Sexual Abuse in Australia and New Zealand, July 2011; 3(1): 1-3

EDITORIAL

The current issue has been a long time coming and will be the only issue for this year. The journal has grown in popularity with requests for subscriptions from Australia, New Zealand and the United States. However, the journal is the product of ANZATSA and without contributions from the membership it will not meet its primary objectives to be an organ of the Association.

The current issue has four papers, the first was submitted by Hansen-Reid in response to our call in the last issue for case studies. This paper addresses the issue of sexual identity within a cultural context in New Zealand prisons and raises some important issues abut the use of cultural processes and treatment communities within prisons. The second paper is an evaluation of the Court Diversion program in Sydney, CEIDA. This paper by Prately & Goodman discuss the important role of denial and minimisation in attendees of the program, a theme picked up in the offering by Winship, Straker & Robinson, reviewing what is meant by denial in clergy accused of sexual offences. These two papers are important for the perspectives they bring on the therapeutic process as a means of working with clients who remain defensive in treatment programs that encourage disclosure in the absence of guarantees of indemnity against the consequences of such disclosures. The final paper by clinicians from within a private practice specialising in the treatment and assessment of sex offenders reviews the use of the Static 99R and represents a growing chorus of concern about the revision of the main stay of actuarial assessment. We would like to encourage our membership to begin their own studies and scholarship on the Static 99R: there is no doubt that age of the offender is an important variable that has to be factored into our assessments, but the best way to do that remains a topic for much more research.

We take this opportunity to thank our book reviewers for this issue as well. We would like to see this as a constant feature of the journal if possible. Finally, the editors would like to record our sympathy for the victims and survivors of the terrible events in Christchurch. There has been substantial loss of life touching our membership profoundly, and also destroying infrastructure and work spaces. The rebuilding job ahead is unimaginable, as is the grieving for many families. We wish you all well.

Editorial Comment: DSM V rejects Paraphilic Coercive Disorder: Throwing the baby out with the bath-water?

It has been both odd and interesting to read the arguments for and against some of the proposed "new" paraphilia diagnoses that have been proposed for the DSM V. I must preface my comments with an admission: after about 15 years with the Correctional Service of Canada doing a lot of risk assessment work for the Crown during that time, I still do the occasional risk assessment of sexual offenders. When I do accept an assessment it is rarely the "average" referral - I get asked to assess some very unusual men and the occasional woman - mostly, but not all of them, sex offenders. When I do that work for either the State (or Crown) or the Defence - the agencies get similar reports focused on risk and risk management.

As a specialist, I arguably have some expertise and experience in the area. Over the years, I recall a few men that I've considered to be paraphilic in their rape behaviour. That means, to me at least, that they seemed to meet Criterion A (usually "3" of A) and Criterion B of the DSM-IV-TR of the Paraphilias (or that of Sexual Sadism, minus clear or obvious arousal to suffering of the victim – but still able to be sexually aroused enough to complete the sexual assault). To save time, I will simply quote the first paragraph of the DSM-IV-TR's section on Paraphilias in its entirety:

"The essential features of a Paraphilia are recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons that occur over a period of at least 6 months (Criterion A). For some individuals, paraphilic fantasies or stimuli are obligatory for erotic arousal and are always included in sexual activity.

In other cases, the paraphilic preferences occur only episodically (e.g., perhaps during periods of stress), whereas at other times the person is able to function sexually without paraphilic fantasies or stimuli. For Pedophilia, Voyeurism, Exhibitionism, and Frotteurism, the diagnosis is made if the person has acted on these urges or the urges or sexual fantasies cause marked distress or interpersonal difficulty. For Sexual Sadism, the diagnosis is made if the person has acted on these urges with a nonconsenting person or the urges, sexual fantasies, or behaviors cause marked distress or

ISSN 0833-8488

interpersonal difficulty. For the remaining Paraphilias, the diagnosis is made if the behavior, sexual urges, or fantasies cause significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B)" (APA, 2000, p. 566).

The proposed diagnosis of Paraphilic Coercive Disorder (PCD) was designed, in part, to eliminate the need for some evaluators to use the specious "Paraphilia Not Otherwise Specified" (PNOS) diagnosis. Sexual preference for rape is not included, but the DSM-IV-TR provided an out for evaluators wanting to use rape as a qualifier: "Examples include, but are not limited to" (APA, 2000, p. 576). Unsurprisingly, this debate is of great interest in the United States where about half of the states have some form of post-sentence civil commitment for sexual offenders as sexually violent predators (SVPs) or terms to that effect. In general, State evaluators need some sort of diagnosis to help make the case for civil commitment and evaluators for the Defence need to rebut any sort of diagnosis to defend their client's lack of mental disorder to facilitate his freedom.

It is beyond the scope of this editorial to examine all of the arguments for and against PCD. However, it should be stated that PCD is not a newly proposed diagnosis. It has been proposed and rejected from a number of editions of the DSM, both prior and since SVP laws have come into effect. However, it seems that the discussion has hit new impassioned heights since the latter laws have been created and the literature seems somewhat partisan. Suffice it to say that currently there is joy on the "Defence" side of this argument in the USA with the much-hyped recent rejection of the diagnosis (see Frances, 2011). In my opening sentence, I mentioned that I have found it both odd and interesting to read the arguments for and against the various paraphilia diagnoses being considered for the DSM V. In my opinion, the legally based partisan arguments by psychologists and psychiatrists alike (mostly US-based) are in the "odd" camp. Frances (2011) noted in his second sentence in a brief article that the rejection of PCD from the upcoming DSM V "sends an important message to everyone involved in approving psychiatric commitment under Sexually Violent Predator (SVP) statutes ... (e.g., evaluators, judges) must all recognize that the act of being a rapist *almost always* (emphasis mine) is an indication of criminality, not of mental disorder".

There are other papers that argue at much greater length about why PCD and PNOS ought not to be (or ought to be) seen as legitimate diagnoses and these articles usually are against (or for) the validity and use of such diagnoses in keeping with the nature of the SVP-work of the author. There are impassioned and well-reasoned arguments for the exclusion of such diagnoses (e.g., Zander, 2008; a defence psychologist) and for the inclusion of PCD in particular (Stern, 2011; a state prosecutor). The reasons are well-argued in such papers, but at the end of the day, what the modus operandi seems to be behind such articles is an argument that will fit the prosecutor's or the defence psychologist's agenda as befits the role of diagnosis for SVP law. That to me is odd - brilliant minds occupied by what could be construed as a legal allegiance agenda - one side trying to make it easier (or perhaps just possible in the first place) to diagnose (hence able to commit more easily) and the other side trying even harder to make it more difficult to diagnose (and thus more difficult to commit) often the same client.

Conversely, what makes this discussion interesting is that, while most rapists "almost always" are criminals (Frances, 2011), some rapists may also be paraphilic and hence have a mental disorder. Even Dr. Frances left that door open just slightly (see the above quote). A quote from an earlier paper by First and Halon (2008) also suggested that paraphilic rape is a possible clinical entity: "conceptually, given the wide variety of stimuli know to be the focus of paraphilias, there is no reason to doubt the existence of a paraphilia in which the aberrant focus of sexual arousal is precisely the nonconsensual aspect of the interaction" (p. 452). If some rapists are, at least conceptually, paraphilic, then why not include PCD in the DSM V instead of the current "other" category of including it in PNOS? There is little doubt that the latter is a weak diagnosis because, by its very nature, PNOS diagnoses are idiosyncratic and therefore lack reliability and validity. It's these very problems that made the proposal of PCD worthy of consideration in the first place!

It would appear that very well-reasoned arguments by Knight in a "debate-style" paper with Thornton (Knight & Thornton, 2011) have resulted in an "empirically based consensus" in which some of the basic arguments for and against PCD were examined and a reasoned conclusion reached that was commensurate with the DSM V PCD rejection of same. There were a number of arguments in the Knight and Thornton (2011) article and some of these are reviewed below (with the others alluded to later).

First, Thornton proposed that PCD would be appropriate for inclusion in the DSM V in order "to facilitate the kind of assessment that can guide the provision of effective treatment; and ... to facilitate the development of associated knowledge and models of good practice" (p. 33). Knight countered this suggestion by stating that "the DSM should only include constructs that have substantial empirical validation, particularly because constructs in the DSM tend to become reified as bonafide syndromes and disorders, producing significant treatment and legal consequences" (p. 44).

The arguments indicate good clinical and scientific advice, in that order.

Second, both authors acknowledged that use of PNOS in civil commitment procedures may lead "to inconsistent practice and may produce diagnostic decisions that are over-inclusive and without empirical foundation" (p. 44). Thornton opined "that providing more concrete and objective diagnostic criteria for PCD would mitigate" this and other problems, while encouraging the study of the issue. Knight, on the other hand, saw Thornton's solution as premature as it might "reify" a "disorder" that currently has "questionable empirical support" (p. 44).

Third, Knight and Thornton agreed that "PCD and sadism are likely dimensions and not taxa" or independent categories (p. 44). The arguments here are long, but in the end Knight claimed that PCD is a dimension of Sadism and therefore "one should avoid talking about a paraphilic coercive "disorder" or "mental illness" (p. 44). Thornton felt it was "reasonable and appropriate to assign the term "disorder" to a specified level of symptoms that cause clinically meaningful levels of dysfunction" (p. 45). Parenthetically, "PCD's relation to Sadism" is the fourth issue addressed in the article and the conclusion is that a dimensional model (hence PCD being on a dimensional scale with Sadism) best accounts for the current data. But, both authors also agree that the "proposed DSM-5 criteria for the sexual sadism disorder are likely to be inadequate and that something (sic) more behaviorally defined and possibly broader in scope may be required to capture the extant data" (p. 45). What may be that "something" pray tell? Something better than PNOS we fervently pray?

These authors continue with examining a few more issues with the process and differing (but not necessarily opposing) opinions largely based on similar analyses each time: Knight depends on the data; Thornton more dependent on his analysis of the role of the DSM - for example, despite the lack of convincing data on PCD, it is true that the DSM often provides "categorical descriptions of the high and dysfunctional forms of underlying dimensions (of disorders)" (p. 45). And, from that perspective, Thornton noted ""disorder" really never meant anything except (the)... identification of the cutoff on a continuum at which clinical attention was warranted" (p. 45). Good arguments on each point it seems - but hardly opposing views - in fact, quite complementary on most points. Yes, we need data, but yes, we need to use our heads as well and compare why PCD (especially if on a continuum with Sadism) is so much different from our current dimensional concepualisations of disorders like Dysthymic Disorder and Major Depressive Disorder.

So, PCD is gone according to Frances (2011). In my opinion, PCD would have been much better as a replacement for the current PNOS for those rare cases where a rapist is not clearly sadistic, but clearly paraphilic. But, the baby is being thrown out due to unempirical bath water - there just isn't reliable and valid data to support PCD. There are other authors (I can't include everything) who don't even want PCD in the DSM-V's appendix of proposed disorders to obviate any chance of being used or studied. Again, these arguments are made largely by authors in the SVP field.

What then do we (in the rest of the world who do this sort of work) do with the rapist who looks paraphilic but is not sadistic? In my opinion, if there is some dimensional data and some support - even if based on clinical examples - then the PCD diagnosis is worthy of consideration and further study (one of the purposes of inclusion in the appendix). In addition, Thornton's analysis for PCD is well-reasoned and clinically astute, providing an additional argument for inclusion of PCD in the DSM V's appendix (thus retaining the baby). However, I think that PNOS's lack of rigour has been proven beyond any doubt - we can lose that bit of bathwater in the DSM V.

While I cannot argue against the data (Knight is convincing), certainly we cannot forget that DSM is not just a statistical manual, it is also a diagnostic manual in which emerging diagnoses are provided for examination and consideration by all professionals, not just those working in the SVP field.

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Associate Professor Douglas P. Boer
The University of Waikato, New Zealand

Sexual Abuse in Australia and New Zealand, May 2011; 3(1): 4-9

Samoan Fa'afafine - Navigating the New Zealand Prison Environment: A Single Case Study

Mette Hansen-Reid
Department of Corrections, New Zealand

Case Study

The term Fa'afafine means "like a woman". It describes people that western culture would consider as biological males, who are members of a third gender, neither male nor female, but are openly recognised within Samoan culture as having a specific gender role (http://en.wikipedia.org/wiki/Fa%27afafine). Gender refers to the socially constructed roles, behaviours and attributes of an individual commonly referred to as masculine and feminine, whereas "sex" describes the biological and physiological characteristics of that same person using the categories male and female (WHO, retrieved 9/12/ 2010). While 'sex' as a Western concept is defined by biological genitalia, 'gender' within Samoan society is defined by the roles that a person undertakes. Fa'afafine typically undertake what would be considered to be women's work, although their lack of ability to bear children precludes them from being considered female. Commonly, their decision not to father children also excludes them from taking on the recognised role of a male within traditional Samoan society. Fa'afafine are therefore distinguished as a third gender who find it difficult to define themselves as either male or female. They gain their status based on the contributions that they make within the family as carers and homemakers, in the community engaging in occupations typically performed by women, or as professionals whose educational and vocational achievements provide kudos to the 'aiga' (extended family) (Poasa, Blanchard and Zucier, 2004; Schmidt, 2010).

Research indicates that gender identity emerges by the age of 2-3 years and is thought to be influenced by both biological and sociological factors (Brill and Pepper, 2008). The Fa'afafine identity is variously hypothesised to have been caused by parents deciding that they did not have enough girls, requiring more help around the house and therefore treating a younger son as a female, as well as biological factors impacted by family size, birth order, and the number of older brothers in the family (Vasey and Van der Laan, 2007). Third gendered individuals are commonly found in the various Pacific Islands and acknowledged and accepted to varying degrees based on cultural, religious, political and historical factors.

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR, 2000), some fa'afafine may meet diagnostic criteria for Gender Identity Disorder. This would require "a strong and persistent cross-gender identification…..persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex…..clinically significant distress or impairment in social, occupational, or other important areas of functioning (p. 581).

As with all diagnoses these factors would need to be considered on an individual basis and it is unlikely that all Fa'afafine would meet criteria. During childhood the criteria include a preference to have playmates of the opposite sex and participation in their stereotypical games. With boys specifically, a preference for make-believe play involving femininity and simulating female attire may be observed. Many of these criteria are evident in the narratives of fa'afafine who describe their childhood (Schmidt, 2010).

Less evident is the desire to change or avoid the development of secondary sexual characteristics and the belief of having been born the wrong sex, though a small percentage will seek transgender surgery. The third criteria involves the experience of clinically significant distress or impairment in social, occupational, or other important areas of functioning. This appears to be a factor of the environment in which the individual was raised and cannot be assumed to be relevant to all.

Traditionally Fa'afafine have been sought out by young Samoan men as providing an opportunity for engaging in 'safe' sexual activity. Sexual liaisons with fa'afafine did not involve the risk of an unwanted pregnancy, was not considered to be homosexual due to the fa'afafine taking the role of a woman, and provided an outlet for sexual frustration that could not be satisfied by females due to cultural and religious norms in regards to chastity (Schmidt, 2010). Homosexuality is illegal in Samoa (Farran, 2010) and seen to breach religious and cultural boundaries.

Correspondence: Mette Hansen-Reid, Registered Clinical Psychologist, Te Piriti Special Treatment Unit, Department of Corrections New Zealand. Email: Mette.hansen-reid@corrections.govt.nz

ISSN 0833-8488

Fa'afafine are unlikely to be able to establish a long-term relationship with a male due to the likelihood that such a partner will eventually form a relationship with a female in order to have children and fulfill his social role. This leaves Fa'afafine in both Samoa and New Zealand in the untenable position of trying to meet their sexual needs without the likely potential for meeting ongoing intimacy needs through the establishment of a long-term relationship. This situation appears to encourage Fa'afafine to engage in casual sexual liaisons for sexual gratification.

The New Zealand Department of Corrections has a Transgender Prisoners Policy to ensure that prisoners who believe that their biological gender is not consistent with their birth gender are supported to undertake their prison term in an environment which enables them to participate in opportunities that will enhance their successful reintegration into the community. This includes the undertaking that those housed in male prisons will be treated as males and those that are housed in female prisoners will be treated as females. However, Fa'afafine who are biologically male but present with marked feminine mannerisms are housed in male prisons, which provides a challenge for both staff and prisoners alike.

This case study follows the progress of an incarcerated self-identified Samoan fa'afafine through a six-month period attending a treatment unit within the New Zealand Prison system and is based on self-report. The participant was a middle-aged biological male who chose for this study to be identified as Lady Gardenia – Gardenia for short. Gardenia was serving a three-year prison sentence for sexual offending against a vulnerable[1] male victim, and on a previous occasion had also been charged with offending against a young boy.

Gardenia used the pronouns 'he' and 'she' interchangeably when referring to self. The pronoun "she" will be used throughout this study when Gardenia refers to herself, as this appeared to be her natural preference. She referred to herself as a male predominantly when discussing factors related to being incarcerated in a male prison, and participating in treatment with other males, perhaps in order to assimilate to some degree into the prison setting. Fa'afafine belong to a heterogeneous group of people and as such have individual characteristics and cultural differences which make it difficult to consistently assign them to dichotomous categories or classifications related to sex, gender identity or sexual orientation (in particular homosexuality). As such their gender reference appears to be based on personal choice with a degree of fluidity.

[1] The exact nature of the relationship will not be further clarified in order to maintain the confidentiality of the victim

In Gardenia's case there was no consistency in her use of the descriptors male/female, he/she, son/daughter or aunty/uncle when referring to herself, as this appeared to depend on who she was speaking with, particularly within the family.

For example, Gardenia was known as aunty to the mother and daughters of the extended family with whom she had lived prior to her incarceration, and either uncle or by her Christian name when speaking to male members of the same family.

When in church Gardenia was referred to by her given Christian name. When associating with friends who were fa'afafine Gardenia used a number of female names commonly referred to as stage names, that she had chosen to use in a variety of settings – particularly night clubs, pageants and known sex hangouts. She reported that fa'afafine also used the term 'sister' when speaking to each other.

Gardenia was effeminate in that she displayed qualities, actions and behaviours that would generally be associated with women or girls. This appeared paradoxical in a tall male but was predominantly accompanied by a high pitched voice, hair flicking, bold animated arm movements, coy head movements, and a pronounced sashay when walking. When challenged by others to monitor or minimise these behaviours Gardenia often exaggerated her actions in what appeared to be an attempt to thumb her nose at the person making the request. Gardenia used what appeared to be well developed cognitive distortions to justify these requests stating either that the requester was jealous, or that they were attracted to her.

Background

Gardenia was born in Samoa in the 1960's to a large traditional family. As a fa'afafine Gardenia was loved and protected by her mother who referred to her as daughter, and abhorred by her father who ridiculed and punished his son for his overtly feminine behaviour. She recalled having been elated one day when her father had offered her the opportunity to join her brothers on an outing to their gardens, only to drive off laughing as she attempted to join the others on the vehicle.

Gardenia spoke of always having been fa'afafine, preferring the company and activities of the girls in her village and being accepted by them and treated as a peer. Following puberty Gardenia was limited in her freedom as her brothers strove to ensure that she was not taken advantage of sexually, or alternatively, shamed the family through the expression of overt sexuality. In her mid-teens Gardenia was sexually molested by an older male which left her frightened and shamed. She was aware that she was sexually attracted to masculine males and participated in consensual sexual activity with a male peer at school. Gardenia was

aware that homosexuality was considered unacceptable both culturally and within her own church teachings, as well as being illegal in Samoa. She did not define herself as homosexual but considered herself more as a feminine fa'afafine who was attracted to masculine males.

Following the death of her mother Gardenia was sent to New Zealand in her mid-twenties to care for family members. She lived what appeared to be two separate lives, one within the family and the other on her own time. Her accepted role in the family was to mind the children and complete household tasks. As such she was respected for her work ethic and the contributions that she made in regards to caring for the children. In the home Gardenia dressed in non-gender specific clothing though she wore necklaces, bangles, earrings and maintained long fingernails which she coloured, and grew her hair long - though wore it in a ponytail.

On the weekends Gardenia was expected to sleep in the garage to allow the family some privacy. She was not allowed to bring friends to the house. It appeared that the family expected that she was either asexual or met her needs outside the home, though this was not discussed or acknowledged. During weekends, particularly when bored she would become sexually preoccupied and seek sexual gratification outside the home. This included cruising for sex in public toilets, sexually assaulting males that she could control, and attending clubs that appeared to actively encourage public sexual displays. Gardenia enjoyed fa'afafine pageants as well as dancing and performing at family events, though said that she had no desire to undergo hormone therapy or gender reassignment surgery to become a woman.

Gardenia attended church with her family and on these occasions dressed as a man. She reported being regularly approached by other Samoan men for sex. She was aware that such liaisons would not result in a long term relationship due to the negative cultural and religious views on homosexuality, as well as the need for masculine men to fulfil social roles in regards to raising children in order to achieve status and fulfil the male role. Gardenia was convicted of sexual offending following her forcing a vulnerable male to participate in non-consensual sexual activity.

Assessment

Gardenia was assessed for suitability to attend a group treatment programme. Her cognitive functioning was found to be in the borderline range, though her scores appeared to have been negatively impacted by her speaking English as a second language. She met the criteria for Paedophilia, Sexually attracted to males, Non-exclusive type. This diagnosis was based on the fact that over a period of at least six months Gardenia had engaged in sexual activity with a prepubescent child, while also engaging in sexual activity with adult males. The results of an assessment of physiological arousal using the penile plethysmograph indicated significant arousal to all ages of male stimuli, with a higher rate of arousal to coercive situations. These findings corresponded with Gardenia's self-report. Her paedophiliac behaviours were not considered to be a factor of Gardenia's being fa'afafine.

Gardenia also presented with evidence of symptoms of personality disorders consistent with Cluster B factors including narcissism ("grandiosity, need for admiration, and a lack of empathy"), antisociality ("disregard for, and violation of, the rights of others"), histrionic ("a pattern of excessive emotionality and attention seeking") and borderline characteristics ("a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity")(DSM-IV-TR, 2000, p.685). Some of these 'symptoms' appeared to be more difficult to distinguish from the fa'afafine presentation. The expectation that personality disorders include a deviation in behaviour from that which is culturally accepted is likely to have been enhanced by the cultural differences between Samoa and New Zealand, particularly for a new immigrant with little opportunity (or perhaps desire) to assimilate into the Western culture of New Zealand. DSM-IV-TR specifically states that an individual's personality functioning must be considered in the context of their background and can be impacted by factors such as problems with acculturation. Gardenia's personality characteristics are likely to have been further impacted by the stressors related to her incarceration, loss of contact with her family, and being housed in a predominantly male environment.

Treatment

Gardenia volunteered to attend a group treatment programme to address her offending. She lived in a unit with other male prisoners and interacted with both male and female custody and therapy staff, from a wide variety of ethnic backgrounds. Gardenia was initially not accepted by her group members. They had concerns that she was sexually attracted to them and there had been some evidence that Gardenia had approached them in an overly familiar manner when they had arrived in the unit – particularly the younger group members. This behaviour became a treatment goal both in regards to the over familiarity, overt sexual attraction and preoccupation, as well as a lack of boundaries in regards to general and sexual touching, particularly in relation to younger men.

Gardenia completed an offence disclosure and was able to verbalise the factors which had led to her offending. She appeared to understand that her life style had led to sexual preoccupation and resulted in her using inappropriate methods for getting her sexual

needs met. Over time Gardenia formed a number of friendships within the group which allowed her to offer support and assistance to other participants. However, her feminine presentation and sexual preoccupation remained an issue for some of the group members who would not associate with her outside of the therapy environment. Gardenia's goal in life was to find herself a "nice palagi[2] man". The difficulty arose when discussing such a relationship in terms of intimacy, trust, commitment and companionship on an on-going basis. In order to reduce risk the goal was to get Gardenia's sexual needs met in a socially appropriate way. She had shown that she was willing to use whatever means available to engage in sexual activity with males. During her initial incarceration she had consistently approached other prisoners offering herself and her belongings in exchange for sexual favours. Both while incarcerated and on the outside Gardenia had played a numbers game in regards to the selection of whom she approached.

She believed that if she did not get sworn at or physically assaulted then there was an opportunity to participate in sexual activity. She consistently misread friendliness as a sign of sexual interest.

Gardenia feared that if she was to engage in a long-term relationship with a male that she would be allocated to a subservient role within the partnership. She did not want to be "told what to do". She did not appear to have observed or experienced an equal relationship in which partners could negotiate and share the household tasks and work responsibilities. She was also aware that her family and church were unlikely to accept her being in a sexual relationship with a male.

Gardenia said that she was aware that she could not live with other fa'afafine as she believed that she would be at risk of being involved in illegal activity which could result in her returning to gaol. Her main concern was in regards to her perception that fa'afafine fought over their men and were often jealous of each other. However, she was clear that she desired to be a part of the fa'afafine pageants and that she would enjoy regular night clubbing and partying with "fa'fa" friends.

Gardenia participated in regular group sessions, was seen on an individual basis by a psychologist, had regular contact with a case officer, and was seen in case management meetings with therapy and custody staff when her behaviour became inappropriate. The goals of these interactions were to minimise her risk of further offending in the context of providing feedback in regards to her maladaptive interpersonal interactions. In addition Gardenia was a member of the gay support group, regularly attended church and participated in weekly bible study sessions facilitated by the local Pacific Island chaplain.

Unit Interactions

Gardenia's effeminate presentation in the unit resulted in daily teasing, put downs and on occasion retaliation when she lost her temper. She refused to conform to others' expectations and maintained her sense of self despite the negative consequences. Gardenia would dress up for the weekly unit meeting using pens to dye her T-shirts pink and to add decorative patterns to the trims. She would make paper flowers to decorate her hair, used palm fronds to make long necklaces, coloured rubber bands to make bangles, and wore her hair flowing down her back. She timed her entrance to have the most effect, choosing to wait until all others were seated and then crossing the room to the furthest point before taking a seat. The first time this occurred she was clapped and jeered, though she chose to interpret this as jealousy of her looks. She described these occasions as making an entrance and planned them meticulously for the greatest effect.

A number of custody staff and prisoners of Samoan descent spoke of their experience of feelings of shame in regards to Gardenia's effeminate behaviour. While it was originally and perhaps naively expected that these individuals could be depended on to support Gardenia as a fa'afafine, this was not the reality. Comments were made that Fa'afafine were no longer accepted and in fact did not exist in some villages in Samoa, and that religious faith conflicted with being fa'afafine. Samoan identity is thought to be developed through kinship and social structures rather than based on individuality. This appeared to have resulted in a sense of collective responsibility for an individual's behaviour and resulted in other people of Samoan descent and indeed other Pacific island peoples, feeling responsible for Gardenia's behaviour and the negative way in which it was perceived in the unit. This issue was discussed with the Pacific Island Chaplain who met with the Pacific Island men and was able to encourage a more accepting and less judgemental attitude towards Gardenia. A similar discussion with some of the Pacific Island staff appeared to have the same positive effect.

Gardenia was a member of an informal Pacific Island group which developed within the unit amongst the prisoners, and acted as a support network. When associating with these males Gardenia provided food and participated in dancing and singing practice, as well as public performances. However, she also noted that she could not discuss her sexual interest in men and avoided discussing this topic. She said she had been told that the other men did not accept that she was attracted to males as it conflicted with their cultural and religious beliefs. She was also specifically told at one

[2] Non-Samoans - especially European westerners or Caucasians

point by an older Samoan man that fa'afafine were not accepted in his village at home. She also noted that she had been asked by the other men to "act like a man", which would mean to cut her hair and fingernails, and tone down her behaviour. Gardenia managed to maintain her relationship with these men without yielding to these requests; however she said this occurred because of her cooking skills, generosity with food, and her tacit agreement not to discuss her attraction to males.

Family

Gardenia regularly spoke of her family and her desire to receive visits while she was in gaol, however she did not appear capable of navigating the official process to ensure this outcome. Her main issues appeared to relate to a lack of motivation to follow procedures and administrative processes. Gardenia appeared to believe that she could ignore the required paper work and that her family would be allowed entry to the prison if they were to turn up at the gate. Gardenia's reluctance appeared rooted in her understanding that her incarceration shamed the family. She was aware that the family with which she had been living had not informed the extended family that she was in gaol. There had been a story circulated that she had travelled overseas. When it was revealed that she was incarcerated the family had apparently lied about the nature of her offending in order to further reduce the shame within the family. It appeared that Gardenia's incarceration had also been kept secret from her church and as such she believed that she would have to attend another church post release.

Outcomes

Overall Gardenia made positive gains in being accepted by her group members and formed a number of platonic friendships with other men in the unit due to her loyalty, generosity with rations, and sense of humour. She gained an understanding that in order to reduce her risk of sexual reoffending she would need to meet her sexual needs in an appropriate way. She accepted that she would not be allowed to return to live with her extended family due to the presence of young children.

Gardenia gained insight into the fact that she would need to find her own independent accommodation in order to balance the incompatible aspects of her life. Optimally this would result in her being able to retain a relationship with her family, attend church, maintain friendships with other fa'afafine, and seek a male partner.

Gardenia learned to accept that her living situation would not be that with which she was culturally familiar. She would no longer be a part of an extended family unit in which she was valued and gained status as a fa'afafine contributing her work to assist others. The goal was to reduce her risk of reoffending by enabling her to meet her interpersonal and sexual needs, while providing her with a safe place from where she could express her various persona and roles as well as avoiding unnecessary conflicting situations.

Unfortunately, despite improvement in her understanding of the need to associate with friends her own age and to seek a consensual relationship with an adult male, Gardenia was removed from the unit for inappropriate sexual behaviour towards another prisoner. She acknowledged that she should not have attempted to touch the man against his will, however she continued to lack a clear understanding of boundaries, consent, and the impact of her behaviour on others. Gardenia was removed from the unit and did not complete treatment.

Gardenia was returned to her previous unit. Subsequent reports indicated that she had reduced the frequency of incidents of approaching men for sexual favours, when compared to her previous time in that unit. However, she was described as being difficult and demanding. More recently it was noted that her behaviour had improved to the point that she had been allocated a job and had been moved to a less restricted area of the unit. Gardenia was being assisted to re-establish contact with her family and had gained approval for supported accommodation. Gardenia continued to receive regular visits from the Pacific Island chaplain. Due to her not having completed treatment she was referred for individual therapy with a psychologist.

While a male prison setting appears questionable as a suitable environment for a person who identifies as fa'afafine, it appears that Gardenia had never lived in an environment that could fully and safely meet her needs. Her plan to reside in her own accommodation and thereby separate the interactions that she has with her family, her fa'afafine friends, a potential partner, and the church, is a first step in acknowledging the various worlds in which she has been forced to live as a fa'afafine.

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Sexual Abuse in Australia and New Zealand, July 2011; 3(1): 10-22

Increased Self-Disclosure of Offending by Intrafamilial Child Sex Offenders

Jessica Pratley
NSW Pre-Trial Diversion of Offenders Program, Australia

Jane Goodman-Delahunty
Charles Sturt University, Australia

Abstract

Acceptance of intrafamilial child sex offenders into a treatment program generally requires the offender to admit and accept responsibility for the crimes with which he was charged. Once this level of disclosure has been reached, it is rare for him to be challenged regarding other offences that he may have committed. Anecdotal clinical reports indicated that some offenders disclosed a higher level of abuse than that provided by the victim. This study built on the limited empirical research on this topic. The sample consisted of 124 male offenders referred for treatment at the NSW Pre-Trial Diversion of Offenders Program (Cedar Cottage) between 1989 and 2003. Analyses of disclosures by offenders referred to the program revealed that following contact with the Cedar Cottage personnel, all offenders disclosed significantly more details regarding their offending behaviour, irrespective of whether they were accepted into the program for treatment or declined. Eleven percent of the offenders disclosed victims beyond the individual identified in the index offence. Expanded details were also provided regarding victim age when offending began, the duration and frequency of offending, the number of locations where abuse occurred, and the range and intrusiveness of abusive acts committed. Program completers did not disclose more than noncompleters. These results suggested that the extent and nature of abuse by intrafamilial child sex offenders in the early stages of detection is underestimated. Refusal of offenders into treatment programs based on denial and minimisation is a practice that warrants review.

Introduction

The dynamics of intrafamilial child sexual abuse result in a high risk that child victims will refuse to testify against their abusers (Herman, 1981), requiring the Director of Public Prosecutions to drop charges against the offender. In 2006, in 13.6% of all cases tried in the Supreme or District Court involving at least one count of a sexual assault against a child, the charges were dropped, most frequently due to applications by the Crown for no further proceedings. In those cases that went to trial, the offenders were convicted of at least one charge in slightly more than half (55%) of the cases, and were acquitted of all charges in a substantial number of cases (45%) (BOCSAR, 2007). In 2007, 45.7% of people convicted of at least one child sex offence who appeared in any NSW court (Local, District or Supreme) were not convicted. Just under half of those convicted did not receive a custodial sentence (45.5%) (NSW BOCSAR, 2008).

This low conviction rate is in part attributable to the fact that misconceptions commonly held by the public and many jurors concerning children's memory abilities, suggestibility, disclosure of and reactions to sexual abuse are incongruent with the experience of most victims of sexual abuse (Cossins, Goodman-Delahunty, & O'Brien, 2009; Goodman-Delahunty, Cossins, & O'Brien, 2010). Thus, legal incentives for offenders to deny all charges when the evidence relies on the testimony of a child witness are strong.

The proclivity of many child sex offenders to deny their offences is undisputed. "Denial has always been the incestuous father's first line of defence" (Herman, 1981, p. 22). Not only are there legal factors that motivate intrafamilial child sex offenders to deny their abuse after it is reported, but denial is integral to the offender's *modus operandi.* Denial and minimisation are important features of the early stages of child sexual abuse, crucial in allowing offenders to overcome their own internal inhibitions, as well as external inhibitions, such as resistance by the victim (Wright & Schneider, 2004). Minimisation is observed when offenders deny part, but not all, of their offence. For example, offenders may admit to fewer incidents and a constrained range of abusive acts, a shorter duration of abuse, or committing the abuse less frequently than they enacted (Beech & Fisher, 2002; Salter, 1988). Offenders learn to avoid taking responsibility for, or to deny the harmfulness of their actions (Schneider & Wright, 2004).

Clinical research indicates that denial can be decreased with treatment (Marshall, Serran, Marshall, & Fernandez, 2005). However, acceptance into a treatment program often requires that the offender admit and accept responsibility for the crimes with

Correspondence: Jessica Pratley, NSW Pre-Trial Diversion of Offenders Program

ISSN 0833-8488

which he[1] has been charged. Once this level of disclosure has been reached, it is rare for an offender to be interviewed regarding other offences that he may have committed. Few studies have explored the extent to which an offender fully discloses his abusive behaviour, in part due to a dearth of corroborating evidence. This study addresses that gap in the empirical literature.

Official records consistently underestimate criminal offending in multiple areas and self report often uncovers additional offences (Payne, 2007). Research suggests that sexual offenders are different from nonsexual offenders (though sexual offenders frequently commit nonsexual offences, nonsexual offenders are unlikely to commit sexual offences) (Hanson & Bussiere, 1998). This study investigates whether the trend of self-reported offending at higher levels than official records observed in nonsexual offenders is evident in intrafamilial child sexual offenders.

Denial

Following conviction, denial and minimisation often persist into the early stages of treatment (Salter, 1988; Schneider & Wright, 2004). Over a 17-year period of monitoring, denial of all or part of a sexual offence was demonstrated in 87% of first interviews of offenders referred to a treatment centre in Oregon (Maletzky, 1991). Another study revealed that 66% of incarcerated child sexual abusers denied commission of an offence, and when the investigators examined both minimisation and denial, this percentage rose to 98% (Barbaree, 1991).

An offender is rarely classified exclusively as either a "denier" or "admitter." Rather, denial tends to fluctuate depending on both internal and external factors (Brake & Shannon, 1997). The degree to which sex offenders deny and minimise their offences has been shown to decrease as they progress through treatment (Wright & Schneider, 2004), signifying that denial is a dynamic factor that can be targeted in treatment. From a relapse-prevention perspective, self-disclosure is seen as beneficial for the offender (Frost, 2004). Denial has been demonstrated to hinder treatment progression (O'Donohue & Letourneau, 1993), and in intrafamilial sex offenders, to increase the likelihood of recidivism (Nunes, et al., 2007). Although denial has not been consistently associated with risk of recidivism (Hanson & Bussiere, 1998) most previous study samples did not differentiate between intrafamilial and extrafamilial child sex offenders. Increased self-disclosure and low denial can assist offenders to complete a treatment program (Levenson & Macgowan, 2004). The level of disclosure by an offender of the abuse he has perpetrated is likely to have important consequences for other family members. An offender who denies or minimises his offences will reduce the support that the non-offending parent is able to provide (Lambie, Seymour, Lee, & Adams, 2002; Saywitz, Mannarino, Berliner, & Cohen, 2000), and increase the likelihood that the child victim will make internal attributions about the abuse (Brake & Shannon, 1997). Researchers who argue that denial should not be a target in treatment of sexual offenders (Marshall, Marshall, & Ware, 2009) fail to acknowledge the impact of an intrafamilial offender's denial or minimisation on victims and their families.

The impact of an offender's denial on the child victim can be substantial. When offenders deny the allegations that are made against them, they remove responsibility from themselves and promote self-blame and feelings of shame in the victim (Brake & Shannon, 1997). Shame, in particular, has been linked to poorer victim outcomes. It is possible for victims to experience shame in the absence of self-blame (Cohen & Mannarino, 2002). Furthermore, if the offender minimises his abuse by admitting to some aspects of the offence but denying others, this may leave the victim with self-doubt (Reid, 1998).

Researchers in the field of child sexual abuse have noted that disclosure of sexual abuse by child victims is a process, rather than an event (e.g., Lewis, 2006; Sorenson & Snow, 1991). Similarly, the phenomenon of disclosure as a process in offenders has been observed anecdotally by treatment providers. One early study provided a brief structured treatment program to 17 child sex offenders who denied their offences. After seven group sessions, 65% of these offenders changed status from that of "denier" to "admitter" (O'Donohue & Letourneau, 1993). However, no systematic investigation has yet been conducted of the precisely contextual features that facilitate disclosure by offenders. Marshall and colleagues (2005) demonstrated that when provided with a face-saving way in which to reveal details of offending, some offenders are able to recall previously "forgotten" aspects of the abuse: a group of 22 Canadian offenders who could not recall details of their offending was given two to four weeks of instruction in a memory recovery technique based on empirical memory research. Thereafter, 90.9% provided an account of their assault that matched that recorded in official statements (Marshall et al., 2005).

Disclosure beyond the child victim's account

Admissions regarding the offences with which one is charged are different, however, from admissions concerning further offences that have not previously

[1] Because the majority of sexual offenders are men, and all participants in this study are male offenders, the male pronoun is used throughout this manuscript.

been reported by a victim. The experience of many clinicians who work with sex offenders is that their clients do not disclose the full extent of their offending until several months into treatment (O'Donohue & Letourneau, 1993; Reid, 1998). This phenomenon may be due to a number of factors, including cognitive distortions regarding the offending, concern about attracting further legal implications, shame about the offending, denial about their level of offending (Baker, Tabacoff, Tornusciolo, & Eisenstadt, 2001) and trust issues with the therapist and therapy milieu (Denov, 2004; Laws, 2008). These factors may be heightened when the offender has abused young children, same-sex victims and relatives (Baker et al., 2001). This clinically observed delay is unsurprising, considering that child sex offenders spend years learning to minimise the harm caused by their actions, or laying responsibility elsewhere (e.g., with an "unresponsive" wife).

Practitioners with clinical experience at sex offender treatment facilities described intrafamilial sex offenders as individuals who generally enter treatment admitting to the bare minimum of offences; presumably sufficient to ensure their acceptance into the diversion program so they can avoid incarceration (Reid, 1998). However, throughout treatment, the abuse admitted by the offender can increase, and in some cases, surpass that disclosed by the victim. This effect was demonstrated in a sample of 47 juvenile male sex offenders aged 12-17 years in New York State (Baker et al., 2001): after 6-36 months in treatment, 30% of offenders admitted to new offences against the victims of offences for which they were adjudicated (either a greater number of the same offences against that victim, additional types of offending against the known victim, or both), and 31.9% of offenders disclosed sexual offences they had committed against victims other than those already known to therapists and law enforcers. In total, 53.2% of participants disclosed a new offence, a new victim, or both. This study provided strong empirical evidence in support of clinical observations that offenders do not disclose the full extent of their offending in the initial stages of treatment. However, young sexual offenders may differ from adult offenders with regards to disclosure in a number of ways. First, they do not necessarily face the same threat of incarceration as adult sexual offenders (Salter, 1988), so the motivation to deny their offences may not be as strong. Second, they have also spent less time denying their offences, and thus may be less resistant to attempts by therapists to gain a full understanding of the extent of their abusive behaviour.

A qualitative study conducted in New South Wales provided further support for the observation that offenders in treatment gradually expand their accounts of their offending behaviour. An in-depth study of ten adult intrafamilial sex offenders revealed that eight expanded their original account of the sexually abusive acts they perpetrated (Reid, 1998). In four of the eight cases, the offenders disclosed abusive behaviour that exceeded the victims' level of disclosure. Seven of the ten offenders disclosed that their abusive behaviour had lasted longer than they originally admitted. In five of these cases, the offenders' further disclosure closely matched that of their victims. Related to this was the finding that seven offenders admitted abusing children younger in age than they had originally stated. The small sample of offenders studied did not permit conclusions regarding the frequency with which intrafamilial sex offenders provide further disclosures in treatment.

The current study

This study examined whether the effects reported by Baker et al. (2001) were replicable in Australian adult intrafamilial sex offenders, and whether a larger sample size yielded statistical significance to the results observed by Reid (1998). Specifically, we hypothesised that intrafamilial child sex offenders undergoing a sex offender treatment program would disclose significantly more abusive behaviour than similarly-situated offenders who did not complete the treatment program. Given that disclosure is an unfolding process seen in children (Sorenson & Snow, 1991) and anecdotally in offenders, it was also expected that offenders who completed the treatment program would disclose significantly more about their abusive behaviour than those who did not complete the program.

Context of the research

The research was conducted using data gathered at the New South Wales Pre-Trial Diversion of Offenders Program (Cedar Cottage). Pursuant to Section 2A of the *NSW Pre-Trial Diversion of Offenders Act* (1985), Cedar Cottage provides community-based treatment for offenders who plead guilty to a sexual offence against their own or their partner's child/ren. Legal proceedings are adjourned until assessment is complete. Treatment consists of individual therapy and group sessions. The treatment draws upon cognitive-behavioural therapy, narrative therapy, the Good Lives Model (Ward and Stewart, 2003) and invitational practice in theory. Treatment takes a holistic approach and supports fathers in the program to make positive changes in all aspects of their lives. Although the term "offender" is used throughout this article, men in the program are referred to as "Program Participants" to reflect that their choice to sexually abuse does not comprise their entire being.

To be accepted into the program, applicants must provide statements about their offending behaviour that

match the statement about that conduct provided to the police by the victim. Applicants are invited to provide as much detail as possible regarding their abusive behaviour. Over an eight-week assessment period, the program director determines if the potential applicant is suitable for the program, and the offender decides whether the program is suitable for him.

Applicants who disclose further information regarding their offending behaviour during the assessment period are encouraged to provide an updated statement to the police, and any eligible offences disclosed within this period are dealt with under the Pre-Trial Diversion of Offenders Program legislation (D. Tolliday, personal communication, March 1, 2010). Once the assessment period ends, further offences that are revealed are reported to the police (by either the offender or the therapist), and, if new charges are laid, they are addressed independent of the offender's participation in the program. Program participants are informed about these limits to confidentiality within the program. Program participants have a minimum of two years to complete the program, with the possibility of an extension of up to one year. Although the initial phases of treatment are uniform, each individual progresses through the treatment program at a different pace.

Method

Participants

The participants were 124 male offenders referred to the NSW Pre-Trial Diversion of Offenders Program (Cedar Cottage) between 1989 and 2003. Of these, 70% (87) were accepted into the treatment program. Forty-two percent (n=52) of offenders successfully completed the treatment program (completers), while 28% (n=35) offenders commenced the treatment program but failed to complete it (22%, n=28, breached their treatment agreement and 6%, n=7, withdrew). A third group was comprised of 30% (n=37) applicants who were not accepted into the treatment program (declined group). A total of 214 offenders were referred to the program between 1989 and 2003; 90 were excluded from the current study as there was not sufficient information in their files to assess changes to their disclosure about their offending.

At the point of assessment, the majority of applicants (89%) reported only female victims, and more were nonbiological fathers (including stepfathers, *de facto* stepfathers, adoptive fathers, foster fathers) (56%) than biological fathers (44%) (Table 1).

The applicants ranged in age from 23 to 57 years (M = 39.47, SD = 7.66). Applicants declined entry to the program were slightly younger on average than those accepted (mean age of 37.43 years versus 39.85 years) whereas those who completed the program were slightly older on average than those who breached (mean age of 41.58 versus 36.25 years). These differences were not statistically significant.

Table 1: Victim-Offender Relationship, Victim Gender, and Applicant Status (percent)

	Completed (n=52)	Noncompleted (n=35)	Declined (n=37)	Total (n=124)
Relationship with victim				
Biological father	46.2	51.4	35.1	44.4
Nonbiological father	53.8	48.6	64.9	55.6
Gender of victim				
Female victims only	86.5	88.6	91.9	88.7
Male victims only	9.6	2.9	2.7	5.6
Male & female victims	3.8	8.6	5.4	5.6
Months in treatment mean (SD)	31.2 (6.13)	16.3 (8.0)	N/A	25.2 (10.05)

Procedure and measures

Offenders' descriptions of their abusive behaviour were examined at up to six points in time to assess their level of disclosure: (1) the offender's initial statement to the police (pre-assessment); (2) the end of the preliminary eight-week assessment period (post-assessment); (3) after 8 months of treatment; (4) after 16 months of treatment; (5) after 24 months of treatment; and (6) for participants who required an extension of treatment, at completion of the program. Overall disclosures were analysed based on each offender's final statement, regardless of time spent in the program, as this was the optimal point in time to measure propensity to disclose.

At each periodic assessment point, participants' descriptions of the abusive conduct were scored on seven dimensions: (1) age of victim at first instance of abuse; (2) number of instances of abuse; (3) duration of abuse; (4) frequency of abuse; (5) location of abuse; (6) type of abuse perpetrated; and (7) the degree of intrusiveness. Victims' accounts, contained in the police records, were scored in the same manner. The number of victims disclosed by the offender was recorded.

Where information regarding the duration and frequency of the abuse was not obvious, estimates were derived from other information (e.g., if number of instances of abuse was not stated, it was estimated from the frequency and duration information provided). The locations coded included the victim's bedroom, offender's bedroom, lounge room, bathroom, other room in house, car, holiday location, and other. Table 2

specifies the criteria used to score intrusiveness on a 5-point scale.

Table 2: Range and Intrusiveness of Abusive Acts

Intrusiveness score	Impact on victim	Examples of conduct
1.0	Non-contact, no exposure	• exposure to pornography • peeping
1.5	Attempted exposure	
2.0	Non-contact, exposure	• exposure/exhibiting • offender masturbated in front of victim
2.5	Attempted physical contact	
3.0	Non-penetrative physical	• touching/fondling • kissing • offender forced victim to touch him • genital to genital contact without penetration
3.5	Attempted non-penile penetration	
4.0	Non-penile penetration	• oral abuse by offender • digital-vaginal penetration • digital-anal penetration
4.5	Attempted penile penetration	
5.0	Penile penetration	• penile-oral penetration by offender • penile-vaginal penetration • penile-anal penetration

The data were collected by systematically examining clinical case records maintained at Cedar Cottage. This information was coded by the first author and four postgraduate interns from the University of New South Wales.

To assess the internal consistency of the coding instrument, K-alpha reliability estimates were calculated (Hayes & Krippendorff, 2007). Eight per cent of the sample was dual-coded. For all respondents, K-alpha had a value of 0.81 indicating almost perfect agreement. When different types of variables were examined independently, this high level of internal reliability was maintained (nominal variables: K-alpha = 0.83; ordinal variables: K-alpha = 0.82; interval variables: K-alpha = 0.99). Disagreements between coders were managed by discussing and resolving the disparities.

Changes in disclosure during assessment were derived for each offender by recording increases or decreases on each aspect of the abuse from the time of the pre-assessment account to the post-assessment account. Treatment change scores were calculated for those offenders accepted into the program by comparing their disclosure on each aspect of abuse from their earliest post-assessment account to their final account. Overall change scores were calculated for accepted offenders by comparing pre-assessment accounts to final accounts. Only one accepted offender failed to provide a pre-assessment account. All declined offenders provided pre-assessment accounts.

A decrease in information provided was scored -1, no change scored 0, and an increase in information was scored as 1. An overall disclosure score at each assessment period was computed, ranging from -7 (maximum an account could decrease in disclosure) to 7 (the maximum increase in information). Only 14% (n=17) participants had second, third, and fourth index victims (n=12, 4, and 1 respectively). All analyses were conducted with regard to information provided about the first index victim. Age was the only variable which was normally distributed; t-tests were conducted to assess differences in this variable, while nonparametric equivalents were conducted on all other variables.

Results

Overall disclosure during assessment

Sixty-four percent (n=79) of the offenders achieved disclosure scores of one or more during assessment, compared with 25% (n=31) who did not change any of the seven aspects of their account of their abuse (change score = 0) and 10% (n=13) who provided less information post-assessment than pre-assessment. No change score was calculated for one accepted offender who did not provide a pre-assessment account.

Accepted offenders were more likely to demonstrate an increase in disclosure (68%, n=59) than a decrease (7%, n=6) or no change (24%, n=21). Similar disclosure patterns emerged among declined offenders: the majority (54%, n=20) achieved positive disclosure scores while 27% (n=10) achieved change scores in assessment of 0 and 19% (n=7) provided less information post-assessment than pre-assessment.

Accepted offenders obtained significantly higher disclosure scores during assessment than their counterparts who were declined treatment (Mdn = 2 and 1, respectively), U=1170, p<.05, r=-0.21. There was no difference between disclosure scores during assessment for completers and noncompleters (Mdn = 2 and 1, respectively), U= 731, *ns*.

Overall disclosure by program completers and noncompleters

As expected, program completers spent significantly longer in the treatment program than those who breached (Mdn = 32.5 months versus 17 months), U = 138, $p < .001$, r=-0.72. Time spent in the program was significantly correlated with offenders' disclosure scores, r_s = 0.21, n = 87, $p < .05$. This significant correlation was not maintained within the two groups, completers: r_s = 0.13, n = 52, ns; noncompleters: r_s = 0.20, n = 35, ns. Further analyses of disclosure by participants in each group were conducted without controlling for the amount of time spent in the program. Program completers did not disclose significantly more than noncompleters during the time they were in treatment (Mdn = 2 and 1, respectively), U=728, *ns.*

Considering overall disclosure (during assessment and in treatment combined), there were no significant differences between total disclosure scores for program completers and noncompleters (Mdn = 4 and 3, respectively), U = 713, *ns*. When the seven aspects of abuse were examined individually, Mann-Whitney tests revealed no significant differences between the groups on any of these seven aspects of abuse.

Intercorrelations

The intercorrelations between changes in the seven aspects of disclosure ranged in strength and direction (see Table 3).

Age of victim at first abuse was negatively correlated with all other variables; the strongest positive correlation emerged between age of victim at first abuse and duration of offending. Number of incidents of abuse was not significantly correlated with any other variable.

Changes in disclosure about individual aspects of abuse during assessment

Bonferroni-adjusted Mann-Whitney tests (a Bonferroni-adjusted independent-sample t-test was conducted for the variable 'age of victim at first abuse'), with alpha levels set at 0.007, revealed no statistically significant differences in disclosure between those accepted into the program and those declined entry to the program at the time of pre-assessment. Similarly, no significant differences were found between the completers and noncompleters in their pre-assessment accounts.

Disclosure change was assessed at Time 1 (pre-assessment) and Time 2 (post-assessment), in order to assess the scope of disclosure that occurred during the offenders' initial contact with Cedar Cottage personnel. Although there was some variation over the period of 14 years in the number of sessions afforded to participants during the assessment phase, these differences were minor (at the program's inception, the assessment phase consisted of fewer sessions), and the goals of the assessment phase remained constant throughout this period.

A Bonferroni-adjusted paired samples t-test revealed that post-assessment, participants disclosed that they began offending when victims were significantly younger (mean age=8.9 years) than was initially claimed (mean age= 9.3 years), $t(114)$=3, p<.007, d=0.14, $r_{Y\lambda}$=0.07. Bonferroni-adjusted Wilcoxon signed ranks tests were conducted on mean disclosure scores for each of the six dimensions of the abuse descriptions noted above (excluding 'age of victim at first abuse'), with alpha levels set at .007. Results of these analyses revealed that offenders disclosed significantly more information about all aspects of their offending behaviour at the end of the assessment period. Using Cohen's (1992) definition of effect sizes (small: r=0.10, medium: r=0.30, large: r=0.50), effect sizes observed were generally medium (see Table 4).

This trend towards increased disclosure was evident irrespective of whether the offenders were ultimately accepted for treatment: those accepted for treatment disclosed significantly more information about all aspects of their offending behaviour (see Figure 1).

The same pattern of results emerged among declined offenders although differences between pre-assessment and post-assessment disclosure scores in the latter group did not reach statistical significance (Figure 2).

Table 3: Intercorrelations Between Change Scores on Seven Aspects Of Abusive Behaviour

Change in:	Age of victim	Number of incidents	Duration	Frequency	Locations	Abusive acts	Intrusive-ness
Age of victim	-						
Number of incidents	-.24*	-					
Duration	-.82**	.11	-				
Frequency	-.35**	.08	.37**	-			
Locations	-.43**	.13	.53**	.38**	-		
Abusive acts	-.26**	.07	.37**	.12	.48**	-	
Intrusiveness	-.24*	.06	.36**	.10	.32**	.60**	-

Notes. Based on raw change scores.
*$p < .05$; **$p < .01$ (2-tailed).

Table 4: Changes in Disclosure Pre-Assessment Versus Post-Assessment

	Pre-assessment median (range)	Post-assessment median (range)	Z	*d*	$r_{Y\lambda}$
Incidents of abuse	4 (1-600)	9.5 (1-1500)	-4.8*	-.28	-.38
Duration of offending (days)	225 (1-3650)	420 (1-3650)	-3.7*	-.24	-.30
Frequency	5 (1-13)	7 (1-12)	-3.2*	-.38	-.27
Locations	2 (1-8)	2 (1-9)	-4.3*	-.48	-.28
Range of abusive acts	3 (0-8)	4 (1-11)	-5.3*	-.58	-.38
Intrusiveness of abuse	4 (2-5)	4 (3-5)	-4.0*	-.38	-.21

Note. * $p < .007$, two-tailed

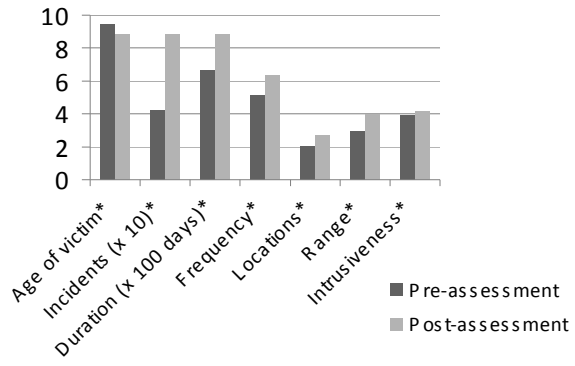

Figure 1: Mean changes in disclosure by offenders accepted for treatment
Note *$p<.007$, two-tailed

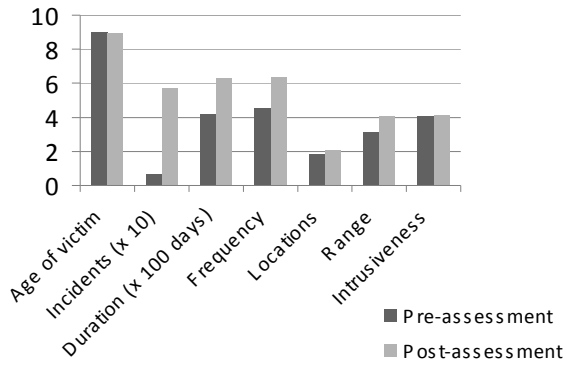

Figure 2. Mean changes in disclosure by offenders declined treatment

Disclosure during treatment

After offenders commenced treatment, the trend of expanded disclosure continued. Similar comparisons of mean disclosure scores on all seven dimensions of abuse were made at the end of the assessment phase and from the offender's final description upon completion of the program. Offenders accepted into the program revealed significantly more information regarding their abusive behaviour on all dimensions. At their final account, they disclosed that they began offending when the victims were significantly younger (mean age = 8.3 years) than they had indicated at post-assessment (mean age = 8.8 years), t(83)=2.9, p<.007,d=0.13, $r_{Y\lambda}$=0.06. This significant trend of increased disclosure was observed for all aspects of abuse as assessed by Wilcoxon signed ranks tests (Table 5).

Wilcoxon signed ranks tests (repeated measures t-tests for age of victim at first abuses) demonstrated the same trend for completers, although frequency of abuse did not reach statistical significance. A similar pattern emerged among noncompleters, however, these changes did not reach statistical significance (Figures 3 and 4).

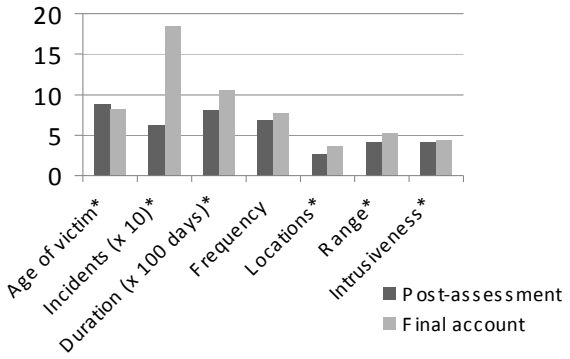

Figure 3: Mean changes in disclosure by completers: post-assessment vs final account
Note *p<.007, two-tailed

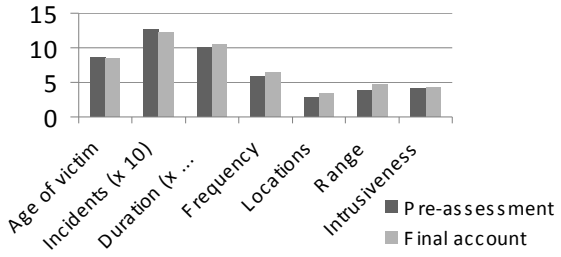

Figure 4: Mean changes in disclosure by noncompleters: post-assessment vs final account

Disclosure by victims compared to offenders

Victims' accounts provided to the police were compared with offenders' pre-assessment statements. The results revealed that offenders declined entry to the program did not provide significantly different accounts to their victims at pre-assessment, on any aspect of abuse.

Prior to the assessment period, offenders who were accepted into the program disclosed significantly less than their children did about the number of times they sexually abused their child (Mdns = 5 and 15, respectively; z = -2.96, p<.007, d = -.25), the frequency of their sexual abuse (Mdns = 5 and 9 respectively; z = -3.06, p<.007, d = -.28), the duration of their offending behaviour (Mdns = 365 and 730 respectively; z = -3.39, p<.007, d = -.28), the intrusiveness of their abuse (Mdns = 4 and 4 respectively, z = -3.72, p<.007, d = -.29) and the number of types of abusive acts they perpetrated (Mdns = 3 and 4 respectively, z= -3.87, p<.007, d = -.30). There were no significant differences between offenders' pre-assessment accounts and victims' police statements for number of locations (Mdns = 2 and 2 respectively, z = -1.91, *ns*) and age of victim at first offence (M = 9.65 and 9.16, respectively; t (76) = -2.43, *ns*).

Of those accepted into the program, program completers were more likely to have discrepancies between their pre-assessment account and their victim's account than were program noncompleters. Program completers disclosed significantly less than their children about the frequency of their offending behaviour (Mdns = 6 and 9, respectively; z = -3.11, p<.007, d = -.37), the duration of their abuse (Mdns = 365 and 730, respectively; z = -3.24, p<.007, d = -.35), the range of abusive acts they perpetrated (Mdns = 3 and 4, respectively; z = -2.97, p<.007, d = -.30), and the age of victim at first abuse (M = 8.8 and 9.73, respectively; t (44) = -3.63, p<.007, d = .23).

Program noncompleters disclosed significantly less about the intrusiveness of their sexually abusive behaviour than their children did (Mdns = 4 and 4, respectively; z = -2.75, p<.007, d = -.33).

At the end of the assessment period, offenders accepted into the program provided accounts that did not differ significantly on any aspect of abuse from their victim's accounts. This pattern was sustained when completers and noncompleters were examined separately. Those declined entry reported that they sexually abused their children on fewer occasions than their children reported (Mdns = 7.5 and 18, respectively, z = -2.92, p<.007, d = -.42).

Table 5: Changes in Disclosure Post-Assessment Versus Completion of Treatment

	Post-assessment median (range)	Final description median (range)	Z	d	$r_{Y\lambda}$
Incidents of abuse	11.5 (1-1500)	20 (1-4000)	-4.3*	-.19	-.35
Duration of offending (days)	730 (1-3650)	880 (1-3650)	-3.8*	-.17	-.30
Frequency	7 (1-12)	8 (1-12)	-3.3*	-.28	-.28
Locations	2 (1-9)	3 (1-10)	-4.5*	-.44	-.34
Range of abusive acts	4 (1-11)	5 (1-11)	-5.1*	-.44	-.38
Intrusiveness of abuse	4 (3-5)	4.5 (3-5)	-3.2*	-.27	-.24

Note. * $p < 0.007$, two-tailed

Finally, offenders' final accounts of their offences were compared with victim accounts provided to police. Results revealed that offenders disclosed that they began abusing when the victim was younger (mean age = 8.46, SD=3.3) than the victim had stated (mean age = 8.89, SD=3.2), however, a repeated measures t-test was not statistically significant.

Although participants disclosed that they offended for longer than was disclosed by the victim, that they committed a wider range of abusive acts in a wider range of locations, and that those abusive acts were more intrusive than those disclosed by the victim, statistically significant differences (using Bonferroni-adjusted Wilcoxon signed ranks tests) emerged only for the number of locations where abusive acts occurred, and the range of abusive acts committed (Table 6). The same trend was observed among offenders accepted for treatment (Table 7).

As expected, offenders displayed some level of minimisation at their first contact with Cedar Cottage personnel. By the time they provided their final account at the completion of the treatment program 2-3 years later, the scope of disclosure in the descriptions of abusive behaviour that they provided exceeded that provided by the victims (Figure 5).

This difference was evident on all seven aspects of abuse.

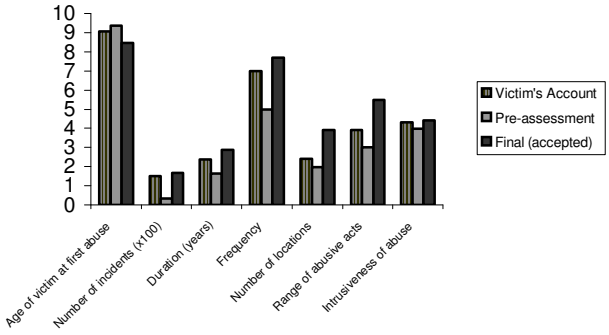

Figure 5: Mean disclosure by victims and offenders prior to and following treatment

Table 6: Comparisons Between Median Scores in Victims' and Offenders' Final Accounts

	Victims' account median (range)	Offenders' final account median (range)	*Z*	*d*	$r_{Y\square}$
Incidents of abuse	15 (1-2555)	20 (1-4000)	-.81		
Duration of offending (in days)	730 (1-4380)	730 (1-3650)	-1.1		
Frequency of offending	9 (1-13)	8 (1-12)	-.24		
Number of locations	2 (1-8)	3 (1-10)	-3.9*	-.59	-.25
Range of abusive acts committed	4 (1-10)	5 (1-11)	-4.1*	-.49	-.26
Intrusiveness of abuse	4.5 (3-5)	4.5 (3-5)	-.28		

Note. * $p < 0.007$, two-tailed

Table 7: Comparisons Between Median Scores in Victims' and Offenders' Final Accounts

	Victims' account median (range)	Offenders' final account median (range)	*Z*	*d*	$r_{Y\square}$
Incidents of abuse	15 (1-1000)	20 (1-4000)	-6.8		
Duration of offending (in days)	730 (1-4380)	880 (1-3650)	-1.5		
Frequency of offending	9 (1-13)	8 (1-12)	-.12		
Number of locations	2 (1-8)	3 (1-10)	-5.2*	-.59	-.40
Range of abusive acts committed	4 (1-9)	5 (1-11)	-4.5*	-.49	-.34
Intrusiveness of abuse	4 (3-5)	4.5 (3-5)	-1.7		

Note. * $p < .007$, two-tailed

Number of victims

At the time of offenders' pre-assessment account, a total of 147 victims were identified. The majority were the stepchildren (49%) or biological children (46%) of the offender. The remainder of victims were adopted or foster children (3%), or victims who were not in the offender's family of procreation: two siblings and one cousin (2%).

The majority of offenders did not disclose further victims throughout treatment. Eleven percent (n = 23) of the offenders disclosed sexual offences against other victims. One offender disclosed a total of 16 further victims (two biological children and 14 family friends). Additional disclosures are summarised in Table 8.

Table 8: Percentage of Offenders Who Disclosed Additional Victims

Number of additional victims	Accepted %(n)		Declined %(n)	Total %(n)
	Assessment	Treatment	Assessment	
1	66.7 (6)	25.0 (3)	50.0(1)	43.5(10)
2	22.2 (2)	16.7 (2)		17.4(4)
3	11.1(1)	25.0(3)	50.0(1)	21.7(5)
4	-	16.7(2)	-	8.7(2)
7	-	8.3(1)	-	4.3(1)
16	-	8.3(1)	-	4.3(1)
Total	100 (9)	100 (12)	100 (2)	100 (23)

Accepted offenders were significantly more likely to disclose additional victims (Mdn = 0) than were declined offenders (Mdn = 0), U=1306.5, p<0.05. Significance was not maintained when only disclosures in assessment were examined, U=-1532.5, *ns*.

Of those who revealed additional victims, approximately one third (n = 8) of the offenders reported that they commenced sexual offending in adolescence (ages 11-15 years), and 22% (n = 5) commenced in early adulthood (ages 21-25 years).

Discussion

The results of this study demonstrated that the information provided by intrafamilial child sex offenders at the time of their apprehension did not accurately represent their abusive conduct. Throughout the course of a treatment program, intrafamilial sex offenders are likely to provide further disclosures relating to the victim's age at time of the first abuse, number of incidents of abuse, duration and frequency of offending, the number of locations at which they offended, the range of abusive behaviours committed, and the intrusiveness of their abusive acts.

The level of disclosure demonstrated in this study is striking considering the legal ramifications for the study participants. Disclosures made by offenders during the assessment period were incorporated into the charges for which they were referred to the Pre-Trial Diversion of Offenders Program. However, during the assessment period, there is no guarantee that referred offenders will be accepted into the treatment program. This puts applicants in a predicament. If they make further disclosures and are subsequently declined treatment, they may face further charges and harsher penalties upon return to the courts for trial.

Offenders declined entry into the program provided pre-assessment accounts of their abuse that did not differ significantly from the police statements made by their children. This contrasts from those accepted into the program, who, at pre-assessment provided less information about their abuse than their children. By the end of the assessment period, there were no significant differences between the accounts provided by offenders accepted into the program and their children's statements.

Offenders who were declined provided less information than their victims about the number of incidents of abuse at the end of the assessment period. It may be that by this stage in the assessment process, these offenders had identified they were unlikely to be accepted and were concerned about the legal implications they may face. Alternatively, they may have found it difficult to acknowledge the extent of their sexually abusive behaviour and for this reason, were assessed as unsuitable for the program.

Program noncompleters provided pre-assessment accounts of their abuse that more closely matched their victims' police statements than did accounts provided by program completers. These significant differences disappeared by the end of the assessment period. These changes in disclosure during assessment fit with what would be expected, given that in order to be accepted into the program, offenders must provide an account of their sexually abusive behaviour that matches the statement provided by their child.

The fact that offenders continued to make disclosures during treatment, after they were no longer protected by the legislation on *Pre-Trial Diversion of Offenders*, suggested that something in the treatment program structure provided a motivation for offenders to disclose that outweighed their fear of the legal consequences. This motivation may be related to the program's focus on responsibility, impact, and victim empathy.

Given that time in program was positively correlated with disclosure, but treatment group was not, it appears that other unmeasured variables account for increases in disclosure. This may include relational issues, such as

an offender's plans to reunite with his family, the type of contact (if any) that he is having with his family during treatment, or the therapeutic relationship. Alternatively, factors such as development of empathy or self-respect may influence an offender's decision-making about how much to disclose, and when.

Changes in the scope of new disclosures did not differ significantly between offenders who completed the treatment program and those who did not. This finding is supported by previous research demonstrating that a brief treatment program focussed on denial was beneficial in reducing denial (Marshall et al., 2005). These findings reinforced earlier research from the Pre-Trial Diversion of Offenders Program which demonstrated an increase in self-disclosure by program participants (Reid, 1998) and suggested that similar effects seen with juvenile sex offenders (Baker et al., 2001) are not unique to young offenders. The similarity in rates of disclosure across the two groups of participants suggested that the message from practitioners at Cedar Cottage that encourages disclosure operates from early on in treatment, and is well-received by participants. Disclosure scores demonstrated by program completers exceeded those of noncompleters, and when individual aspects of abuse were considered, significant differences disappeared for noncompleters. This suggested that there might be a relationship between disclosure and successful completion of an intrafamilial child sex offender treatment program.

An increase in self-disclosure by offenders potentially provides benefits relating to victim recovery. First, increases in disclosure by offenders can provide substantial therapeutic benefit for victims who are engaged in counselling by removing the responsibility from children who have experienced abuse to disclose this information themselves (Jenkins, 1990). Second, one factor that has been identified as mitigating the impact of sexual abuse is the role of social, and particularly parental, support for the victim. That is, the best mental health outcomes for child victims of sexual assault are seen in children who are believed and supported throughout disclosure and its aftermath (Lambie et al., 2002; Wilcox, Richards, & O'Keefe, 2004). Specifically, studies of sexually abused children highlight that the best outcomes are seen when nonoffending parents or caregivers are involved in the treatment process and able to provide appropriate support (Saywitz et al., 2000). In families where a parent has sexually abused a child, there is a strong likelihood that the offender will have created an atmosphere of conflict between the nonoffending parent and the child victim, in order to allow him to continue offending undetected (Herman, 1981). This highlights the importance of the offender's further disclosures in assisting the nonoffending parent to understand what the child has experienced and work on rebuilding her relationship with the victim. In addition, when an offender discloses the full extent of the abuse he has perpetrated, by providing the nonoffending parent with full details regarding what the child victim has experienced, he places her in a better position to provide support for the victim. Third, some types of abuse (e.g., penetration, abuse that occurs over an extended period of time) are associated with poorer victim outcomes (Wilcox et al., 2004). Knowing the full extent of the abuse assists the nonoffending parent to be more aware of the increased risk of negative psychological outcomes and to be vigilant towards warning signs of these outcomes.

Fourth, a mitigating factor which decreases the likelihood that a victim will experience psychopathology following sexual abuse is the victim's attributions about the abuse and why it happened. Victims who make internal attributions for the abuse that place themselves at blame are more likely to display negative psychological symptoms, such as depression and Post-Traumatic Stress Disorder. Increased self-disclosure by the offender may assist victims to make external attributions about their abuse and diminish self-blame (Feiring, Taska, & Chen, 2002).

Treatment programs that require intrafamilial child sex offenders to provide an account that matches the child victim's statement in a single session as a criterion for acceptance into the program may be operating under a faulty premise. Denial and minimisation are dynamic and fluid factors (Brake & Shannon, 1997); a measurement conducted at one time point only may be problematic in assessing an individual's amenability to treatment. The data reported in this study combined with the results of Marshall et al. (2005) and similar findings in a juvenile population (Baker et al., 2001) present a strong case for the implementation of an assessment period that allows potential treatment program participants time and the necessary cognitive tools to progressively expand on their account of their abuse until it matches the experience described by the victim.

The finding that offenders' disclosures often exceed the initial accounts by victims suggested that clinicians who provide treatment to victims of intrafamilial sexual abuse should heed the fact that their clients may not have revealed the full extent of their abusive experiences. In this situation, psychoeducation for victims may help remove feelings of self-blame that are exacerbated by the offender's minimisation. Psychoeducation regarding the phenomenon of increased self-disclosure by the offender over time would also assist nonoffending parents to provide appropriate support to the child victim.

Observed increases in disclosure by participants throughout the course of the 24-36 month treatment program provided a strong argument for researchers to exercise caution when interpreting results from studies that rely on child sex offender self-report where the offenders have not participated in any form of treatment (regardless of completion). This study demonstrated that child sex offenders are likely to provide details of further abusive behaviour if given time and treatment. Data collected from offenders in early phases of treatment, or from those who are incarcerated without treatment, are likely to be only partially correct.

The results of this study suggested that intrafamilial child sex offenders are not "one-off" offenders who capitalise on opportunities to offend as they arise. The nature of abuse described by offenders referred to Cedar Cottage suggested that they planned their actions. Although access to potential victims does increase as the offenders raise families, it is likely that thoughts of abuse and abusive conduct began much earlier.

Strengths and limitations of this study

This is the first empirical study to investigate self-disclosure of offending by adult intrafamilial child sex offenders. The results provide empirical confirmation of a phenomenon that was previously acknowledged anecdotally by treatment providers. The findings provide valuable support to qualitative analyses in a small sample (Reid, 1998), and similar findings in a juvenile population (Baker et al., 2001).

Although study participants were not randomly selected, all available data from all referrals to Cedar Cottage within a specified study period were included in the analyses, and data from offenders who were accepted and declined were compared. Any biases attributable to selection for treatment are not a threat to the interpretation of the data in this study.

Future research directions

Research conducted at different treatment centres and with extrafamilial offenders can establish whether this phenomenon extends to other offenders or is specific to Cedar Cottage. It is also vital that the therapeutic techniques that encourage disclosure are identified.

There is a clear need for research which incorporates victim data with offender data to investigate the relationship between expanded self-disclosure by offenders with victim outcomes and experiences. Although previous research has suggested that this will be the case, the depth of data regarding increased disclosure by offenders available at Cedar Cottage provides a rich and unique possibility to confirm this theory.

Conclusions

A goal of the *New South Wales Pre-Trial Diversion of Offenders Act* 1985 was to provide protection for victims while keeping offenders out of prison. Victims of intrafamilial child sexual abuse may experience further victimisation through the experience of testifying in court or when the offender is imprisoned and unable to provide financial support to the family. The expanded disclosure demonstrated in the current study provides potential further benefits to index victims, and to previously unknown victims who never received validation or support following their abusive experiences.

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Sexual Abuse in Australia and New Zealand, July 2011; 3(1): 23-33

A Qualitative Study of Denial in Catholic Clergy Child Sexual Abusers

Jacqui Winship
University of Sydney, Australia

Gillian Straker
University of Sydney, Australia

Tony Robinson
Private Practice, Sydney

Abstract

The role of denial in sexual offending has received a great deal of research attention and there has been increasing recognition that denial is a complex phenomenon which is more than just the negation of the existence of an offence. This paper identifies and illustrates themes of denial in a qualitative study of Catholic clergy who had sexually abused children aged 13 years or under, with denial being defined in terms of the cognitive distortions used to discount responsibility for the abuse. Three themes emerged and were labelled denial of impact, denial of personal salience and denial of meaning. The first two are equivalent to minimisation and depersonalisation as defined by Schneider and Wright (2004). The third, denial of meaning, is particularly related to denial of the sexual meaning of the offence. This appeared to implicate two distinct cognitive processes, which were labelled disbelieving and disallowing. In disbelieving there is a cognitive split between two contradictory mind states, one that knows that the offence was indeed sexual and another which is unable to believe this. Disallowing, on the other hand, involves an inaccurate coding of cues at the time of the offence which leaves pertinent information relating to the sexual nature of the offence unassimilated.

Introduction

This paper explores themes of denial in a qualitative study of Catholic priests and Brothers who had sexually abused children aged 13 years or under. The aim of the paper is to contribute to the literature on denial in sex offenders, and in clergy offenders in particular, through identifying and illustrating the use of denial in this under researched group.

Defining Denial

A common dictionary definition of denial is the refusal to acknowledge the truth of a statement or allegation. Its use in popular culture as a psychological concept stems from Freud's use of the term to describe an unconscious defence mechanism which protects the ego from psychic conflict. Its definition in modern psychological literature has broadened, as will be discussed below, but we all use denial at times to hide the truth from others and/or ourselves. This use of denial has been discussed by existentialists (Becker, 1973), environmentalists (Stoll-Kleemann, O'Riordan, & Jaeger, 2001) and socio-political theorists (Cohen, 2001). However the role of denial in sexual offenders has received a great deal of research attention from cognitive behavioural theorists, with denial being identified as highly prevalent in this group (Barbaree & Cortoni, 1993; Happel & Auffrey, 1995).

Denial in Sex Offenders

The interest in denial within the sexual offending literature has historically been associated with an assumption that denial needs to be a focus of treatment to reduce recidivism (Happel & Auffrey, 1995; Jung, 2004; Moster, Wnuk, & Jeglic, 2008; Schneider & Wright, 2001). However this assumption has been challenged in recent times (Hanson & Morton-Bourgon, 2005; Nunes et al., 2007; Yates, 2009). Earlier this year Harkins, Beech and Goodwill (2010) published research that found high risk offenders (as identified by the Risk Matrix 2000) who were in denial had a significantly lower rate of recidivism on follow up. One reason proffered for this is that offenders who deny their offences may do so out of shame or guilt, which may in turn be a motivator not to reoffend. Interestingly, however, Harkins et al. found that there was a positive, albeit insignificant, correlation between denial and recidivism in lower risk groups, as did Nunes et al. (2007). Harkins et al., citing Lund (2000), suggest that denial may only be a risk factor for recidivism in the absence of other compelling risk factors, which is more likely to be the case with low risk offenders. These findings provide some support for further investigation of the role of denial among low risk offenders. Harkins

Correspondence: Jacqui Winship, Department of Psychiatry, PO Box 49 Belrose NSW 2085, University of Sydney, Australia
Email: jacquiwinship@gmail.com

ISSN 0833-8488

et al. also acknowledge that denial can be measured in many ways and suggest that a qualitative study of denial could provide an enhanced understanding of individual beliefs.

There has been an increasing recognition that denial is not a clear-cut phenomenon which offenders can be categorised as either 'in' or 'out' of and several useful attempts have been made to distinguish different types and levels of denial. Barbaree (1991) initially identified absolute denial and minimisation as two levels of denial. Kennedy and Grubin (1992) divided deniers according to their pattern of denial: rationalisers (those who tried to justify their offences), externalisers (those who blamed the victim or others) and internalisers (those most likely to blame an abnormal mental state). Similar to Barbaree, Kennedy and Grubin labelled a fourth group who completely denied the occurrence of the offence as 'absolute deniers'.

In 2004, Schneider and Wright provided a comprehensive account of the evolution of interest in denial as a complex multifaceted construct, summarising the types of denial identified in the literature. These include denial of the offence, denial of victim impact, denial of the extent of the offence, denial of responsibility, denial of planning, denial of sexual deviancy, denial of relapse prevention and denial of denial. Schneider and Wright (2004) identified three levels of accountability associated with denial. The first of these, complete refutation, is described as intentional lying in which offenders completely reject the notion that any offensive event took place. In addition Schneider and Wright also classify minimisation and depersonalisation as denial. In minimisation offenders underplay the seriousness or harmful impact of an offence. In depersonalisation, which Schneider and Wright see as the most entrenched form of denial, offenders admit to the offence but reject the notion that they are a child abuser.

There has also been an exploration of the relationship between denial, cognitive distortions and belief systems (Mann & Beech, 2003; Marshall & Barbaree, 1990; Moster et al., 2008; Ward, 2000; Ward & Keenan, 1999; Yates, 2009). Wright and Schneider (2004) suggest that denial can best be understood as a range of explanations that diminish accountability and that these explanations are supported by distorted beliefs and thinking processes. Yates (2009) suggests that much of what has come to be termed denial is actually a cognitive distortion. She argues further that:

> Denial represents normal cognitive processes in which all humans engage to maintain self-esteem and to cope with dissonance between themselves and their behavior … although some sexual offenders may consciously distort their actions, it is also evident that others engage in denial and distortion as a self-protective mechanism, and some who truly believe their actions did not constitute sexual offending as a result of cognitive schema and common cognitive processes (Yates, 2009, pp. 190-191).

The authors would concur with Yates (2009). For example, statements such as 'I didn't go that far' or 'I only did what he wanted' both implicate diminished responsibility. However the underlying distorted cognitions and degree of intentionality underpinning these statements may differ significantly. Some offenders may intentionally lie to avoid negative external consequences (approbation, prison, etc). Others may be either unable to acknowledge the truth to themselves because of negative internal consequences (self-image) or they may not have accurately encoded information relating to the offence.

To complicate the issue further, in any offender sample there is always the remote possibility that someone has been wrongly accused or convicted. In such cases the denial would not be any kind of cognitive distortion but simply a statement of fact. However this is likely to apply to only a very small percentage of offenders given that there is usually a thorough investigation of accusations, whether this is undertaken by the courts or, in the case of the offenders in our sample, the Church.

Denial in Catholic Clergy Child Abusers

The media have paid much attention to the crisis of sexual abuse within the Catholic Church over the past 20 years but little systematic research exists with respect to this particular group of offenders. What research there is has tended to focus on prevalence and demography.

Commentaries have largely focussed on institutional secrecy and denial (Porter, 2003; Sipe, 1990) rather than on manifestations of denial in the individual clergy offender. However the general literature on denial in sexual offenders would be presumed to apply equally to this group. Nevertheless additional factors may be salient to this group given their role, their commitment to a life of celibacy and a general denial of sexuality that may be part of Religious life (Goodstein, 2003; Sipe, 1990).

The most comprehensive report on sexual abuse by priests to date is a study conducted by the John Jay College of Criminal Justice research team (2004). This report on the nature and scope of the problem was commissioned by the United States Conference of Catholic Bishops in 2002 in response to the emerging abuse scandal in the United States. Following on from the release of this report the John Jay researchers compiled a supplementary report (2006) to address key issues in more detail. A special issue of *Criminal Justice and Behavior* (Bartol, 2008) provided a forum for the results of these two studies to be presented and

discussed in the context of the general sexual abuse literature.

The John Jay study provided the first empirical study of a large sample of clergy sexual abusers and it provided important data with respect to the prevalence and nature of the abuse, the age and gender of victims and the response of the Church to allegations. In summarising the results in the special issue, Terry (2008) noted several core findings. Four percent of priests in active ministry between 1950 and 2002 had allegations made against them. The peak of the abuse cases occurred in the late 1970s. The most common age group for priests at the time they were abusing was 30 to 39 and the most common sexually abusive act involved touching under the victims' clothes. The majority of victims were between the ages of 11 and 14 and 81% were male. Most priests had a single known victim and opportunity appears to have played a large role in victim selection.

Additional articles in the special issue of *Criminal Justice and Behavior* (Bartol, 2008) focus on event structure and reporting (Smith, Rengifo, & Vollman, 2008), the criminal careers of priests with allegations (Piquero, Piquero, Terry, Youstin, & Nobles, 2008), predictors of risk (Perillo, Mercado, & Terry, 2008), victim choice (Tallon & Terry, 2008), offending patterns (Mercado, Alvarez, & Levenson, 2008), situational crime perspectives (Terry & Ackerman, 2008) and organisational factors (White & Terry, 2008). What seems clear from this series of articles is that there are many similarities between offence patterns, behaviour and risk prediction in both clergy and non-clergy sexual abusers. Points of difference appear to be related to background (priests generally have higher levels of education and higher IQs), age of onset (considerably higher for priests) and victim gender (significantly higher percentage of male victims for priests).

Whilst the John Jay report is very comprehensive, there were several limitations to the study. The database only included priests and deacons in the United States and did not include any Religious Brothers, although many of the abuse allegations made to the Church involve Brothers. The data was obtained by a self-report survey of religious leaders, who may not have all interpreted the questions in a uniform manner and who would often only have had limited information included in files to draw on. The study was not able to comment on individual psychological factors (including cognitive distortions and denial) and an analysis of the causes and context of the sexual abuse crisis in the Church is yet to emerge, although it is currently being conducted by the John Jay researchers.

Studies by Saradjian and Nobus (2003) and Ryan, Baerwald and McGlone (2008) provide greater insight into the cognitions of clergy offenders. Ryan et al. found that sexually abusive clergy display significantly higher distorted thinking styles (as measured by the Rorschach Inkblot test) than non-sexually abusive clergy. Furthermore, Saradjian and Nobus found that religious professionals who offend hold many similar cognitive distortions to offenders in the general population. However they also found that religious professionals additionally use many religion related cognitive distortions. These include distortions such as 'I do so much good for others so how can this be harmful'; and 'How can it be that bad if God allows it'. Such distortions certainly implicate diminished responsibility and thus in Schneider and Wright's (2004) terms, are forms of denial.

Background to the Study

The current paper focuses on denial in a sample of Catholic priests and Brothers who had previously participated in a sex offender treatment program. The results form part of a broader grounded theory investigation into the subjective experience of sexual desire for a child in this group of men. Grounded theory was chosen as a methodology for the broader study because of its usefulness in generating middle level theory based on rich data from a relatively small purposively selected sample (Charmaz, 2006; Glaser, 1978; Glaser & Strauss, 1968; Henwood & Pidgeon, 1995; Strauss & Corbin, 1994, 1997, 1998). In this method raw data is collected and analysed concurrently, with the latter continually influencing the former. The data is coded into units of meaning and these are arranged by category. The relationships between the categories are explored and the categories themselves are checked back against the data.

Denial emerged as one of the categories described above. For the purposes of this paper a thematic analysis of this category was conducted. The aim was to explore themes of denial in this particular group, which has received relatively little research attention to date, and to consider the findings within the context of the broader literature on denial.

Method

Context for the Research

At the time that the study was initiated, the authors worked at a treatment center for Catholic clergy that offered a specialised six month residential treatment program for those who had sexually abused children and/or adolescents. The center was based in Sydney, Australia, but catered for Priests and Brothers from the Asia-Pacific region and beyond. In the time that the authors were employed at the center over 90 men were treated in this program. The treatment program consisted of twice weekly individual therapy, daily

group therapy, art therapy and psychoeducational modules. At the end of treatment the majority of these men returned to their religious congregations but were not allowed public ministry or contact with children. Most did not have criminal charges laid against them as their victims had chosen not to lay a charge through the police, although this option was made available to them. In cases where guilt was contested, an internal Catholic Church *Towards Healing* investigation was conducted to establish the probability of guilt on the basis of the available evidence prior to referral for treatment.

Research Participants

Purposive sampling (Glaser & Strauss, 1968; Strauss & Corbin, 1990) was used to identify participants. That is, participants were sourced on the basis of their particular subjective knowledge of the issue under investigation. Data from the center assisted the researchers in identifying 40 Priests and Brothers who had been accused of sexually abusing a child/children of 13 years and under. Ethics permission for the study was sought from the appropriate review board. Once this was granted a letter was sent to each of these men (all of whom had already completed the treatment program described above), inviting them to participate in the study. Twelve agreed to participate by returning an enclosed slip of paper in which they were identified only by number. This sample size fell within the researchers' target range of 10 – 15 participants which was believed to be an adequate number in order to reach saturation of the research question (Guest, Bunce, & Johnson, 2006), particularly given the homogenous nature of the sample.

Of these 12 participants, 11 had abused boys and one had abused girls. The mean age at the time of interview was 59. However the average age for a first offence was 20 - 25 and most had offended for the last time in their thirties (it was difficult to identify exact ages given the length of time that had elapsed since the offences). Seven of the participants had engaged in some form of genital touching, sometimes leading to masturbation but not penetration. Five had engaged in fondling that did not involve any genital touching, such as kissing and cuddling, and one had additionally engaged in accessing Internet child pornography involving boys under the age of 13.

Procedure

The participants were contacted by telephone to set up a date, time and venue for an interview. They were advised both at this stage and also at the beginning of the interview of their rights with respect to confidentiality and withdrawal from the study.

In depth interviews were conducted with each of the participants at a neutral location. Such interviews are well suited to grounded theory research as they facilitate access to open ended and rich accounts of participants' subjective experience (Charmaz, 2003; Smith & Biley, 1997). While the interviewer had prepared an 'aide memoire' of potential issues to cover, the interviews were unstructured. Participants were asked to tell their own story of experiencing sexual desire for a child and how they understood this. Questions were asked for the purpose of clarification or to encourage participants to expand on certain issues that emerged. As the analysis of the interviews proceeded alongside the data collection, certain emerging concepts were explored more closely in the proceeding interviews, as is usual in this methodology (Charmaz, 2003, 2006; Strauss & Corbin, 1994) . The interviews were on average two to three hours in length and were audio taped and transcribed verbatim. Anonymity was assured and while extracts from these interviews are quoted in this paper, the identities of the participants are heavily disguised.

Analysis

The data was coded according to concepts or units of meaning in the text of the interview transcripts. An initial line by line coding was utilised in order to maximise the potential for the researcher to remain open to nuances in the data and to reduce the risk of superimposing preconceived notions on the data (Charmaz, 2006). A process of constant comparison and conceptual refining of codes resulted in the emergence of core conceptual categories. For the purposes of this paper a thematic analysis of the category 'denial' was conducted to explicate specific patterns which were inherent in the category (Boyatzis, 1998; Joffe & Yardley, 2004).

There are no hard and fast rules in thematic analysis as to what constitutes a theme and the existence or importance of a theme is not necessarily related to prevalence. What is important is that the theme reflects an important aspect of the issue under investigation (Braun & Clarke, 2006). However ideally the theme will occur a number of times across the data set (Braun & Clarke, 2006) and for the purposes of this study a theme was defined as a pattern that occurred in at least 25% of the interviews that form the data set.

Results

Three central themes relating to denial emerged in the data. We have labeled these denial of impact, denial of personal salience and denial of meaning. The first two are equivalent to Schneider and Wright's (2004) descriptions of minimisation and depersonalisation. Minimisation is essentially the denial of impact of the

abuse on the victim. Similarly depersonalisation could be understood as the denial of personal salience of the act. The third theme, denial of meaning, relates particularly to the denial of the sexual meaning of the offence. These three themes could be exemplified as follows: 'It happened but it didn't hurt them' (denial of impact), 'I abused them but it doesn't mean I'm a child abuser' (denial of personal salience), 'I touched them sexually but I don't believe it was sexual' (denial of meaning - disbelieving) and 'I touched them but it wasn't sexual' (denial of meaning - disallowing). These themes are elaborated below.

Denial of Impact

As would be expected from Schneider and Wright's (2004) description of minimisation, in denial of impact there is a recognition that a sexual offence took place but attempts are made to downplay how bad the offence was, particularly with respect to the impact on the victim. Of course there is some evidence to suggest that not all victims of child sexual abuse experience it as harmful (Rind, Tromovitch, & Bauserman, 1998); however the victim reports that had been received in these cases suggested substantial harm.

Participants who displayed denial of impact or minimisation (Schneider & Wright, 2004) were able to admit to the facts of the offence but could not acknowledge the implications for the victim. Participant One, for example, claimed "I had no idea of the pain I was causing people" and participant Seven remarked "I didn't read their behaviors saying they were uncomfortable, or they didn't like it, I didn't read it that way at all."

In some instances the denial of impact was related to participants' belief systems with regard to how serious or 'wrong' a certain sexual activity might be. Participant Four could justify talking to boys about masturbation as he could frame this as "education" but he could not admit to any sexual fantasy in this regard. Thus the act of talking was portrayed as less serious than fantasising: "I have never fantasised about masturbating with a boy – I have always seen that as wrong. I would talk to them about it, but I never once I think fantasised ..."

Similarly participant Nine made a distinction between the respective wrongfulness of touching as opposed to undressing, with the former thereby being construed as less harmful: "There was touching OK, there would be situations where there would be running your hand down their back or something like that, but not taking anyone off somewhere and undressing them."

Denial of Personal Salience

In denial of personal salience there is also an admission that a sexual offence took place but, as with Schneider and Wright's (2004) depersonalisation, there is a reluctance to generalise from this to an admission that they are a child abuser.

Participants who displayed denial of personal salience or depersonalisation (Schneider & Wright, 2004) presented in a manner similar to participant Two, who had molested several boys over a long period of time and did not deny the occurrence of the abuse in most instances, yet found it difficult to accept that the term paedophile might apply to him: "I don't fully accept that because paedophilia is a term, is a person who um even though I have abused a kid (pause) ... if you use the term paedophilia with anybody then straight away they think that person is a sexual abuser." This participant clearly could not see himself as a sexual abuser, despite all the evidence to the contrary.

Participant Nine resisted generalising from the offence to which he admitted to a categorisation which would have implications for his self-concept: "I believe that if that person thought it was an abusive situation – well yeah, I can see that – but I would not see myself as an abuser."

Denial of Meaning

Denial of meaning differs from the above two themes in that while there is an admission that something took place, the *meaning* of the incident is denied, in particular the sexual nature of the act is refuted. Within this category, two particular modes of denial of meaning were identified that appeared to implicate different cognitive processes. These were labelled disbelieving and disallowing.

Disbelieving

In the disbelieving mode the participants appeared to hold two contradictory positions. On the one hand there appeared to be a partial admission of the sexual meaning of the act but on the other hand there is a resistance to believing that it could be true. This form of denial could be summarised in the epithet "I know but still I believe" (Barthe cited in Straker, 2007). Thus the participants evidencing disbelieving appeared unable to integrate two conflicting cognitions, one that acknowledged the sexual nature of the act and one that disavowed it.

The clergy molesters that we interviewed had all been through an intensive treatment program in which there was a focus on the sexual nature of their offending. In reflecting back on their thought processes at the time, however, there are clear indications of the level at which disbelieving was operative and certain of the terms used illustrate that it still remained difficult for them to acknowledge the sexual nature of the offences. In the following quotes the words that indicate disbelieving have been italicised:

"I thought I was acting as a parent but at the same time *the affection was inappropriate* because it was, it included touching and um, um caressing that was more than a parent would do with a student." (Participant One)

"I didn't actually deliberately rub the penis but I would rub the whole area above the penis and umm at times I'd be aware that the back of my fingers were brushing the penis ... *I wasn't holding the penis or masturbating the penis therefore it wasn't sexual*." (Participant Three)

"And then sort of a real struggle within me at the time. Is this right, is this wrong, am I hurting – *not that I was really hurting* ..." (Participant Nine)

Some of the above extracts could also be classified as denial of impact given the emphasis on "just affection" or "not hurting". However they have been used here to illustrate disbelieving because each implies an inherent struggle to believe in the sexual meaning of the act in one cognitive state even though in another cognitive state the participant appears to know that it was indeed sexual.

Disallowing

In the disallowing mode it appeared that the participants had not allowed the sexual meaning of their actions to be formulated in any way at all. It was refigured as asexual attention or affection. Certain information related to the act appeared to be unattended to and unprocessed. These participants did not evidence the type of cognitive struggle that was inherent in disbelieving.

In the accounts of their mindsets at the time of the offences, disallowing appeared to operate as a process that protected participants from the traumatic implications of their actions for their self image. It differed from disbelieving (a struggle between two cognitive states), in that it involved keeping aspects of the abuse experience unassimilated, particularly information that might suggest that their feelings and actions were sexual. However an extension of this appears to have been a disallowing that their behavior involved a breach of celibacy and in most cases a same sex act. Because of their belief system and the mores of the Catholic Church, assimilating this information constituted a traumatic threat to their self image.

The disallowing of sexual meaning is one of the features that enabled some of the participants not to fear exposure and added to their shock when accusations were made, as expressed by participant Nine: "The fact that they accused me came as quite a surprise because to me I had done nothing wrong." This cognition was present even though the participant freely admitted having touched the boy in what he described as an affectionate manner. Likewise, participant Four noted that "I didn't worry [about exposure] because I didn't think it was wrong."

In many instances there appears to have been a blindness to any information that might allow a sexual interpretation of their behavior. Participant Seven explained that "To me the hugging had no sexual connotation whatsoever so I thought that what I was doing ... I had no idea that anything was wrong. In therapy one of the things that I looked at was the fact that I would have been blind to it anyway ..."

Participant Three similarly appeared to have truly not assimilated the fact that his viewing of naked children online was sexually motivated:

"I certainly didn't use it to act out in the sense of you know trying to get myself stimulated sexually ... cause when I did then I turned it off, if it was child pornography I would turn it off ... so I didn't do it for that – it was just that I found pleasure in seeing naked kids... I would turn the thing off if it aroused me because that was subject matter for my next confession."

Equally, participant Five appeared genuinely perplexed: "I must confess I had no sexual feelings towards these people at all ... um ... not that I was aware of anyway ... maybe there were some signs of it but at the time I had no sexual attraction."

As noted above, some participants appear not to have assimilated any information that would implicate a breach of celibacy or chastity. Participant Four, for example, noted that because his offence did not involve an adult woman it did not fit into his (limited) framework of non-celibate behavior: "To me a boy was safe as it did not affect my vows." While this is certainly a cognitive distortion based on a particular schema regarding sexuality, it also seems to implicate unprocessed information.

Likewise, Participant Six's mental framework of sexual behavior was limited to the notion of intercourse with a woman. Hence, even when he was confronted about his behavior with boys, he continued to disallow the notion that it was a breach of celibacy: "Even then I still did not think it was breaking my vows of chastity."

Several participants appeared to have difficulty in formulating their behavior as sexual because it involved children of the same sex as themselves, and *in their own minds* this was associated with homosexuality. In pointing to this we need to note that there is no evidence to suggest that there is an association between homosexuality and child sexual abuse. All evidence is to the contrary (Groth & Birnbaum, 1978; Jenny, Roesler, & Poyer, 1994; McConaghy, 1998) and the authors are in agreement with this. However some participants *in this study* appeared to experience an internal pressure to deny the idea that their actions had sexual meaning because they themselves feared that this meant they were homosexual and that others would

think so too. The following comments illustrate this trend:

"I wouldn't let myself see it as gay behavior. I think I stopped myself from thinking about that in case it got too touchy, too near the bone." (Participant Nine)

"My greatest fear was that this could be seen not as affection but as gay behavior." (Participant Three)

"It worried me more that they were boys than that they were children." (Participant Seven)

Discussion

This paper explores themes of denial in a qualitative study of Catholic clergy who had sexually abused children aged 13 years or under. As already indicated, in this study denial is defined in terms of the cognitive distortions used to discount responsibility for the abuse. Thus the study focussed on manifestations of denial in the participants.

Three themes relating to denial emerged from the data: denial of impact, denial of personal salience and denial of meaning. The first two are equivalent to minimisation and depersonalisation as defined by Schneider and Wright (2004). The third, denial of meaning, is particularly related to denial of the sexual meaning of the offence. This appeared to implicate two distinct cognitive processes, which were labeled disbelieving and disallowing.

No instances were found of what Kennedy and Grubin (1992) termed absolute denial and Schneider and Wright (2004) named complete refutation. This can be attributed to the fact that all of the participants in this study had been through an intensive treatment program in which they had been confronted with victim statements that may have made it difficult to sustain this level of denial. In addition, the 12 participants had voluntarily agreed to participate in the study and it is unlikely they would have done so if they believed in their complete innocence. Thus in all cases the participants in this study were able to admit that something had occurred, but the level of responsibility that they were able to own differed. Despite the intensive nature of the treatment and the willingness of these men to participate and talk about their offending, it is notable that none of them were able to claim full responsibility (in terms of the three themes identified), suggesting a level of intransigence inherent in the denial of sexual offending. Nevertheless it was obvious from their comments that treatment had had a positive impact in terms of helping them to accept a greater level of accountability for their offending.

Clergy Offenders and Offenders in the General Population

The results of this study seem to suggest that clergy offenders are akin to offenders in the general population in terms of denial. Like other offenders there was a tendency to minimise the harmful impact of their behavior on victims. This form of denial in the general population of offenders has been well documented (Abel et al., 1989; Barbaree, 1991; Kennedy & Grubin, 1992; Schneider & Wright, 2004; Ward, 2000). Similarly, Saradjian and Nobus (2003) found that denial of injury, as they termed it, was extensively used by clergy offenders in their study, some of whom "minimized or even denied the negative or harmful effects of the abuse" (Saradjian & Nobus, 2003; p. 917).

Likewise, the denial of personal salience found in the participants in the current study does not differentiate them from offenders in the general population, who display a strong tendency to depersonalise (Schneider & Wright, 2004) in terms of making links between the abuse they have perpetrated and any description of themselves as a child abuser. The implications of this description for self image would be highly significant and perhaps even more so for a Religious, whose self image rests on being seen as a representative of God.

Denial of sexual meaning is also not unique to clergy offenders. The assertion that the abuse was 'just affection' is common among child abusers in the general population. However we would argue that denial of sexual meaning is particularly germane to Catholic clergy offenders given their commitment to a celibate life as well as a more pervasive denial of sexuality in Religious life (Goodstein, 2003; Sipe, 1990).

In the current study, denial of sexual meaning was sustained by mechanisms that we termed disallowing and disbelieving. These are psychological mechanisms that are common in other circumstances where the meaning of a situation is denied. In the context of this study, disbelieving maintained a cognitive split between what the participant was able to acknowledge and that which he also knew to be true but could not accept (i.e., the sexual meaning of the behaviour). This split allows an offender to avoid the negative internal consequences associated with integrating the non-accepted cognition.

Disallowing, on the other hand, appeared to involve keeping aspects of the abuse experience unassimilated, particularly information that might implicate sexual feelings or intentions. Particular manifestations of disallowing seemed to be related to beliefs around celibacy and same sex behavior. The attitudes of the Catholic Church to sexuality, celibacy and homosexuality may make assimilating sexual information related to the abuse particularly difficult or traumatic for this group of offenders, thus fostering the emergence of disallowing in relation to these issues.

Disallowing is reminiscent of dissociation as described by Stern (1999) in his comments on unformulated experience. For certain of the participants

in our study it appears that the abuse experience was never formulated as sexual. Thus the sexual nature of the offence was never integrated into the network of associations connected to sexuality in the mind of the perpetrator but was instead interpreted as implicating only affection and nurturance. This mirrors to some extent the dissociative phenomenon that Grand (1997) observed among incest offenders. She noted that certain types of perpetrators of incest genuinely experience these acts as "not really real, not really sex, not really mine" (p. 465). Similarly, this lack of formulation of experience is perhaps operative in the somewhat controversial amnesia that Taylor & Kopelman (1984) describe among perpetrators of violent crime. They suggest that this is related in certain cases to high states of emotional arousal at the time of the offence.

Disallowing and Homosexual Fears

The finding that certain participants in this study appeared to disallow sexual meaning in same sex abuse because of the homosexual implications they feared might accrue from this, is both interesting and challenging. There has been much controversy over the assertion by certain of the Catholic Church hierarchy that the sexual abuse problem in the Church is a homosexual one. This assertion has rested on the fact that by far the majority of the reported abuse cases have involved male victims, which is not reflective of the situation in the general population. It is further sustained by the Church's interpretation of homosexuality as something aberrant and perverse. Opponents of this view have argued that there is no evidence to suggest that homosexuals are more likely to engage in child sexual abuse than heterosexuals. They also note that Priests and Brothers have largely had more ready access to boys than girls and that opportunity has therefore played a large role in the selection of male victims.

However Finkelhor (2003) suggests that perhaps within this specific group of offenders homosexuality may indeed play a role, albeit not in the way the Church has hitherto suggested. He posits that the celibate priesthood may in certain cases be attractive to those who are experiencing conflict over conscious or denied homosexual feelings. In the absence of any avenues to deal with this conflict and the accompanying shame and confusion in a healthy way, such men might be vulnerable to the kinds of abuse of boys that has been reported. Finkelhor is at pains to point out that it is the *conflict* over homosexual feelings, which is fostered by certain sectors of society and certainly by the Church, that is related to the abuse in such cases rather than a homosexual orientation per se.

Finkelhor's (2003) assertion that celibate priesthood or religious life might be attractive to those who have unresolved homosexual feelings was borne out anecdotally in our small sample. Seven of the 12 participants (58%) self identified as having an egodystonic adult homosexual orientation. Several of these noted that it was only post-treatment that they were even able to describe themselves as such. It would be foolhardy to draw any sweeping conclusions as to the significance of this in terms of their vulnerability to offend and it is important to reiterate once again, given the controversies and risk of misperception in this regard, that homosexuality itself is not linked to any greater risk of child sexual abuse than heterosexuality. However it does appear that a fear of interpreting their own behaviour as homosexual contributed to the disallowing of sexual meaning in some instances in this study.

Limitations of the Study

This study was designed to elicit detailed and subjective qualitative data from a very specific group of child molesters. Such a design does not aim for or support generalisation of the findings and it is not therefore possible to make broad claims about sex offenders in general based on these results. Indeed, the results may not be representative of clergy offenders who have not been through a treatment program or those who would not willingly participate in such a study (where one may for example find higher levels or even different types of denial).

Another limitation of the study is that it is retrospective and most of the participants were drawing on memories of thoughts, feelings and behaviours from many years prior. This is a limitation that is common to all studies of Catholic clergy offenders as by far the majority of abuse allegations relate to incidents that occurred in the 1960s and 1970s. Thus as Saradjian and Nobus (2003) point out with respect to their own study, there is likely to be an element of recall bias. In addition, the participants in this study would have been interpreting the past through a particular lens related to the treatment program they had all been through.

Recommendations for Further Research

Given the above, it would be interesting to replicate this study with a group of clergy offenders who have not received treatment. This would provide some insight into the impact of treatment on denial in this group of offenders.

A study of the relationship between denial and recidivism with respect to clergy offenders would also provide interesting data that might have implications for the management of denial in clergy treatment programs, particularly in light of the current debates surrounding this issue (Harkins et al., 2010; Nunes et al., 2007). One hypothesis would be that many clergy offenders would tend to fall into the lower risk categories in Harkins et

al.'s study given their age, that they seldom have a history of criminal convictions and seldom abuse strangers. There might therefore be a higher chance of finding a positive relationship between denial and recidivism in this group.

A comparison of the results of this study with two anticipated publications may yield further data with respect to denial in Catholic clergy offenders. As noted earlier, the John Jay researchers are due to release a report on the causes and context of the sexual abuse crisis in the church which will provide further information on individual psychological factors implicated in clergy abuse. A book by Dr Marie Keenan (In press) based on the results of interviews with Catholic clergy sexual offenders in Ireland is also due to be published later this year and will provide a further counterpoint to the current study.

Conclusion

Notwithstanding the limitations noted above, it is hoped that this paper provides a unique and detailed insight into the mind of the clergy perpetrator. Few other studies are based on direct and in depth interviews with this group and it is hoped that the results will complement the literature on denial in child sexual abusers in general, and clergy abusers in particular.

Finally, while it has not been the focus of this paper, it would be remiss not to note the context of institutional denial that has often masked and maintained clergy sexual abuse. There seems little doubt that the challenge to this denial in recent decades will do much to both expose and reduce the prevalence of sexual abuse by clergy.

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Sexual Abuse in Australia and New Zealand, July 2011; 3(1): 34-41

Age and the Static 99R

Christopher Lennings
LSC Psychology Research Group
University of Sydney

Katie Seidler
LSC Psychology Research Group

Rob Heard
University of Sydney

Emma Collins
LSC Psychology Research Group

Rima Nasr
LSC Psychology Research Group

Abstract

A total of 51 client files referred for sex offender risk assessment through 2010 were re-analysed to allow for a comparison of the relative efficacy of the Static 99 and the Static 99R in risk of recidivism. Of this group only eleven clients retained the same actuarial risk score when re-assessed on the Static 99R, and a total of two clients increased their risk rating, whilst eleven reduced their risk rating. In particular, no client previously rated as high risk remained in the high-risk group once the Static 99R was used. Implications for risk assessment with a predominantly elderly client group are discussed.

Introduction

In order to curb emotional and artifactual influences on and, therefore, maximise the predictive utility of sex offender risk assessment, a tendency over the last 15 years has been to develop actuarial and structured risk assessment devices. Examples of actuarial risk predictors include the Static 99 and the RRASOR index (Hanson, 1998). An example of a structured risk assessment device is the Sexual Violence Risk–20 (SVR-20; Boer et al., 1997). A detailed examination of the strengths and weaknesses of various assessment approaches can be found in Blanchette (1996), Hanson (1998), and Serin (1993). In essence, actuarial approaches assign weights to variables that have been established either through cogent argument or empirical studies as related to the capacity to predict sexual offending behaviour. An individual is assessed on each of these variables, his or her score is then "weighted" and the resultant variable string added. A specific cut off score identifies membership of a group whose risk value (recidivism potential) has been determined by analysis of recidivism rates obtained from previous follow-ups. Although there is some argument about actuarial instruments (Blackburn, 1993), the reality is that they have consistently proven to be more accurate than clinical judgment alone.

Whilst debate continues about the predictive accuracy of actuarial assessment, there is general consensus that such assessments are on the whole superior to unstructured clinical assessment, and when combined with structured clinical assessment in what is called Structured Decision Making (SDM), predictive accuracy is maximised (Schwalbe, Fraser, & Day, 2006). In sex offender assessments, the "gold standard" of risk assessment has been the Static 99. The Static 99 has, however, been the subject of significant cautionary research. Ogloff and Doyle (2009), for instance, warn that the Static 99's predictive accuracy is subject to fluctuation in the base rate of offending, and the instrument is subject to considerations about how similar the offender being assessed is to the original normative sample. Smallbone and Wortley (2008) have also cautioned about the use of the Static 99, finding for instance in their Queensland sample that predictive accuracy of the Static 99 was improved when some demographic and criminological variables were added, such as age of first criminal offence.

In recent times, criticism of the apparent bias in the Static 99 against older offenders has been levied. The survival curves in the 2003 manual review (Harris, Phenix, Hanson, & Thornton, 2003) show that, typically, a reduction in risk occurs after the middle of the fourth decade of life. Barbaree and Blanchard (2008) argue that both as a matter of logic and

Correspondence: Dr Christopher Lennings, LSC Psychology, PO Box 20494 World Square NSW 2002.
Email: clennings@lscpsych.com.au

ISSN 0833-8488

experience, older offenders demonstrated a lower risk than their younger counterparts. This was hypothesised to be a function of age and the natural decline in sexual drive. Therefore, the use of the age variable in the Static 99 discriminates against older offenders by over-inflating their risk. Given the importance of the accuracy of actuarial assessment for matters such as extended supervision (preventative detention), a bias that serves to exaggerate a person's risk has enormous human rights implications. For instance, in New South Wales, it is necessary to have a score of six or more on the Static 99 to trigger the referral process for consideration under the extended supervision legislation. Thus, for an elderly client whose Static 99 score may be six (but whose Static 99R score may only be three), there is a major dilemma that has far reaching implications.

The Static 99, developed by Hanson and Harris (2000), is an actuarial tool that is designed to assess the risk of sexual or violent recidivism (as defined by new convictions), using static or historical variables. As stated, the variables that are assessed are couched in the extant literature as having an empirically demonstrable relationship with recidivism and include items such as the number of previous sexual offence convictions, the gender of and relationship to the victim and the presence of any violence in the offences. The instrument has been developed based on group data relating to offenders and therefore does not relate to personal risk for any one offender. Rather, it can be considered as indicating a general potential for sexual or violent reoffending based on the nature of past offending. The Static 99 was then revised in 2009 (referred to as the Static 99R: Helmus, Babchisin, Hanson & Thornton, 2009), with the primary change pertaining to allowing for a reduction in risk for older age offenders, although as a component of the change, offenders aged between 25 years and 35 years have a slight increase in risk estimate as a function of age. The Static 99R is relatively new and has, as yet, not been subject to rigorous empirical investigation and, therefore, its applicability over and above the Static 99 is not yet well established. A further complication in the use of the Static 99R (and even the Static 99) is confusion over which reference group of norms should be used, following the reanalysis of the normative data for the Static 99 (Helmus, Hanson, & Thornton, 2009).

As a consequence of the empirical, logical, statistical and experiential arguments that have been mounted about the use of the age variable in the Static 99, Phenix, Helmus and Hanson (2009) conducted a series of trials and provided tables to assist in the interpretation of a revised version of the Static 99. Their trials have suggested that the old cut-off scores for the Static 99 be retained for the Static 99R despite changes in predictive accuracy and recidivism rate calculations. Table 1 shows the changes in recidivism rates using the Static 99R (as reported in Phenix et al., 2009) comparing the five year recidivism rates (expressed as percentile of the sample) across multiple studies to the Static 99 sample as reported in the 2003 scoring manual. There are some boundary violations in that depending on which sample is used from the Phenix et al. (2009) paper, some low-risk scorers on the Static 99R would best be described as moderate-low-risk scorers, and for those in the high risk group in the Static 99R samples, most in fact have recidivism rates equivalent to those in the moderately high group based on the Static 99.

The concern has been that the Static 99 over-emphasises risk of older clients, and thus the revision adjusts risk for the elderly (Hanson, 2006). However, the original survival curves provide a difficulty in interpretation, in that they are based on raw scores of the surviving cohort and do not take into account adjustments that might occur for those with highest risk also having criminogenic lifestyles that might expose them to risk of early death. Thus, the survival curve may be affected by the non-random attrition in the highest risk group due to early death, leaving an artifactual drop in risk after age 45 associated with this non-random effect. If this argument is accepted, then it is not clear that a direct empirical basis exists for the argument that a significant age correction is required, although the "logical" argument remains as well as the observation that for many offenders, as they age they seem to burn out of the energy and deviance that characterised their earlier behaviour. However, without a firm empirical base, it is not clear how to interpret the ranges on the Static 99R as opposed to the Static 99.

An example of the difficulty in coming to understand how to interpret the coding for the Static 99R can be seen by comparing the percentile for recidivism (columns three and four) with the relative risk ratios (column five) in Table 1. Because the Static 99R evaluators manual provides five tables to decide on risk, we have reproduced the first two risk samples (column three) and last sample (column four). The last percentile reference table in the evaluators manual is referred to as high need. The studies making up this group consist of pre-trial assessments, which most closely approximate the pre-sentence setting in the local jurisdiction in which the authors of this paper work. An examination of the likelihood ratios reveals there is some inconsistency between what the likelihood ratios indicate and what the percentiles from this group imply. The relative risk ratio shows a person has a higher than the base rate risk once it exceeds 1, so this is equivalent to a score somewhere between 3 and 4 in the old Static 99 (base rate for offending is 3.2 on the Static 99) and marks the jump from moderately low to moderately high but is between score 2 and 3 in the Static 99R.

Table 1: Comparison of percentile recidivism rates for Static99 and Static99R samples

Raw score	Static 99 Sample	5 years Static 99	Percentiles* for Static 99R 5 years	High Risk 99R	Relative risk ratio	Previous description Static 99	Revised risk 99R
-3			.012 – 0.14	-	.26		Low
-2			.016 – 0.2	-	.34		Low
-1			.021 - .026	.05	.45		Low
0	107 (10%)	.05	.028 - .036	.07	.59	Low	Low
1	150 (14%)	.06	.038 - .05	.09	.77	Low	Low
2	204 (19%)	.09	.05 - .07	.12	1.00	Moderate Low	Moderately Low
3	206 (19%)	.12	.07 - .09	.16	1.31	Moderate Low	Moderately Low
4	190 (18%)	.26	09 - .12	.20	1.71	Moderate high	Moderately high
5	100 (9%)	.33	.11 - .15	.25	2.23	Moderate High	Moderate High
6	+ 129 (12%)	.39	.15 - .20	.31	2.91	High	High
7		+.39	.19 - .25	.38	3.80	High	High
8		+.39	.24 - .30	.45	4.96		High
9		+.39	.30 - .37	.52	6.48		High
10		+.39	.43	.60	8.47		
Base Rate 3.2	1086 (100%)	.18					

*Percentile estimates on Static 99R were calculated separately for routine and non-routine samples. Non-routine samples appeared to have high risk ratings. The estimates appear aggregated in the original Static 99 sample. Source www.static99.org (accessed 12.2.2011).

We illustrate the above concerns by reference to a hypothetical case. "Howard Jones" is a 68 year old man, with a long if intermittent history of sexual offending. His charges include previous offensive behaviour, such as masturbating in public in the sight of school girls, photographing school girls, as well as paraphillic behaviour, such as stealing women's underwear and the like. His most recent offence; masturbation in a public place, occurred only in the previous year. He has never had a relationship that included sexual intimacy. His Static 99 score was six, but because of his age, his Static 99R score was reduced to three. His dynamic risk assessment continued to indicate high risk based on the number of prior convictions and multiple types of sexually deviant behaviour present, the lack of any genuine ability to form intimate adult relationships, some mental health concerns, poor psychosocial adjustment generally, and poor responsiveness to past treatment. Despite his age, there was no evidence of any reduction in the interest he showed in school girls, and he continued to put himself at risk by arranging to do his shopping at major centres around the time that school was ending in the afternoon. Using his Static 99R score and looking at Table 1, his relative risk ratio is 1.31, and the risk of his re-offending for this score on the Static 99R is that for every 100 offenders somewhere between approximately seven to 16 will re-offend, depending on the criterion group used. By contrast, if using the Static 99 score, the risk of re-offending over five years is approximately 39 in every 100 offenders with a score of six. Most importantly, the score on the Static 99R raises the issue of the base rate for recidivism. Since the base rate is 3.2 on the Static 99, and the Static 99R uses the same cut-offs as the Static 99, Mr. Jones' score now sits just on or below the base rate, radically altering the prediction of future sexual offending and the potential risk management strategies that would be recommended.

The Issue

As forensic clinicians specialising in risk assessment, we are often required to undertake risk assessments for the purpose of pre-sentence evaluations, as well as matters in relation to Prohibited Employment Legislation and Extended Supervision. As a function of the nature of the issues presented in the last two categories, many of the clients are perforce elderly: a reasonably common scenario being a man who was convicted many years earlier of a sexual offence, has lived a reasonably blameless life subsequently for many years, is approaching retirement and wants to change to a different job or relocates and seeks to be a school bus driver, or work as a handyman or the like. As a function of moving towards child related employment, a Working with Children Check reveals an old conviction for a sexual offence and a referral for formal risk assessment is triggered. If the person is assessed on the Static 99R, their score will be significantly lower than if assessed on the Static 99. The issue then becomes what test should be applied? A clinician could, for instance, if kindly disposed to an older client, decide to use the Static 99R as it would reduce that person's risk, whilst should they wish to and were inclined to see a client as dangerous, chose to use the Static 99 in order to amplify

the concern over risk of re-offence. Whilst it is assumed that clinicians would not "cherry-pick" their instruments to obtain the result they want, the problem remains when there are two existing measures that for a specific sample can provide radically different risk estimates.

As a consequence of this dilemma, we have decided to investigate within our specific environment how the Static 99R compares to the Static 99. Since the research literature reveals that predictive accuracy of the risk assessment instruments does vary by the population it is used on, and the context it is used in, such studies as ours, whilst small, add to the literature about the behaviour of these various instruments and helps to build a picture of the validity of their use in defined contexts and with specific populations.

Method

Participants

A total of 51 risk assessments undertaken within the last 12 months were identified by the four clinicians (CL, KS, EC, RN). Most clients were seen for pre-sentence matters but some were seen for civil risk assessments such as Prohibited Employment referrals. All data was de-identified, but as a matter of policy all clients of our service are asked to sign a consent form for their data to be used in evaluation research. A number of additional risk assessments were not used as only those offenders seen for sentencing matters who were convicted of or pleaded guilty to a hands on (contact) offence were used in the research. If the primary offence was a non-contact offence (mainly possession of child pornography), they were not included in the current study, as the Static 99 cannot be rated for these offence types in the absence of a "contact" offence history.

Measures

All offenders had been assessed on the Static 99. In addition, all but one offender was assessed with the Sexual Violence Risk-20 (SVR-20; Boer et al., 1997). The SVR-20 is an assessment instrument used in the structured clinical judgment for dynamic risks associated with sexual reoffending. The instrument includes both empirically and criminogenic related variables such as the presence of a major mental illness, substance abuse disorder or current employment or relationship concerns. However, the instrument also rates items that make clinical "sense", such as the presence of threats, the use of weapons or the infliction of harm on the victims during the offence/s. One offender in the sample was aged 17 at the time of the offence, and was assessed on the Juvenile–Sex Offender Assessment Protocol-11 (J-SOAP II; Prentky & Righthand, 2003). The J-SOAP II is a checklist designed to assist in the systematic evaluation and consideration of risk factors known to be associated with the recidivism of juvenile male sex offenders between the ages of 12 and 18 years. It is an empirical scale, not yet widely validated and, therefore, it should not be used independently to categorise and make decisions about risk assessment and management. Rather, it is used as a clinical guide to highlight issues relevant in considering risk in much the same way as the SVR-20.

Clinicians were asked to retrospectively re-rate their participants on the Static 99R. In addition, clinicians were asked to provide data on the age at which the person began general offending, sexual offending, and the age of the index sex offence. Further, we collected data on age at time of assessment.

As part of the study, we calculated the risk classification for each participant based on both their Static 99 and Static 99R scores, the risk assessment derived from the SVR-20 and an overall (SDM) risk classification based on combining their Static 99 and the dynamic risk assessment score using an algorithm developed by Lennings, Bolton and Collins (2011). The algorithm was based on a similar approach to Structured Decision Making proposed by Schwalbe et al. (2006) and follows the common sense observation that actuarial risk in and of itself is insensitive to change and some mechanism for developing a consistent approach to moderating actuarial assessments to reflect shifts in dynamic risk has to occur (Lennings et al., 2011). The algorithm provides for a conservative risk assessment, such that the actuarial risk assessment provides a baseline measure and this base line risk can be varied by one classification level up or down depending on the dynamic risk assessment. For instance, a person whose actuarial risk was moderate-low and whose dynamic risk was moderate-low would remain in the moderate-low group. If the dynamic risk was low, they would still remain in the moderate-low risk group but if their dynamic risk was moderate-high, their baseline risk would be raised to moderate-high. If a person's baseline risk was moderate-high and their dynamic risk was low, they would then drop down one risk classification to moderate-low.

Reliability analysis

As part of the study, three of the authors were asked to cross-calculate risk ratings on the Static 99/R and SVR-20 to ensure consistency of risk ratings. Each of the assessors were asked to assess 6 reports (total reports checked for consistency was therefore 18 reports or 35% of the sample).

Results

Sample Description

The average age of the sample was 44 years (median 43 years; range 18 – 81 years; S.D. = 16.12). The mean age for participants' first criminal offence was 27 years (range 13-67 years, S.D. = 13.35) and the mean age of the first sexual offence was 34 years (range 16-68, S.D. = 14.28 years). For our participants, the mean age of the index sexual offence was 40 years of age (range 17-81, S.D. = 15.95 years). Approximately 50% (24 offenders of 45 valid cases) committed their first criminal offence as a sexual offence, and 23 were seen for their first time sex offence. Due to some difficulties in ensuring accurate information, for some cases, numbers for specific items differ as there is some missing data.

Of the 51 offenders, approximately one third of each primarily offended against child, teenager or adult victims. However, significant overlap occurred, especially between teenager/adult victims. Table 2 shows the numbers of offenders choosing children, teenagers or adults as victims and the overlap across victim types. For instance, in the last row it can be seen that the number of offenders who offended against both teenagers and with adults was nine.

Table 2: Victim type by offender and incidence of "cross-over" offending.

N=50	Child under 12	Teenager (12-16)	Adult offender
Number of offenders	21	20	21
Child with		4	4
Teenager with			9

Age

Table 3 reveals that age is not meaningfully associated with the Static 99 or dynamic risk estimate, but is associated with the Static 99R risk estimate. The older the age of the offender, the lower the Static 99R risk rating, as would be expected. Table 4 reports on the number of participants falling into age bands on the Static 99R and the Static 99.

Table 3: Age and Risk Instrument Inter-correlations

	Static 99	Static 99R	Dynamic Risk
Age	.10	-.41*	0.12
Static99		0.74**	0.61**
Static99R			0.49*

(N = 50, *P<.01; **p<.001)

Table 4: Participants and Age Bands on the Static 99 and Static 99R

		n	%
Static 99R			
18 – 34.9	score =1	17	33%
35 – 39.9	score =0	4	08%
40 – 59.9	score=-1	21	41%
60 & older	score= -3	9	18%
Static 99			
18 – 24.9 (1)		7	14%
25 & older (0)		44	86%

Convergent Validity

Table 3 also reveals the high correlations between the three kinds of risk measures. The Static 99 and Static 99R have the highest inter-correlations (r=.74), which is to be expected given the overlap of content. The fact that it is not higher suggests that the two measures are related but are discriminately different notions of risk. Interestingly, the Static 99 correlates quite highly with the SVR-20 (r=.61), whilst the Static 99R also correlates highly but less so than the Static 99 (r=.49). However, the strong associations between all three measures indicate good convergent validity, which supports the use of both static and dynamic instruments in assessing risk with this population.

Risk Estimates

There is a significant difference between the means for the Static 99 and the Static 99R. The mean Static 99 score is 2.68 and for the Static 99R, the mean is 1.90 ($t = 3.80$, d.f. = 50, $p<.001$). In examining the scores, 10 offenders increased their score by one as a function of the higher age bandwidth attracting a positive loading of one on the Static 99R as opposed to the Static 99, and 30 reduced their score; 21 by one point and nine by three points. Thus, whilst only 11 offenders have the same score on both the Static 99 and the Static 99R, because each risk classification spans two points (on the Static 99), the actual number of participants who change risk classifications is only 22 participants, most reducing in their risk classification (five offenders increase their risk classification, most of these moving from low risk to moderately low risk). Table 5 describes these changes.

As can be seen, by using the Static 99R, no offender remains in the high risk group. The most significant change is the expansion of the moderate-low risk group, made up because of the large number of high risk elderly participants whose risk moves from either high risk or moderate-high risk to moderately low risk as a function of the heavy weight (-3) given to age in the sample over 60 years. Using the base rate figure from the Static 99, almost 20% of the sample shifts their score below the base rate for recidivism when the Static 99R is used.

Table 5: Frequency counts of change in risk score as a result of using the Static 99R

	Overall risk based on Static 99 (Dynamic + Static 99)				
Difference in overall risk 99 vs 99R	**Low risk**	**Moderately low risk**	**Moderately high risk**	**High risk**	**Total**
99R 1 level higher than 99	4	1	0	0	5
99R same risk level as 99	13	12	3	0	28
99R 1 risk level lower than 99	0	3	10	1	14
99R 2 levels lower than 99	0	0	0	3	3
Total	17	16	13	4	50

Prediction of Dynamic Risk

To assess the relationship between the Static 99 and the Static 99R and dynamic variables, post hoc analyses were undertaken. Two multiple hierarchical regression equations were calculated. The first equation used the SVR-20 score as the dependent variable, and age, Static 99 risk classification, as well as the age of first criminal offence, age at first sexual offence and age at the index offence as predictor variables. The second equation substituted the Static 99R risk classification for the Static 99 risk classification. The regression model was built up by first adding in the relevant Static 99/R variable, then age, and then the criminogenic variables (age of first offence, age of first sex offence and age of last sex offence). Table 6 reports the relevant outputs for the final model. For the Static 99 equation, only the Static 99 score significantly predicted the dynamic risk rating and this was true no matter what combination of variables was added to the Static 99 variable. The output for the Static 99R was more complex. Age does have a relationship with the Static 99R; adding it into the regression equation meant that in the first step with only age and the Static 99R as predictors, both age (Standardised Beta = .382) and the Static 99R (Standardised Beta = .649) was significant. However, when the criminogenic variables were added into the equation, the significant effect for age disappeared. That is, the variance involved in age can be explained as a function of other criminogenic predictors such as age of last sex offence and the co-linearity between these variables affects the regression output (the correlation between age and age of last sexual offence, for instance, is r=.84).

Table 6: Regression results for prediction of dynamic risk rating for the final model

	F ratio	Variance explained	Standardised Beta
Static 99 Risk Classification	F=7.60, 5-37, p<.001	R2= .51	S 99 B = .506
Static 99R Risk Classification	F= 7.08, 5-37, p<.001	R2=.47	S 99R B= .633

As can be seen, despite the weaker correlation between the raw score on the Static 99R compared to the Static 99 with the SVR-20, both measures appear to predict the dynamic risk score equally efficiently when the risk classification score is used. Each accounts for similar amounts of the variance, and each reveals a similar Beta weight.

Reliability analysis

Table 7 reports the concordance for three clinicians assessing a total of 18 reports prepared by the four clinicians taking part in the study. As can be seen concordance is high. No Kappa is calculated due to small numbers and multiple comparisons, but eyeballing the data reveals few inconsistencies. In the one case between Clinician 1 and 4, the raw score on the Static 99 differed by one, and the risk rating in the original assessment (low risk) was raised to medium low for the static 99, but remained "low" on the Static 99R. The risk rating on the Static 99R for the same participant did not alter, despite a change in score by one on that measure as well.

Table 7: Concordance of risk ratings on actuarial and dynamic risk measures by clinicians

	Static 99	Static 99R	SVR-20
Clinician 1/Clinican3	Full agreement	Full agreement	Full Agreement
Clinician 1/Clinican 4	3/4 agreement,	Full agreement	Full Agreement
Clinician1/Clinician2	Full Agreement	Full Agreement	Full agreement
Clinician 2/Clinican 3	Full Agreement	Full Agreement	Full Agreement
Clincian2/Clinician 4	Full Agreement	Full Agreement	Full Agreement
Clinician 3/Clinician4	Full agreement	Full Agreement	Full Agreement

Discussion

The current study represents an analysis of a case series. It is subject to the potential biases found in any convenience sample in that there is no way of knowing whether the clients referred to our practice are representative of sex offenders in general. In particular, our intuitive sense is that our sample has a higher proportion of elderly participants than might be found in other practices. It does, however, serve a valuable purpose in reflecting the dilemma for practising clinicians when variations in test instruments are released and when there remains uncertainty about how to choose between them. As with any applied research, some interesting findings were revealed. The good relationship between the Static 99 and the SVR-20 supports the use of SDM models. As practising clinicians, we note with some concern assessment reports that occasionally come before us where over-reliance on only one form of risk assessment is used. An SDM approach allows for the systematic use of actuarial and dynamic risk information in a way that compensates for the at best moderate predictive accuracy of actuarial assessment alone (Ogloff & Doyle, 2009). We also note the reasonably high rates of cross over offending in our sample: a finding that is consistent across various studies that there is a small but persistent percentage of offenders who offend across both the gender and the age spectrum (Porporino & Motiuk, 1991).

The critical finding in our study is the impact that Static 99R has on elderly clients in the high-risk group. On our data, no elderly client remained in the high-risk group, and in fact a few jumped two classifications to move from high risk to moderately low risk when assessed with the revised Static. Such a move raises the potential for a number of high-risk clients to be misclassified as moderately low risk for re-offence. Whilst the whole purpose of the Static 99R was to effect such a change (that is, to counter the "bias" inherent in the Static 99 against older clients), it is necessary to validate the substantial reduction in risk afforded by the Static 99 revision, and to our mind that validation has yet to be conducted.

In general, advice to assessors when using both actuarial and dynamic measures of risk is not to adjust actuarial risk ratings by more than one category with reference to the dynamic risk estimate. That is, when considering change in risk, it may be best to keep to the view that risk status changes slowly. However, the Static 99R, at least with elderly clients, provides quite an abrupt and dramatic alteration in risk. It seems to us that moderation of the actuarial risk assessment as provided by the Static 99 by the use of a dynamic measure, such as SVR-20 or its revision, does much the same job, and more safely. That is, the dynamic measure can take into account the critical factors associated with age, such as reduction in deviance, impulsivity, anti-social behaviour and the like, that justify the reduction in risk based on demonstrated age related behaviour, and not simply assuming change on the basis of age. It should be noted that, on the basis of our findings, if there were to be a reduction in final risk score on the basis of age, the influence of other criminogenic factors such as age of onset of offending and age of last offence appear important moderators of the impact of age on the Static 99R score (see Table 6), and thus no simple heuristic such as weighting age in the absence of considering criminogenic risk factors should be attempted.

An additional concern is the observation that the correlation between the Static 99 raw score and the SVR-20 was higher than the Static 99R raw score and the SVR-20. Given the influence that criminogenic and dynamic risk factors may play in moderating the relationship between age and actuarial risk, it may be that the relative lack of association between the revised Static as compared to the original Static with the dynamic risk factors suggests that a reduction simply to age alone without reference to dynamic risk factors justifying such a reduction would be dangerous. However, we acknowledge that each of the Static scales, when using only the risk classifications, appeared to be equally efficacious in predicting the dynamic risk classification.

In addition, we note the participants who increased their risk on the Static 99R as compared to the Static 99. Whilst only four individuals actually changed risk classification and moved from low to moderately low risk and one from moderately low to moderately high, nine individuals had their risk increased by one simply because they were aged between 25 and 35 years. There needs to be further research into the effect of raising the risk estimate for those between 25 and 35, as to date, the empirical research has been supportive of the 25 year age limit, and in particular, the belief that early onset offending confers greater risk than later onset offending.

To our thinking, it may not be the alteration in weight attributed to age that is the problem in interpreting the Static 99R but the use of the cutting scores based on a simple approach to age, as in the Static 99. That is, there is no advantage to having a test that is developed to be sensitive to age, if the cutting scores used are based on a test that is by comparison insensitive to the age variable.

The strong correlation between the Static 99 and the Static 99R indicates that the Static 99R is a useful measure of potential recidivism, but there seems little advantage to its use over the Static 99 at the present time. If it is to be used, such use should be qualified, and comparisons with the Static 99 discussed and an

explanation as to why the risk estimate of the Static 99R is to be preferred advanced. In particular, as long as there are no validation studies to establish the utility of the cutting scores, it is our thinking that the Static 99R should not be used as it runs the risk of artificially lowering risk for older participants, without a clear empirical justification for so doing.

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Sexual Abuse in Australia and New Zealand, July 2011; 3(1): 42-43

A Review of "Understanding, Assessing, and Rehabilitating Juvenile Sexual Offending (Second Edition)"

By Phillip Rich

New Jersey, USA: John Wiley & Sons, Ltd., 2011

Emma Collins
LSC Psychology, Australia

Phillip Rich's second edition of juvenile sexual offending is a thorough update of its predecessor. It is separated into the three parts related to "understanding", "evaluating" and "treating" adolescents who sexually abuse. The book claims to adopt a "third direction" approach, which reports to be an informed and integrative manner of assessing the adolescent based on their development. In doing so, the adolescent is seen uniquely and individually, and not based on the adult population of sexual offenders. What follows in the book appears to live up to that claim. It is indeed well balanced and it reviews all of the theory to assist in working with adolescent sexual offenders, in order to undertake a multifactorial approach. There are six chapters that examine in-depth issues such as the aetiology of offending, attachment, and the developmental pathways, very much in line with contemporary thinking. There are also some interesting and valuable areas of commentary in these chapters. For example, Dr. Rich reviews the literature between what constitutes sexualised behaviour versus sexual offending, children's exposure to sex through the media, and the age-old argument regarding the role that sexual victimisation has on sexual offending.

Part two of the book provides three chapters on risk assessment with adolescent sexual offenders. These stress the importance of the risk assessment process occurring within a strong evaluation process so as to best inform treatment decisions and hopefully deter further offending. An assessment process based on multiple collateral sources, clinical interview, psychometric testing and a risk assessment is advocated. By undertaking such a comprehensive assessment process, it is argued that the risk assessment is "fuelled" by information as opposed to a "one-step" assessment that only provides a statistical risk rating. The two following chapters on risk assessment review the actuarial and clinical approaches and promote the structured clinical judgement where reassessment over time is important because risk assessment with juveniles is time limited. Dr. Rich reviews the current risk assessment tools, but rather than advocate one tool, he provides a checklist regarding "quality assurance" when selecting a risk assessment tool. One thing he rightly does stress is the consideration of protective factors within the risk assessment process.

The third part of the book focuses on treatment and rehabilitation. This is split into two parts: the first provides an overview of the types of treatment available, how treatment should be structured and the importance of taking an integrated approach. Of particular interest in this section are the checklists that review offence-specific treatment goals, client objectives and what is described as the "road map" of the stages of treatment. Additionally, there is valuable coverage on dealing with the disclosure (or lack) of sexual offending. In this way, the first part provides an overview of the treatment process, discussing some of the ways to approach treatment, factors related to treatment efficacy, and methods to monitor progress and reassess risk. This is all held together by an essential chapter on an integrated model of treatment.

The following section, part four of the book, supplies the detail of undertaking treatment. Four chapters loosely cover cognitions, behaviour, psychoeducation, safety planning, relapse prevention and victim awareness. The last chapters of the book review modes of treatment, by way of individualised, group and family therapy, and a final summary chapter appropriately termed "treating the whole child in a whole-minded manner". This chapter has some excellent rules for working with sexually abusive behaviour in addition to clinician factors important for success (e.g., tips in working within the forensic field). To this end, this last chapter almost reads like a checklist of things you wish you knew when you first began working in this field, and otherwise serves as a great reminder of things you may have let slip over the years.

Correspondence: Emma Collins, LSC Psychology, PO Box 20494, World Square, NSW, Australia 2002. Email: ecollins@lscpsych.com.au

ISSN 0833-8488

Overall, I found this to be an excellent book to use when working with adolescent sexual offenders. It provides a thorough review of the literature in order to help with assessing and treating such a population, and in doing so really leaves no stone unturned. I am a great lover of having a 'one-stop' book for areas of my clinical practice. This book certainly is an exhaustive reference for working with adolescent sexual offenders that caters for both the novice and experienced clinician in this area.

Sexual Abuse in Australia and New Zealand, July 2011; 3(1): 44-45

A Review of "Rehabilitating Sexual Offenders: A Strength-Based Approach"

By William L. Marshall, Liam E. Marshall, Geris A. Serran, and Matt D. O'Brien
Washington DC: American Psychological Association, 2011

Jayson Ware
Corrective Services New South Wales, Australia

Anyone familiar with the treatment of sexual offenders will know of Professor William (Bill) Marshall and his team at Rockwood Psychological Services. *Rehabilitating sexual offenders: A strength-based approach* this team's most recent contribution to the sexual offender literature. It represents both a state-of-the-art review of *what* we know about sexual offender treatment but also - and perhaps more importantly - *how* we should use what we know. One of the great strengths of the Rockwood Psychological Services team and therefore of this book is that they represent the quintessential scientist-practitioners. They are both researchers and therapists. The outcome of their research guides how they treat sexual offenders and in turn their treatment guides what research they complete. This book describes how they approach the treatment of sexual offenders and the research that has guided this.

This book is organised into three sections. An initial introduction outlines how Marshall and his team have arrived at a positive strength-based approach to treating sexual offenders. They firstly outline the problems with the traditional relapse prevention approach and then describe how sex offender treatment has tentatively started to embrace what is now known as a "positive psychology" approach to treatment.

Part I of the book describes in a concise yet detailed manner the research and theory behind contemporary sexual offender treatment. All five chapters represent an excellent review of the literature in areas of fundamental importance to the treatment of sexual offenders. Chapter 1 summarises pre-and post-treatment assessment approaches. Here Marshall and his team challenge the importance often ascribed to individual case formulation completed prior to treatment commencing. They advocate instead for an "in-treatment" formulation approach. Chapter 2 is especially important reading for anyone responsible for developing, reviewing, or managing sexual offender treatment programs. This chapter addresses such questions as: Should treatment manuals be used? Should group therapy be the preferred treatment option? How frequent should treatment be and how long should it continue for? Each of these – and other such important design decisions – are discussed in the level of detail that those tasked with developing or managing sexual offender treatment programmes crave for.

Chapter 3 focuses on the importance of the therapist. The authors note that "the client-therapist relationship provides the best explanation of why treatment does or does not work" (p.75). Their arguments and the theoretical and empirical evidence used to justify this statement are compelling. Similarly persuasive are the arguments within Chapter 4. Marshall and his colleagues continue to focus on *how* to deliver treatment. Here, they argue that most sexual offender programmes that are labeled cognitive-behavioural are, in fact, almost entirely cognitive. They further note that important human learning techniques such as role play, behavioural rehearsal, and between-sessions practice are often absent from sexual offender treatment and sessions can often therefore de devoid of the important yet forgotten group therapy ingredient of emotional expressiveness. Chapter 5 is a review of the evidence for the effectiveness of sexual offender treatment including a forthright discussion about the strengths of different research designs that are often used. This chapter concludes with the very positive evaluations of the Rockwood Psychology Services sexual offender treatment programmes.

At this point, the reader will thirst for detail about these programmes. Part II of the book provides just that. It represents a gold mine of detailed treatment-related knowledge for those who assess or treat sexual offenders. Over the course of three chapters Marshall and his team describe in detail their Preparatory, Primary, and Deniers programmes. This is effectively a "how to treat sexual offenders" section. In other words – it represents a treatment manual of sorts. In particular the Preparatory and Deniers Programmes chapters are examples of innovative approaches for groups of sexual offenders who have traditionally been difficult to manage – such as those who refuse to volunteer for

Correspondence: Jayson Ware, Director, Sex and Violent Offender Therapeutic Programmes, NSW Department of Corrective Services, Level 4/66 Wentworth Ave, Surry Hills, NSW 2010, Australia. Email: jayson.ware@dcs.nsw.gov.au

ISSN 0833-8488

treatment; those who are likely to drop out of treatment, and those offenders who categorically or adamantly deny responsibility for their sexual offences.

All in all this is certainly an impressive book. One need only look at the references section to note the important contributions that Bill Marshall and his team have already made to what we know about the treatment of sexual offenders. This book collates and then significantly adds to this knowledge.

This makes this book a "*must have"* for students, researchers, and both inexperienced and experienced therapists alike. Irrespective of whether treatment is provided within the community or within prison, by a therapist employed by a correctional jurisdiction, or a therapist in private practice – this is a book which will provide guidance for those tasked with treating sexual offenders.

I note that this book is the first of a new Psychology, Crime, and Justice series from APA books. It has set a very high standard.