed items.

Coupled with the foregoing limitations, the aforementioned research has its counterpoint in a study by Stermac and Segal (1989). In their research of 186 subjects across 6 respondent groups, Stermac et al. demonstrated that although the Cognitions Scale differentiated offenders from non-offenders, it failed to distinguish between the various sex offender populations.

In 1994 Hanson, Gizzarelli, and Scott devised the forerunner to the Sex Attitude Questionnaire (Short version). Constructing six scales measuring sex offender attitudes, Hanson, et al. administered the Hanson-SAQ to 100 incarcerated men (50 male incest offenders, 25 male batters and 25 non treatment men). The study both confirmed the existence of a unique set of beliefs and attitudes held by child sex offenders, as well as extending previous research by pioneering the empirical documentation of the cognitive distortion now termed 'sexual entitlement'.

Hanson, Gizzarelli, and Scott (1994) contended that these results supported the notion that child sex offenders are egocentric, uninhibited individuals who believe their own sexual impulses must be fulfilled. Furthermore, they saw the child sex offender as actively seeking out opportunities to abuse in times of sexual arousal.

The most recent study to advance a psychometric measure of child sex offender distortions is that advanced by Bumby's (1996) assimilation of existing cognitive scales. Proving a reliable and valid measure of sex offender distortions, the Molest Scale was found to discriminate child sex offenders from rapists and non-sexually assaultive inmates. Finding consistency with previous research, the results of Bumby's study concluded that child sex offenders hold more distorted beliefs about the acceptability of sexual activity with children.

A further important finding reported by Bumby was that the endorsement of items on the Molest Scale was positively correlated to the number of past victims and the length of time an individual had been offending. This finding has extensive significance in the aetiology of an offender's distortions, as it indirectly implies that a child sex offender's dysfunctional attitudes and beliefs are 'learned'. That is, they develop as the offender tries to manipulate his beliefs in order to rationalise and justify his aberrant behaviour.

If not self evident, what the above research suggests, is that the beliefs and attitudes held by child sex offenders in relation to children, both in sexual and non-sexual contexts, are different from those endorsed by non-child sex offenders, and non-offending populations. Whether this difference represents a dysfunction in the underlying cognitive structure (schemata), which facilitates the construction of these distorted perceptions, is yet undetermined. However, at this point it is imperative that a better understanding of the contributory role such cognitive factors play in the initiation and maintenance of adult/child sexual contact is obtained

2.3.2. Denial

Common sense allows one to assume that only a small proportion of child sex offenders who deny their offence/s are incorrectly convicted. Many perpetrators simply lie, while a small percentage actually convince themselves that they are innocent. As has been argued (Barbaree, 1991; Jackson & Thomas-Peter, 1994; Marshall, 1994; Shaw & Schlank, 1992; Ward, Hudson, & Marshall, 1995), most sex offenders present with some level of distortion in regard to their past sexual deviancy.

Viewed as a self protective process, this distortion, most commonly denial, minimisation and/or justification, acts to reduce the level of guilt arising from an offenders behaviour. In the case of the child sex offender, where the abuse is even more socially unacceptable than offences against older victims, denial and minimisation may also serve to avoid punishment.

2.3.2.1 Conceptual Framework for Denial

In responding to the processes of denial and minimisation, it is important to develop a broad conceptual framework from which explanations of an offender's distorted views can be advanced. Numerous researchers (Alaska State Department of Corrections,

1994; Barrett, Sykes, & Byrnes, 1986; Hoke, Skyes, & Winn, 1989; Kennedy & Grubin, 1992; Langevin, 1988; Pollock & Hashmall, 1991; Salter, 1988; Trepper & Barrett, 1989) have posited theoretical conceptualisation of denial, with early investigators opting for a categorical approach.

Barrett, Sykes, and Byrnes (1986), Trepper and Barrett (1989), and Hoke et al., (1989) all saw denial comprising of seven overlapping, yet distinct, types. That is; denial of fact, denial of awareness, denial of impact, denial of responsibility, denial of grooming oneself and the environment, denial of deviant sexual arousal and inappropriate sexualisation of non sexual problems, and denial of denial.

Similarly, Langevin (1988) described five types, or more correctly 'degrees' of denial. In so doing denial was conceived as 'stages' on a continuum of offender admission. At one extreme was full admission of past and present offending (whether convicted of previous offences or not), while at the other was absolute denial. Intermittent degrees of denial involved admitting the offence but denying anomalous sexual preferences, admitting the offence and anomalous sexual preferences but claiming special circumstances, and denying the offence but admitting anomalous sexual preferences. This categorisation was mirrored in Kennedy and Grubin's (1992) research when they proposed four groups. That is, admitting the offence but denying it caused harm; externalisers; internalisers; and absolute denial.

Salter (1988) also suggested there was a 'spectrum' of denial. Emphasising its complexities, a six 'level' continuum was advanced rather than a single state. Like many of her fellow researchers, Salter's conceptualisation was bounded by the extremes of complete admission and outright psychological denial. The interim levels included admission with justification, minimisation of the extent of the behaviour, physical denial of the act, denial of the seriousness, and denial of responsibility.

An important distinction made by Salter was that between physical and psychological denial. The former is seen as denial of the 'specifics'. That is, denying a certain behaviour on a given day at a particular time and place. Such denial arises as the perpetrator focuses on specific detail rather than the overall charge or offence. In contrast, psychological denial is where the offender denies the overall charge of sexual abuse. Hence, because the 'psychological denier' does not accept such activity took place they are often outraged by the accusation and see no reason to change an abusive behaviour they deny exists.

An intriguing approach to categorising the denial evidenced in child sex offenders was that advanced by Pollock and Hashmall (1991). In their study of 86 male child molesters aged between 16 and 73 years (mean 37.4), Pollock et al., developed an 'excuse syntax' to define the structure and justification themes for an offenders explanatory statements. From over 250 statements provided by the offenders, 21 excuses were identified in six thematic categories (mitigating factors: situational; sex with children is not wrong; incident was non-sexual; mitigating factors: psychological; blaming the victim; denial). These categories were utilised in the construction of a hierarchical excuse syntax (see Figure 1) where each branch represents a dichotomous choice of excuse, and each end-point describes a qualitatively different level of denial.

Therefore Pollock and Hashmall construed denial as a continuous, five stage process, ranging from denial of fact (nothing happened) at the top, to denial of self determination (something happened and it was my idea and it was sexual and it was wrong but there were extenuating factors) at the bottom. Intermediate steps on the decision tree include, denial of responsibility, denial of sexual intent, and denial of wrongfulness.

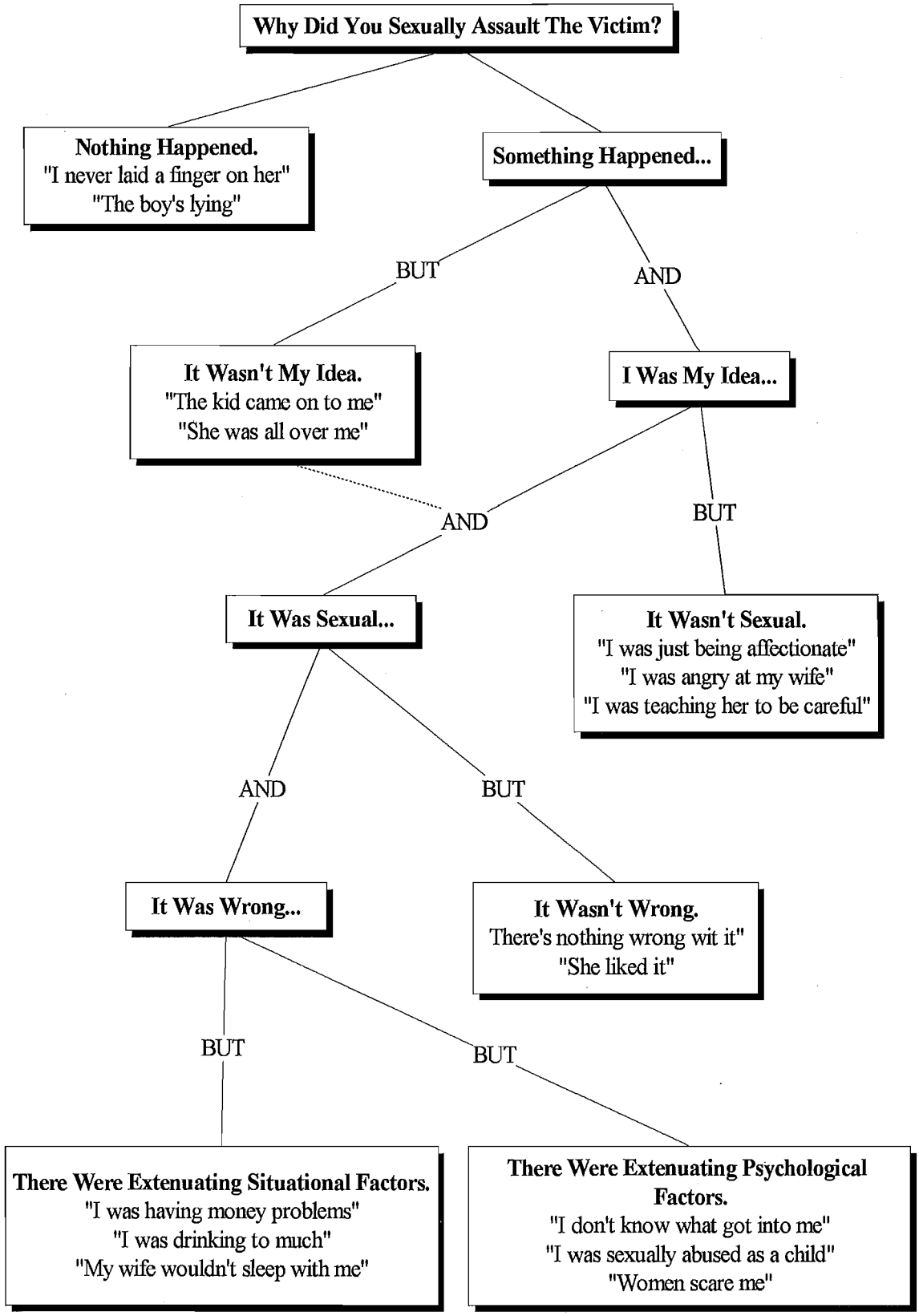


FIGURE 1: Child Sex Offender Excuse Syntax. Source: Pollock and Hashmall, (1991).

The utility of such an approach is seen in its ability to measure the degree of defensiveness in the perpetrator (by counting the number of thematic categories). From here, the researchers argue it is only a short step to quantify such judgements and devising a simple responsibility index.

2.3.2.2 Characteristics of Denial

As one offender explained, "there is nothing wrong with what I did. It's just illegal, that's all. But there's nothing wrong with it" (Salter, 1988 p.124). This response illustrates the extensive diversity of the dysfunctional attitudes and behaviours evident in the denial process.

Many offenders minimise the nature, extent and coerciveness of their behaviours, admitting responsibility in part, but blaming the majority of their behaviour on external factors. Maletzky (1996) noted that offenders often choose only to divulge a limited number of abusive acts or a single victim. Similarly, Ward, Hudson and Marshall (1995) noted that regardless of whether an offender initially admits guilt, or whether the individual is persuaded to admit to their offending, they typically maintain their offending was not as extensive or severe as others claim.

Barbaree (1991) reported that 66 per cent of his sample of child sex offenders were in denial, while a further 33 per cent minimised their offending. Marshall (1994) reinforced these findings when two judges where used to independently rate (95% agreement) the level of denial and minimisation in 81 incarcerated child sex offenders. Results demonstrated that outright categorical denial was evident in 31 per cent of the sample, while 32 per cent of the child sex offenders minimised their role in the offence.

A further feature which dominates the process of denial is the widespread inability of child sex offenders to accept responsibility for their offending. Researchers have demonstrated that in displacing culpability, perpetrators allude more toward the victim

and other individuals, or to either factors outside ones control which impinge on better judgement or an intermittent lapses in their current state, than to oneself (Gocke, 1991; Maletzky, 1996; Marshall & Barbaree, 1989; Stermac & Segal, 1989; Taylor, 1972)

One final problem often evidenced in child sex offenders is their inability to acknowledge that a problematic behaviour exists. Maletzky (1996) contended that many offenders have the utmost difficulty acknowledging that the satisfaction of a sexual urge was responsible for their behaviour. While many others consistently present with notions of 'I did it but I am not a sex offender' or 'I did it but I will never do it again' (Alaska State Department of Corrections and Charter North Hospital, 1994).

2.3.2.3 Impact on Treatment

The degree to which a child sex offender denies or minimises his abusive behaviour is often believed to reflect his motivation for treatment (Winn, 1996). A number of researchers (Kennedy & Grubin, 1992; Marshall, 1994; McGrath, 1991; Winn, 1996) have suggested that because of such denial many offenders are refused access to, or are dismissed soon after entering, sex offender treatment programs. As a result, all to readily the doctrine of 'you cannot treat a client unless they want to change' is invoked.

In light of Schlank and Shaw's (1996) claim that therapists are continually faced with a large number of absolute deniers, together with Schwartz (1992) contention that the first task in treatment is to break down denial and assist the perpetrator in acknowledging they have problems managing their sexuality, questions have been raised as to whether complete deniers are mutable to treatment.

Responding to such questions, Maletzky and his colleges argue in the affirmative. It has been shown that over 60 per cent of the absolute deniers who enter treatment admit something by the end of a cognitive/behavioural group and individual treatment program (Maletzky & McFarland, 1995). Similarly, men in total denial who completed treatment

were safer at large than those who admitted their complicity yet never completed treatment (Maletzky, 1991, 1993; Maletzky & McFarland, 1995; Winn 1996).

The contemporary re-emergence of denial as a focal point in the investigation of the child sex offender denotes its importance. Despite categorically denying any and all sexually deviant behaviours, these perpetrators are as much, if not more, in need of treatment, than are those who admit their offending. Furthermore, as the research demonstrates, not only do these individuals deserve treatment, but they also show extensive benefits from participation. To quote Maletzky (1996), "denying a crime is natural; to deny treatment to those who deny is a crime itself." (p.4).

2.3.3. Empathy Deficits

Of all the characteristics expressed by the child sex offender, empathy (or more specifically empathy deficits) is perhaps the most contentious, ill defined and poorly validated. A frequently cited variable in child sex offending (Abel, Gore, Holland, Camp, Becker, & Rathner, 1989; Finkelhor, 1984; Finkelhor & Lewis, 1988; Gilgun & Connor, 1989; Hanson & Scott, 1995; Langevin, Wright, & Handy, 1988; Hildebran & Pithers, 1989; Marshall & Barbaree, 1989; 1990; Marshall, Hudson, & Jones, 1992; Marshall, Hudson, Jones, & Fernandez, 1995; Marshall, Jones, Hudson, & McDonald, 1993; Marshall, O'Sullivan & Fernandez, 1996; Pithers, 1993; Stermac & Segal, 1989; Ward, Hudson, & Marshall, 1995; Williams & Finkelhor, 1990), empathy is seen by most as a critical etiological and maintenance component in sexual assault.

Although researchers have trace empathy as far back as Smith, a Scottish economic philosopher of the 1750's (Marshall, Hudson, Jones, & Fernandez, 1995), to do so only complicates things. Early theoretical conceptualisations (Davis, 1983; Williams, 1990), despite holding face validity, were based on highly theoretical assumptions, which when empirically tested produced equivocal results. Stemming from this early definitional

disagreement, current dilemmas have resulted in a broadly conceived notion of empathy. Contemporary researchers advance a multidimensional approach, focusing on aspects of perspective taking (the capacity to accurately identify another persons emotional state in a particular situation), emotional response (the ability to mirror the perceived emotional responses of another), and care (having a vested emotional and psychological interest in another).

2.3.3.1 Reconceptualisation of Empathy

The latest reconceptualisation of empathy is that advanced by Marshall, Hudson, Jones, and Fernandez (1995). In their paper, Marshal et al., advocate that empathy is a continuous, but staged, process involving four components. That is, emotional recognition, perspective-taking, emotion replication, and response decision. What follows is a brief summary of what Marshall, Hudson, Jones, and Fernandez (1995) construe as empathy, and how it applies to the child sexual offender.

Stage one in the empathy process necessitates an ability to perceive and accurately discriminate the emotional state of others. Marshall et al., argued that if an individual is unable to discern the emotional distress of another, then the remaining stages of the empathic response would be blocked, allowing for the continuation of an offensive behaviour. Thus if the child sex offender is unable to recognise the resultant negative emotional state caused by his actions, it would be impossible for them to 'feel' or experience the impacts of such abuse.

The second stage involves perspective-taking, that is, the ability to put oneself in the observed person's place, experiencing the world as they do. If a child sex offender can accurately perceive and experience the world as viewed by their victim it forces them to recognise the unpleasantness of their sexual act/s. Hence it may inhibit the continuation of an act that is now seen by the offender as hurtful to the child. However, it has been

argued that men who consistently victimise a particular group (such as children) may view the members of this group as significantly different from themselves and thus they may be unable, or find it difficult, to adopt the perspective of their chosen victim.

The third stage of empathy, as conceived by Marshall et al., is emotional replication. That is, an individual must have an ability to replicate (or nearly replicate) the emotional responses of a target person. Such a process is not only pre-empted by the ability to recognise that emotion (Stage 1) and to adopt the perspective of that person (Stage 2), but also requires that the individual has the emotional capacity and repertoire to do so. Therefore if the child sex offender has a limited emotional range, it is plausible that they are unable to accurately label, or replicate, the emotional responses expressed by their victim.

Finally, empathic responding requires what Marshall et al., termed 'response decision'. Response decision involves an individuals conscious and/or automatic decision to act or inhibit their behaviours based on their feelings. Even if the child sex offender has sufficient abilities in all the previous stages, it is still possible that they will fail to react to, or have an ability to suspend or dissociate themselves from, such processes.

It is plausible that the empathy deficits evidenced in child sex offenders could stem from deficiencies in one, some, or all of these stages. Hence the child sex offender could block or be unable to recognise their victims distress (Stage 1), refuse or be unable to adopt the victims perspective (Stage 2), inhibit their emotional responding or be unable to replicate the child's emotions (Stage 3), or decide not to change the behaviour that is causing the victim's distress (Stage 4).

2.3.3.2 Characteristics of Empathy

Despite the diversity of both theoretical discussion and empirical investigation, as yet what best constitutes empathy still eludes the researcher. Is it a stable or situational characteristic? Is it a generalised or specific deficit? How should it best be measured? These questions, along with numerous others, have only compounded the already extensive confusion within the empathy literature.

In an attempt to answer the aforementioned questions, research by Gilgun (1988) concluded that a child sex offender's self-centredness impedes the possibility of experiencing empathy for others during the abusive act. Similarly, a later study which utilised life history interviews (Gilgun & Connor, 1989) suggested that child sex offenders tended to view their victims as objects, focusing primarily on their own pleasure and satisfaction.

This lack, or inability to empathise with the victims experiences was mirrored in Williams and Finkelhor's (1990) review of the characteristics of incestuous fathers. Here too it was concluded that child sex offenders were impaired in their capacity for empathy or bonding.

A study which addressed whether empathy deficits in sex offenders are a situational or stable characteristic was conducted by Hanson and Scott (1995). In their research, Hanson et al. demonstrated that empathy deficits were not evidenced in all types of deviant sexual interaction, but instead were expressed only in those situations which closely resembled an offender's own offensive behaviours. It was also shown that such empathy deficits are not apparent in all aspects of an individual's life, but rather an offenders empathetic abilities vary across circumstance. Thus, in times of sexual arousal, intoxication, or anger, a sex offender may experience a decrease in empathic ability.

Arguably, one of the most researched and contested notions in the empathy literature is the extent to which such deficits present themselves in the sex offender. It is generally accepted that child sex offenders are deficient in empathy, although some (Johnston & Ward, 1996) contend that offenders do not necessarily lack the capacity to empathise with their victims, but rather they unconsciously seek evidence which supports distorted attitudes and beliefs.

The point raising considerable theoretical and empirical debate is whether these empathy deficiencies constitute a generalised or specific deficit. Marshall, Hudson, and Jones (1992) advanced, that, the sex offender may suffer from an inability to feel empathy for anyone, or their deficits may be more specific and restricted to a class of potential victim (i.e., children), a class of actual victims, or only toward the offenders own victim/s.

Many authors who advance empathy deficits in child sex offenders, do so with an assumption that such deficits are generalised and manifest toward everybody. Finkelhor and Lewis (1988) posited that it is an offenders inability to be empathic toward children in general, which allows the child sex offender to abuse their victim. This finding was supported by Marshall, Jones, Hudson, and McDonald, (1993) when they examined a group of outpatient child sex offenders, who were also found to demonstrate a generalised lack of empathy. A further study which strengthened this assumption was that by Abel, Mittelman and Becker, (1985) when they to found that offenders displayed a generalised deficit in empathy.

An investigation by Hudson, Marshall, Wales, McDonald, Bakker, McLean (1993) into the emotional recognition amongst child sex offenders revealed that these individuals were significantly more deficient in their ability to recognise emotional displays in both adults and children, than were other sex offenders and non-sexual offending populations.

This research also demonstrated that no differences existed in a child sex offenders ability to determine the emotional states of adults or children. Based on their findings Hudson et al., concluded that, contra to expectations, child sex offenders have a more generalised emotional recognition deficit.

In contrast to the generalised conception of sex offender empathy, other researchers (and contradictory evidence advanced by the foregoing experimenters) have argued that the child sex offenders empathy deficits are more specific in nature. Abel, Gore, Holland, Camp, Becker, and Rathner (1989) concluded that, the apparent lack of empathy in child sex offenders is clearly victim-specific, or limited to the class of potential victims. This claim was mirrored in Ward, Hudson, and Marshall's (1995) cognitive deconstruction paper, in which it was argued that the expected empathy deficits among sex offenders are not a broad based personality deficit. Instead, a cognitive deconstructive view sees empathy deficiencies as more person-specific, restricted to the offender's victim/s.

A recent study by Marshall, Fernandez, Lightbody, and O'Sullivan (1994) constructed and utilised a measure aimed at testing a child sex offenders emotional recognition and empathy for child victims. Results showed that child sex offenders, as compared to non-offenders, had considerable deficits in their able to recognise the emotional state of a non-specific sexual abuse victim, while accurately identifying the emotions presented by a non-sexual child victim (i.e., a car accident victim). The study also demonstrated, that child sex offenders were significantly deficient in discerning the emotional states expressed by their own abuse victim/s.

What is evident from the limited and often contradictory evidence advanced from within the literature, is that empathy, as it applies to the child sex offenders, is an ill-defined and misunderstood notion. Currently, 91 per cent of all sex offender treatment

programs operating in the United States devote some effort to increasing an offenders' empathy for their victim (Freeman-Longo, Bird, Stevenson, and Fiske, 1995). Motivated by the assumption that increased victim empathy should inhibit offending and change the offenders apathetic approach toward their victims, the efficacy of such procedures are brought into question. If one has trouble formulating a standardised measure of such a concept, and at a more fundamental level, has difficulty advancing a universally agreed upon definition, how can one be expected to draw any concrete conclusions about the role empathy plays in child sexual abuse. Moreover, and of greater importance, how can the benefits of treating such deficits be established if the concept itself is continually evolving and under constant debate.

What the forgoing plethora of research demonstrates is that child sex offenders, like most populations, are heterogeneous in their makeup. Despite such diversity, as a group these individuals present with numerous attitudes, beliefs, cognitions and demographic characteristics in common. What is also evident is that these features, in many instances differ substantially from those evidenced in both non-sex offender and non-offending populations. Thus what continues to be of paramount importance is gaining a better insight into these features and how they impinge on a child sex offenders functioning.

CHAPTER III

Child Sex Offender Treatment:

The efficacy and cost-effectiveness of treating the child sex offender is a controversial topic, sparking often heated debate. On the one hand is society's need to inflict punishment and retribution on the wrongdoer. While contrary to such an approach are the, all to often noted, shortcomings of judicial punishment. Results of such debate often stem from society's adherence to the classical school of criminology, where crime deterrence is gained through severe retributive incapacitation for punishment. In adopting such beliefs, both the public and private sector have raised questions as to whether the child sex offender can firstly be treated, and secondly, whether these individuals are deserved of such 'humane' efforts.

With writers such as Perkins (1993) advancing that "sex offenders can never be cured, so why should we waste resources on providing treatment for them" and "treatment just gives sex offenders a lot of excuses for their inexcusable behaviour" (p. 170) it is no wonder that the early doctrine of 'nothing works' continues to hinder advancements within contemporary society.

This prevailing attitude, based on early methodologically flawed research, is all to often transformed into ideas that the child sex offender can not, meaning ever, be treated. Perhaps no more strongly evidenced than in Walker's (1989) conclusion "it is wishful thinking to believe that additional research is going to uncover a magic key that has somehow been overlooked for 150 years." (p. 231), this assumption of untreatability depicts a society that is ready to, or perhaps already has, given up on habilitating these individuals.

Before reviewing the literature on past and present treatment modalities, it is important to acknowledge that most successful treatment procedures are grounded in aetiological theory. In advancing this, the author intends to direct the readers attention elsewhere for theories of etiology. As space precludes a review that would do justice to

this body of literature, the reader is referred firstly to the writing of Finkelhor (1984, 1986; Finkelhor & Araji, 1986) for what some believe are the pioneering works in sex offender causation. Beyond these works exists a large body of research investigating the etiology of child sexual abuse. For a comprehensive review of this literature the reader is referred to Marshall and Barbaree (1990).

3.1. Historical Perspectives on Treatment

As with many things involving human nature, the early techniques for child sex offender treatment date back to traditional psychoanalysis. With the underlying assumption that child sexual abuse resulted from disruptions in personality dynamics, the early psychoanalytic approaches aimed to rework the disordered personalities of those limited few who received the private, individualised treatment.

With the advancement of behaviourism came what Wormith and Hanson (1991) termed the 'modern era' in sex offender treatment. Utilising the basic tenets of behaviourism (that is, learning through association) the early behavioural programs (Bond & Hutchinson, 1960; Bond & Evans, 1967; Stevenson & Wolpe, 1960) conceptualised sexual deviancy entirely in terms of motivational factors. Therefore, changing an individual's sexual preference was seen to be the key in alleviating the undesirable behaviour.

The 1970's and early 80's saw a consolidation of behavioural techniques with procedures such as satiation, aversion, and biofeedback being implemented to aid the reconditioning of a child sex offenders deviant sexual arousal. Around this time a number of controversial techniques were also developing in Europe under the umbrella term 'Bioimpedance' (Bloom, Bradford, & Kofoed, 1988). These procedures aimed to

control an offenders aberrant sexual behaviour through either surgical or neurosurgical techniques, or hormonal suppression.

3.1.1 Castration

The first of the more controversial techniques adopted for sex offender treatment was physical castration, that is, the surgical removal of the *testes*. Although considered barbaric in many contemporary societies, the procedure was widely used on a voluntary basis in Europe. Grounded in laboratory studies of inter-male animal aggression, it was postulated that sexual aggression in human males is regulated by testosterone levels. Hence, reducing testosterone levels was deemed the answer to reducing sexually aberrant behaviours.

Indeed three researchers (Hawke, 1951; Laschet, 1973; Sturup, 1961) reported that both heterosexual and homosexual aggression, along with an offender's sex drive, disappear once an individual has been castrated. Similarly, reviews of the outcome literature evidence dramatic reductions in sexual offending after castration (Heim, 1981; Langenluddeke, 1965 cited in Pallone, 1993), with a maximum of 7.4 per cent of men reoffending over a 20 year follow up period (Heim & Hursch, 1979).

Despite Bradford's (1990) claim that these studies provide the most comprehensive data on treatment outcome in the literature, Lanyon (1986) is one of many who have questioned the efficacy of such procedures. Citing methodological difficulties, such as a reliance on self reports and a lack of control data, the reported recidivism rates advanced for castration are not without their flaws. Similarly Marshall, Jones, Ward, Johnston, and Barbaree (1991) have raised concerns over the effectiveness of castration as a treatment procedure, when they noted that many of the men castrated were first time offenders who were far less likely to reoffend even if left untreated.

3.1.2 Psychosurgery

Perhaps even more dubious than castration, psychosurgery, as a form of treatment for sexual offending, involves the surgical destruction of the ventromedial hypothalamic nucleus. Despite rising concern over ethical merit, due to the poorly understood functioning of this specialised region of the central nervous system, hypothalamotomies were strongly advocated by a group of German surgeons (Roeder, Orthner, & Muller, 1972) in the late 60's and early 70's. Together with the limited, if non-existent, positive outcome dated from such procedures, Schneider and Schorsch's (1979) research demonstrated that surgical ablation of the hypothalamus often resulted in unexpected and irreversible changes in a persons temperament and intellectual functioning. Moreover, based on Muller, Roeder and Orthner's (1973) research summaries, Marshall, Jones, Ward, Johnston, and Barbaree (1991) concluded that failure rates of 26 per cent saw this psychosurgical procedure as no better off in treating child sex offenders than would be expected in the absence of treatment altogether.

3.1.3 Pharmacologic Interventions

Less controversial than the surgical options, the final technique assembled under the Bioimpedance umbrella are those considered pharmacologic. With an underpinning in the medical model's 'disease processes', the rationale for pharmacologic interventions' stems from animal research into the androgenic promotion of male sexual behaviour (Bradford, 1983). Termed 'Chemical Castration' by one researcher (Pallone, 1993), the pharmacological suppression of sexual behaviour (via hormone suppressing biochemicals) was pioneered at John Hopkins School of Medicine and became widely accepted and utilised throughout Western Europe in the mid-1960s.

Early attempts to suppress and alleviate aberrant sexual behaviour using biochemicals such as oestrogen, although successful, were overshadowed by the

undesirable and problematic side effect of feminisation (Symmers, 1968). Such negative effects prompted investigation in alternative biochemical agents which would produce the same androgenic-antagonist results without the undue side-effects.

Two of the more noteworthy contemporary pharmacologic agents are the anti-androgens, medroxyprogesterone acetate (MPA) and cyproterone acetate (CPA) (Bradford, 1990). Although at least one study has produced equivocal results (Wincze, Sudhir, & Malamud 1986), most researchers conclude that both MPA and CPA do produce a reduction in sexual aberrant behaviour (Bowden, 1991; Bradford & Pawlak, 1987; Cooper, 1986; Emory, Cole, & Meyer, 1992; Gagne, 1981; Ortmann, 1980). Together with MPA and CPA, other psychopharmacologic agents currently in use for the treatment of child sex offending include Prozac, Lithium Carbonate, Anafranil (Freeman-Longo, Bird, Stevenson, and Fiske, 1995) and Buspirone (Pearson, Marshall, Barbaree, Southmayd, 1992).

In light of the reported benefits of pharmacologic interventions, an important point must be raised when evaluating the success of this treatment modality. That is, although drugs are successful in reducing the strength of sexual arousal to inappropriate stimuli, the changes are only temporary. With the cessation of medication the decreased levels of inappropriate behaviour are seen to return to that evidenced prior to treatment. Such a concern is mirrored in Marshall, Jones, Ward, Johnston, and Barbaree (1991) assertions, when they advanced that the administration of antiandrogens should not be employed as a primary intervention for sexual offending. Instead, it was concluded that antiandrogens should be used in reducing excessively high sexual activity to more manageable levels. Hence, antiandrogens are deemed beneficial in treating child sex offenders if they are used for reducing recidivism among those at immediate risk of offence, or if their

purpose is to decrease excessive sexual activity in certain offenders, making them more responsive to other intervention procedures.

3.2. Contemporary Approaches to Treatment

Since the early intervention techniques for child sex offending there has been a proliferation in both the number and modality of treatment programs. A recent review of treatment providers in the United States (Freeman-Longo, Bird, Stevenson, & Fiske, 1995) revealed that 309 Residential, and 1,475 Community-based treatment programs are currently operating. These figures, up 284 on the previous review (Knopp, Freeman-Longo, & Stevenson, 1992), are almost three times that of the number of providers operating in 1986 (Knopp, Rosenberg, & Stevenson, 1986). Aimed not only at the adult sex offender (710), but also the juvenile (640) and child (390) offender, over 45 per cent (334) of the adult programs specifically target the male sex offender, while the remainder accept both male and female offenders.

Broadly categorised into nine treatment modalities (i.e.; cognitive-behavioural, relapse prevention, psycho-socio-educational, psychotherapeutic, family systems, sexual-addictive, behavioural, psychoanalytic and bio-medical) the extensive array of child sex offender treatment procedures currently available (over sixty in the United States [Freeman-Longo, Bird, Stevenson, & Fiske, 1995]) bear little resemblance to the historical, single component approaches.

Despite this program numerousity and modality multiplicity, all successful sex offender programs have similar treatment goals. These include; (1) getting the perpetrator to admit to and assume full responsibility for all sexually deviant behaviour; (2) helping the offender understand the impact that such behaviours have on the child victim; and (3) instilling, and/or working through the guilt and remorse that surrounds such sexually aberrant acts. Program co-ordinators also recognise the importance of

bringing the offender to understand the reasons and motives underlying their abusive acts, whilst emphasising the need to provide them with realistic strategies to cope with and prevent any reoccurrence of their sexually aberrant behaviour.

3.2.1. Institutional-Based Programs

It is generally accepted that incarceration alone does not prevent recidivism among child sex offenders (George & Marlatt, 1989; Lockhart, Saunders, & Cleveland, 1988; McGrath, 1991). In fact due to the social networks evidenced within the incarcerated child sex offender population, prison may even act to promote future reoffence (Hanson & Scott, in press). Thus, to slow or halt recidivism among incarcerated child sex offenders necessitates some form of intervention.

Various researchers have emphasised the importance of timing in the delivery of effective correctional treatment. Marshall, Eccles, and Barbaree (1993) advanced a need to weigh the timing of treatment against the potential costs and drawbacks of inappropriately timed services within each correction facility. If treatment occurs solely at the commencement of incarceration, the offender may be returned to an aversive institutional environment which may result in any and all treatment benefits being eroded. Whereas, if treatment is delayed until the end of an offender's sentence, time spent in prison may lead to either severe discouragement of the intervention process, or the enhancement and/or concretisation of pro-offending attitudes.

Currently the two most widely used interventions for treating incarcerated child sex offenders are those which adopt a general cognitive behavioural framework and those which focus more specifically on relapse prevention. Although the latter is sometimes seen as a sub-component of the broader cognitive behavioural framework, not all agree. Acknowledging that these two approaches are by no means independent, what follows is

a brief account of each intervention, and how it applies to the treatment of child sex offenders.

3.2.1.1 Cognitive Behavioural Treatment

As early as 1977 researchers postulated that recidivism prevention in the chronic sex offender comes about through the restructuring of thought and behaviour patterns (Yochelson & Samenow, 1977). Traditional single component cognitive/behavioural (CB) approaches fell short in accommodating the diverse array of dysfunctional behaviour and cognition's evidenced in the child sex offender. As a result, these early programs failed to reduce (at best only marginally lowered) an offenders potential for recidivism (Prendergast, 1978; Quinsey, Chaplin, & Carrigan, 1980; Rooth & Marks, 1974; Saylor, 1979).

More recent CB conceptualisations incorporate a comprehensive, multifaceted approach to child sex offender treatment. Comprising of cognitive, behavioural, psychotherapeutic, social, life skill, and relapse prevention components, these broad based contemporary programs target a more encompassing array of problematic sexual behaviours and interests, social difficulties, and cognitive distortions.

The basic tenet of the CB approach is that an individuals belief system and attitudes play a significant role in the initiation, maintenance and justification of sexually aberrant behaviour. Presumed to be 'learned' (Robinson, 1989) these beliefs, along with their resultant behaviour, derive from complex socio-economic, cognitive, emotional, and behavioural interactions (Valliant & Antonowicz, 1992). Therefore, effective treatment is seen not only to conceptualise and incorporate these complex interactions, but also to alter the diverse array of dysfunctional beliefs, attitudes and behaviours expressed by the child sex offender.

An integral component of CB treatment is the technique of cognitive restructuring (Laflen & Sturm, 1994; Marshall, Eccles, & Barbaree, 1993; Robinson, 1989). That is, through a process of confrontation, education and reflection, an offender's cognitions (the internal processes used by the offender to deny, rationalise, minimise, justify or understand their offending [Johnston & Ward, 1996]) are challenged, and the consequences of holding such dysfunctional views are elaborated.

As previously noted, cognitions play a pivotal role in sex offender treatment. Thus numerous intervention targets have been advanced within a cognitive/behavioural framework. Such cognitions include, the denial of any wrongdoing, minimisation of the admitted offences, misattributions of responsibility, lack of awareness of victim impact and misperceptions about the nature of sexual offending (Marshall, Eccles, & Barbaree, 1993). Furthermore, Marshall et al., contend that other offence supportive beliefs (rape acceptance myths, adult sexual entitlement, ownership of children) also require attention.

A second major assertion of the CB approach is that many child sex offenders are characterised by inappropriate sexual preferences. Notwithstanding the extensive controversy over the measurement of sexual preference (especially when using phallometric measures [Barbaree & Marshall, 1989; Blader & Marshall, 1988; Hall, Proctor, & Nelson, 1988; Quinsey & Chaplin, 1988; Quinsey & Earls, 1990]) research demonstrates that child sex offenders show higher absolute sexual arousal on the pedophile index, whilst also displaying higher overall sexual arousal to inappropriate sexual contact.

Incorporating the assumptions of classical behaviour conditioning (i.e., learning through association), cognitive/ behavioural treatment attempts to pair instances of appropriate and inappropriate sexual behaviour with reward and punishment procedures. It is presumed that if an offender can learn an association between his sexually aberrant

behaviours and negative consequence, he is less likely to participate in such behaviours, hence facilitating punishment avoidance. Similarly, if a sex offender is rewarded for appropriate sexual behaviour patterns it is assumed he will more readily participate in such activities. Currently such conditioning procedures include masturbatory or orgasmic re/conditioning, electric shock, and olfactory aversion (Freeman-Longo, Bird, Stevenson, & Fiske, 1995).

Child sex offenders are also seen to posses a diverse array of social incompetencies. Because this social ineffectiveness hinders an offenders ability to form and maintain peer sexual and emotional relationship, the deficits are specifically targeted in the CB treatment process. By providing the child sex offender with specific skills (i.e., social problem solving, conversational skills, social anxiety, assertiveness, conflict resolution, empathy, intimacy and self-confidence) they become more competent to function in a peer society which was once viewed as hostile.

In recent years numerous researchers (Andrews, Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990; Grubin & Thornton, 1994; Lipsey, 1992; Perkins, 1993) have advanced that multimodal cognitive-behavioural approaches are the most effective programs for prison based sex offender treatment. With an extensive plethora of contemporary research (Gordon, 1989; Marques, Day, Nelson, & Miner, 1989; Marshall & Barbaree, 1990; Marshall & Eccles, 1991; Marshall, Eccles, & Barbaree, 1993; Marshall, Hudson, & Ward, 1992; Marshall, Jones, Ward, Johnston, & Barbaree, 1991; Marshall & Pithers, 1994; Marshall, Ward, Jones, Johnston, & Barbaree, 1991; Pithers, Martin, & Cumming, 1989; Valliant & Antonowicz, 1992) demonstrating the unquestionable benefits of a comprehensive CB approach, Marques, Day, Nelson, and West (1994) highlight the significance of such findings in the light of more sophisticated evaluation methods,

extended follow-up periods, multiple outcome measures and the use of appropriate comparison groups.

In their 1991 paper, Marshall, Jones, Ward, Johnston, and Barbaree claimed "the outcome of comprehensive cognitive-behavioural programs are positive whether they are institutionally-based or located in the community" (p. 479). With such a claim must come a note of caution. Being cognitive-behavioural in orientation by no means predisposes or guarantees a child sex offender program of success. The failure of the Ontario penitentiary program (Leger, 1989) together with Rice, Harris and Quinsey's (1990) forensic hospital based program, highlight's the point that CB treatment, like most other interventions, is not uniformly effective.

In drawing conclusions, perhaps the most distinctive feature of the cognitive/ behavioural approach to child sex offender treatment stems from its ability to identify the important features and individual characteristics within a particular setting, and provide services best suited to those specific circumstances.

3.2.1.2 Relapse Prevention

Despite falling into a broader Cognitive-behavioural framework, the fundamental assumptions of relapse prevention (RP) see it deserved of special mention. What follows is a brief account of the RP model and how it applies to the treatment of child sex offenders. For a more comprehensive review of the relapse prevention process, together with its application within a child sex offender context, the reader is referred to "the special issue on relapse prevention" in *Sexual Abuse: A Journal of Research and Treatment* (Hudson & Ward, 1996) and Laws (1989, 1995, 1995a).

The theoretical underpinnings of relapse prevention derive from Bandura's social cognitive theory (Laws, 1989), whilst its origins can be found in the addiction field (Marlatt and Gordon, 1980) where it was developed as a behavioural maintenance

program for the treatment of addictive behaviours. Therefore, the goal and key emphasis of such treatment was to assist an 'addict' to stop engaging in their addictive behaviour (i.e., harm reduction), or at the very least reduce its frequency.

With a realisation that cessation by no means assures continued abstinence, early RP provided a self-administered program for enhancing self-management, thereby enabling long-term abstinence. Thus, the focus was on strengthening self-control by providing the addict with the skills necessary for identifying problematic situations, analysing decisions which may enable the resumption of substance abuse, and developing strategies for effectively coping with and avoiding , such problematic situations (Marlatt & George, 1984).

A number of researchers have advanced the similarities between sex offending and other addictive behaviours (Carnes, 1983; Laws, 1989; 1995; Pithers, 1990; Pithers, Marques, Gibat, & Marlatt, 1983). Carnes (1983) argued that compulsive sexual activity, like other addictive behaviours, offers the allure of a reliable mood-altering experience. Laws (1989) added that sexually aberrant behaviour emphasises immediate, short-term gratification at the expense of delayed, long-term negative consequence.

Notwithstanding the aforementioned similarities, Laws (1989) advanced numerous important, yet problematic, differences between sex offending and other addictive behaviours. These include the increased negative consequences faced by the other parties involved, the more crucial role fantasy plays in sex offending, and a greater difficulty defining instances of 'lapse' and 'relapse'.

Since its adaptation to the sex offender field (Pithers, Marques, Gibat, & Marlatt, 1983), relapse prevention has become the second most utilised modality in the treatment of sex offenders, overshadowed only by those considered cognitive/behavioural in orientation. Currently in the United States 37 per cent (662) of all sex offender

programs classify their primary treatment modality as relapse prevention (Freeman-Longo, Bird, Stevenson, & Fiske, 1995), while over 90 per cent of the programs incorporate some form of RP technique.

Acknowledging the enormous growth and contemporary popularity of RP, these figures may reflect an overestimation, as treatment providers are all to ready to adopted the latest catch phrase and the benefits that stem from its application. Marshall and Anderson (1996) went further when contending that in some cases the term 'Relapse prevention' denotes little more than a descriptor change from the traditional cognitive/behavioural approach.

Advancing that sexual offending is neither a disease nor congenital defect, RP is not seen to provide a 'cure' to sexual offending. Instead, with an assumption of multi-determined etiology (i.e., early life experiences, irrational thoughts, low self-esteem, inability to obtain emotional intimacy, situational factors and maladaptive coping strategies) RP serves to control an individuals urges and behaviours, while increasing the range of choices available to the child sex offender in relation to their aberrant behaviour.

Therefore the key tenet of RP, as it applies to the treatment of child sex offenders, is teaching perpetrators to recognise and interrupt the chain of events which lead up to an offence. In so doing RP provides the child sex offender with the necessary skills to anticipate and cope with 'lapses' (defined as either voluntarily induced risk behaviour which threatens an offender's sense of self-control, or situations which demonstrate clear intentionality to reoffend [S. Hudson, August 1996, personal communication]) reducing the likelihood that they will develop into a full blown 'relapse' (i.e., remission into, or first instance of, reoffence).

Laws' (1995) recent contention that RP's comprehensive and distinct nature depicts a treatment approach which can stand alone as a general theory of therapy is

strengthened and ground in numerous empirical studies of treatment effectiveness. Schlank and Shaw (1996) argue that the utility of RP as a treatment modality can be measures by lower recidivism rates in those who successfully complete such programs. This conclusion has support in the early works of Pithers (1990), when he followed a group of 167 sex offenders (20 rapists, 147 pedophiles) treated under relapse prevention, over a five-year post release period. The 4 per cent reoffence rate was considered evidence for RP's effectiveness in enhancing long-term maintenance of change in sexual aggressors.

More recent reviews of institutionally based relapse prevention programs have demonstrated similar benefits of adding RP components into treatment. An evaluation of Canadian penitentiaries revealed that 4.7 per cent of those child sex offenders treated under the RP model reoffended. While an analysis of a New Zealand corrections based program demonstrated that less than one per cent (i.e., one man) of the 160 released individuals had been reconvicted over an average 18 month post-release period (Hudson, Marshall, Ward, Johnston, & Jones, 1995). These findings were mirrored in an evaluation of the Bath Institute program (Ontario), where Marshall and Fernandez (1996) reported that 3 out of 107 (2.7%) post-release child sex offenders had committed a further sexual offence over a 2-year (average) follow-up period.

In general, the benefits of adopting a relapse prevention framework (or incorporating RP into existing treatment) stem from its ability to reduce recidivism among child sex offenders to between 2.8 and 12.3 per cent (Marshall & Anderson, 1996). Secondly, because the RP program is tailored to the individual, the changing needs of the offender can be combated through revised models which encapsulate newly identified risk factors and potential targets in treatment. Hence the utility of relapse prevention as a long-term habilitation program for child sex offenders is assured through its metamorphic qualities.

What becomes evident from the aforementioned is that within the midst of public disdain, increased acceptance of the need to treat the child sex offender is being voiced by therapist, probation officer and program administrator alike. The continual increase in the number of specialised sex offender treatment facilities may firstly be a reflection of the increased reporting and incarceration of child sex offenders. Secondly, and perhaps of more importance, it may reflect a change in the attitudes of those professionals who come into contact with these individuals.

Acknowledging that not all sex offenders are amenable to treatment and also that not all treatment modalities are equally effective, it is now widely established that, in most child sex offender cases, the efficacy of treatment is indisputable. As lowering the reoffence rate is one of the criteria, if not the primary objective, for the effective treatment of child sex offenders, what is of increasing importance is finding ways to assess which treatment will be most effective, in what circumstances, and with whom.

Although the treatment of child sex offenders is by no means a cure to the problem of sex offending, in light of the lacking primary intervention, it is perhaps the next best thing. Treatment of the child sex offender must continue. However, it is important to stress that if institutionally based programs are to demonstrate long-term effectiveness, there must also be a bridge between them and the broader community services available to the perpetrator. Such a bridge would allow for the continuity in treatment for not only the offender, but also their families and society as a whole.

CHAPTER IV

New Zealand Sex Offender Treatment Programs:

As of 1994 New Zealand now has two institutionally-based child sex offender treatment programs. Operating as part of Psychological Services (a division of the Department of Corrections) these two units ("Kia Marama" and "Te Piriti") target the relatively small proportion (approximately 18% (1457): Spier, 1996) of adult males who are serving sentences for sex offences against children.

Both programs have a similar set of intake criteria which stipulate the following;

1) He has committed one or more sexual offences against children or young persons under 16 years of age (e.g., indecent assault, sexual violation, incest). These offences need not be his current convictions (nor, in fact, need he ever have been formally convicted of such an offence).

2) He is fully informed about, and voluntarily consents to enter, the treatment program. Volunteers who exhibit varying degrees of denial of legal guilt (even complete denial of ever having committed an offence) are not excluded.

3) The term of imprisonment is of sufficient length to permit completion of the full program prior to the earliest possible release date.

4) He is not intellectually disabled, but has sufficient ability to comprehend and participate in the treatment program (literacy is not a requirement).

5) He is currently free of any psychotic disorders.

6) He does not require maximum security containment

Source: New Zealand Department of Corrections (1995, p.2).

What follows is a brief outline of the two programs and a review of treatment success to date. For more detailed reviews the reader is referred to Hudson, Marshall, Ward, Johnston, and Jones (1995), New Zealand Department of Corrections (1995) and Ward, Neilson, and Marshall (1990).

4.1 Kia Marama

The "Kia Marama" unit (translating to "let there be light, let there be insight") was established in October 1989 in response to an increasing number of reported and incarcerated child sex offenders. Based on the success of the American based Atascadero program, the purpose-built facility at Rolleston Prison (Christchurch) houses up to sixty men at any one time. Its primary objective is the reduction of recidivism among incarcerated child sex offenders. To aid in this goal a multi-disciplinary team of psychologists, therapists and social workers, administer a combination of cognitive-behavioural and psychotherapeutic techniques.

The multi-component nature of Kia Marama's cognitive-behavioural approach sees it targeting numerous deficits across a thirty three week period (see Appendix 1). After two weeks of comprehensive assessment including interviews, psychometric questionnaires and penile plethysmograph measures, a successful applicant is integrated into the program.

In small groups (8 individuals) which meet three times a week for 2.5 hours per day, the men spend the next eight weeks establishing a personal "offence chain" (that is, the factors which build up to an offence). By this it is meant that an individual becomes aware of the masturbatory fantasies, distorted cognitions, seemingly irrelevant decisions, and the high risk situations which lead the offender to commit a sexual offence.

At this point (when each man has formed a realistic offence chain and can identify the specific changes that must be made) the focus shifts to equipping the child sex offender with the skills required to maintain an offence free life. For the next 21 weeks individuals undergo a series of 14 components (all bar two of which, substance abuse and life skills, are compulsory) utilising various treatment techniques (see Hudson, Marshall, Ward, Johnston, and Jones, 1995 for a discussion). Such treatment targets an offenders

deviant sexual preferences, problems in mood and stress management, social incompetence and problem solving, and his deficits in victim empathy and impact.

The final phase of the program involves a three week period of relapse prevention and release planning. Men are assisted in identifying previous patterns (offence chain) that in the future may signal an increased risk of relapse. They learn about the process of 'lapsing' and the 'abstinence violation effect', while at the same time they are taught specific skills enabling them to avoid relapse. The program ends with a reassessment of the offenders progress, and post-release management sees the offender handed over to a Probation Officer who facilitates his integration back into society.

As of April 1996 the Kia Marama unit has seen 383 men commence treatment. Of these twenty seven individuals were either dismissed (19) for disruptive behaviour, or chose to withdraw (8) from the program for personal reasons. Since its opening three hundred and fifty six men have completed the program, of which 310 have been released. The average post-release period for this group is 33 months, ranging from 0 to 66 months.

The success of the Kia Marama treatment facility can be measured by the low recidivism rates seen in those child sex offenders who have completed the program. At present 10 individuals (3.1%) have been reconvicted of sexual offences. Although promising, a note of caution must accompany this figure. It is plausible that an unknown percentage of the released individuals have reoffended, but as yet have not been caught. Such a concern was mirrored by Kia Marama program administrators when they advanced that a small number of men were suspected of having reoffended (New Zealand Department of Corrections, 1995).

4.2 Te Piriti

Partly due to the success of the Kia Marama program, a second child sex offender unit was opened in Auckland in May 1994. Based at the Albany Campus "Te Piriti" (meaning "the bridge") holds up to 60 inmates referred to the program from through the North Island of New Zealand (North Shore Times Advertiser, 1995)

The program demonstrates the typical diversity evident in the child sex offender population. Some of the individuals present with non violent forms of offending, whilst others demonstrate more sadistic tendencies. The men are also diverse in age and socio-economic status, with 30 per cent being Maori, 65 per cent Pakeha, and 5 per cent being from other ethnic groups (J. Larsen, personal correspondence, May 1996).

As with Kia Marama, Te Piriti is a multi-component cognitive-behavioural treatment program where groups of ten men progress through ten modules spread over a slightly longer thirty eight week period. The content and order of the ten modules is similar to that of the Kia Marama program, although more time is given for the components of cognitive restructuring, victim empathy/impact, and mood management (see Appendix 2).

Despite Te Piriti only being in its second year, since its opening, 121 men have commence treatment. Of the 121 participants, 2 have withdrawn and 5 have been dismissed. One hundred and three men have since completed treatment, 76 of which have been released and at large for an average of 8.5 months (range 0-19 months). Although it is difficult to comment on the programs success at such an early stage, thus far, none of the men released from the Te Piriti treatment program have been reconvicted of sexual offences.

What is evident from the forgoing review is that individuals who participate in either of New Zealand's child sex offender programs recidivate at lower rates than is expected

for individuals who remain untreated. Although at present one cannot be certain that the reduction in reoffence rates is a direct consequence of treatment, given the lack of research involving appropriate comparison groups, it is generally accepted that child sex offender treatment is effective. Hence, the broad based cognitive/ behavioural framework, together with the relapse prevention techniques, which are adopted by New Zealand's child sex offender programs seem to be effective in reducing the reoffence rates among those who choose to participate in them.

CHAPTER V

Treatment Efficacy/Recidivism:

Assessing the efficacy of child sex offender treatment programs is a difficult and multilevel process. Noted as the most direct measure of treatment effectiveness, 'recidivism' among child sex offenders is best conceived as the reported percentage of convicted perpetrators who reoffend. Despite the predominating focus of current conceptualisations on this measure, official indices of recidivism presents us with numerous methodological quandaries.

5.1 Methodological Quandaries

First and foremost is the definitional dilemma. That is, although recidivism can be operationally defined as both 'failure' and 'reoffence' rate, at present there is no consensus on what best constitutes failure or reoffence. On the one hand failure can be defined as an allegation, a parole violation, a charge, an arrest, a conviction, any re-incarceration, or re-incarceration for a specified period. While in criminal terms reoffence can be conceived as, recommitting any offence, recommitting an offence against a person, recommitting a sexual offence, recommitting a specific sexual offence, or recommitting an identical sexual offence.

As previous research has demonstrated, those who select a broader definition of recidivism, (e.g., an allegation of any offence) tend to inflate the percentage of individuals who sexually reoffend against children. Whereas those who choose a more constrictive definition (e.g., reincarceration for an identical sexual offence) underestimate the true proportion of child sex offenders who recidivate.

A second problem in determining recidivism rates arises from the multiple sources of information pertaining to reoffence. Is it best to rely on self report measures, or is it, as Marshall, Jones, Ward, Johnston, and Barbaree (1991) contend, better to draw information from official rearrest or reconviction records. The utility of the former is severely compromised by the low rate and notorious imprecision of self reported sexual

offences, while the more fundamental problem of low base rates hinders the application of the latter. That is, only a small percentage of child sex offences (6%) (Shand & Milford, 1993) are ever reported to authorities, with even fewer pursued to arrest, and only a handful resulting in reincarceration (Abel, Becker, Mittelman, Cunningham-Rathner, Rouleau, & Murphy, 1987; Bonta & Hanson,1994; McGrath, 1991).

A further finding which brings the applicability of such measures into question is that by Marshall & Barbaree (1988). In an investigation into the reported incidence of recidivism across different information sources, it was revealed that unofficial reports from Children's Aid sources produced 2.7 times more cases of sexual reoffence than were evidenced in official reconviction records.

Objecting to both the self report measure, and those which use more official rearrest or reconviction records, Quinsey, Harris, Rice, and Lalumiere (1993) argue for a more qualitative approach to sexual recidivism. That is, they believe sexual recidivism is best measured from actual offence descriptions, rather than simply an arrest or conviction record.

A third quandary to surface when measuring the recidivism among child sex offenders is the length of follow-up. Both Hanson, Steffy, and Gauthier (1993) and Quinsey, Lalumiere, Rice, and Harris (1995) have advanced the importance of follow-up length and reoffence opportunity in establishing accurate rates of recidivism.

Early research saw Gibbens, Soothill, and Way (1978) conclude that, although child sex offenders are most likely to be reconvicted within the first few years of release, there are a significant number of reincarcerations after follow-up periods of 10 years or more. This early conclusion was mirrored in Hanson, Steffy, and Gauthier's (1992, 1993) research where it was demonstrated that of the 50 per cent of offenders that were

eventually reconvicted, 23 per cent of their sample were reincarcerated more than 10 years after their initial release.

Similarly, Barbaree and Marshall (1988) showed that recidivism rates were positively correlated with follow-up length. This study demonstrated that offenders (both treated and untreated) who were at large for less than two years had an 8.8 per cent chance of reoffence, while 16.7 per cent of those men at risk for 2-4 years reoffended. The possibility of reoffence among offenders who had a post-release period of more than four years was 40.9 per cent.

Based on the above findings Quinsey, Lalumiere, Rice, and Harris (1995) contend that short follow-up periods significantly underestimate recidivism in child sex offenders. In so doing they adhere to Fury, Weinrott, and Blackshaw's (1989) recommendation of the need for extended follow-up periods when assessing the recidivism among post-release child sex offenders.

What the aforementioned demonstrates is that in light of the predominating focus on recidivism as a measure of treatment efficacy, considerable care is needed when interpreting rates of reoffence. Not only is caution needed when comparing recidivism rates within and between child sex offender populations, but it is also important to question how any one measure of recidivism is derived.

5.2. Comparing Recidivism

Based on an extensive review of forty-two studies of sex offender recidivism, Furby, Weinrott, and Blackshaw (1989) concluded that "methodological variability and ambiguity precluded any meaningful conclusions about the recidivism rates for sex offenders" (p.27). The study noted that a diverse array of factors (i.e., length of follow-up, definition of reoffence, offender characteristics, and victim composition) interacted to

make outcome data incomparable. Moreover, Furby, Weinrott, and Blackshaw (1989) deduced that "there was no evidence that clinical treatment reduces rates of sex reoffences in general, and no appropriate data for assessing whether it may be differentially effective for different types of offenders" (p. 27).

The conclusions of Furby, Weinrott, and Blackshaw (1989) have since been contested in a number of studies on child sex offenders, and offender treatment programs (Alexander 1993; Hall, 1995; Hanson, Scott, & Steffy, 1995; Marques, Day, Nelson, & West, 1994; Marshall & Pithers, 1994; Quinsey, Harris, Rice, & Lalumiere, 1993; Quinsey, Lalumiere, Rice, & Harris, 1995). More contemporary researchers all agree that, although care is needed to ensure the similarity of methodological variables, it is possible to reliably compare recidivism rates within and between different child sex offender populations and programs.

5.2.1 Treatment vs. Non-treatment

The question most often addressed in sex offender research is whether a difference exists in the recidivism rates of treated and untreated individuals. A number of studies (Alexander, 1993; Becker & Hunter, 1992; Marshall & Barbaree, 1990; Marshall, Eccles, & Barbaree, 1993; McGrath, 1991; Meyer, Cole, & Emory, 1992; Robinson, 1989) have demonstrated the positive effects treatment has on reducing the reoffence rates in child sex offenders.

Recently McGrath demonstrated just how effective contemporary treatment procedures are becoming. In his review of the literature, McGrath (1995) revealed that the recidivism among treated offenders reported in studies prior to 1980 was 12.8 per cent, whereas post-1980 studies revealed rates of 7.4 per cent.

Early research by the US Department of Justice (McGrath, 1991) suggested that recidivism among untreated, incarcerated child sex offenders was in the order of 60 per

cent within three years of release. While those who completed specialised treatment were reconvicted at rates of between 15 and 20 per cent. These findings were mirrored in Marshall, Eccles, and Barbaree's (1993) review of the treatment outcome literature when they to concluded that reoffence rates for treated offenders were 15 per cent or less. The review also advanced that recidivism for untreated sex offenders was in the order of 20-60 per cent (depending on the type of offence) over a five year post release period.

In an investigation into the effects of follow-up length on recidivism, Marshall and Barbaree (1988) found that not only was post-release length and reconviction positively correlated, but in every instance of measurement untreated sex offenders were reconvicted at higher rates than offenders who participated in treatment. That is, up to 2 years post-release, the reoffence rates for treated and untreated child sex offenders were 5.5 and 12.5 per cent respectively, while rates for treated offenders who had been at risk for at least four years was 25 per cent. For untreated offenders a four year post-release recidivism rate was in the order of 64 per cent (64.3%).

Two of the most recent and comprehensive studies of sex offender treatment efficacy are those by Alexander (1993) and Hall (1995). In Alexander's study it was reported that recidivism among treated child sex offenders was 10.9 per cent, while among the untreated sex offender population, reconviction was in the order of 18.5 per cent. Two further important finding were also uncovered in this research. Firstly, sex offenders who were mandated to treatment had slightly lower recidivism rate (10.5%) than those offenders who entered treatment voluntarily (12.4%). Second, sex offenders who completed treatment were much less likely to be reconvicted than those who dropped out or failed to complete treatment.

A meta-analysis conducted by Hall (1995), in which 12 studies of treatment effectiveness were reviewed, produced similar divergence between the treated and untreated child sex offender populations. However, the overall recidivism rates for the two groups were considerably higher than those reported by Alexander. Hall's review revealed that reconviction among treated sex offenders (i.e., both child sex offenders and rapists) was 19 per cent, whereas the comparative reoffence rate for the untreated offenders was 27 per cent. This latter figure is mirrored in McLean and Rush's (1990) research, where 25 per cent of untreated child sex offenders were reconvicted after a five year post-release period.

Aside from the fundamental goal of sex offender treatment (i.e., the reduction of recidivism among incarcerated offenders), it is also important to view the effectiveness of treatment in terms of reoffence onset. If, as has been suggested by Abel, Becker, Cunningham-Rather, Rouleau, Kaplan, and Reich (1984), child sex offenders commit, on average, 380 acts of sexual abuse in their life time, then any delay in the onset of future offending would result in a reduction of potential victims. Indeed this was addressed in Marques, Day, Nelson, and West's (1993) research where it was suggested that even when little difference exists in subsequent recidivism between treated individuals and matched untreated offenders is evident, those offenders who receive treatment remain offence free far longer than untreated individuals.

5.3. Characteristics of the Recidivist

As discussed earlier a number methodological quandaries hinder ones ability to obtain truly representative recidivism data. Despite absolute recidivism showing considerable variability across samples, conclusions about relative rates are more easily drawn. It has become widely established that not all child sex offenders are equally likely

to recidivate. Indeed a wide array of factors including age, sexual preference, marital status, deviant sexual arousal, and criminal history appear to affect the likelihood of reoffence. Quinsey, (1995) and Rice, Quinsey, and Harris (1991) went as far as to say such characteristics significantly predict recidivism among child sex offenders.

Before reviewing the extensive plethora of research pertaining to the characteristics that predict or place a child sex offender at greater risk of reoffence, an important distinction must be made. That is, such characteristics, or potential risk factors, can be broadly conceived in two groups, 'static' and 'dynamic'. Static factors are variables that, despite holding utility as overall risk predictors, are resistant to outside influence (e.g., age, previous offence history) and hence are not targeted in treatment.

On the other hand dynamic risk factors (or "criminogenic needs" [Hanson & Bussière, 1996]) and those variables relating to reoffence opportunity (e.g., criminal attitude, sexual preference, and future employment) are potentially mutable, and thus more plausible targets in treatment. Bonta (1996) notes the importance of dynamic factors in treating the child sex offender, when arguing that a decrease in deviancy levels, or an outright reduction in the occurrence of such factors, is directly associated with reduced recidivism.

5.3.1 Victim Selection

One of the most consistent variables influencing the probability of reoffence among child sex offenders is the type of offence committed. That is, in relation to the original conviction, was the sexual act one of incest (i.e., where the offender is related to the victim, e.g., adopted/parent, sibling, step-parent), or one of non-incestuous offending. If the latter, researchers (Broadhurst & Maller, 1992; Khan & Chambers, 1991; Maletzky, 1993; Quinsey, Lalumiere, Rice, & Harris, 1995) further distinguish between those offenders who are acquainted to the victim, and those who are strangers.

In an early study, Frisbie and Dondis (1965) followed 318 incarcerated incest offenders (father-daughter, father step-daughter) over a 6 year period. The cumulative recidivism rate for the sample was 10 per cent. A similar study of untreated sex offenders (Gibbens, Soothill, & Way, 1981) also revealed that in general, less than 10 per cent of incarcerated incest offenders reoffend. Furthermore Gibbens et al., also demonstrated that this rate was the lowest amongst the entire untreated sex offender population.

Support for these early studies can be found in the contemporary works of McGrath (1991). In his research it was reported that recidivism rates for the incest offender were between 4 and 10 per cent. Similarly, Hanson, Steffy, and Gauthier (1992, 1993), Marshall and Barbaree (1988), and Robinson (1989) all report that familial child sex offenders demonstrate the lowest rates of reconviction. Gordon, Holden, and Leis (1991) went one step further when advancing that regardless of whether treated or untreated, the incestuous child sex offender has the lowest rate of reoffence among sexual offenders.

A second victim related characteristic which is seen to increase the potential for recidivism among child sex offenders is gender. That is, was the victim/s of the abuse a boy, girl, or both. Early research by Radzinowicz (1957), which followed-up 1,985 sex offenders, reported that 13 per cent of the 397 individuals who were eventually reconvicted were heterosexual child sex offenders. The comparative rate for homosexual offenders was found to be 27 per cent. Similar research by Fitch (1962), which followed 139 men convicted of sex crimes against children over a 1 to 9 year post release period, uncovered an identical figure for men who abused girls (13%). However, Fitch's study placed the recidivism among homosexual offenders at a much higher point, with 40 per cent of these offenders eventually reconvicted. Robinson (1989) imparts further support

for the aforementioned claims when he to advocated that homosexual pedophiles have considerably higher recidivism rates than heterosexual child sex offenders.

The above findings have their counterpoint in more recent research. Gordon, Holden, and Leis (1991) found that although more than half (57%) of the bisexual child sex offenders in their sample were reconvicted, the heterosexual offenders were in fact reconvicted at a much 'higher' rate (17%) than the non-existent reconvictions for homosexual pedophiles. These results were consistent with Abel Mittelman, Becker, Rathner, and Rouleau, (1988) finding that a greater variance in the age and gender of victims was associated with higher rates of recidivism.

An important consideration when assessing victim selection as an indicator of future reoffence is the interaction between the type of offence and victim gender. A number of studies (Furby, Weinrott, & Blackshaw, 1989; Hanson, Steffy, & Gauthier, 1993; McGrath, 1991; Perkins, 1993; Quinsey, Rice, & Harris, 1995) have shown that victim gender and offence type interact producing varying levels of reoffence. Furby, Weinrott, & Blackshaw's (1989) review reported that untreated incest offenders had the lowest rates of reoffence (4-10%), while non-familial child sex offenders who abused girls had reoffence rates of 10-29 per cent. Non-familial child sex offenders who abused boys displayed the highest rates (13-40%) of recidivism.

Likewise, Hanson, Steffy, and Gauthier (1993) concluded that offenders who selected only male victims were at greatest risk of reoffence, followed by those who victimise any extra-familial girl. The lowest reconviction rates for sex offenders in Hanson et al.'s study were evidenced in those who selected only female relatives.

The most recent piece of research investigating the effects of victim selection on future recidivism rates is that of Quinsey, Lalumiere, Rice, and Harris (1995). Comprising of 15 independent victim samples (7 female, 4 male, 4 incestuous), results

revealed an overall reconviction rate for the heterosexual offender sample of 18.3 per cent (N=1167). A comparable rate for homosexual child sex offender was 35.2 per cent (N=561), while for the incest offenders a reconviction rate of 8.5 per cent (N= 499) was reported.

Acknowledging that such rates necessarily underestimate the true reoffence rates, both Quinsey, Lalumiere, Rice, and Harris (1995) and Quinsey, Rice, and Harris (1995) concluded that child sex offenders with male victims have the highest recidivism, those with unrelated female victims have lower rates, and heterosexual incest offenders demonstrate the lowest rates of reconviction.

Although research into the effects victim selection has on recidivism have occasionally produced contradictory findings, it is apparent that not all child sex offenders are equal in there recidivism rates. What is also becoming evident is that victim preference may provide a valuable key for measuring the potential for reoffence among child sex offenders.

5.3.2 Denial

It has been contented that a prerequisite for the entrance into many sex offender treatment programs is the acceptance of at least some level of responsibility on the part of the offender (Kennedy & Grubin, 1992; Winn, 1996). Hence those men who deny their offences are less likely to undergo treatment, and as research has shown, are thus at a higher risk of reoffence.

A study by Simkins, Ward, Bowman, and Rinck (1989) found that even if deniers are admitted into treatment programs, an increased level of denial was positively correlated with a less favourable treatment outcome, and a greater likelihood of reoffence. This finding was mirrored in Maletzky's (1993) research when he demonstrated that men who admitted crimes when entering treatment were more successful and less likely to

recidivate than those who denied their crimes. A further point to note with respect to denial is that child sex offenders who abused girls are more likely to deny responsibility for their acts than are offenders who abuse boys (Marshall & Barbaree, 1988).

A review which goes against the above findings is that by Furby, Weinrott, and Blackshaw (1989). In their review of the literature Furby et al., noted that when denial is viewed through the conceptual framework posited by both Kennedy and Grubin (1992) and Langevin (1988), those in group one (child sex offenders who admitted their offence), who expressed the least amount of denial, were shown to have the greatest likelihood of reoffence. Whether this resulted from an individual being more accepting of their offensive behaviour, or because Furby et al.'s review constituted of studies with more dysfunctional populations is not completely known. However it may be the case that one, or both of these explanations were operating as the studies used in the review often comprised of child sex offenders who abused male children.

Arguing for or against whether denial is an important variable in relation to future reoffence is difficult. Findings are often confounded by the process of treatment, where the denial/treatment interaction makes it difficult to assess whether it is indeed denial which influences recidivism. Is an offender's denial causing recidivism? Does the often reported relationship between offender denial and recidivism stem from a child sex offenders inability to enter treatment because of such denial? Or is treatment somehow the cause of denial?

5.3.3 Criminality

The plethora of recent research (Fitch, 1962; Hanson, Scott, & Steffy, 1995; Hanson, Steffy, & Gauthier, 1992; 1993; Marshall, 1994; Marshall & Barbaree, 1988; McGrath, 1991, 1992; Perkins, 1993; Proulx, Pellerin, McKibben, Aubut, & Ouimet, 1995; Quinsey, Lalumiere, Rice, & Harris, 1995; Quinsey, Rice, & Harris, 1995; Rice,

Quinsey, & Harris, 1991; Sturgeon & Taylor, 1980) has made prior criminal history one of the most cited variables influencing the probability of future reincarceration for child sex offenders.

In assessing the potential for reoffence among child sex offenders, McGrath (1992) argues in favour of adopting the axiomatic approach which suggests "the best predictor of future behaviour is past behaviour". That is, if an individual has a history of child sex offending they present a greater risk of future reoffence than does a first-time offender. Numerous researchers (Hanson, Steffy, & Gauthier, 1992; McGrath, 1991; Perkins, 1993; Rice, Quinsey, & Harris, 1991) have concluded that although the probability of reconviction after the first sexual offence is low (10%), if an individual has two or more prior sexual convictions the probability of reoffence dramatically increases (20-40%).

A recent literature review by Quinsey, Lalumiere, Rice, and Harris (1995) strengthen the above claims when it reported a greater likelihood of reoffence among repeat offenders. They found that offender with more than one prior sexual conviction (indiscriminate of offence type) demonstrated recidivism rates in the order of 33-71 per cent, whereas a comparative rate for the first time offender was between 10 and 21 per cent.

Two further studies confirmed the importance of a previous sexual offence history on future recidivism. Both Bonta and Hanson, (1995) and Hanson, Scott, and Steffy, (1995) reported that offenders who had previous child sex offence convictions were more likely to reoffend (30.6%) in a sexually aberrant manner than were those who only had prior non sexual convictions. In fact the study demonstrated that the child sex offender sample was responsible for 97 per cent of all sexual recidivism, while they accounted for only 4 per cent of the non-sexual violent recidivism.

Barbaree and Marshall (1988) and McGrath (1991) have also shown that also with previous sexual convictions, the degree of deviant sexual contact is highly correlated with the likelihood of future sexual recidivism. If prior convictions were for hands off offences (e.g., exhibitionism, voyeurism), or for an offence early on in the grooming process (e.g., inappropriate touching, kissing), the offender had a lower rate of recidivism than did the individual with a more serious sexual offence history (i.e., digital penetration, genital-to-genital contact, anal/vaginal intercourse).

5.3.4 Offence Range

As reported above, prior sex offence convictions are a good indicator of future recidivism among child sex offenders. What is becoming apparent is that a history of non-sexual criminal behaviour may also inflate a child sex offender's chance of future reconviction for a sexual offence. Hall and Proctor (1987), Marques, Day, Nelson, and West (1993), and Proulx, Pellerin, McKibben, Aubut, and Ouimet (1995) all postulate that sexual offenders with any prior non-sexual criminal convictions have a greater likelihood of reoffending in a sexually abusive manner, than does an offender with no prior criminal record. These conclusions were supported by Quinsey, Lalumiere, Rice, and Harris' (1995) research, where it was revealed that most recidivist sex offenders are convicted of a variety of criminal offences.

In drawing conclusions, Quinsey, Lalumiere, Rice, and Harris postulated that the recidivist child sex offender tends to be a generalist rather than specialist in offence preference. Moreover, the large number of offenders demonstrating aggressive behaviour patterns lead Quinsey et al., to contend that aggression, rather than sexual deviance, is the most salient characteristic of some child sex offenders.

Notwithstanding the importance of prior criminal history (both sexual and non-sexual) as an indicator of an individuals chance of future reconviction, Abel, Mittelman,

Becker, Rathner, and Rouleau (1988) have shown that just harbouring pro-criminal attitudes or personality traits inflates an individual's potential for recidivism. Although, as argued by Rice, Harris and Quinsey (1989), a DSM (American Psychiatric Association, 1994) diagnosis of antisocial personality disorder is not a good indicator of sexual recidivism, higher scores on the Psychopathy Checklist (Hare, 1980) were found to indicate a higher rate of sexual recidivism in a substantial proportion of child sex offenders.

5.3.5 Sexual Arousal

The most consistent influence on reoffence rates among child sex offenders is an enduring sexual preference for children. Sexual motivation is an important consideration in child sex offending, especially with researchers suggesting that a greater arousal to deviant sexual themes (measured by phallometric measures, but not self-reports) results in consistently higher reconviction rates (Barbaree & Marshall, 1988; Hanson, Steffy, & Gauthier, 1992, 1993; Marques, Nelson, West, & Day, 1994; McGrath, 1991; Quinsey, Lalumiere, Rice, & Harris, 1995; Rice, Harris & Quinsey, 1989; Rice, Quinsey, & Harris, 1991).

In 1991, Maletzky reported on his 1 to 17 year follow-up of almost 4000 outpatient sex offenders. Of the pre-treatment sample who demonstrated deviant sexual arousal levels above 80 per cent, close to three-fifths (57.8%) were eventually reconvicted of sexual offences. Alternately, only 18.9 per cent of treatment successes evidenced such arousal patterns. An important point to note in this study was that despite all offenders being sexually involved with a child, not all were seen to have a primary or sole sexual interest in children (i.e., not all were preferential offenders). In fact many showed a sexual interest in adult women.

Previous research has suggested that sexual preferences for children are most common among offenders who select boys. Freund and Watson (1992) have advanced that all men convicted of more than one sexual offence against a boy are expected to have a preference for that victim type. It has also been shown that such sexual preferences are less common among offender who select extra-familial girls and even more sparse among incest offenders (Barbaree & Marshall, 1989; Lang & Frenzel, 1989; Marshall, Barbaree, & Christophe, 1986; Quinsey, 1986).

When Hanson, Steffy and Gauthier (1992) drew conclusions based on their study of 197 child sex offenders released between 1958 and 1974, results were seen to be consistent with the expected level of deviant sexual preference expressed by the offender. That is, the chance of recidivism was highest among unmarried men with a history of sexual offences against male children, whilst lowest among married incest offenders with no prior offences. McGrath (1992) advanced one further point with respect to sexual preference when his research revealed that those offenders who engage in multiple pedophilic behaviours are at higher risk of reoffence than those who have less generalised deviant interests.

Abel, Mittelman, Becker, Rathner, and Rouleau (1988) provided a plausible explanation for McGrath's findings when they postulated that offenders with multiple paraphilic interests differ qualitatively from those with only a single deviant sexual preference. That is, the multi paraphilic offender has more serious problem, and therefore presents with a greater risk of future reoffence and incarceration.

The true significance of sexual preference as an underlying variable of the reoffence potential among child sex offenders stems from its dynamic nature. Although some would disagree, sexual preference can be seen as a changeable variable, and hence

potentially mutable in treatment. Thus when specifically targeted it has the ability to directly impact on future reoffence rates.

5.3.6 Alcohol Abuse

"There is no suggestion that alcohol causes sexual aggression; rather, alcohol can facilitate a pre-existing inclination to sexual aggression" (Crowe & George, 1989, p.384). McGrath (1992) was seen to adhere to this conclusion when he postulated that alcohol serves to disinhibit the already fragile control some offenders have over their deviant sexual urges. Early research by Rada (1976) and Rada, Kellner, Laws, and Winslow (1979) advanced that incestuous child sex offenders had the highest rate of drinking prior to committing an offence (63%), while offence-related drinking among extrafamilial child sex offenders who target girls was 57 per cent. The male-oriented pedophiles used alcohol least (38%) prior to the commission of a sex offences. One further study by Abel Mittelman and Becker (1985) demonstrated that alcohol not only served as a disinhibitor, but it also increased sexual arousal to children in 30 per cent of the child sex offenders in their sample.

5.3.7 Other Variables

Although less often cited, a number of demographic variables have been shown to increase a child sex offenders likelihood of recommitting a sexual offence. Abel, Mittelman, Becker, Rathner, and Rouleau (1988); Hanson, Steffy and Gauthier (1992); Maletzky (1991); Quinsey, Rice, and Harris (1995); and Rice, Quinsey, and Harris (1991) have all demonstrated that martial status influences the rate of recidivism among child sex offenders. All five studies showed that unmarried offenders were more likely to be reconvicted of a sexual offence than were a married individual. While those offenders who were divorced and/or in a defacto style relationships fell between the two.

Similarly, a number of other researchers (Hall, 1988; Malcolm, Andrews, & Quinsey, 1993; Marques, Nelson, West, & Day, 1994; McGrath, 1992; Quinsey, Lalumiere, Rice, & Harris, 1995) have reported that an offender's age, both at the onset of sexual offending and their current age, effects the possibility of future reoffence.

Despite the elongation of the child sex offenders offence curve in relation to other criminal activities, what the above studies have demonstrated is that an early onset of sexual misconduct is significantly correlated to future reoffence. Thus, those individuals who begin offending in late childhood or early adolescence (i.e., preferential offenders) are more likely to be reconvicted of future sex crimes, than is the individual who begins offending later in life (i.e., during the child rearing years or later). Similarly, the aforementioned studies have also revealed that, in general, the older child sex offender is more likely to discontinue his abusive behaviour, while those younger offenders have a greater risk of recidivism.

What the foregoing research demonstrates, is that despite the extensive heterogeneity witnessed in the broader child sex offender population, the sexual recidivist presents with a number of similarities. While many of these commonalties result from criminal history and offence related characteristics, others relate more specifically to the individual. Furthermore, although the majority of these features are static in nature, and therefore immutable to treatment, others are more dynamic. It is these latter characteristics (i.e., denial and sexual preference) which are of paramount importance when considering treatment.

5.4 Risk Assessment

From the extensive research presented above, it is clearly evident that not all child sex offenders are equally likely to recidivate. It may be that case that, as Rice, Quinsey,

and Harris (1991) have suggested, these variables may lay the platform from which predictions of reoffence risk among child sex offenders can be advanced. If the assessment of dangerousness in child sex offenders is indeed possible, it will be important not only to have accurate recidivism rates, but also some understanding of the diversity of potential predictors. Thus, the importance for researchers investigating recidivism risk to have a comprehensive understanding of the static, and more importantly the dynamic, variables which both increase and decrease the potential for sexual recidivism is paramount.

A recent study which addresses this diversity is the meta-analysis by Hanson and Bussière (1996). Hanson et al., reviewed 87 articles (of which the earliest was Doshey, [1943], and half were post 1989) which reported on 61 different data sets from six countries (USA, Canada, United Kingdom, Australia, Denmark, Norway). The 61 samples had a mean size of 198 (median = 475, range = 12 to 4,428) and a total sex offender subject pool of 28,972. Follow-up periods for the samples ranged from six months to 23 years, with a mean of five years six months and a median of 4 years.

Categorising recidivism into three levels (sexual offence, non-sexual violent offence, any offence) the average 4-5 year follow-up period of the analysis revealed an overall recidivism rate of 13.4 per cent for sexual offences. Rapists were found to display the highest level of recidivism with 18.9 per cent of the 1,839 offenders reoffending, while the child sex offender population had a recidivism rate of 12.7 per cent. For non-sexual violent offences the rate of recidivism was 12.2 per cent, while recidivism in the third category (committing any offence) was 36.3 per cent. Non-sexual violent recidivism was seen to be much more likely among rapists (22.1%) than for child sex offenders (9.9%).

Hanson and Bussière's review identified 1,235 correlation's between predictor characteristics and recidivism, of which 970 were useable under the study's inclusion

criteria. After conducting a meta-analysis a total of 165 factor were seen to be significantly ($p < .05$) related to recidivism, with correlation's of .10 or greater. Of these, 69 were predictors of sexual recidivism, 38 were predictors on non-sexual violent recidivism, and 58 related to general recidivism.

Overall the best predictor of recidivism (indiscriminant of category) was a phallometrically assessed sexual preference for children ($r=.32$). Other potential predictors of sexual recidivism included, prior sexual offences (.19), age (-.13), early onset of sexual offending (.12), any prior offences (.13), never being married (.11), diversity of sex crimes (.10), low motivation for treatment (.15) and a variety of psychological measures (personality disorder .16, anger problems .13, high score on the MMPI Masculinity-femininity scale .27).

The study also revealed that recidivism among child sex offenders who were related to, or who knew, their victim was lower than instances where the victim was unknown (family member < acquaintances < stranger). Furthermore, the analysis showed that non-sexual recidivism among child sex offenders was predicted by the same variables that predicted recidivism among non-sexual criminals.

One final feature uncovered by Hanson and Bussière's analysis was the numerous factors which were reported to have no relation to future sexual recidivism. These included being socially introverted, having alcohol abuse problems, using force or injuring a victim, being sexually abused as a child, and belonging to minority race.

Despite the findings of Hanson and Bussière (1996), a note of caution must accompany their meta-analysis. That is, although the study revealed 69 predictors of sexual recidivism, the strength of correlation for these predictors with respect to reoffence was relatively low (i.e., the highest was .32, while the majority were below .20).

Two further points of caution with respect to these data relate to the studies incorporated into the analysis. Firstly, the number of studies analysed with respect to some variables was small (i.e., three in some instances). Especially during those instances where the authors reported a variable had no relation to future sexual recidivism (i.e., being socially introverted and being sexually abused as a child). Secondly, during some instances where the authors had noted potentially problematic outlier studies, such studies were both excluded, then included in the analysis (i.e., producing two separate correlation's). However during other instances the same studies were not considered problematic, and thus treated no differently from the rest.

The ultimate goals of research into the static and dynamic predictors of sex offender recidivism are multifold. Firstly, as advanced by Quinsey, Rice, Harris (1995), research aims to specify how much a certain course of action reduces a particular sex offenders likelihood of recidivism. Second, and perhaps of more importance, a greater awareness of the predictors of sexual assault, child sex offending in particular, would result in an ability to develop more accurate risk assessment scales.

As Hanson et al., noted in their meta-analysis, even the strongest predictor of recidivism does not hold sufficient predictive reliability to justify its use in isolation. Hence, what is called for is an assessment tool which encapsulates the diverse array of variables which significantly predict future sexual reoffending.

CHAPTER VI

Treatment Cost-Effectiveness:

Aside from the primary objective of treatment (i.e., to reduce reoffending), fiscal requirements are also important when appraising the success of child sex offender treatment programs. In light of the growing pressures being placed on resources at all levels of sexual offending (both in relation to the victim and the offender) a number of researchers have suggested it is far less expensive to treat an offender than it is to have them incarcerated. (Consedine, 1995; Marshall, Jones, Ward, Johnston, & Barbaree, 1991; Prentky & Burgess, 1990; Valliant, & Antonowicz, 1992). With research by Marshall (1986: cited in Marshall, Eccles, & Barbaree, 1993) demonstrating that the Canadian taxpayer must part with $200,000 for the investigation, prosecution, and incarceration (for one year) of each new child sex offender, a study into the cost effectiveness of rehabilitation programs was eagerly awaited.

In 1990 Prentky and Burgess constructed and tested a stringent cost-benefit model of sex offender habilitation. Factoring in the cost of incarceration (either in treatment or prison), together with the total cost of reoffence, and the offenders reoffence potential, Prentky et al.'s projected cost for a single reoffence was seen to be $67,989 less for a treated offender than for an untreated child sex offenders. Thus, for ever 100 child sex offenders released from prison, American society must part with an extra 6.8 million dollars over a five year period if offenders remain untreated. Based on these findings Prentky et al. concluded that useless recidivism for untreated sex offenders was at least 22 per cent lower than that seen in treated offenders, it is financially cost-effective to treat the child sex offender.

The extent of these savings becomes even more apparent when viewed through the conclusions of Marshall and his colleagues (Marshall & Barbaree, 1988; Marshall, Eccles, & Barbaree, 1993; Marshall, Jones, Ward, Johnston, & Barbaree, 1991). That is, the recidivist sex offender typically victimises more than one individual. With Abel,

Becker, Cunningham-Rather, Rouleau, Kaplan, and Reich (1984) claiming that the recidivist child sex offender has the potential to commit, on average, 380 sexual offences across his lifetime, an assumption of multiple victimisation is one that results in huge savings, both in terms of the costs incurred by the potential victim, and also the momentous savings in monetary terms.

6.1. Cost Effectiveness of New Zealand Treatment

Currently New Zealand's two child sex offender treatment programs are yet to undergo formal scrutiny in relation to their financial cost effectiveness. What the following sets out to achieve is not so much an in-depth analysis of treatment effectiveness, but instead to provide a basic cost-benefit structure for the institutionally based treatment programs operating in New Zealand. In addressing the issue of cost effectiveness, the present analysis adopts a similar methodology to that advanced by Prentky and Burgess' (1990) cost-benefit model, and draws on data from the Kia Marama sex offender treatment program (Hudson, Marshall, Ward, Johnston, & Jones, 1995; New Zealand Department of Corrections, 1995).

6.1.1 Duration of Incarceration

A review of over 570 cases of sexual victimisation presented in the 'Paedophile and Sex Offender Index' (Coddington, 1996) uncovered 300 instances of sexual abuse involving persons under the age of 16. Acknowledging that the book reports only on offenders who are not granted name suppression (which is usually reserved for incest cases as a means of protecting victim identity), 47 of the 300 sentences handed down between 1990 and 1996 were non-custodial in nature. Three of the remaining sentences were for 'life' imprisonment, while in 16 cases preventive detention (PD) was invoked. For the purposes of this study, an informed estimate (based on the Crimes Act, 1961) of

'life' and PD was set at 14 years in all but one case, where PD was given with a 25 year minimum non parole period.

Averaging the 300 aforementioned convictions, the mean sentence length for child sex offender over the six year period was calculated at 4.6 years (3.9 years excluding the 19 cases of PD and Life). With the 1993 amendments to the Criminal Justice Act (1985) the minimum non-parole period of incarceration is 1/3 of an offenders minimum sentence, except in instances where a sentence of 14 years or more is handed down. In the latter case, such as during life imprisonment or preventive detention, an offenders minimum non-parole period is ten years.

Based on the foregoing, an average minimum non-parole period of incarceration given to child sex offenders between 1990 and 1996 was 1.9 years (22.8 months).

6.1.2 Cost of Incarceration

Within New Zealand nearly $70,000 a year is spent on the incarceration of a maximum security offender, whilst between $24,000 - $35,000 is spent on the confinement of a minimum-security offender (Consedine, 1995). An often reported average for a minimum security child sex offenders is $33,000 per annum, or $2,750 monthly (J. Consedine, personal communication, September, 1996).

Thus in the case of the child sex offender, the cost of an average minimum non-parole sentence would be $133,000 for each new maximum security offender, and $45,600 - $66,500 for a minimum security child molester. Based on the often reported average of $33,000 per annum ($2,750 monthly), a conservative cost estimate for maintaining a minimum security child sex offender over his 22.8 month (minimum) period of incarceration, would cost the New Zealand taxpayer $62,700.

6.1.3 Duration and Cost of Treatment

Currently the Kia Marama habilitation program treats an offender over an intensive eight month period, served concurrently with an individual's custodial sentence. Hence any treatment costs are in addition to, and on top of, the cost of incarceration. This is perhaps the most fundamental deviation from Prentky and Burgess' model, in which child sex offender treatment was an alternative to incarceration.

The annual running cost of the Kia Marama unit is approximately $600,000 (D. Wales, personal communication, January 1997), and in 1996 some 60 men participated in the program. Thus the average cost for the eight months of treatment at the Kia Marama unit is $10,000 for each child sex offender (D. Wales, personal communication, August 1996). Therefore the average cost of maintaining a minimum security treated child sex offender for the minimum 22.8 month non-parole sentence equates to $72,700. That is, $62,700 for an offenders incarceration (22.8 months at $2,750), plus $10,000 for the eight months of treatment. Figures for a maximum security offender were not calculated as the present intake criteria for New Zealand based programs exclude such individuals from participating in treatment.

6.2 Cost-Benefit Analysis

The data entered into the cost-benefit model is shown in Table 3. Offender and Victim related costs were derived from various Government agencies, including New Zealand Child and Young Persons Service (CYPS), Department of Correction (Psychological Services; Community Corrections; Communications Section), ACC, Crown Solicitors Office, Courts Department (Operations Support; Canterbury District Legal Support), and the New Zealand Police (Accounts Section; Sexual Abuse Teams: Auckland, Takapuna, Christchurch) .

All figures are averaged estimates used for the purposes of cost estimation, hence the reader is cautioned against drawing any concrete conclusions. Moreover, all costs presented are seen to vary extensively with respect to incarceration length, number of victims, length of victimisation, nature of the abuse, length of pre-trial investigation, duration of trial, and length of parole.

TABLE 3: New Zealand Cost-Benefit Expenditure Model.

CATEGORY	EXPENDITURE	
Offender-Related Expenses		
Pre-trial Investigation [1]	$ 2,163.50	
Trial Costs [2]	16,440.00	
Incarceration (51.1 months at $2,750) [3]	135,425.00	
Parole (12 months) [4]	3,240.00	
Total Offender Expenses		$ 157,268.50
Victim-Related Expenses		
Specialist Medical Examination [5]	$ 554.75	
E.S.R. Analysis [6]	956.25	
Child Young Persons Services (CYPS) [7]	4,880.00	
Counselling/Therapy (ACC) [8]	843.75	
Compensation Claims [9]	833.00	
Total Victim Expenses		$ 8,067.75
Total Expenses Per Offence		$ 165,336.25

NOTES:

1 Cost of pre-trial investigation was based on a single offender/single victim situation with three witnesses. The average time of investigation totalled 2½ weeks pre-trial (M. Churches: Auckland Sexual Abuse Team, personal communication, August, 1996). Based on a Detectives salary ($45,000 per annum) a figure of $2163.50 was reached. It must be noted that this figure only accounts for one investigators time, whereas at various points in the investigation more than one person is required.

2 Costs are based on an average, yet conservative, three day trial for a non-incestuous child sex offender. Inclusive in the figure is the cost o f Prosecution ($6,500; R. Melville: Crown Solicitors Office, personal communication, August, 1996), the cost of Defence ($6,000 legal aid; Secretary, Canterbury District Legal Services, personal communication, 1996), Police costs ($520; M. Churches: Auckland Sexual Abuse Team, personal communication, August, 1996) and the cost to the Department of Courts ($3,420; W. Jackson: Department of Courts, Christchurch, personal communication, September, 1996). It must be noted that the figure presented for the Department of Courts only includes the cost of the jury, and is exclusive of overheads and other wages (judge, court reporter, court attendant).

[3] Given the extensive variance and erratic nature of sentencing involving the recidivist child sex offenders (ranging from terms of preventive detention to non-custodial community based sentences) the author opted for an averaged minimum non-parole period obtained from 49 actual sentences passed on recidivist child sex offenders presented in the Paedophile and Sex Offender Index (Coddington, September, 1996).

[4] Length of parole was calculated from the averaged parole lengths of the Kia Marama treatment program (12 months: P. Johnston: Kia Marama, personal correspondence, August, 1996), while the cost was derived from the average 9 month parole order (1995-1996) of $2,430. Thus an average twelve month parole cost was set at $2,430 plus one third.

[5] Actual billed cost to the Christchurch Police Sexual Abuse Team from a specialist medical examiner. Figure is based on an average 3 hour medical examination ($131.25 x 3hr.) and its accompanying written report ($81) The cost does not include an after-hours callout fee ($80) or the medical examiners travel expenses ($1.60/km) (M. Neutze: Police Accounts Section, Christchurch, personal communication, July, 1996). However it does includes the cost of a specialised Forensic Examination Kit ($80) provided by the Police.

[6] The billed cost to the Sexual Abuse Team for the analysis of the Forensic Examination Kit by Environmental Science and Research Ltd. (ESR). Note that if DNA sampling is required the cost increases to $1687.50. While if there is also a need for other Toxicology the cost is $4,443.75 [M. Churches, Auckland Sexual Abuse Team, personal communication, July, 1996]. It must be noted that in some instances a second Kit (from the perpetrator) is also required.

[7] Figure based on a non-incestuous case and includes the cost of a Risk Assessment ($2000), an average of three days of social work time ($1440), plus three days ongoing monitoring ($1440). In cases of incest there are additional costs of alternative accommodation for the child if it is required ($100/ week), plus the costs of Family Group Conference processes ($3000). Furthermore, if the current family situation requires a court evaluation an extra 25% of the overall cost can be added (M. English: National Manager of Reporting, CYPS, personal communication, July, 1996).

[8] The Sensitive Claims Unit (ACC) provides an average of 15 counselling sessions for each sexual abuse victim at a cost of $56.25 per hour. Alternately a similar statistic ($833) can be obtained from the units annual counselling budget of $10,000,000 and an upper estimate of 12,000 cases per year. (J. Birkin: Team Leader Sensitive Claims Unit, personal communication, July, 1996).

[9] The Sensitive Claims Unit has an annual claims budget of $10,000,000 (approx.), and with an upper estimate of 12,000 individuals eligible for compensation, the average claim for child sexual abuse is $833.

As evidenced in Table 3 the total average cost resulting from a single instance of child sexual abuse is $165,336.25. However, it must also be acknowledged that there exists numerous other indirect and/or behind the scenes costs in each category, both in terms of the offender and the victim, which further contribute to the financial costs incurred through child sexual abuse.

As with any cost-benefit model of sex offender treatment, the most irresolute feature of the present analysis is the lack of reliable and accurate recidivism data. In light of the

quandaries surrounding recidivism estimation, the current analysis utilised actual reoffence data from the Kia Marama treatment program, and a best estimation of recidivism among untreated child sex offenders.

To obtain a best estimation, an averaged recidivism rate was obtained from three of the most recent, and comprehensive, investigations of sexual reoffence. The first two studies, meta-analyses conducted by Alexander (1993) and Hall (1995), produced untreated reoffence rates of 18.5 and 27 per cent respectively. While the third study was the New Zealand based investigation of McLean and Rush (1990) which reported a recidivism rate for untreated child sex offenders in the order of 25 per cent. Taking these three studies into account, an averaged reoffence rate for untreated child sex offenders was 23.5 per cent.

Based on the above statistics the total projected cost (original case plus reoffence) associated with a single instance of reoffence against a single victim is reported in Table 4.

TABLE 4: Expected Costs Associated With Reoffence.

Type Of Offender	Cost Of Maintaining[1]	Total Cost Per Reoffence	Risk Of Reoffence	Expected Cost Of Reoffence
Untreated	$62,700	+ [$165,336.25	x .235[2]]	= $ 101,554.02
Treated	$72,700	+ [$165,336.25	x .031[3]]	= $ 77,824.42
				$ 23,728.60

NOTES:

1 Cost of initial incarceration either with (Treated) or without (Untreated) specialised treatment.

2 Best estimation of reoffence risk. Averaged rate of Alexander (1993), Hall (1995), and McLean and Rush (1990).

3 Actual recidivism rate at 33 months (average) post-release for the Kia Marama sex offender Unit (New Zealand Department of Corrections, 1995).

Conceding that the aforementioned severely underestimates the complexity of factors and costs involved in the incarceration of child sex offenders, the most conservative estimates of the total projected cost of reoffence for untreated offenders is $101,554. What is also evident from these data is that the projected cost of reoffence for treated individuals ($77,824.42) is $23,728.60 less than is expected if an offender is released without treatment. Therefore, for every 100 child sex offenders released, the cost to society is $2,372,860 greater if these child sex offenders are released from correctional facilities without participating in either of New Zealand's specialised sex offender treatment programs.

In summing up the findings of the present analysis, despite their potential limitations, the results are seen to be in accordance with those advanced by previous researchers (Marshall, 1986: cited in Marshall, Eccles, & Barbaree, 1993; Prentky & Burgess, 1990). Furthermore, given the potential monetary savings, the present data is also in agreement with those who suggest that in the long term, it is far less expensive to treat child sex offenders than it is to incarcerate them (Consedine, 1995; Marshall, Jones, Ward, Johnston, & Barbaree, 1991; Prentky & Burgess, 1990; Valliant & Antonowicz, 1992).

As has been demonstrated, currently within New Zealand the treatment of child sex offenders is a financially cost effective way of dealing with this incarcerated population. When such a finding is coupled with the substantial reduction in recidivism rates evidenced among offenders who participate in treatment, the benefits of the two institutionally based child sex offender treatment programs operating in New Zealand are almost beyond question.

CHAPTER VII

Justification for the Study:

To briefly recap, what we are currently faced with is a serious societal problem which has reached near epidemic, if not pandemic proportions. The ever increasing percentage of child sex offenders within correctional facilities, coupled with the assumption that incarceration alone does not deter (let alone prevent) future reoffence, only further fuels the often heated debate over the habilitation of child sex offenders.

Presenting with various character similarities, treatment of this heterogeneous population is difficult to say the least. Traditional single component approaches failed to encapsulate the diverse and complex dysfunctional cognition's, behaviours and attitudes evident in the child sex offender. Hence with the inevitable failure came a bolstering of the predominating societal conception of untreatability. Thus, the negativity portrayed by lay society toward habilitation was not only confirmed, but grounded in empirical research.

More contemporary conceptualisations, which adopt a comprehensive, multifaceted approach to sex offender treatment, have produced markedly different results. It is now widely accepted that if treatment comprises of a broad-based cognitive behavioural framework, while also incorporating relapse prevention techniques, it can effectively deal with, although not cure, the potential for recidivism among incarcerated child sex offenders.

Together with the positive effects seen in contemporary treatment programs, a growing plethora of research into the recidivism of both treated and untreated child sex offenders suggests that not all offenders present with similar levels of reoffence risk. What becomes apparent is that a complex set of interacting variables place an offender at greater risk of, or may even predict, future recidivism among child sex offenders.

Within New Zealand, as is the case internationally, the two institutionally based child sex offender treatment programs have proven effective in lowering the recidivism among

those who participate. Coupled with such benefits, the findings of the present cost benefit analysis, which suggest that the Kia Marama treatment unit is a financially cost effective program, place the efficacy of child sex offender treatment in New Zealand almost beyond question. However, what if such programs were comprised of a disproportionate number of low risk offenders, instead of a representative cross-section of the child sex offender population. Given such a scenario would the efficacy of such programs still remain unquestionable?

7.1 Rationale for the Study

Within New Zealand the sexual exploitation of children not only predates the arrival of the European, but may have been an acceptable part of early society. In 1908 the Crimes Act set in place legislation which encapsulated the moral and legal sentiments deemed important in society at that time. Hence society's morals were mirrored by legal enforcement, making acts such as pedophilia, incest and rape not only unacceptable, but also illegal. Conceding that legislation stems form social demands and that societal morals may change, the law surrounding such acts has changed little since its inception.

Acknowledging that both cultural diversity and historical discontinuity (i.e., changing attitudes over time) have played an important role in shaping the normalcy of acceptable sexual behaviour, not all persons within any one society accept and abide by the morals and laws imposed on them by that society. This lack of coherence, seen in contemporary society with respect to the morality and legality of child sex offending, has resulted in problems for treatment providers with respect to those who participate in such programs,

especially when treatment adopts similar intake/selection criteria to those advanced by the institutionally based programs of New Zealand.

Given that each of the six intake criterion invoked by New Zealand's two child sex offender treatment programs (see p.56) act to exclude a certain proportion of offenders from treatment, all but one does so on the grounds of an informed judgement made by program administrators. It is this latter criterion, seen to be outside an administrator's control, which is the focus of the present research.

Therefore it is postulated that the second of the intake criteria used by the Kia Marama sex offender treatment program, that is

> "He is fully informed about, and voluntarily consents to enter, the treatment program. Volunteers who exhibit varying degrees of denial of legal guilt (even complete denial of ever having committed an offence) are not excluded" (New Zealand Department of Corrections, 1995 p. 2),

is having an extensive impact on those who participate in such a program and those who remain untreated.

First and foremost, the voluntary nature of New Zealand treatment allows for the existence of a group of individuals who not only refuse to participate in treatment, but who contest that such programs are a waste of time, and the taxpayer's money. With pedophilic organisations such as the Rene Guyon Society and AMBLA (Australasian Man Boy Love Association) holding the motto 'sex before eight or it's too late', together with communities such as the Centrepoint Commune (Albany, Auckland) embracing the philosophy 'you should do whatever feels right', it is not surprising that various sub-cultural norms have developed, within which the words law, justice and morality are not synonymous.

Advancing that society is robbing them of the right to fulfil their needs, and that early sexual experiences for children are educationally beneficial, this group of individual, best viewed as the true pedophile, accept they are operating outside the law but argue the law

is wrong. Hence this group not only supports adult/child sexual contact, but openly admit to and acknowledge their participation in such activities.

Together with such deep seated beliefs, the dysfunctional perceptions held by these men toward contemporary society makes treatment, especially that which is voluntary, less likely, as they both morally and legally dispute child sexual abuse is wrong. Therefore, a voluntary based program like that of the Kia Marama unit acts to exclude what can be viewed as the most chronic and problematic child sex offender from treatment.

Apart from the individuals in the above category, there exists an extensive child sex offender population who exhibit varying levels of minimisation and justification in relation to their offending. As the research suggests, these individuals display a number of offence supportive attitudes, beliefs and cognitions. Many offenders present with ideas that children enjoy and eagerly seek to initiate sexual encounters with adults. While within the offending population, it is widely contended that children can, and are free to, consent to such activities.

This being the case, the issues of legality, which may inhibit an offender's actions, are soon overcome by issues of morality that depict such behaviour as "OK". Therefore if, in the offender's mind, the only thing wrong with child sex offending is that it is against the law, these individuals would be less likely to voluntarily seek placement in a treatment program that acts to change something they view as morally acceptable.

Thirdly, the process of denial plays an important role in child sex offender treatment, especially when such habilitation is voluntary. Acting as a filter against self compunction, denial not only minimises an offender's susceptibility to treatment, but may also reduce their likelihood of participation. Furthermore, even during instances where a child sex offender accepts what they are doing is wrong, more often than not they deny

the existence of a problem and therefore their potential for future reoffence (Barbaree, 1991; Kennedy & Grubin, 1992; Marshall, 1994).

Both Kia Marama and Te Piriti stipulate that volunteers who exhibit varying degrees of denial of legal guilt (even complete denial of ever having committed an offence) are not excluded from treatment. However, if an offender does not view their aberrant behaviour as problematic would they not be less likely to engage in such treatment?

An offender's denial is further compounded within the penal system, where the child sex offender is typically viewed at the bottom of the prison inmate hierarchy, and thus is often the target of unambiguous hostility. Ranging from verbal abuse, assaults, cell fire-bombings and in at least two cases, death, to more indirect attacks (i.e., tampering with a person's food and drink), a child sex offender must, or is more likely to, deny and conceal his offending in order to survive without assault. Indeed a study by McCaghy (1968) found it not uncommon for undisclosed child sex offenders to react with the same militant zeal toward disclosed offenders as was evidenced by the general population.

Furthermore, because an incarcerated child sex offender is often a target while in general population, he would be more reluctant to volunteer for treatment in fear that such a step (especially if treatment and its accompanying segregation was not forthcoming) would lead to his identification as a child sex offender.

In light of the aforementioned, and despite its polemic nature, are those who deny the existence of a problem, or deny any and all legal guilt, not the ones for whom treatment, especially voluntary treatment, is less likely?

One final factor that has an impact on the make-up of a voluntary based treatment program is 'motive'. That is, an individuals underlying reasons for seeking out, and/or participating in treatment. During those instances where child sex offenders opt into treatment for 'treatments sake', individuals can be viewed as the less dysfunctional

offender in that, because they have acknowledged there is a problem and are prepared to make an effort to change, they are halfway toward the goal of minimising future reoffence. Therefore, 'motive' would allow for the accumulation of less dysfunctional offenders, who present with the more attractive personality, within New Zealand's voluntary based child sex offender treatment programs.

What the foregoing suggests is that a number of child sex offenders deny, minimise, or accept their aberrant sexual behaviour and in so doing, legally and/or morally dispute that child sexual abuse is wrong. Because of the inherent dysfunction's which stem from such distorted beliefs, this population of child sex offender can be viewed as the more dangerous offender who presents with the greatest risk of reoffence.

Coupled with the aforementioned assertions, an underlying justification for the current research stems from the extensive variation in reoffence rates of those who undergo treatment and those individuals who do not take part in, or are denied access to, child sex offender treatment programs while incarcerated (Alexander, 1993; Becker & Hunter, 1992; Hall, 1995; Hudson, Marshall, Ward, Johnston, & Jones, 1995; Marshall & Anderson, 1996; Marshall & Barbaree, 1988; Marshall, Eccles, & Barbaree, 1993; Marshall & Fernandez, 1996). Conceding that this variation may arise as the direct and sole consequence of treatment, it can also be questioned as to what extent the voluntary nature of New Zealand based treatment influences such rates.

It is postulated that the inherent categories which stem from New Zealand adopting a voluntary approach to child sex offender treatment, are in fact fundamentally different. That is, on the one hand are those child sex offenders who volunteer for treatment. While on the other are those men who deny, minimise, justify and accept their sexually aberrant behaviour, and by doing so do not volunteer, although eligible, for treatment while incarcerated.

In light of the aforementioned assumptions, it is contended that those who do not volunteer for treatment, despite being eligible, will be the individuals who present with more distorted attitudes, beliefs, and cognitions in respect to adult/child sexual contact and sexual contact in general. Furthermore, these individuals will also display differences in the affective components of personal functioning.

Couple with the cognitive and affective differences, it is also postulated that those child sex offenders who do not volunteer for treatment while incarcerated are the more dysfunctional individuals and therefore present a greater risk of post-release reoffence.

7.2 Hypotheses

Given the aforementioned assertions, contentions and justification, the aims of the present research are multifold. Firstly it will formally document the demographic and personality characteristics of child sex offenders who do not volunteer, despite being eligible, for the Kia Marama treatment program.

Secondly, using the pre-treatment assessment battery of the Kia Marama program, the current research will compare the cognitive and affective components of men who do not volunteers for treatment, with those of child sex offenders who volunteer for the Kia Marama sex offender treatment program.

Third, using the Sex Attitude Questionnaire, the Victim Empathy Measure, and the Relationship Questionnaire the present research will assess, the degree of distorted sexual cognitions, the level of empathic responding, and the styles of adult attachment among the child sex offenders who do not volunteer for treatment while incarcerated.

Finally, based on the often reported predictors of recidivism among child sex offenders, the research will assess the recidivism potential between those child sex offenders who volunteer for treatment and those who do not volunteer for the Kia Marama treatment program while incarcerated.

It is therefore hypothesised that,

1a. Child sex offenders who do not volunteer for treatment while incarcerated, despite being eligible, will have a more dysfunctional cognitive disposition than the pre-treatment characteristics of those men who have undergone treatment.

1b. Child sex offenders who do not volunteer for treatment while incarcerated, despite being eligible, will differ in their affective make-up from those who volunteer for treatment

2. Child sex offenders who do not volunteer for treatment while incarcerated, despite being eligible, will display more deviant cognitions with respect to adult/child sexual contact, as measured by the Hanson-Sex Attitude Questionnaire, than either a 'normal' population or Hanson, Gizzarelli and Scott's (1994) scale development sample of child sex offenders.

3. Child sex offenders who do not volunteer for treatment while incarcerated, despite being eligible, will display less empathy, as measured by the Victim Empathy Measure, than was reported in the scale development sample of Marshall, Fernandez, Lightbody, and O'Sullivan (1994).

4. Child sex offenders who do not volunteer for treatment while incarcerated, despite being eligible, will differ from the pre-treatment Kia Marama participant sample of Ward, Hudson, and Marshall (1996) in their style of adult attachment, as measured by the Relationship Questionnaire.

5. Child sex offenders who do not volunteer for treatment while incarcerated, despite being eligible, will display more of the characteristics reported to predict recidivism than do those men who volunteer for treatment. In so doing the former group would be viewed as posing a greater risk of post-release recidivism.

6. Child sex offenders who do not volunteer for the Kia Marama treatment program, despite being eligible, will present with higher levels of denial of legal guilt than those who volunteer for treatment.

PART II

THE STUDY:

1. Method

1.1 Participants:

Participants were recruited from the child sex offender population at Rolleston and Paparua prisons. Taking into account the 2 year minimum sentence length intake criteria needed to complete the Kia Marama programme, a review of the prisons' musters produced 56 potential participants. Given that prospective applicants for Kia Marama undergo an assessment as soon as possible after their initial incarceration, some offenders will either be awaiting the commencement of treatment, or awaiting a date closer to their release to be transferred to the unit. Therefore any offender who had indicated their willingness to enter Kia Marama at the time of their assessment was excluded from the present analysis. A resultant population of 42 qualifying individuals was found.

When this group of individuals were approached, 20 (48%) declined the invitation to participate. These 20 individuals made up the first data group in the present analysis. That is, individuals who did not volunteer for the Kia Marama program, despite being eligible, and also did not volunteer for the present study (i.e., Non-Participants).

After conducting assessments two of the remaining 22 individuals were dropped from the study. The first was deemed inappropriate because, despite convictions for rape and assaults on a child, he had not been specifically charged with a sexual offence against a minor. The second individual, although not originally interested in the Kia Marama program, showed extensive interest in taking part in the program throughout the current assessment procedures.

In one further case, an individual's data was retained despite not being specifically charged with a child sexual offence. In the forgoing instance the individual had been convicted of murder, but as the victim was a 16 year old girl with whom the perpetrator

had been sexually involved with since she was thirteen, his circumstances were deemed appropriate.

After accounting for the two individuals who did not meet the present studies inclusion criteria, a second data group, comprising of 20 child sex offenders who volunteered for the study but refused treatment at Kia Marama, was formed (i.e., Participants).

A final data group (i.e., Kia Marama Participants) was formed from a randomly drawn sample of Kia Marama treatment participants. Individuals for this group continued to be drawn until 20 child sex offenders, for whom a complete set of pre-treatment data was available, were obtained.

1.2 Apparatus:

An extensive test battery was constructed and utilised for data collection. Page one of the battery (Information Sheet: see Appendix 3) invited inmates to participate in a research project investigating their perceptions of children, women, and adult/child sexual contact. Participants were informed that participation was strictly voluntary and any involvement in the study would have no bearing on their sentence or future parole eligibility. Furthermore, participants were assured of complete anonymity and confidentiality.

Page two consisted of a Consent Form (see Appendix 4), which when signed indicated an individuals consent to both participation and publication of the results. Participants were again reminded that any involvement was strictly voluntary, and that they had the right to withdraw them-self and their data from the study at any time without further repercussion.

The remainder of the battery comprised of a series of questionnaires and scales measuring a diverse array of attitudes, cognition's, personality characteristics, empathy deficits, and adult attachment style.

1.3 Measures:

In all, 17 questionnaire were used for data collection. For administration and scoring purposes, nine of the questionnaires (Abel & Becker Cognition's Scale; Hostility Towards Women Scale; Hanson-Sex Attitudes Questionnaire; Wilson Sex Fantasy Questionnaire; Social Self-Esteem Inventory; Assertion Inventory; Fear of Intimacy Scale; Loneliness Scale; Social Desirability Inventory) were transferred to a computer based administration scoring program ("Quest": Barrett, 1996).

What follows is an outline of each scale, together with their scoring and interpretation procedures;

Abel & Becker Cognition Scale (Abel, Becker, Cunningham-Rathner, Rouleau, Kaplan, & Reich, 1984): The Cognition scale comprises of 29 items measuring the extent of an individuals cognitive distortions. Each statement reflects an individuals values about adult sexual contact with children. Scored on a 5-point Likert scale, lower score on each item reflect a greater degree of acceptance of child sexual contact. An overall score of less than 100 indicates the presence of deviant adult/child sexual cognitions. Test-retest reliability was found to be .76 over a three week period with coefficient alphas ranging from .59 to .84 (Hayashino, Wurtele, & Klebe, 1995).

Hostility Towards Women Scale (Check, 1985) The hostility toward women scale comprises of 30 true/false questions designed to tap an individual's feelings toward women. With total scores ranging between 0 and 30, a score of 7 or more indicates an

individual shows hostile tendencies towards women. An Inter-item correlation for the scale is reported to be .11, while its Chronbach Alpha was reported to be .65. The correlation with social desirability was .04.

Rape Myth Acceptance Scale (Burt, 1980): Burt's rape myth scale consists of 19 items measuring the rejection or acceptance of rape myths. Items 1-11 are scored on a 7-point scale from 'strongly disagree' to 'strongly agree', with item 2 reverse keyed. Questions 12 and 13 are scored from 'almost none' to 'almost all', while items 14-19 are reverse keyed and scored on a 7-point scale from 'never' to 'always'. Scale scores range from 19 to 133, with a mean of 53.4 and a standard deviation of 18 (Salter, Kairys, & Teague: cited in Salter, 1988). Generally, scores greater than 35 indicate the acceptance of inappropriate rape myths.

Wilson Sexual Fantasy Questionnaire (Wilson, 1978a): The sexual fantasy questionnaire is a 40-item scale measuring a diverse array of sexual activity, ranging from sadomasochism to object fetishism. Participants are required to rate how often they fantasise about each theme on a six point Likert scale (0= Never to 5= Regularly). The 40 items are clasped into four fantasy factors; Exploratory, Intimate, Impersonal, and Sado-masochistic with each category score ranging from 0 to 50. A study by Gosselin, and Wilson (1980) normed the four categories at 8.1, 16.9, 7.6, 2.3 respectively (total = 34.9) for a 'normal' population.

Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979; Beck & Steer, 1987): Beck's depression inventory comprises of 21 items designed to assess the severity of depression in adolescents and adults. Scored on a 4-point scale from 0 to 3, an overall score of between 0 and 63 results. Although individuals may indicate more than one response on any one item, during scoring the response with the highest rating is

used. A score of 30+ reflects extreme severe depression, while those below 10 indicate a normal, non-depressive state. Intermediary scores reflect mild-moderate depression (10-18) and moderate-severe depression (19-29). Test-retest reliability was reported at .90 over a two week period (Lightfoot & Oliver, 1985), whilst Beck and Steer (1987) also identified numerous forms of validity (content, discriminant, construct, concurrent, and factorial).

State-Trait Anxiety Inventory (Spielberger, 1983; 1984): The State-trait anxiety inventory contains two sub-scales. The 'A-State' scale consists of 20 short descriptive statements answered in reference to an individuals current feeling state. Scored on a four point scale (not at all - very much so) overall scores range from 20 to 80. Scores greater than 37 indicate an individual is currently anxious. Sub-scale two (A-Trait) measures the relative stability of anxiety proneness. Like the former it to is scored on four point scale (almost never, sometimes, often, almost always), with the 20 items (nine of which are reverse keyed) generating an overall score between 20 and 80. Scores above 40 depict a person who is typically anxious. Internal consistency for the two scales is .80 and .90 respectively, with the A-Trait scale demonstrating a test-retest reliability of .70. The A-State scale has a test-retest reliability (20 to 104 days) ranging from .27 to .62.

State-Trait Anger Express Inventory (Spielberger, 1988): The STAXI comprises of 44 item which result in six scales and two subscales. The State-Anger (S-Anger) component contains 10 items scored on a four point scale (1= Not at all, 4= Very much so). Measuring the intensity of angry feelings at a particular time, scores above 15 indicate the individual is presently angry. Similarly, the Trait-Anger (T-Anger) component comprises of 10 items, scored from Almost never (1) to Almost always (4). Measuring an individuals disposition to experience anger, an overall score above 15

indicates the individual is typically angry. T-Anger contains two sub-scales each consisting of four items. Angry Temperament (T-Anger/T) measures a general propensity to experience and express anger without provocation, while Angry Reaction (T-Anger/R) measures differences in disposition to express anger when criticised of treated unfairly. Three of the remaining scales comprise of 8 items answered on a four point scale from Almost never (1) to Almost always (4). Scores above 15 on the Anger-in (AX/In) and Anger-out (AX/Out) indicates an individual suppresses (internalises anger) or externalises (acts out anger) the anger, respectively. A score of below 20 on the Anger control (AX/Con) indicates the individual has poor anger control. The final scale is a generalised frequency of anger expression and is derived from scores on the three former scales (AX/In, AX/Out, AX/Con).

Social Self-Esteem Inventory (Lawson, Marshall, & McGrath, 1979): This 30 item scale was developed to measure the self confidence of individuals in social situations. Reflecting a single factor, the questionnaire is scored on a 6-point scale (1 to 6). Total scores range from 30 (low in self-esteem) to 180 (high in self esteem), with scores below 130 indicating low social self-esteem. Test-retest reliability for the overall score was .88 over a four week period, while retest reliability for individual items ranged from .33 (item 20) to .70 (item 7).

Assertion Inventory: Response Probability (Gambrill & Richey, 1975): The Response probability portion of the Assertion Inventory is a 40-item self-report questionnaire measuring an individuals probability of displaying certain assertive behaviours in varying situations. In essence the AI:RP is a measure of an individuals degree of assertiveness. Scored from 'always do it' (1) to 'never do it' (5), an overall scale score between 40 and 200 is obtained. Scores of 105 and above indicates a high

assertive response probability, while those below 105 demonstrate low assertiveness. Test-retest reliability for the AI:RP is reported to be .81.

Fear of Intimacy Scale (Descutner & Thelen, 1991): The FIS was designed to assess a specific variable that influences intimacy (fear of intimacy) in close relationships, or at the prospect of a close relationship. The 35 item questionnaire is scored on a five-point Likert scale from 1 (not at all characteristic of me) to 5 (extremely characteristic of me). Consisting of two parts, Part A (Questions 1-26) is answered with regard to an individuals present relationship (if only hypothetical), while Part B (items 27-35) relates to previous relationships. Overall scores range from 35 to 175, with scores above 100 indicating a fear of intimacy within close relationships. The FIS scale has proven to have high internal consistency (.93 [Descutner & Thelen, 1991], .92 [Doi & Thelen, 1993]) and high test-retest reliability (.89).

University of California Loneliness Scale (Revised) (Russell, Peplau, & Cutrona, 1980): Scored on a 1 (never) to 4 (often) scale, the 20 self-reported items that make up the revised version of the UCLS are designed to measure loneliness. Overall scores range from 20 to 80, with 10 items reverse keyed. Scores greater than 45 indicate the individual has experiences and emotions associated with loneliness. The scale has a co-efficient alpha (internal consistency) of .94, and is seen to hold both concurrent and discriminant validity.

Marlowe-Crowne Social Desirability Inventory (Crowne & Marlowe, 1960): The 33-item SDI assess the tendency to perceive and present oneself in an unrealistically positive (or negative) light. Scored on a True/False basis, a scale total ranges from 0 to 33. Scores above 15 reveal the individual is "faking good" by presenting himself in an unrealistically positive light. Test-retest reliability is reported to be .89, while the scales

internal consistency coefficient is .88 for a sample of normal college students (Crowne & Marlowe, 1964). Similarly, Hayashino, Wurtele, and Klebe (1995) reported a Cronbach's alpha of .87.

Shipley - Vocabulary and Abstraction Test (Shipley, 1940): The Shipley intelligence test is a 60 question test divided into to components. Section A (Vocabulary Test) comprises of 40 questions assessing an individuals vocabulary/ language ability. A scale score results from summing one point for each correct answer, and one point for each four questions unanswered. Section B assess and individuals abstraction ability via a 20 question test. Scale scores result from summing one point for each correct answer and them multiplying it by 2. Once these adjustments have been made the two scores are combined to give an overall raw scale score. This score is then used to obtain a WAIS Equivalent from conversion tables based on the individuals age. Intelligence Classifications range from Mental Defective through to Very Superior. Intermittent classes include; Borderline; Dull Normal; Average; Bright Normal; and Superior.

Victim Empathy Measure (Marshall, Fernandez, Lightbody, & O'Sullivan, 1994): Marshall et al.'s empathy measure is a multi-component self-report questionnaire designed to measure the diversity and complexity of sex offender empathy deficits. Consisting of three scales, one measuring generalised empathy for a non-specific incident (i.e., a car accident child victim [parts A and C]), one measuring generalised empathy for an incident-specific event (an act of child molestation [parts B and D]), and the third measuring victim specific empathy (empathy for an offenders actual victim [parts E and F]). Parts A, B, and E tap an offenders ability to recognise and take the perspective of a child victim, while parts C, D, and F measure the degree to which an offender expresses an appropriate feeling toward child victims. Each of the former three parts contain 30

items (five of which are reverse keyed) measured on a scale from 'not at all' (0) to 'very much' (10), while the three latter scales comprise of 20 items each (six of which are reverse keyed). Responses are made in relation to the degree to which an individual endorses the feelings expressed in each question. Total scale score range from 0 to 500 with higher scores indicating greater degrees of empathy. Mean scores for a child molester sample were reported to be 277.62 (accident victim), 284.76 (sexual abuse victim), and 173.59 (own victim). While Marshall et al., found the internal reliability of the first two scales to be .85 and .84 respectively, and a two-week test-retest reliability for the scales of .83 and .64.

Hanson-Sex Attitude Questionnaire (Short version) (Hanson, Gizzarelli, & Scott, 1994): The Hanson SAQ-short version is a condensed form of the Hanson Sex Attitude Questionnaire. Comprising of two of the original six scales, one of the SAQ scales measures the tendency to perceive children as sexually attractive and sexually motivated (Sexy Kids - 12 items), while the other measures beliefs about male sexual entitlement and the necessity to fulfil ones sexual urges (Sexual Entitlement - 9 items). These 21 items, together with six questions (Factor 1) drawn from the Abel and Becker Cognition Scale, and two from Hanson's Sexual Harm Scale are combined to form a 29 item questionnaire scored on a five point Likert scale (completely disagree to completely agree). Results are obtained by summing scale scores then categorising them into various levels of deviancy. For the Sexy Kids scale scores below 24 are within the normal range, while those above 29 indicate serious deviance. Similarly, scores of below 22 on the Sexual Entitlement scale are deemed normal, while those above 24 represent serious deviance. Intermediate scores on both scales represent moderate levels of deviancy.

Relationship Questionnaire (Griffin & Bartholomew, 1994): The Relationship Questionnaire is an adapted version of Hazan and Shaver's (1987) attachment measure. Comprising of four descriptive paragraphs reflecting the four attachment styles (that is, Secure, Pre-occupied, Fearful, Dismissing), the RQ is a self-reported measure of adult attachment. Consisting of two parts, an individual is firstly required to indicate the overall style that best describes their adult romantic relationships. Part two requires the individual to rate each of the four paragraphs on a 7-point scale (from 'not at all like me' to 'very much like me') depicting the degree to which each reflects his romantic style.

Millon Clinical Multiaxial Inventory-II (Millon, 1987): The MCMI-II comprises of 175 self administered items answered on a True/False basis. Twenty two clinical scales divided into four main sections result; Basic clinical personality patterns (Scales 1-5, 6A, 6B, 7, 8A, 8B); Severe or pathological personality disorders (Scales S, C, P); Moderate clinical syndrome (Scales A, H, N, D, B, T); and Severe clinical syndrome (Scales SS, CC, PP). By summing each scales weighted scores, raw scale totals are then converted to their Base Rate (BR) equivalents using standardised tables. After undergoing numerous transformations for inappropriate responding, denoted by elevated scores on scales V(Validity), X(Disclosure), Y(Desirability) and Z(Debasement), a final BR score is obtained for each scale.

Interpretation of the first section, Basic Clinical Personality, is derived from the top three cluster of scales that are above the BR=75 cut-off. Using the resultant personality configuration a corresponding narrative is obtained which identifies the various interpersonal pattern, affectivity, cognitive style, and behavioural tendencies evident in the individuals personality. For the remaining three sections classification stems from BR scores of 75-84, or scores of 85 and above.

For section two (Severe Personality Pathologies) BR's between and inclusive of 75-84 suggest chronic and moderately severe levels of personality functioning, while those above 84 are indicative of more decompensated personality patterns (Schizopal, Borderline, and Paranoid). In the case of Moderate Clinical Syndrome, BR's within the first range indicate the presence of the scales disorder, whereas those above 84 provide strong support for the presence of the pathological symptom.

The final section, Severe Clinical Syndrome, is designed to assess an individuals level of psychotic disturbance. BR scores within the range 75-84 are highly suggestive, while those above 84 provide strong support for the presence of the scales psychotic disturbance.

1.4 Procedure:

Test administration was conducted on a one-to-one basis (administrator and offender) in the interview room of the respective prison wings. In two cases interviews were conducted outside the offender's wing to preserve harmony and avoid the possibility of negative retribution, as the individuals were undisclosed within their wing as to the nature of their criminal offending. After a brief introduction (in some instances this took up to an hour) twenty men declined the invitation to participate in the present study. For these individuals, (referred to from this point on as Non-Participants) a file review was conducted to gain demographic and offence history characteristics.

In the case of research participants, data collection occurred over 2 three hour sessions. Session one began with a brief discussion outlining the research and the rights of the participant. Upon completion consent was obtained and the individual spent the remainder of the session working through the battery of seventeen randomly assigned questionnaires. At the end of the first session any concerns the participant had were discussed, after which they were free to leave.

The second session occurred in an identical time slot during the proceeding week, at which time individuals completed the remainder of the questionnaires. Upon completion of the test battery any concerns were again discussed, and all participants where asked for feedback on the testing and administration procedures.

During the administration of all questionnaires except three, the researcher was present (in an unintrusive manner) in the interview room to answer any questions. Prior to the commencement of the Hanson Sex Attitude Questionnaire, the Abel & Becker Cognition Scale, and the Victim Empathy Measure, the researcher excused himself from the room to minimise any effects his presence may have had on the participant's answers.

It must be noted that data for three of the questionnaires in the current battery (i.e., the Hanson-Sex Attitude Questionnaire, the Relationship Questionnaire, and the Victim Empathy Measure) was obtained from the participant sample only and thus these scales were not used in the comparative analysis. This was the case as data for the Kia Marama participant sample was obtained from the existing pool of information for those individuals who have undergone treatment. As the current Kia Marama assessment battery does not include these three measures, together with the fact that many of the individuals in the Kia Marama participant sample have since been released from prison, it was impossible to obtain data with respect to these three scales.

A detailed file review of the participant's criminal record was then undertaken. With respect to an offender's denial, a subjective measure of the degree of denial of legal guilt was obtained during the file review process. In the case of the participant sample (and in some instances, the non-participant sample) this was further validated during the interview, where individuals were asked 'do you think your current conviction is fair? Why/why not?'.

A 'complete denial' classification (i.e., 3) was given to an individual if, in the Judges summation notes, they denied the charges brought against them and if, during the various psychological assessments present in an offender's file, they denied committing the alleged act/s. Furthermore, if the offender denied their alleged crimes when asked during the interview, this was taken as further proof of their denial of legal guilt.

Given that most child sex offenders present with some level of denial in regard to their past sexual deviancy (Barbaree, 1991; Jackson & Thomas-Peter, 1994; Marshall, 1994; Shaw & Schlank, 1992; Ward, Hudson, & Marshall, 1995), in the present context an individual was classified as having 'no denial' (i.e., 1) if, in all instances of measurement (i.e., the judges summation notes, other psychological assessments in their file, and when asked), the offender accepted the charges, their conviction, and their alleged sexual deviancy.

A classification of 'minimisation' (i.e., 2) was given to those individuals who did not fall into either of the two aforementioned categories. Hence, those in the minimisation group were potentially the most heterogeneous with respect to their degree of denial of legal guilt.

2. *Results*

2.1 Demographic/Personality Characteristics.

Table 5 displays a brief account of the demographic characteristics for the three samples used in the current analysis. For more comprehensive data the reader is referred to Appendix 5. As reported in the table the non-participant sample was significantly older, had significantly less formal education and was significantly less likely to have been in full-time employment prior to their arrest than were either the Participant sample or the Kia Marama Participant sample.

TABLE 5: Demographic Characteristics of Offender Groups.

	Non-Participants[1]	*Participants*[1]	*Kia Marama Participants*[1]
Age (years)	52.25 (11.1)^{aa}	43.65 (13.6)^{bb}	39.85 (9.63)^{bb}
Education (highest form completed)	3.05 (1.57)^{a}	4.45 (1.50)^{b}	4.30 (1.38)^{b}
Employment (prior to arrest)	1.15 (0.37)^{a}	1.55 (0.51)^{b}	1.55 (0.51)^{b}
Marital Status (prior to arrest)	2.65 (1.04)	2.70 (1.08)	3.00 (0.97)
Number of Children (+ step-children)	3.35 (2.68)	3.05 (2.95)	2.60 (1.10)

NOTES:
[1] n = 20.
Figures in parenthesis are standard deviations.
Different scripts (^{a,b}) indicate significant differences
(^{a,b}), (^{aa,bb}) indicate significance at $p < .05$, $p < .01$ respectively.

Personality Characteristics.

Table 6 presents the Millon clinical profiles for 19 of the 20 individuals in the participant sample, together with the resulting personality profiles for each offender. The remaining participant provided data which was well above the scales acceptable level and therefore was invalid and uninterpretable.

TABLE 6: Millon Clinical Multiaxial Inventory Profiles.

	MCMI-II Profiles[1]	*Personality Cluster*[2]	*Personality Profile*[3]
1[ac]	8B356B7**8A*6A421+ // P** // - // PP**SS* //	3, 5, 7	357
2	-*56A6B*48A2738B+1" // C* // B* // - //	5, 6A, 0	564
3	8A6A**5*6B+48B"7321 // - // - // - //	8A, 6A, 5	856
4[c]	5**46B*7+6A38A"8B21 // - // - // - //	5, 4, 0	540
5[ac]	7326B**18B*8A4+6A5" // C* // AHD* // - //	7, 3, 2	370
6	6B8A2**6A1*8B57+43" // - // T* // - //	8A, 2, 6A	826
7[bc]	7**3*1+456B8B"26A8A // - // - // - //	7, 0, 0	700
8[a]	8B238A** -*416A6B+75" // CS* // D* // - //	2, 3, 8A	238
9[a]	46A6B58A** -*8B+27"13//P**C*//NT**B*//PP*//	4, 6A, 5	468
10[c]	6A8A5**6B*28B3417" // C* // - // - //	6A, 8A, 5	658
11[c]	75**36B*6A1+48B28A" // - // AH* // - //	7, 5, 3	750
12[c]	-**7*56A36B4+18B2"8A // - // - // - //	7, 0, 0	700
13[c]	537** -*8B146A26B+8A" // - // - // - //	5, 3, 7	530
14[ad]	8B2318A7** -*6A+6B54" // S** //AB*// PPSS*//	2, 3, 1	231
15[a]	8B26A3**1*8A74+6B5" // - // B**DT* // - //	2, 6A, 3	260
16[c]	71**2*35+6B8B6A4"8A // SP* // - // PP* //	7, 1, 2	720
17[c]	4**56A6B*8A372+8B1" // - // - // - //	4, 5, 6A	456
18[b]	-** -*71+6A6B3"5248A8B1 // - // - // - //	0, 0, 0	000
19[c]	37** -*18B25+46B8A"6A // - // - // - //	3, 7, 0	370

NOTATION:

[1] The 22 clinical scales are divided into four main sections; Section One: Basic clinical personality patterns (1= Schizoid, 2= Avoidant, 3= Dependent, 4= Histrionic, 5= Narcissistic, 6A= Antisocial, 6B= Aggressive[Sadistic], 7= Compulsive, 8A= Passive-Aggressive, 8B= Self-Defeating); Section Two: Severe or pathological personality disorders (S= Schizotypal, C= Borderline, P= Paranoid); Section Three: Moderate clinical syndromes (A= Anxiety, H= Somatoform, N= Bipolar:Manic, D= Dysthymia, B= Alcohol Dependence, T= Drug Dependence); and Section Four: Severe clinical syndromes (SS= Thought Disorder, CC= Major Depression, PP= Delusional Disorder). Divided by double slashes (//), the first set of scales are to the left of the first double slash, while the final set of three scales is to the left of the fourth set of double slashes. In all cases scales followed by a double star (**) indicate BR scale scores of 85 or greater; while those with a BR score 84-75 are followed by a single star (*). In the case of the first section only, BR scores between 74 and 60 are followed by a plus (+); while those in the order of 59-35 are followed by quotation marks ("). Scores falling below a BR of 35 close the first section to the left of the first double slash. In all instances a dash (-) indicates no scale was in the respective range.

[2] Highest three clinical personality pattern scales which are above the BR = 75 cut-off criteria. Scores of 0 are used as a place holder and indicate their was no scale above the BR = 75 threshold. Note that scales 6B and 8B are excluded in the formation of the personality cluster.

[3] Personality Profiles derived from an individuals personality cluster. See Choca, Shanley, & Van Denburg (1993) (pp.73-114) for a narrative interpretation of each Profile.

NOTES:

[a] Caution advised as BR scores of greater than 75 on Scale X (Disclosure) indicates an individual who presented with an unusually open and self-revealing attitude.

[b] Caution advised as BR scores of less than 35 on Scale X indicates an individual who is generally hesitant or unwilling to be candid about psychological feelings or problems.

[c] Caution advised during interpretation as participant displayed a tendency to portray himself in a favourable, if not personally appealing, light (BR scores of above 75 on the Desirability Gauge[Scale Y]).

[d] Caution advised during interpretation as participant displayed an inclination to depreciate or devalue himself (BR scores of above 75 on Debasement Measure[Scale Z]).

With regard to the Basic Clinical Personality patterns (section one), if all cases where the BR cut-off of 75 was not reached are excluded, two personality patterns (7 & 5) accounted for 39% of the position one places (i.e., highest BR score) in the personality clusters. Extending this to include the second highest score in each cluster, 35.3% of the variability was accounted for by these two scales. While as an overall percentage, scales seven and five accounted for 36.1% of the entire personality clusters. If the third most frequent scale (i.e., scale 3) is factored into the equation the percentages rise to 55.6%, 52.9% and 53.2% respectively. While if one also incorporates scale 6A (that is, scale 7, 5, 3, 6A) the amount of variability accounted for by these four scales is increases to 61.1%, 67.6% and 68.1% respectively.

Other noteworthy findings depicted in these data are the eight individuals whom presented with at least moderately severe Pathological Personality Disorders (section two), three of which (participants one, nine, and fourteen) expressed chronic pathological patterns of Paranoia or Schizopal.

Similarly, eight participants displayed patterns (BR= 75-84) indicative of at least one Moderate Clinical Syndrome, with individual Nine providing strong support for the

presence of both Bipolar Mania and Drug Dependency (BR ≥ 85). While participant Fifteen displayed strong support for Alcohol Dependency.

As can also be seen in the Table 6, four individuals displayed scores (BR= 75-84) that were highly suggestive of a Psychotic Disturbance. Whereas individual One providing strong support (i.e., a BR score greater than 84 [PP**]) for the presence of a Delusional Disorder.

2.2 Analysis of Questionnaire Measures.

Hypothesis 1a & 1b

Table 7 displays the mean scale scores for each of the measures used in the comparative analysis.

A note of caution accompanies seven of the Participant scale scores as they showed significant correlation's (i.e., all four of the Wilson Sex Fantasy Questionnaire scales Exploration [-.75, $p < .001$]; Intimacy -.58, Impersonal -.61, Sado-masochistic -.57 [$p < .01$]. The Trait Anxiety scale [-.61, $p < .01$] and both the Social Self Esteem .46 and Anger Control .50 scales [$p < .05$]) with the Social Desirability Inventory.

Caution is also advised when interpreting five of the Kia Marama Participant sample scores as they too showed significant correlation's (Anger Suppression -.52, Anger Control -.49 [$p < .05$]; Trait Anger -.61, Anger Expression -.70, Overall Anger Expression -.73 [$p < .01$]) with social desirability.

A multivariate analysis of variance (MANOVA) was performed on these data and revealed an overall significant difference between the two groups ($F[22,17] = 2.212$, $p < .05$). F-tests resulted in significant differences on the following scales; SSEI: $Ft(1,38) = 16.821$, $p < .00001$; STAI-SA: $Ft(1,38) = 11.893$, $p < .001$; STAI-TA: $Ft(1,38) =$

10.185, $p < .005$; STAXI-SA: $Ft(1,38) = 6.135$, $p < .02$; UCLS-R: $Ft(1,38) = 6.22$, $p < .02$; and AI:RP: $Ft(1,38) = 4.271$, $p < .05$ (see Table 7).

TABLE 7: Summary Table Of Scale Means.

	Participants[1]	*Kia Marama Participants*[1]
Cognitive/Intellectual Components.		
Abel & Becker Cognition's Scale (A&B-CS)	123.90 (11.56)	123.45 (14.71)
Hostility Towards Women Scale (HTW)	**9.95** (5.43)	**10.70** (4.82)
Rape Myth Acceptance Scale (RMAS)	**45.30** (17.00)	**37.65** (20.73)
Wilson Sex Fantasy Questionnaire (WSFQ)		
Exploratory	6.65 (5.79)	10.45 (7.24)
Intimacy	19.85 (11.27)	23.35 (8.10)
Impersonal	6.55 (5.64)	10.60 (7.46)
Sado/Masochistic	2.20 (3.12)	3.15 (3.82)
Shipley Intelligence Test (WAIS-R Equivalent)	99.45 (15.87)	97.95 (17.61)
Marlowe-Crowne Social Desirability Inventory (SDI)	**18.70** (5.94)	**17.40** (5.95)
Affective Components.		
Beck Depression Inventory (BDI)	9.25 (6.87)	13.9 (9.01)
State-Trait Anxiety Inventory (STAI)		
State anxiety	29.75 (8.19)***	**40.55** (11.36)***
Trait anxiety	34.25 (10.52)**	**44.60** (9.99)**
State-Trait Anger Express Inventory (STAXI)		
State anger	10.20 (0.70)*	11.90 (2.99)*
Trait anger	**18.40** (6.75)	**18.15** (4.96)
Anger expression	**17.80** (5.57)	**16.90** (3.65)
Anger suppression	14.95 (4.08)	13.75 (3.57)
Anger control	24.30 (6.13)	22.90 (6.14)
Anger	24.45 (11.49)	23.75 (10.15)
Social Self-Esteem Inventory (SSEI)	140.10 (27.16)****	**105.50** (26.19)****
Assertion Inventory: Response Probability (AI:RP)	99.45 (18.61)*	**115.65** (29.71)*
Fear of Intimacy Scale (FIS)	98.85 (17.67)	91.00 (17.25)
University of California Loneliness Scale (UCLS-R)	37.60 (12.89)*	**46.35** (8.94)*

NOTES:

[1] n = 20. Standard deviations are in parentheses.
Figures in bold indicate scale means which are outside the scales 'normal' range.
(*), (**), (***) and (****) indicate significance at $p < .05$, $p < .01$, $p < .001$, $p < .0001$ respectively.

Hypothesis 2

Mean scale scores on the Hanson-Sex Attitude Questionnaire were 17.65 (SD=6.33: Sexy Kids) and 15.25 (SD=4.10: Sexual Entitlement). Two individuals scored at least a moderate degree of deviancy on both Sexual Entitlement (scores of 22, 23) and the Sexy Kids scale's (26, 33), with the latter participant displaying serious deviancy on the Sexy Kids scale (33). Two other participants scored a moderate degree of deviancy on the Sexy Kids scale (scores of 26, 27), while a third showed moderate deviancy on the Sexual Entitlement scale (23).

When mean scale response scores (i.e., Scale mean/ Scale items) of the present study (1.47 [SD=.53], 1.69 [SD=.46]) were compared to those of Hanson et al.'s original study (1.9 [SD=.92], 2.3 [SD=.98]), a significant difference ($p < .01$) was found in responding on the latter of these two scales. That is, the Sexual Entitlement scale.

Hypothesis 3

Using the Victim Empathy Measure data was collected from 19 individuals on two of the scale measures (Traffic Accident Victim and Child Sexual Abuse Victim), while 14 individuals accepted they had offended and provided information with regard to their Own Victim/s.

Combining the two parts of each scale, (Traffic Accident/Child, 167.95[SD=73.96] + Traffic Accident/Offender, 119.74[SD=34.21]), (Sexual Abuse/Child, 209.74[SD=68.96] + Sexual Abuse/Offender, 140.89[SD=45.78]), (Own Victim/Child, 189.50[SD=56.06] + Own Victim/Offender, 147.21[SD=40.00]) the resultant mean scale scores (Figure 2) for the Traffic Accident Victim, Sexual Abuse Victim and Own Victim were 285.68 (SD=94.31), 350.63 (SD=107.46) and 336.71 (SD=82.40) respectively.

Results of individual ANOVA's performed on the three means revealed a significant difference between the Sexual Abuse Victim scale and the Traffic Accident scale, $F(1,18)$

= 10.44, $p < .01$. A significant difference was also obtained between the Sexual Abuse Victim scale and an offenders Own Victim $F(1,13) = 7.602$, $p < .05$.

When mean scale scores were compared to those of the original sample (i.e., Traffic Accident Victim: 277.62 [SD= 61.06], Sexual Abuse Victim: 284.76 [SD= 101.47], Own Victim: 173.59 [SD= 127.47]), empathic responding in the present sample was significantly higher for the Own Victim scale ($p < .0001$) and the Sexual Abuse Victim scale ($p < .05$) (see Figure 2).

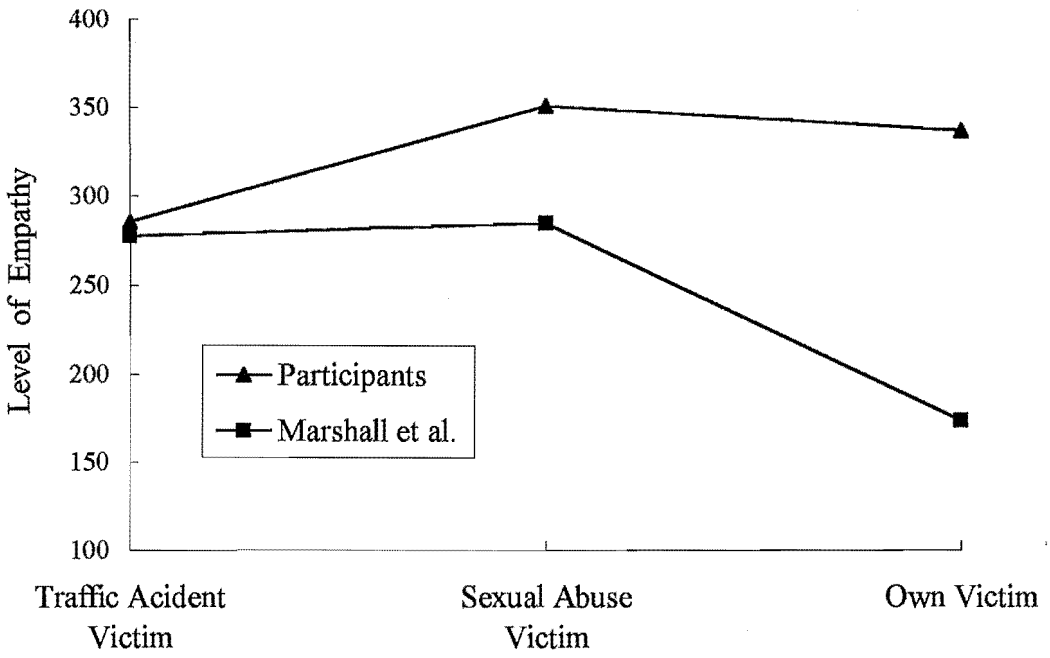


FIGURE 2: Comparison of empathic responding between the present Participant sample and Marshall, Fernandez, Lightbody, and O'Sullivan's (1994) child sex offender sample.

Hypothesis 4

Results from the Relationship Questionnaire saw 50% (10) of respondents considering themselves as Securely Attached, while 40% (8) were in the Dismissing category. One (5%) of each of the remaining individuals was in the Pre-occupied and Fearful categories. On a general level, the child sex offenders in the present sample displayed a Secure or Dismissing attachment more frequently than they did a Preoccupied or Fearful style (Table 8).

When the Secure/Insecure percentages of the present study (50%, 50%) are compared to the pre-treatment Kia Marama participant sample of Ward, Hudson, and Marshall (1996) (18%, 82%) the two samples differ significantly ($p < .01$).

TABLE 8: Prototypical Style Choice Within/Between Groups (Percentages).

Prototypical Style Choice	*Present Sample* (n = 20)	*Ward et al., 's Sample* (n = 55)
Secure	50^{a}*	18^{aa}*
Preoccupied	5^{bb}	22
Fearful	5^{bb}*	38^{bb}*
Dismissing	40^{aa}	22

NOTES:
Different scripts (^{a,b}), (^{aa,bb}) indicate significant within group differences ($p < .01$, $p < .05$ respectively).
* Indicates significant ($p < .01$) between group differences.

When one looks more closely at the prototypical style choice's of each sample (see Table 8), the present sample had significantly more individuals advancing a Secure attachment style, while significantly fewer participants displayed a Fearful style of attachment. Caution is advised with respect to the forgoing data, as the present sample showed a significant correlation ($p < .05$) between scores on the secure attachment scale and the Social Desirability Inventory (.47).

Part two results of the Relationship Questionnaire, that is the mean prototypical ratings on the four attachment dimensions, for the current sample were; Secure 5.05 (SD= 2.14); Fearful 3.25 (SD= 1.89); Preoccupied 2.60 (SD= 1.93); Dismissing 4.90 (SD= 2.10). As was the case with results from part one, the current sample expressed overall degrees of Secure attachment which were significantly higher ($p < .01$) than that expressed by Ward et al.'s sample. Mean scores for the Preoccupied and Fearful dimensions on the other hand, were significantly lower ($p < .01$, $p < .05$ respectively) in the present sample.

2.3 Analysis of Recidivism Predictors.

Hypothesis 5

Table 9 displays a summary of mean scores for each of the recidivism predictor variables used in the current analysis.

TABLE 9: Summary Table of Recidivism Predictor Means.

	Non-Participants	*Participants*	*Kia Marama Participants*
Age (years)	52.25 (11.1)^{aa}	43.65 (13.6)^{bb}	39.85 (9.63)^{bb}
Education (highest grade completed)	3.05 (1.57)^{a}	4.45 (1.50)^{b}	4.30 (1.38)^{b}
Employment (prior to arrest)	1.15 (0.37)^{a}	1.55 (0.51)^{b}	1.55 (0.51)^{b}
Marital Status (prior to arrest)	2.65 (1.04)	2.70 (1.08)	3.00 (0.97)
Number of Children (+ step-children)	3.35 (2.68)	3.05 (2.95)	2.60 (1.10)
Alcohol/Drug Problem	0.50 (0.76)	0.75 (1.12)	1.00 (1.21)
Age at First Criminal Conviction	35.80 (18.7)	32.55 (15.1)	30.15 (13.8)
Age at First Child Sexual Conviction	47.00 (14.1)^{a}	38.70 (12.0)^{b}	35.30 (11.9)^{b}
Prior Convictions			
Any Offence	8.30 (14.3)	7.50 (12.5)	8.55 (19.2)
Violent Offences	0.30 (0.66)	0.60 (1.82)	0.35 (1.18)
Adult Sexual	0.15 (0.37)	0.05 (0.22)	0.20 (0.89)
Child Sexual	1.45 (3.59)	0.50 (1.24)	1.05 (2.54)
Parole Violations	0.25 (0.64)	0.55 (1.67)	0.55 (1.57)
Current Sentence Length (years)	8.07 (3.26)^{aaa}	6.08 (3.54)^{aa}	3.24 (1.42)^{b}
Present Victims'			
Age Bracket (at offence)	1.10 (0.31)	1.35 (0.49)	1.30 (0.47)
Gender	2.45 (0.69)	2.55 (0.76)	2.65 (0.59)
Nature	1.55 (0.51)	1.45 (0.51)	1.30 (0.47)
Offence Denial	2.30 (0.86)^{aa}	2.05 (0.69)^{aabb}	1.60 (0.68)^{bb}
Treatment Motivation	1.00	1.00	2.00

NOTES:
Different scripts (^{a,b}) indicate significant differences.
(^{a,b}) indicate significance at $p < .05$.
(^{aa,bb}) indicate significance at $p < .01$.
(^{aaa,bbb}) indicate significance at $p < .001$.

A general MANOVA was performed on these data and resulted in an overall significant difference between the three samples ($F[42,74] = 1.81$ $p < .05$). F-tests revealed significant differences on the following six variables; Age: $Ft(2,57) = 6.05$, $p < .005$; Age at First Child Sexual Conviction: $Ft(2,57) = 4.486$, $p < .05$; Current Sentence Length: $Ft(2,57) = 14.053$, $p < .0001$; Degree of Offence Denial: $Ft(2,57) = 4.49$, $p < .05$; Employment Status: $Ft(2,57) = 4.884$, $p < .05$; and Education Level: $Ft(2,57) = 5.341$, $p < .01$. Results of post hoc tests are displayed in Table 9.

As illustrated by these data, the mean age of the Non-Participant sample was significantly greater than that of the other two groups, while education levels for this group were considerably lower. The Non-Participant sample were also less likely to have been in full-time employment prior to their arrest, and were of an older age at the time of their first child sex abuse conviction.

What is also evident from the table is that the current sentence length of the Kia Marama participant sample is significantly shorter than either the Participant or Non-Participant samples. Furthermore, the Kia Marama sample displayed significantly less denial in relation to their current offence than was evidenced in the Non-Participant sample, and although of questionable significance ($p < .06$) showed some disparity from the denial expressed by the Participant sample.

Hypothesis 6

An ANOVA was performed on these data and resulted in a significant difference $F(1,58) = 7.85$, $p < .01$ in the level of denial of legal guilt between those who volunteer for treatment and those who do not (see Figure 3). A MANOVA found a significant difference between the three samples ($F[2,57] = 4.49$, $p < .05$) while planned comparison's revealed that the Non-Participants showed significantly more denial of legal guilt than did the Kia Marama sample $F(1,57) = 8.74$, $p < .01$ (see Figure 4).

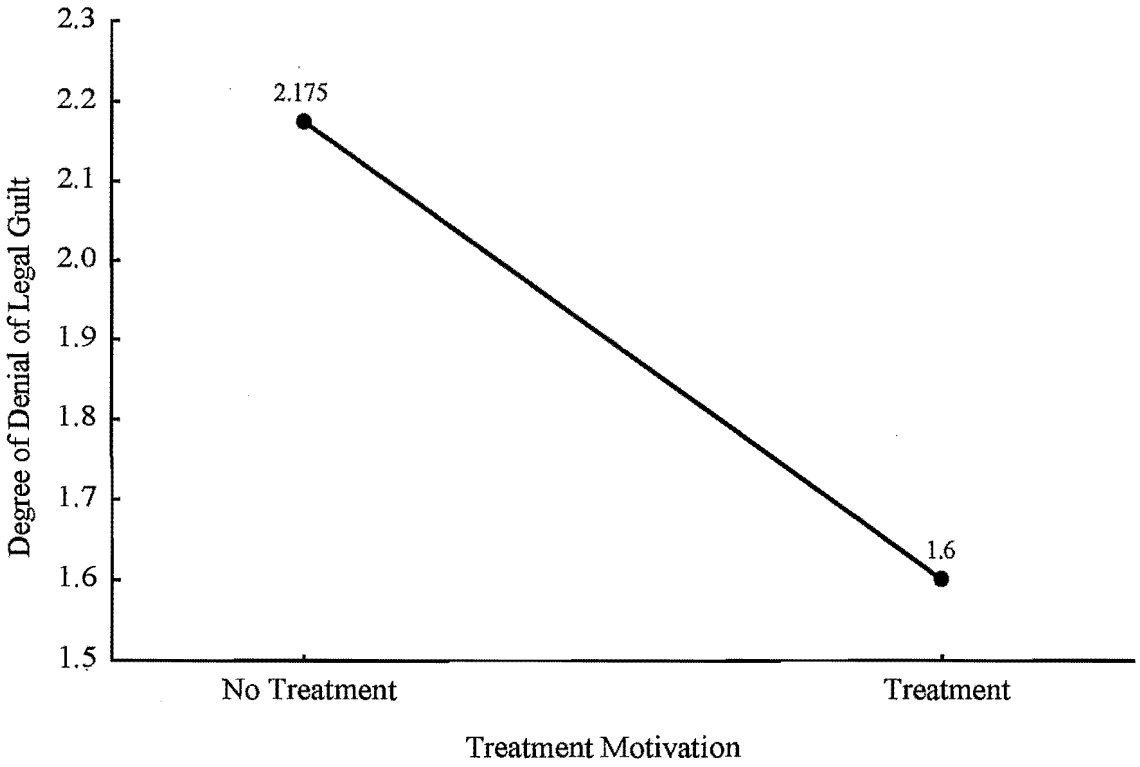


FIGURE 3: Treatment motivation as a function of the Degree of Denial of Legal Guilt.

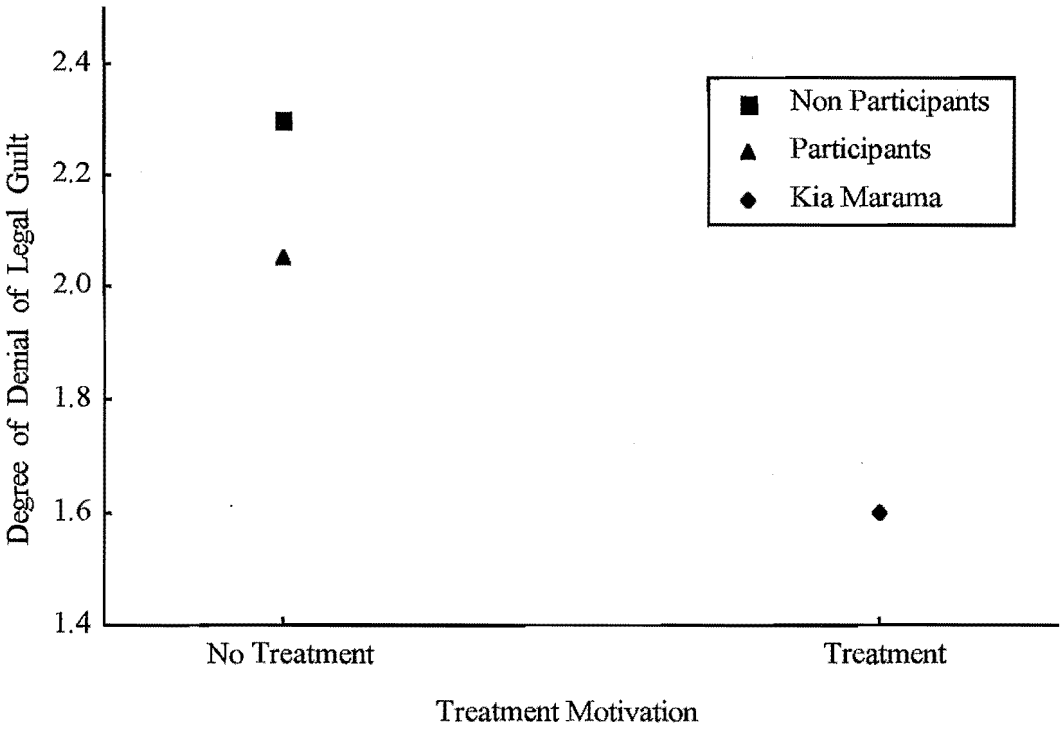


FIGURE 4: Treatment motivation by sample group as a function of the degree of denial of legal guilt.

3. Discussion

3.1 Non-treatment Offender Characteristics

As a group, the Participant sample of the present analysis (i.e., those who do not volunteer for treatment while incarcerated, despite being eligible) demonstrated a more negative disposition toward the female population than is evidenced in society as a whole. These individuals harboured more hostile feelings towards women, while also displaying a greater acceptance of the numerous 'rape myths' evident in contemporary society.

Furthermore, these offenders also experience higher levels of anger and frustration, whilst perceiving themselves as suffering more frequently as a result of unfair treatment from others. Coupled with such hostility, these men displayed a greater tendency to externalise anger in the form of aggressive behaviours directed toward other persons or objects. One final finding saw this group of offenders presenting themselves in an extremely socially desirable light.

With respect to personality profiles, the current offender population most frequently advanced the characteristics of Compulsiveness, Narcissism, Dependency and Antisocial personalities. Therefore those individuals who did not volunteer for the Kia Marama treatment program are best described by a Compulsive-Narcissistic personality. A narrative interpretation of the Compulsive-Narcissistic personality is as follows;

> "Indicates the prominence of disciplined and confident personality traits. The disciplined aspects suggest that there is an emphasis on perfectionism and maintaining good control of the environment. Individuals are somewhat defensive and unlikely to admit failures or mistakes. At times, they may be seen as too inflexible, formal, or proper and may relate to others in a somewhat distant manner.
> Together with these disciplined elements, individuals have a tendency to feel that they are more special, capable, and worthy than most other people. They are field-independent people who rely more on their own feelings or judgements than they do on the opinions of others. A confident air of self assurance may be present. They have trouble accepting somebody else's ideas and doing what they are told. Such situations may cause conflict between them and the other people involved" (Choca, Shanley, & Van Denburg, 1993: p.107).

3.2. Discussion of Questionnaire Measures

3.2.1 Cognitive/Intellectual Components

On a general level, none of the cognitive or intellectual measures incorporated into the present analysis discriminated between the current Participant sample and those individuals who volunteered for the Kia Marama treatment program. Although unexpected, given the nature of the first research hypothesis (i.e., Child sex offenders who do not volunteer for treatment while incarcerated, despite being eligible, will have a more dysfunctional cognitive disposition than the pre-treatment characteristics of those men who have undergone treatment), such findings are encouraging. What it suggests is that the voluntary nature of the Kia Marama program does not act to exclude from treatment, those individual who present with more distorted views of adult/child and peer sexual contact.

On a more specific level, an important feature with respect to the cognitions advanced by those who did not volunteer for treatment was their lower level of responding on the Sexual Entitlement scale of Hanson's Sex Attitude Questionnaire. Although this too was unexpected, the lower responding among the present sample, as compared to that of Hanson Gizzarelli, and Scott (1994), may in part be attributed to differing samples. That is, because Hanson et al.'s study comprised solely of incest offenders it is plausible that this sample was more likely to view the victim as belonging to them, as the child was either their own or a close relative. Thus, these individuals may have viewed themselves as more entitled to such sexual contact than did the large proportion of non-incestuous offenders in the current Participant sample.

A further explanation, which seems just as plausible within the present context is that which stems from the relative transparency of the scale. That is, an offender may simply be looking for the "correct answer" in response to each question. This concern was

raised by Hanson when he noted that offenders, as opposed to non-offenders, are more likely to give completely correct responses (January 1997, personal communication).

Given that many of the offenders in the present Participant sample either minimised or completely denied their crime/s, coupled with the fact that these individuals tended to present themselves in a socially desirable light, such an explanation would account for the eight individuals who demonstrated completely correct responding (i.e., the minimum scores of 12) on the Sexy Kids scale. Furthermore, it would also explain why only one individual responded in such a manner on the more ambiguous Sexual Entitlement scale.

Taken together, the aforementioned suggests that those who do not volunteer, although eligible, for the Kia Marama treatment program are no different, with respect to intellectual functioning and their beliefs about adult/child and peer sexual contact, than those who do volunteer for treatment. Thus it is comforting to know that the voluntariness of the institutionally based sex offender treatment programs in New Zealand are not acting to exclude the more cognitively distorted child sex offender from treatment, but instead are capturing a representative cross section of New Zealand's sexual perpetrators.

Although this finding is promising, a cautionary note must accompany the measure assembled under the cognitive/intellectual banner. This is the case as the Cognitions Scale, the Wilson Sex Fantasy Questionnaire, the Hostility Toward Women Scale, and the Rape Myth Acceptance Scale are all relatively transparent measures. Thus, it may be the case that offenders in both the treated and non-treated samples were simply answering in ways that present themselves in a more favourable light. An assertion such as this seems plausible, given that both the Cognitions Scale and the Wilson Sex Fantasy Questionnaire showed significant correlation's with social desirability.

3.2.2 Affective Components

Unlike the foregoing cognitive factors, numerous emotional and interpersonal measures were seen to discriminate those child sex offenders who do not volunteer for treatment and those who participated in the Kia Marama program.

Acknowledging that the higher levels of State Anger and State Anxiety evidenced in the Kia Marama Participant sample may be attributed to a more negative disposition at the time of testing, that is this sample underwent testing in a treatment environment just prior to starting the Kia Marama program, the remainder of the differences with respect to affective functioning are more fundamental.

Those individuals who did not volunteer for the Kia Marama program (i.e., the current Participant sample) were typically less anxious with respect to everyday functioning than those who did volunteer. Similarly, these individuals were less likely to have experiences associated with loneliness. Coupled with such characteristics, those who did not volunteer for treatment were also seen to be more assertive and have a higher level of self esteem than was evidenced in those who volunteered for treatment.

Therefore, contrary to expectation, those who do not volunteer for treatment while incarcerated were found to advance a more positive affective disposition than those who volunteered for the Kia Marama program.

Victim Empathy Measure: Marshall, Fernandez, Lightbody, and O'Sullivan (1994) noted that although there was no difference in empathy expressed for a traffic and sexual abuse victim, both scales produced significantly higher empathic responding than was expressed toward an offenders own victim.

In contrast, responding in the present study was markedly different. Empathy for the Sexual Abuse victim was greater than that displayed for either the Traffic Accident victim or an offenders Own victim. Furthermore, it was empathy for the Traffic

Accident victim, and not that for an offenders Own Victim, which produced the lowest level of empathetic responding. A final point of interest was that in both cases where empathy for child sexual abuse was being measured (i.e., Own victim and Sexual Abuse victim) the present sample showed considerably more empathy than Marshall et al.'s sample.

Whether these differences stem from differing samples is unknown. However the situation surrounding testing may in part be responsible for such differences. That is, the current participant sample comprised of child sex offenders who refused to participate in New Zealand's voluntary treatment programs. Given such a scenario, together with the fact that many of the current sample maintained their innocence, the present individuals may have been presenting themselves in a more favourable light, responding in ways that were consistent with a position of innocence.

Perhaps a more plausible explanation for such disparity stems from the diversity of offenders in the current sample. Marshall et al.'s sample consisted solely of non-familial, heterosexual offenders, whereas the present sample was more heterogeneous. That is, the current participant sample comprised of both familial and non-familial offenders, who's victims were either boys, girls, or both. Given that over half (55%) of the sample were incest offenders, together with the fact that 55 per cent of the pedophilic offenders were bisexual or homosexual, it is not surprising that such disparity from Marshall et al.'s sample exists.

One final source of explanation for the differences between the present sample and those advanced by Marshal et al. arises through contamination via hypersensitivity. It may be the case that because many offenders maintained their innocence, coupled with the fact that numerous individuals had themselves been victims of sexual abused, the current sample may have been hypersensitive to the construct of empathy as it applies to

child sex abuse. Such an assumption seems particularly plausible within the current context as both scales involving child sexual abuse produced significantly higher responding than was seen in Marshall et al.'s sample.

What the aforementioned illustrates is that the current sample, despite refusing to participate in the Kia Marama treatment program showed considerably more empathy, especially during instances of child sexual abuse, than was evident in Marshall et al.'s sample.

Relationship Questionnaire: Results obtained in the present analysis, although in accordance with the normative data provided by Bartholomew and Horowitz (1991), are in stark contrast to those advanced in the preliminary research of Ward, Hudson, and Marshall (1996). The findings of the analysis lend support to the assumption that those who do not volunteer for treatment are a fundamentally different population from those who volunteer for Kia Marama.

What the present research suggests is that those who do not volunteer for treatment while incarcerated are more likely to view themselves as securely attachment than are those individuals who volunteer for the Kia Marama treatment program. Moreover, in the majority of cases where an individual did not present with a secure attachment style in the present context, the offender was comfortable without such close emotional relationships. That is, an individual was more likely to advance a dismissing style of attachment.

In light of these differences, caution is advised in drawing any concrete conclusions based on the present findings for two reasons. Firstly, the current analysis used a single self administered questionnaire, which by its very nature is open to response bias, to tap adult attachment. The degree to which the measure was affected by such desirability is

unknown, although tentative support for its influence was found in the significant correlation between secure attachment styles (which was most pronounced in the present sample) and the social desirability inventory.

Secondly, it is plausible that the Relationship Questionnaire is to simplistic to tap the diversity and complexity recognised as inherent in the process of adult attachment. This concern is evidenced in Ward et al.'s research where they incorporated a number of measures to tap adult attachment. Although successful, the move did lead to discrepancies in classification, especially with respect to the three insecure attachment styles.

What the foregoing suggests is that although no differences with respect to cognitive or intellectual functioning between those who volunteer for treatment while incarcerated and those child sex offenders who do not, these two groups do differ with respect to affective functioning. Moreover, contrary to expectation, this latter group of individuals is seen to have a more 'normal' affective disposition than do those who volunteer for the Kia Marama child sex offender treatment program.

Despite the present findings the reader is cautioned against drawing any concrete conclusions. It is plausible that, given only 50 per cent of the non-Kia Marama offenders volunteered for the study, the present group of offenders may not be a representative sample of those child sex offenders who do not volunteer for treatment while incarcerated. Evidence for such an assertion, although limited, can be found in the difference in demographic variables of the participant and non-participant samples'. Furthermore, these two groups also differed with respect to an offenders age at the time of their first child sex offence. Hence because the non-participant sample had more features in common with the situational child sex offender than did the participant

sample, they may also display the inherent cognitive and affective disposition advanced by such a population.

Secondly, because both the current sample and the Kia Marama participant sample presented themselves in a more socially desirable light than is realistic, it is possible that the data provided is not a true reflection of an individuals actual disposition.

3.3 Discussion of Recidivism Prediction

With respect to the recidivism potential among New Zealand's sexual perpetrators, results can be divided into two broad categories. Firstly, Non-Participants in the present analysis were seen to differ from both the Participant and Kia Marama Participant samples with respect to education, employment, age, and age at first child sexual conviction. When interpreted with respect to future recidivism potential, these findings are somewhat contradictory. On the one hand is limited evidence which suggests that individuals with lower education (Abel, Mittelman, Becker, Rathner, & Rouleau, 1988; Hanson, Steffy, & Gauthier, 1993; Quinsey, Rice, & Harris, 1995) and lower levels of employment (Abel, Mittelman, Becker, Rathner, & Rouleau, 1988; Maletzky, 1993), both of which were evident in the present Participant sample, are more likely to recidivate.

Contrary to the above are a number of studies (Hall, 1988; Malcolm, Andrews, & Quinsey, 1993; Marques, Nelson, West, & Day, 1994; McGrath, 1992; Quinsey, Lalumiere, Rice, & Harris, 1995) which advance that older individuals, and perpetrators whom began offending later in life, are less likely to reoffend. Although these latter findings suggest that the current Non-Participant sample is less likely to reoffend, a finding which was unexpected, a note of caution must be attached. It is not necessarily the case that this sample began offending later in life, but rather they may have had a longer conviction free offence history. A point which is strengthened by the fact that in

at least three case an offenders current conviction related to sexual misconduct that occurred some 15 to 20 years earlier.

Of greater significance, and undoubtedly of more importance, the second group of findings revealed that both of the non Kia Marama participant samples (i.e., the Non-Participant and Participant samples) differed significantly from the Kia Marama Participants with respect to treatment motivation and degree of offence denial. Not surprising given the nature of the sixth research hypothesis, these findings do provide support for the assertion that those who do not volunteer for treatment while incarcerated present with a higher post-release recidivism potential.

The final difference evidenced between the three groups was that of current sentence length. Insignificant as an independent predictor of future recidivism, the difference between Kia Marama and non-Kia Marama participants with respect to sentence length is intriguing, especially given that the samples were indiscriminable on most other offence related variables. Although one can only speculate as to why current sentence length was such a significant discriminating factor, it may be the case that the latter individuals were treated more harshly during sentencing. Highly plausible within the present context, evidence for such an explanation is found in the Judges summation notes, where more often than not a judge alluded to the fact that in spite of an offenders eligibility for treatment, these individuals lacked the necessary motivation for, or willingness to enter, specialised treatment. As is the case within the Corrections facilities, such refusal may have been taken as evidence for an individuals unwillingness to address his aberrant behaviour.

Together with the former, the fact that those who did not volunteer for treatment displayed more denial (albeit of sometimes questionable significance) with regard to their

offending may have contributed to a more negative outlook for these individuals, and thus the enactment of harsher penalties.

What the forgoing demonstrates is that those who do not volunteer, although eligible, for treatment while incarcerated advance a disposition not to dissimilar from those who enter the voluntary based Kia Marama child sex offender treatment program. In fact the most significant difference is that which is the most fundamental, that is one group of offenders volunteered for treatment while the other did not. Part and parcel with such a difference, this latter group were significantly more likely to deny their aberrant behaviour, and thus were significantly less likely to volunteer for treatment.

4. General Discussion

In all bar one set of circumstances, New Zealand law prescribes that the child sex offender be granted release at a fixed date from the time of initial incarceration. Even during instances of indeterminate life imprisonment, the child sex offender is eligible for release after serving ten years of a life sentence. Thus, the majority of sexual perpetrators incarcerated within New Zealand correctional facilities will eventually return, irrespective of dangerousness, to an environment which may be in many respects similar to that where their offending occurred.

The exception to inevitable release can be found in the High Court enactment of Preventive Detention. That is, community protection via the removal of an offender from his/her offence environment for a substantial period of time. Despite being eligible for release after ten years, a pre-release or 'dangerousness review' hearing means that

incarceration must no longer be expedient for public protection, or an offender must no longer present a substantial risk to society, in order to satisfy the review board release criteria. Therefore under the terms of Preventive Detention a child sex offender has no presumptive right to parole and thus, in theory, there will be a number of offenders for whom societal segregation will in fact be lifelong.

Aside from the aforementioned provision, it seems apparent that current New Zealand legislation is unable (or unwilling) to protect contemporary society from the majority of child sex offender recidivists. Despite the multiple functions of the prison system, the erratic and scant nature of sentences imposed by New Zealand judges (see Spier, [1996] and Coddington [1996] for offence/sentence reviews), coupled with an offender's inevitable release, depicts a judicial system which can in no way be viewed as a deterrent to post-release sexual recidivism, let alone a means of preventing child sexual abuse.

Highlighted in the aforementioned is the misplaced focus of the current New Zealand judicial system. The pendulum has swung to far in favour of the offender, compromising both the rights of the victim and of the greater society. It is often said that the needs of the many outweigh the needs of the few, or the one. Currently however, with respect to child sexual abuse, the offender's rights rein supreme. Recently, just such an assertion has been highlighted in the media , in that uninhibited 'high risk' offenders have been released back into fearful communities only to further victimise innocent children.

If the overall goal of the criminal justice system is to deter crime and prevent reoffence (as is reflected in the Department of Corrections corporate mission statement "Reducing Reoffending") should it not be utilising the most effective means possible? For child sex offenders such means undoubtedly necessitates intervention aimed at minimising post-release recidivism. Thus far what is known about such interventions is

that, regardless of whether mandatory or voluntary, they do result in the lowering of reoffence rates among the child sex offender population.

With respect to child sex offender treatment, the present research has demonstrated that the voluntary nature of New Zealand programs does not preclude the more dysfunctional offender, who presents with higher post-release recidivism potential, from entering treatment. But instead, the Kia Marama program is capturing a representative cross-section of New Zealand's child sex offender population.

Despite such a finding, what the research also suggests is that the process of denial has a significant effect on the make-up of New Zealand's voluntary based child sex offender treatment programs. Similarly, those child sex offenders how feel 'OK' about their aberrant sexual behavior are also seen to impact on the make-up of voluntary treatment. Therefore, it is perhaps with respect to these latter groups of offender, that is, those who deny their crimes and those who morally and legally accept their aberrant behaviour, that the need to reduce the potential for recidivism is greatest. Thus given that treatment goes some way in dealing with the problem of recidivism, perhaps treatment of these groups is the key.

4.1 Limitations

If one is to draw any concrete conclusions based on the present research it is important to do so with respect to its potential methodological limitations, and those factors which preclude its generalisability.

First and foremost, caution must be advanced as a precluding variable to the current study's generalisability arises from it relatively small sample size. Coupled with the former is the study's predominating focus on a single geographic location, that is, Rolleston Prison. It may be the case that the cognitive and affective components of the child sex offender population accumulating within this prison, which houses one of only

two sex offender treatment programs in New Zealand, are in fact different from offenders who do not enter into such a custodial environment. Such an assertion is entirely plausible, especially given that Rolleston is a low security prison which houses the less 'at risk' offenders.

Compensating for such a possibility would make for a more geographically expansive study and would substantially increase the potential participant pool. In turn this would not only result in a larger sample size, but it would act to combat the undesirable effects which have eventuated from the repeated and over testing of the child sex offenders within Rolleston prison. Problems which were clearly evident among the individual who refused to participate in the current study.

Perhaps the greatest limitation of the present research stems from the same problematic feature which hinders accurate interpretation. That is, the participants' inability to portray themselves as anything but socially desirable. Evidenced on the Social Desirability Scale, and also the Desirability Gauge of the MCMI-II, a substantial proportion of individuals within the current study present with such a disposition. Acknowledging that this is by no means surprising, given that the majority of individuals denied or greatly minimised their offending, it does present difficulties as the participants' were more likely to answer questions in ways which were consistent with a position of innocence.

In an attempt to counteract this problem numerous sources of information were sort in relation to each individual. However, despite extensive file reviews it must be noted that much of the information, like the foregoing questionnaire measures, is open to undesirable influence, as it is substantially based on retrospective self-reports made on the part of the offender.

An enviable problem when administering self-report measures to such a dysfunctional population, one way to overcome this limitation, although not in its entirety, would be to used a more direct and objective means of investigation. Phallometric measures have displayed considerable versatility in the assessment of sexual preference, while the competency based Emotional Apperception Test (Ware & Hudson, 1997) holds potential utility as a more objective measure of empathy among child sex offenders.

A methodological problem which had to be overcome in testing stemmed from the randomisation of questionnaire presentation order. Initially done to eliminate order effects, such an approach presented problems during testing. On numerous occasions the administrator found himself reshuffling questionnaire presentation in order to combat fatigue, boredom and in some instances, an adverse disposition. It is therefore advised that in future research, where a similar diversity of measures is advanced, the researcher is best to adopt a more relaxed approach to randomisation, hence lessening the chance of participant attrition.

One final point must be raised with respect to the studies potential limitation. That is, although the Participant sample and those who volunteered for the Kia Marama program are currently independent samples, this may not also be the case. It is possible that with time, given that a number of offenders are at the start of long jail terms, some individuals who made up the Participant sample (i.e., those who do not volunteer for treatment) may choose to enter, or be persuaded into, treatment. Similarly, some of the individuals who were discard from the present study because they expressed an initial interest in the Kia Marama program may choose not to participate at a later date.

4.2 Future Research

The need for future research has been highlighted at numerous points in the aforementioned thesis, both in terms of our current limitations in understanding and also with respect to the lacking methodological rigor used in child sex offender research.

Firstly there is a dire need for the consolidation of information pertaining to the characteristics of the child sex offender population. More specifically, a better understanding of empathy, denial, and the cognitive distortions evidenced in the sex offender population is required. Coupled with the former, is the need for greater insight into how each is best measures, together with the role each may play in the initiation and maintenance of sexual offending. Such insight would allow for more grounded theory in relation to the potential targets needed to effectively habilitate the child sex offender.

Secondly, given that denial plays an important role in the make-up of New Zealand child sex offender programs, what is called for is a better understanding of how to deal with the child sex offender who completely denies his crimes. More specifically, there is a need to address how one should best go about breaking down and/or overcoming the denial evident in this population. There is also the need for a better understanding as to the most appropriate form of treatment for this sexually perverse group of offenders. Furthermore, and of paramount importance for a country with adopts a voluntary basis to child sex offender treatment, there is the need to find an alternative means to get the complete denier who does not volunteer for treatment, into some form of program which will address their aberrant sexual behaviours.

Third, as a stepping stone toward the possibility of mandatory treatment within New Zealand, substantial investigation is required into the repercussions and limitations of the voluntarily nature of New Zealand sex offender treatment programs. Comparisons are needed between treatment participants and the diverse array of populations which are

excluded from such programs. Investigation is also necessary in regard to the small, but potentially dangerous, group of child sex offenders who fall into a gap between the criminal justice system and the mental health system. That is, violent sex offenders, and those perpetrators who present with varying levels of psychosis, well below average IQ, or mental retardation.

A final limitation in the contemporary literature, and that which is of utmost importance, especially if New Zealand was to adopt a mandatory based treatment program, is the development of a valid, reliable, and accurate risk assessment tool for child sex offenders. Such a diagnostic instrument would have extensive utility within the New Zealand judicial system, whilst its benefits would be multifold.

Firstly it would have potential as a pre-treatment screening device. Reducing the number of offenders for whom treatment is deemed unnecessary as they pose no, or minimal (such as many incest offenders) risk of re-offence.

Currently, as noted by Gordon, Holden, and Leis (1991), incest offenders are as likely (if not more likely) as pedophiles to receive treatment while incarcerated. If one could reduce unnecessary and expensive institutional treatment it would result in huge financial saving, and savings to the already limited resources available for the institutional treatment of child sex offenders.

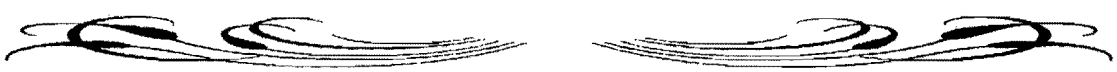
A second use for such a predictive tool is in the post-treatment/pre-release assessment of incarcerated sex offender dangerousness. Within the New Zealand justice system such a procedure has the potential to be extremely beneficial as it would allow for the pre-release detection of those child sex offenders most at risk of post-release reoffence. In so doing it would provide an opportunity for the enactment of preventive detention or some other form of intense and restrictive parole based supervision.

Finally, a further application for such a diagnostic tool which binds the two former, is sex offender management. Prior to sentencing an accurate predictor of post-release recidivism could allow for special treatment provisions being incorporated into the sentences of those who present the greatest risk of reoffence. Hence those most in need of treatment would be the individual assured of the most extensive treatment programs while incarcerated. Similarly, at the other extreme, it would allow for the prescription of post release community-based treatment for the less dysfunctional offender who presents with minimal risk of reoffence.

5 Conclusion

Given the extensive plethora of research that suggests both voluntary and mandatory treatment programs significantly reduce post-release recidivism among child sex offenders, it is of paramount importance that New Zealand legislators look seriously at way of coaxing those offenders who refuse treatment into some form of program which aims to address their aberrant behaviour. Whether this need necessitates the call for mandatory treatment, or just a relaxing of policies to give more persuasive powers to those in the criminal justice system, is not full known. However if New Zealand were to adopt a mandatory approach to child sex offender treatment, with it would come extensive long-term benefits. As evidenced in the current cost benefit analysis, treating the child sex offender is a financially cost effective way of dealing with this deviant population. Furthermore, a move to mandatory treatment would also significantly reduce the burden placed on society, both with respect to the extensive physical, emotion, and psychological costs incurred by potential victims and their families, and

also the resources required for the investigation, prosecution and incarceration of the child sex offender.



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Appendix One

KIA MARAMA SEX OFFENDER TREATMENT PROGRAMME.

PROGRAMME SCHEDULE

WEEKS	CONTENT
1 - 2	Assessment
3	Norm-building, motivational issues
4 - 10	Constructing Offence chain
11 - 12	Sexual Arousal Reconditioning
13 - 16	Victim Impact/Empathy
17 - 21	Social Skills Relationship Skills Sexuality Education
22 - 27	Mood Management Anger, Stress Management Problem Solving
28 - 31	Relapse Prevention Release Planning
32 - 33	Reassessment

Source: New Zealand Department of Corrections, (1995)

Appendix Two

TE PIRITI SEX OFFENDER TREATMENT PROGRAMME.

PROGRAMME SCHEDULE

WEEKS	CONTENT
1 - 2	Assessment
3	Norm-building
4 - 12	Cognitive Restructuring
13 - 14	Reconditioning
15 - 19	Victim Impact/Empathy
20 - 24	Relationship Skills/Sexuality Education
25 - 29	Mood Management
30 - 33	Relapse Prevention
34 - 37	Reassessment
38	Discretionary Week

Source: J. Larsen, (personal communication, July, 1996).

Appendix Three

University of Canterbury

Department of Psychology

INFORMATION SHEET

You are invited to take part in the study named "Sex offender attitudes and cognitions".

The aim of this study is to look at the thoughts, attitudes and beliefs held by men who have offended against children. As part of the study I will be looking at prison records, as well as collecting data from a number of questionnaires.

Your involvement in the study will require you to complete a set of questionnaires (19 in total). The study will require about six hours of your time which will be spread over two sessions. You are under no pressure to take part and if you want to leave the study at any time you can. Whether or not you choose to take part will have no effect on your sentence or future parole.

The results of the project may be published, however your name will not be made public and nobody will know that the data you have provided is yours. To make sure nobody can find out who you are I will not require your name, and all the information you give me will remain under lock and key at the University of Canterbury until destroyed.

You are reminded at this time that if you say anything which would result in injury to yourself or any other person I am obligated to report that information to the proper authorities.

The project is being carried out by Dion Gee as part of his Masters of Science degree (Psychology), and is being supervised by Dr. Steve Hudson. If you have any concerns or further questions about taking part in the project Dion will be happy to talk about them. Please contact him at the University of Canterbury (Psychology Department) on 366-7001 (ext 7195).

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee.

Appendix Four

Code No: _____ **Date**_____

CONSENT FORM

University Of Canterbury
Department of Psychology

"Sex Offender Attitudes and Cognition's"

I have read and understood the description of the above named project. On this basis I agree to participate in the project, and I consent to publication of the results of the project with the understanding that anonymity will be preserved. I understand also that I may at any time withdraw from the project, including the withdrawal of any information I have provided.

Signed..... Date.....

Appendix Five

DEMOGRAPHIC/OFFENCE HISTORY CHARACTERISTICS

	Non-Participants	*Participants*	*Kia Marama Participants*
Sample Size	20	20	20
Age (%) (years)			
20-30	5	20	15
31-40	5	20	40
41-50	30	20	30
51-60	40	30	15
61-70	15	10	--
71-80	5	--	--
Ethnicity (%)			
Caucasian	90	90	90
Maori	5	10	5
Pacific Islander	5	--	5
Education (%) (highest grade)			
Form 1	15	5	5
Form 2	30	5	--
Form 3	15	5	15
Form 4	25	40	40
Form 5	10	25	30
Form 6	--	15	5
Form 7	5	--	--
University	--	5	5
Employment (%) (prior to arrest)			
Unemployed	25	20	20
Employed	15	55	55
Benefit/Retired	60	25	25
Marital Status (%) (prior to arrest)			
Never Married	10	15	5
De-facto/Partner	15	25	30
Married	30	30	25
Divorced/Separated	45	30	40
Number of Children (%) (including step-children)			
0	15	10	5
1-3	45	55	80
4-6	30	25	15
7-9	5	5	--
10-12	5	5	--
Alcohol/Drug Problem (%)			
No	60	60	50
Alcohol	35	20	20
Drug	--	5	10
Both	5	15	20

Age at First Conviction (%)			
(any offence)			
10-20	25	35	35
21-30	20	15	20
31-40	20	15	15
41-50	10	25	25
51-60	10	10	5
61-70	10	--	--
71-80	5	--	--
Age at First Conviction (%)			
(child sexual offence)			
10-20	5	15	10
21-30	10	10	20
31-40	10	30	30
41-50	35	30	35
51-60	20	15	5
61-70	15	--	--
71-80	5	--	--
Prior Convictions (%)			
(offender with priors for:)			
Any Offence	55	65	55
Violent Offences	20	20	10
Adult Sexual	15	5	5
Child Sexual	20	15	25
Parole Violations	15	15	15
Current Sentence (%)			
(years: inclusive)			
0-2	5	10	20
>2-4	5	20	55
>4-6	20	35	20
>6-8	30	15	5
>8-10	25	10	--
>10/ Life/ PD	15	10	--
Present Victims' (%)			
Age (at initial offence)			
<12 years	90	65	70
12-16 years	10	35	30
Gender			
Male	10	15	5
Female	55	70	70
Both	35	15	25
Nature			
Pedophile	55	45	30
Incestuous	45	55	70
Offence Denial (%)			
(degree of offender denial)			
No Denial	25	20	50
Minimisation	20	55	40
Complete	55	25	10