

# Sexual Abuse in Australia and New Zealand

Volume 5, Number 1, May 2013

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## EDITORIAL

This edition of *Sexual Abuse in Australia and New Zealand* (SAANZ) brings together two themes of theoretical developments and clinical innovation. The field of sexual abuse is a dynamic one and our aim is to search for best practice in our field so that we are using the most up to date technologies in understanding this behaviour and assessing the risk of such behaviour recurring. Further, however, we aim to expand our horizons in terms of “what works” (Gendreau & Goggin, 1996) so that treatments are as effective as they can be and risk is reduced in order to protect the community. SAANZ aims to represent the developments in working with sexual abuse issues in Australia and New Zealand and the papers in this volume speak to some of the recent initiatives in our area of the world that are adding to the knowledge base in working within this specialist field.

Firstly, Willis, Prescott and Yates provide us with a paper that aims to extend the Good Lives Model (GLM; Ward & Gannon, 2006; Ward & Stewart, 2003) to the practical domain of therapeutic practice. This addresses some of the earlier criticisms of Ward’s work on this model by giving the theory practical utility in the application of treatment. This is important work and will assist clinicians in breaking down some of the concepts so that clients can work with them more effectively in developing Good Lives that seek to eliminate risk.

The article by Lennings seeks to discuss the ways in which actuarial and dynamic risk assessments of sex offenders can be usefully combined. The debate on risk assessment is a lively one and it important that assessors keep in mind their responsibilities in conducting effective and comprehensive assessments of risk, especially in the recent climate of post-detention supervision and the potential human rights issues that are at play in this domain (Ogloff & Doyle, 2009). Lennings provides us with a useful understanding of how to combine risk assessments into a cogent whole that maximise the utility of both actuarial and dynamic measures of risk.

The next three articles are in relation to the application of treatment with sex offenders in a number of settings. The first article is written by myself and my colleague, Ms. Nasr. We discuss some of the challenges and limitations of providing group-based treatment for sex offenders in the community within the structures of a private practice. This article discusses some of the ways in which we have tried to work with these challenges and limitations to provide best practice intervention outside of the criminal justice system. Further, recommendations for future initiatives and considerations are made.

Signal and colleagues present data in relation to their innovative application of Equine Facilitated Therapy with victims of child sexual abuse. The participants in this study were all abused as children but at the time of the research, were aged across the span from childhood to adulthood. There was also a notable portion of the sample who identified as Indigenous Australians, and the outcomes for this client group were noted specifically. In particular, comment is made about the usefulness of this form of therapy in reducing depressed mood, which is one of the common sequelae of childhood trauma.

Robson and Lambie offer insights via several case studies of female sex offenders from their practice in New Zealand. In particular, these authors seek to describe some of the common presenting characteristics of this client group, as well as discussing the implications of these for the application of treatment. Of particular note in this paper is the useful comparison between presentations of young females who have abused, as well as older adult women. Understandings of female sexual offending are increasing with the growing recognition of abuse perpetrated by women, and the paper by Robson and Lambie will assist in this developing knowledge base, with a particular focus on the presentation of these clients in New Zealand.

The next article by Withington, Ogilvie and Watt follows a similar theme. Specifically, this paper seeks to summarise the presentations and characteristics common to a group of young people who have engaged in sexually abusive behaviours, to a service in Queensland, Australia. Hence, this paper extends to some degree on the existing literature of young offenders, however, these authors also offer/make useful recommendations about how service provision may be improved and the needs of young people, at least in their area, can be more consistently met.

Lastly, this edition includes a paper by Madsen which reviews the applicability of polygraph testing in the treatment of sexual offenders. Specifically, they argue that using polygraphy sensibly can add to treatment efficacy, in addition to more effective supervision of and an improved quality of life for individual offenders. Polygraphy is not something that is widely practiced in this part of the world and therefore, much of the literature drawn on by these authors is international. Nonetheless, the article is thought provoking and worth reading with a view to considering the mechanisms by which the treatment and management of sex offenders may be supplemented to increase effectiveness.

Lastly, Brown and Kebell have authored an article that provides a different and interesting perspective on the form of sexual offending that has come more

recently to public attention in the form of child abuse images. Specifically, this article focusses on the forms of law enforcement response to this kind of offending, in addition to exploring what is known about the relationship between internet based offending and that of a contact nature, as well as offering discussion of the impact of internet based offending on the victims involved. This is an important paper that stimulates thought about the “other side” of working with these offenders.

For those of you who may not know, Dr. Doug Boer has now relocated to Australia and therefore, can no longer be our New Zealand Editor of SAANZ. Doug, thank you for your tireless work and support as Editor from New Zealand, It will be a pleasure to continue working with you on this side of the “ditch” as an Editorial Committee member. In Doug’s place, we welcome Dr. Armon Tamatea to the post of New Zealand Editor. Armon has extensive experience as a clinician in Corrections in New Zealand he has recently made the leap to academia. Armon’s support has been invaluable in preparing for this edition. Thank you also to Jessica Hall, whose amazing editorial support makes all this happen. Lastly, thank you to all our contributors, and on behalf of the Editorial Committee, we look forward to receiving your continued submissions that speak to the theoretical and clinical developments we are making in the field of sexual abuse in Australia and New Zealand.

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## The Good Lives Model (GLM) in Theory and Practice

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### Abstract

The Good Lives Model (GLM) is a strengths-based rehabilitation theory that augments the risk, need, and responsivity principles of effective correctional intervention through its focus on assisting clients to develop and implement meaningful life plans that are incompatible with future offending. During the decade of its existence, the GLM has seen advances in its underlying theory and application, as well as in its popularity, although empirical support for its application in practice remains in its infancy. This article briefly reviews the evolution of the application of the GLM, describes new and more accessible terminology for key GLM constructs, and offers ideas for situating traditional treatment programme components within the GLM framework. This brief article is intended to provide a summary of recent developments from existing texts on the application of the GLM.

### Introduction

The Good Lives Model (GLM; Ward & Gannon, 2006; Ward & Stewart, 2003) has become increasingly popular in sexual offending treatment programmes (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010) and is in use in diverse jurisdictions around the world. The GLM is a strengths-based approach to offender rehabilitation that augments the risk, need, and responsivity principles of effective correctional intervention (RNR; Andrews & Bonta, 2010) through its focus on assisting clients to develop and implement meaningful life plans that are incompatible with offending. Preliminary research suggests that the GLM can enhance client engagement in treatment and reduce dropouts from programmes (e.g., Simons, McCullar, & Tyler, 2006), a factor well-known to be associated with higher recidivism rates (Hanson, et al., 2002; Olver, Stockdale, & Wormith, 2011). This article reviews the evolution of the application of the GLM since its introduction, describes recently developed accessible terminology for key constructs, and offers suggestions for applying the GLM in traditional treatment programmes.

In brief, a central assumption of the GLM is that offending results from problems in the way an individual seeks to attain primary human goods, which reflect certain states of mind, outcomes, and experiences that are important for all humans to have in their lives. Examples include happiness, relationships/friendships, and experiencing mastery in work and leisure activities. Identifying the primary goods that are most important to clients, and those that are implicated in the offence process, constitutes a fundamental component of assessment because treatment explicitly aims to assist clients to attain these primary goods in personally meaningful, rewarding, and non-harmful ways in addition to addressing re-offence risk (Ward, Yates, & Long, 2006; Yates, Prescott, & Ward, 2010; Yates & Ward, 2008). Within the GLM, in addition to representing risk factors for recidivism, criminogenic needs are conceptualised as obstacles that block or otherwise frustrate pro-social attainment of primary human goods. They are therefore directly targeted in treatment as a crucial step towards assisting clients to attain primary goods in their lives. In this way, clients become invested in the treatment process because treatment explicitly aims to assist them to live a fulfilling life in addition to reducing and managing risk. As suggested by Ward, Mann, & Gannon (2007) "...offenders want better lives not simply the promise of less harmful ones" (pp. 106). It is beyond the scope of the current article to describe the GLM theory and its development in detail. However, key developments in recent years include its alignment with desistance theory and research (Laws & Ward, 2011) and integration with the Self-Regulation Model – Revised (SRM-R; Yates, et al., 2010; Yates & Ward, 2008). Several journal articles, books, book chapters, and guides for implementation are available that provide comprehensive descriptions of the GLM theory, including these recent developments (Laws & Ward, 2011; Ward & Maruna, 2007; Ward, Yates, & Willis, 2012; Willis & Yates, in press; Yates, et al., 2010).

Ward and colleagues first proposed the GLM over a decade ago (Ward, 2002; Ward & Stewart, 2003), however, its operationalisation in practice has been much more recent (Willis, Yates, Gannon, & Ward, in press; Yates & Prescott, 2011b; Yates, et al., 2010). Not surprisingly, as with any new model, technique, or approach, its application has not been without problems. Many professionals first learned about the GLM at professional conferences and in journal articles and book chapters in the absence of more comprehensive training and implementation packages (e.g., Ward, et al., 2006; Yates, Kingston, & Ward, 2009; Yates & Prescott, 2011b; Yates, et al., 2010). As a consequence, there was a tendency for programmes to adopt elements of the GLM without necessarily re-designing their philosophical underpinnings, mission statements, supervisory activities, or programme manuals and materials. For example, while some programmes may have replaced RP-based avoidant goals with more positive and forward-looking approach goals, others have not. Still others have attempted to apply avoidance-based approaches to achieving primary goods. Furthermore, programmes replacing avoidant goals with approach goals have done so typically without assessing primary human goods and developing intervention plans based on the GLM (Willis, Ward, & Levenson, in press). In the absence of concise, comprehensive resources for implementation, many programmes interested in the GLM have been challenged in their capacity to fully and comprehensively implement the GLM. The resulting well-intended but haphazard approaches have sometimes resulted in programmes claiming to follow the GLM that are each different in their understanding and implementation of the GLM. In the first years of its existence, there were few resources for clinicians for the GLM, such as structured methods for assessing and examining the role of primary goods in the life and offence process of each client. As a result, it was common to find that programmes attempting to implement aspects of the GLM were in fact implementing strategies that were not always in keeping with the tenets of the GLM; for example, simply adding a GLM module or component onto the end of a traditional risk-oriented treatment programme (Willis, Ward, et al., in press). Introducing the GLM at the end of a treatment programme is considered too late because the potential for enhancing client engagement in each stage of treatment has been lost, and because this approach does not allow for examination of the relationships between GLM constructs, such as primary goods, and offending and risk factors. More recently, an assessment protocol (Yates, et al., 2009), clinicians' guide (Yates, et al., 2010), client workbook (Yates & Prescott, 2011b), and overview for integrating the GLM into structured treatment programmes (Willis, Yates, et

al., in press) have become available, in order to better aid clinicians to implement a fully informed GLM approach to treatment.

As trainers in the practical application of the GLM, the authors have identified specific obstacles which, once overcome, have the potential to improve its application in treatment. Specifically, some clinicians have acknowledged difficulties understanding and applying GLM terminology as a result of its initial theoretical presentation, as well as determining how the GLM can be effectively integrated with treatment modules targeting criminogenic needs. The GLM primary goods are abstract concepts that were not initially intended for direct use with clients; however, in the absence of more concrete terminology and application to practice, the theoretical terminology has been used in clinical practice, which has resulted in some confusion for practitioners and clients alike. In the following sections we introduce readers to more accessible terminology for each of the GLM primary goods – to which we refer as common life goals (Yates & Prescott, 2011a) – and outline how each of the common life goals and broader GLM concepts align with the typical module or phase-based structure of best-practice sexual offending treatment programmes (i.e., programmes that adhere to the RNR principles, use cognitive-behavioural methods, and employ therapists who demonstrate positive therapist characteristics; e.g., Hanson, et al., 2002; Lösel & Schmucker, 2005; Marshall, 2005; Yates, 2002). In doing so, it is our hope to make the GLM increasingly accessible to practitioners and to promote a positive approach to treatment and the change process itself. After all, treatment programmes for sexual aggression have historically been a challenging environment for all involved (Marshall, 2005; Prescott, 2013). Clinicians have often been expected to focus on full disclosure of past sexual aggression to the detriment of the client taking responsibility for future actions (Ware & Mann, 2012). Such a focus can preclude identification of strengths and goal pursuits that, together with risk management strategies, can help clients remain safe in the community.

### **Primary Human Goods/Common Life Goals**

The GLM primary human goods were identified through an extensive review and synthesis of psychological, social, biological, and anthropological research (Ward & Stewart, 2003). Initial descriptions of the GLM proposed 10 primary human goods, while Purvis (2010) has suggested the separation of one of the initially proposed primary goods into two separate primary goods, suggesting the possibility of 11 primary human goods. In addition, the terminology associated with these goods has been explicitly revised (Yates & Prescott, 2011a) in order to be more accessible to

clinicians and clients than previous terminology, and to reflect common life goals in order to emphasise the importance of the goods to all individuals. Table 1 (derived from Ward & Gannon, 2006; Yates & Prescott, 2011a; Yates & Prescott, 2011b; Yates, et al., 2010) lists primary goods, common life goals, and their definitions. Examples of associated secondary or instrumental goods, which represent the concrete activities or means through which primary goods are attained, are also provided. Secondary goods can be pro-social or antisocial, and examples of each are provided.

Importantly, the common life goals represent changes to the labels of the original primary human goods, but not to their original definitions, based on the authors' experience and feedback from clinicians and clients that the use of goal-based language is more accessible to clients and practitioners and that revision to terminology was required for implementation in practice. What is crucial is clinicians' ability to convey the meaning to clients in a manner that engages them in treatment, for clients to be able to relate important constructs to their own lives and experiences, and to differentiate between secondary or instrumental goods and the underlying primary goods or common life goals they seek to attain via these specific activities. When asking clients about their life goals and valued activities, clients typically respond at the level of secondary goods, from which the underlying primary goods or common life goals must be inferred upon exploration (a semi-structured interview protocol is also available to assist this; see Yates, et al., 2009). That is, a secondary good could indicate importance placed on any number of primary goods, and assessment is required to determine which life goal is being sought. For example, creating Aboriginal art might reflect numerous underlying primary goods/common life goals, including creativity, being good at work, being good at play, peace of mind, spirituality, belonging to a group, and community. Only through exploration of what the Aboriginal art means to the client can the underlying primary goods or common life goals be identified. Using a different example, a client might have an extensive history of theft, an instrumental/secondary good which that could indicate attempts to achieve the common life goals of life (e.g., stealing money to pay rent), happiness (e.g., enjoying the risk-taking element of stealing), personal choice and independence (e.g., being financially independent), community (e.g., belonging to a gang), or any combination of these. Without exploring what the client gains from theft, the clinician could erroneously conclude that the client is simply antisocial, resulting in an incomplete treatment approach to this behaviour.

The common life goal terminology was designed to provide a concrete and more accessible language to

convey primary human goods. It is acknowledged that jurisdictional and cultural differences might warrant subtle changes to the labels provided. In a recent small-scale study in Australia which that used the common life goal terminology, this terminology was found to be generally well understood; however, clients indicated that "being good at play" was better understood as "being good at hobbies and leisure activities;" and "life: living and surviving" was better understood as "physical well-being and safety" (Willis & Yates, 2012). Whatever labels are used, it is crucial that each client's valued common life goals and the goals implicated in offending are identified at the point of assessment, that treatment is designed around these goals and their relationships to offending, and that clients understand these and are able to apply them to their lives and during treatment. Using the GLM, each client's treatment or intervention plan is centred around these common life goals (see Willis, Yates, et al., in press), which forms the basis of a future-oriented good life plan (GLP). GLPs contain a detailed set of plans for achieving valued common life goals in personally meaningful ways that are incompatible with future offending.

#### **Integrating Common Life Goals with Traditional Treatment Components**

Critical to using the GLM and in keeping with the needs principle of effective correctional interventions (Andrews & Bonta, 2010) is the assessment of criminogenic needs. The key difference in using the GLM is how criminogenic needs are understood, included, and addressed within the overarching framework of a treatment programme and the emphasis on each client's GLP (for details see Willis, Yates, et al., in press; Yates & Prescott, 2011b; Yates, et al., 2010; Yates & Ward, 2008). The aims of each treatment component or module are framed using approach goals, as opposed to solely avoidant goals, and are linked to the fulfillment of common life goals. For example, a module addressing relationships would focus on how to seek out and establish satisfying relationships rather than a focus on overcoming intimacy deficits and avoiding problematic relationships. Most modules common to RNR-based programmes, and all modules targeting the reduction or management of criminogenic needs, can be linked to one or more common life goals. Table 2 details common components of RNR-based programmes and associated GLM constructs and common life goals.

To review, treatment from a GLM perspective aims to assist clients to attain common life goals in pro-social, non-offending ways, while simultaneously targeting risk reduction. Addressing criminogenic needs is a crucial step in working towards these dual aims. For example, consider a client who places high importance

*The Good Lives Model*

Table 1  
*Primary Goods, Common Life Goals, Definitions, and Possible Secondary/Instrumental Goods<sup>1</sup>*

Primary Good	Common Life Goal	Definition	Possible Secondary/Instrumental Goods
Life (healthy living and functioning)	Life: Living and Surviving	Looking after physical health, and/or staying alive and safe.	Pursuing a healthy diet, engaging in regular exercise, managing specific health problems, earning or stealing money to pay rent or to meet basic survival or safety needs.
Knowledge	Knowledge: Learning and Knowing	Seeking knowledge about oneself, other people, the environment, or specific subjects.	Attending school or training courses, self-study (e.g., reading), mentoring or coaching others, attending a treatment or rehabilitation programme.
Excellence in Work and Play <sup>2</sup>	Being Good at Work and Play	Striving for excellence and mastery in work, hobbies or leisure activities.	Being employed or volunteering in meaningful work, advancing in one's career; participating in a sport, playing a musical instrument, arts and crafts.
Excellence in Agency (autonomy and self-directedness)	Personal Choice and Independence	Seeking independence and autonomy, making one's own way in life.	Developing and following through with life plans, being assertive, having control over other people, abusing or manipulating others.
Inner Peace (freedom from emotional turmoil and stress)	Peace of Mind	The experience of emotional equilibrium; freedom from emotional turmoil and stress.	Exercise, meditation, use of alcohol or other drugs, sex, and any other activities that help manage emotions and reduce stress.
Relatedness (intimate, romantic, and family relationships)	Relationships and Friendships	Sharing close and mutual bonds with other people, including relationships with intimate partners, family, and friends.	Spending time with family and/or friends, having an intimate relationship with another person.
Community	Community: Being Part of a Group	Being part of, or belonging to, a group of people who share common interests, concerns or values.	Belonging to a service club, volunteer group, or sports team; being a member of a gang.
Spirituality (finding meaning and purpose in life)	Spirituality: Having Meaning in Life	Having meaning and purpose in life; being a part of a larger whole.	Participating in religious activities (e.g., going to church, prayer), participating in groups that share a common purpose (e.g., environmental groups).
Happiness	Happiness	The desire to experience happiness and pleasure.	Socialising with friends, watching movies, sex, thrill-seeking activities, drinking alcohol, taking drugs.
Creativity	Creativity	The desire to create something, do things differently, or try new things.	Painting, photography, and other types of artistic expression; participating in new or novel activities.

<sup>1</sup> Adapted from Yates and Prescott (2011a, 2011b), and Yates et al. (2010)

<sup>2</sup> The primary good that has been suggested as being separated into two primary goods (i.e., Excellence in Work and Excellence in Play; Purvis, 2010)

Table 2

*RNR Treatment Components and Associated GLM Constructs/Common Life Goals*

RNR Treatment Component	GLM Construct/Common Life Goals
Autobiography	Good Life Plan (past and present)
Offence Progression	Knowledge, Good Life Plan (past and present)
Cognition/Problem-Solving	Knowledge, Personal Choice and Independence, Peace of Mind, Relationships and Friendships
Relationships/Intimacy Deficits	Relationships and Friendships; Community
Sexual Self-Regulation	Happiness, Peace of Mind, Relationships and Friendships ++
General Self-Regulation	Peace of Mind, Personal Choice & Independence, ++
Emotion Regulation	Peace of Mind, Personal Choice & Independence, ++
Relapse Prevention Plan	Integrated Good Life/Self-Regulation/Risk Management Plan (present and future-oriented)

*Note.* The common life goals listed represent those conceptually linked to each RNR treatment component. For any given individual, additional common life goals will be relevant (especially for general/sexual/emotion regulation as indicated by ++).

Table 3

*Good Lives Plan Template (Adapted from Yates, Prescott, & Ward, 2010)*

Common life goals desired	Ways to obtain goals	How I will know I am getting these	Problems I will need to manage	Risk factors	Risk management strategies
Life: Living and Surviving					
Knowledge: Learning and Knowing					
Being Good at Play					
Being Good at Work					
Personal Choice and Independence					
Peace of Mind					
Relationships and Friendships					
Community: Being Part of a Group					
Spirituality: Having Meaning in Life					
Happiness					
Creativity					



developing and rehearsing strategies to simply cope with these states when they occur as a risk reduction strategy.

As illustrated in Table 2, using the GLM, construction of an integrated good life/self-regulation/risk management plan (including a future oriented GLP) replaces the traditional relapse prevention plan towards which clients work throughout treatment. Rather than a focus solely on risk factors, high risk situations, warning signs, and coping strategies, this plan centres on clients' valued common life goals and their relationships to offending, risk factors, and self-regulation failure. In addition to factors that are targeted in and of themselves, risk factors are also conceptualised as obstacles, barriers, or threats toward implementing the GLP, and strategies for addressing risk factors are included such that any potential threats to the GLP can be effectively managed. For example, the risk factor of emotional congruence with children may be seen as interfering with the common life goal of relationships and friendships with others, in addition to creating a risk to re-offend. Risk factors are incorporated into the GLP, but in a way that is meaningful to the client. Returning to the same example, using treatment as a means of solely or predominantly for avoiding all interactions with children will likely be less successful than developing skills in interpersonal competence in relationships with adults. "Risk factors" that signal that the GLP is not being implemented and that individuals are not actively pursuing valued goals, are also included (Yates et al., 2010). Table 3 provides a future-oriented GLP template, illustrating the integration of common life goals, risk factors, and risk management strategies.

### Conclusion

The GLM is a theoretical and rehabilitation framework that augments accepted empirically derived principles of effective correctional programming and that supplements existing research-based practice. As illustrated in the current article, the GLM and its operationalisation and application have evolved considerably over the past decade. This brief article has described alternative terminology for key GLM concepts and outlined how treatment components based on established risk factors can be situated within a GLM framework. The developments presented in this article are designed to supplement existing GLM resources (see Willis, Yates, et al., in press; Yates, et al., 2009; Yates & Prescott, 2011b; Yates, et al., 2010) and to promote the GLM's application as intended – as a treatment approach and a framework informing treatment programmes in their entirety. Integrated appropriately, the GLM offers the potential to enhance outcomes of cognitive-behavioural, RNR-based

treatment programmes through keeping offenders meaningfully engaged in treatment and in activities to attain life goals in ways that are incompatible with offending. However, misguided application could unintentionally increase the very risk practitioners work to prevent and manage.

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## Can We Sensibly Combine Dynamic and Actuarial Assessment? A Comment.

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### Abstract

There is a strong tradition of assessing the predictive validity of actuarial and dynamic risk assessment instruments. To date the bulk of studies indicate moderate predictive validity of both actuarial and dynamic measures. However, the critical issue remains largely neglected: the best way to combine actuarial and dynamic risk measures so as to improve the overall risk assessment. This commentary indicates three strategies that might be subject to empirical investigation.

Prediction of re-offending remains an enduring and problematic issue in forensic psychology and psychiatry. There is now broad consensus and empirical support that a small set of static factors can be moderately successful in predicting sexual re-offence (Doyle, Ogloff & Thomas, 2011; Ogloff & Doyle, 2009; Philipse, Koeter, Staak, & Brink, 2006; Skelton, Riley, Wales & Vess, 2006) and there is hope, albeit some uncertainty, about the role dynamic risk factors may play in risk assessment (see the following for various positions in this debate: Boer, 2006; Doyle et al., 2011; Hanson & Morton-Bourgon, 2009; Vogel et al., 2004). There seems no doubt that structural decision making (SDM) aided by actuarial risk assessment is superior to unaided clinical judgement, but the debate remains as to how to use dynamic risk factors to modify (if at all) actuarial risk assessment (Doyle et al., 2011)?

A typical issue facing clinicians is the assessment of sexual recidivism, in which actuarial risk assessment remains the sine qua non of risk assessment, but the obvious issue that causes concern for the field is the recognition that people change and risk should thence, as well. If someone is to be encouraged to do treatment, and commit to it, then surely risk assessment should reflect changes if they occur? However, actuarial risk assessment is mostly insensitive to idiopathic factors, such as treatment experience, life changes, luck, and except in the broadest sense, maturation. There are no clear guidelines about how clinicians should work with this and amend risk assessment if at all to recognise the influence of such changes.

Actuarial risk assessment assigns a group or level of risk to a person based on their result on a rating scale. It is unknown what the individual risk is, all that is provided is a risk assessment based on membership of group variously defined as low, medium or high, or

low, medium low, medium high or high risk. Typically, clinicians then seek to refine the assessment by considering dynamic risk factors. Structured risk assessments also provide the clinician with an opportunity not only to assess risk, but also to assess needs that can be addressed through either treatment or management (Andrews & Bonta, 1994). Needs assessments, and the resultant treatment plan, can then modify the offender's risk.

Assessments that incorporate both static and dynamic risk factors are the preferred approach to risk assessment (Craissati & Beech, 2006) and should provide for a more holistic assessment and one that allows for the impact of change. In addition, the use of scenario planning (Rettenberger, Hucker, Boer & Eher, 2009), encourages the development of projecting future situations of risk for the offender. Scenario planning based on the identified dynamic risk factors allows for the idiopathic analysis of risk situations for the offender. Scenario planning leads naturally to risk management strategies and has been incorporated into revised versions of SDMs such as the Risk for Sexual Violence Protocol (RSVP; Hart, Kropp et al., 2003). Given that forensic assessments have a wider remit than just assessing risk, and that readers of such risk assessments include probation officers, supervision and treatment specialists, review boards, as well as judges, the broader assessment base provided by structured clinical assessments is an important consideration in any assessment.

The Sexual Violence Risk-20 (SVR-20; Boer, Hart, Kropp, & Webster, 1997) and its successor the RSVP (Hart, Kropp et al., 2003) are examples of structured risk assessment tools that seeks to identify an offender's standing on a set of criminogenic and sex-offender specific variables. Unlike many other instruments, they do not typically result in a numeric score, and they retain a requirement for the clinician to exercise a judgment about the risk level that an offender poses. They also have the advantage in that such tools require the clinician to carefully consider each of the variables research has found to be important in predicting recidivism, keeping the instrument well tied to empirical work.

The strength of dynamic risk assessment in the requirement on the clinician to exercise judgment is

also, however, its weakness. It remains entirely unclear how to manage the exercise of judgment vis a vis actuarial risk assessment. Harris and Hanson (2010) note that in the relatively brief time since tools for the assessment of risk of sexual recidivism have been developed, a bewildering array of assessment tools have become available. Hanson and colleagues have developed a range of dynamic measures tied to providing some kind of numeric score: initially the Sex Offender Need Assessment Rating (SONAR), replaced by the Stable-2000/Acute-2000 then upgraded to the Stable-2007/Acute-2007 (see Harris and Hanson, 2010 for explanation and description of the tests). The aim in developing these tools was to complement actuarial (historical) assessment of risk based on the Rapid Risk Assessment of Sexual Offender Risk (RRASOR; Hanson, 1997) or STATIC-99 (Harris, Phenix, Hanson & Thornton, 2003). As a class, the dynamic tools avoid the reliance on the clinicians' judgment, as found in the SVR-20 or RSVP, but also consider a much briefer set of dynamic needs. The Stable/Acute is able to evaluate change in an offender after treatment, although it is noted that it is not necessary to undergo treatment to have a change in one's circumstances. Measures, such as the Stable/Acute, that utilise numeric tables also have the problem of ensuring that, for the offender under consideration, the normative group applies. Normative data collected in one country may not be applicable in another (although generally it is provided there is a sufficient similarity in cultures and demographics of the respective countries). For instance, research with the STATIC-99 in Australia has found broad consensus that the risk assessments apply in Australia as in the United States (Allan, Dawson & Allan, 2006; Greenberg, Da Silva, & Loh, 2002). In New Zealand, the comparisons between the STATIC-99 and the ASRS (Automated Statistical System managed by New Zealand Department of Corrections) showed broad consensus although the ASRS provided more modest risk loadings for medium high and high risk scores on the STATIC-99 (Skelton et al., 2006).

### **Combining Actuarial and Dynamic Risk Assessments**

There are three broad positions that can be taken in considering how to align dynamic risk assessments with actuarial assessments. The first is the idiopathic position; the second is the matrix approach, and the third, for want of a better term, is the combination model.

**Idiopathic (Case Management) approaches.** The Idiopathic approach uses dynamic risk assessment following actuarial assessment to paint a picture of an offender's specific needs, leading to the construction of likely scenarios in which re-offence may occur. Such a

process has been termed Scenario Planning (Rettenburger et al., 2009) and leads directly on to case management. For instance, two offenders may be assigned to different STATIC99 risk levels – medium low and medium high. One may be young, has never been in a committed relationship and with significant impulse control problems and a history of lawlessness, rule breaking (but not resulting in criminal offending to date) and with moderate alcohol and drug problems. A second may be medium high, older, also without a history of committed relationships and, with the exception of sexual offending, is not evidently reckless, impulsive or rule breaking and without substance abuse problems. For the first case, risk is primarily a function of impulsiveness, immaturity and inebriation and a scenario predicting re-offence takes his age, and lifestyle pattern into consideration. Treatment would target the general criminogenic needs accordingly. In the second case, the presence of entrenched intimacy deficits, and persistent sexualised self-soothing behaviours present a differing re-offence scenario and thus, pose different treatment/ management needs. In this approach, the dynamic risk assessment is secondary to the actuarial risk assessment; the dynamic risk assessment helps flesh out what might be expected from the offender, but does not really modify the actuarial risk assessment. If the two offenders had the same actuarial risk, the question then arises whether there is a role for the dynamic risk assessment in modifying the actuarial risk assessment? For instance, if we assume both offenders had the same starting actuarial risk measure, but the march of time has occurred, treatment has helped assist the young offender to moderate his alcohol use and to develop greater impulse control, do we moderate the medium risk assessment to low? For the older offender, he too has engaged with treatment but remains socially isolated, unable to form meaningful adult relationships, but claims to have altered his masturbatory fantasies to age appropriate models. Do we consider that as the primary idiopathic concerns have not been addressed (inability to meet intimacy needs and continuing sexualised self soothing despite the reported alteration in target of fantasies) and would we decide to leave his actuarial risk assessment unchanged?

There is no formula and no clear means to use the additional dynamic risk assessment data gained in modifying the risk assessment. It is guided guesswork if the clinician decides to use dynamic risk data to modify the risk assessment. It is noted that this is, however, commonly done and with increasing attention to structured approaches to scenario planning is a recommended approach in instruments such as the RSVP. Vess, Ward and Collie (2008) have argued that the case formulation approach (idiopathic assessment and scenario planning) is both more useful for the

offender and also more relevant to public safety than simply relying on risk assessment per se. However, there is limited empirical support to date for this approach. A concern for the case formulation approach is that the risk assessment may vary as a function of the critical professional experiences of the clinician. In a judicial environment in which an individual's civil rights are encroached upon by arguments of dangerousness and community protection (Seidler, 2010; Watson & Vess, 2008), reliability between assessing experts is a critical issue.

**Matrix assessment.** A controversial approach in risk assessment is the attempt to formalise the relationship between actuarial and dynamic risk assessment. The rationale against doing so has been clearly spelt out by Doyle et al. (2011), who argues that such approaches lack empirical support, in addition to making comment on the obvious loss of flexibility bought about by the use of such an approach. In essence, a matrix uses the actuarial risk as the base line assessment and varies the overall risk assessment down or up one risk category based on the dynamic risk assessment. Such an approach was suggested by Schwalbe (Schwalbe, 2007; Schwalbe, Fraser, & Day, 2006). The critical element of the matrix approach is that it codifies the relationship between the extent to which dynamic risk assessment can modify actuarial risk assessment. The argument for such an approach is the potential to improve predictive validity, not by considering the relative importance of how various items in each assessment approach may line up in some regression model, but how the two total scores operate to define the risk profile of the individual assessed (bearing in mind actuarial assessment only predicts group membership). However, there has been almost no take up of the proposal advanced by Schwalbe within the field.

Lennings (Bolton & Lennings, 2010; Lennings, Seidler et al., 2011) investigated the reliability of the matrix approach in both civil (child protection) risk assessment (Bolton & Lennings, 2010) and sex offender risk assessment (Lennings, Seidler et al., 2011). A specific hypothesis investigated by Bolton and Lennings was that reliability of risk assessment would be greatest in the circumstance where both actuarial and dynamic risk assessment approaches were combined in a matrix system. Although the results bore out of the hypothesis, feedback from the clinician's panel used to undertake the risk assessments revealed that most clinicians did not like the matrix, finding it too limiting in their judgements. That is, despite creating good reliability between clinicians, the clinicians would not typically use such a system as they felt it placed too many restrictions on their clinical judgement (the

preferred approach by the majority of clinicians in the study was to use the actuarial approach).

In the Lennings, Seidler et al. (2011) study, the matrix was used as a mechanism to increase the reliability of clinical judgements in relation to sex offender risk. This study was an evaluation of the relative merits of the STATIC99 and the STATIC 99R. An incidental observation of the study (as seen in the inter-rater reliability checks) was some deviation between the five clinicians on the actuarial and the dynamic risk assessment device (SRV-20) but the overall clinical judgements cohered in every case following the use of the matrix.

The concern about reliability should not be overstated. It is a truism in psychometrics that without reliability, there is no validity. However, good reliability in and of itself does not necessarily lead to a valid assessment. Nonetheless, it appears that the Matrix approach, despite the many concerns raised by clinicians and researchers about it, needs to be subjected to good empirical validation to explore its benefits in improving the reliability and validity of risk assessments.

**Combination approaches.** The third approach, that of combination models, has been apparent in the literature for some time. For instance, Philipse et al. (2006) combined various static and dynamic risk factors in a Cox' regression, finding no support for the inclusion of dynamic variables over that of static variables. However, this study revealed an interesting approach. The study utilised 15 actuarial items, and six scales, representing the composites of some 47 different dynamic risk factors. One of the scales had quite low reliability. Philipse et al.'s approach entered the actuarial items first, and then the six dynamic variable scales in a second step. A third step entered specific dynamic risk variables from the discarded dynamic risk scales not subsequently entered into the final equation (due to lack of significance). In essence, the regression model followed the same rationale as matrix approaches; that is, dynamic risk factors are entered after actuarial risk had established the base line risk. Reconviction data was the dependent variable. Interestingly, three of the four most significant actuarial risk factors were Axis 1 disorder, substance abuse disorder and personality disorder. It could be argued that these actuarial items in the Philipse study represent dynamic needs and might account for the lack of significance of subsequent dynamic risk factors in the final solution.

There are practical problems in adjusting regression models in individual assessments, but the development of measures such as the VRS-SO (Olver, Wong, Nicholaichuk, & Gordon, 2007) have gone some way to meeting those needs, creating a measure that combines

both actuarial and needs based assessment in the one scale, although this requires multiple assessments to assess change. For instance, using the VRS-SO scale, a clinician can compute a risk assessment score based on the actuarial items alone, or on the total of both actuarial and dynamic items. Through the use of multiple assessments, a change score on the dynamic items can be developed that allows for a modification of the overall risk assessment based on the observation of change as measured by the dynamic risk items. Idiopathic analysis can occur by examining the change in motivation on each dynamic item over repeated assessments. The combined actuarial/dynamic risk assessment approach, in which separate measures of actuarial and dynamic risk are undertaken then combine to assess an idiopathic risk is similar, but in a more structured way to that of the idiopathic understanding approach.

The major drawback for the combination strategy, as operationalised by the VRS, is the requirement for multiple assessments over sufficient time to observe change (or at least allow for the possibility of meaningful change). However, good support for the use of the VRS-SO by Beggs and Grace (2010) in a New Zealand sample is encouraging. Their study used an average follow up time of 12 years (7.9 to 18.9 years), reporting strong validity (AUC about .8) and good inter-rater reliability. However the VRS:SO scores was retrospectively rated, by file review. Although encouraging results, a prospective study of the usefulness of the measure needs to occur. The obvious requirement is the consensus that the VRS suite be used on initial assessment to allow for the multiple assessments necessary to document change in behaviours and motivation. Unless there was consensus that risk assessments should be based on the VRS approach, the opportunity to establish a base line against which future assessments could then occur is unlikely.

### Conclusion

It seems time has come for a study to assess the best means to combine the actuarial/dynamic risk approach. The use of a structure, such as a matrix or combination model, to improve the reliability of assessments seems an important research goal. In a world in which expert judgements are under close scrutiny and carry considerable import (such as in extended supervision cases), the reliance on idiopathic approaches to aligning actuarial and dynamic risk assessments is understandable, but in the “hothouse” situation of Court, likely to lead to low confidence in clinician estimates of risk. However, there is an obvious criticism to matrix and/or combination approaches. Such approaches can be viewed as over-specifying the relationship between actuarial and dynamic

assessments, and therefore, “pseudo-scientific”, implying a technology and knowledge base that, as yet, does not exist (Keyzer, Pereira, & Southwood, 2004). However, a philosophy that suggests change is possible in offenders means we have to develop assessment techniques sensitive to such change, for instance as Wong has done with the VRS-SO.

To date, research appears to have primarily addressed the separate predictive validities of actuarial and dynamic risk instruments (Hanson & Morton-Bourgon, 2009). A collaborative research effort to explore the best ways to combine actuarial and dynamic risk assessment is urgently required in Oceania to guide both offender rehabilitation and public safety.

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## Offering an Alternative: The Challenges of Working in a Group Context in a Private Practice

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### Abstract

Knowledge has developed considerably in recent decades regarding “what works” in the rehabilitation of sex offenders. However, much of this literature has its foundation in correctional or custody-based programmes. It is increasingly recognised that the community is an often unrecognised site where the intervention of sex offenders will occur. This is especially crucial when it is noted that the majority of sex offenders will not be incarcerated for their crimes. However, resources are scarce and there are generally more offenders to be treated than can be accommodated for by Government funded community corrections programmes. This article will discuss the challenges that a private practice in Sydney, Australia has faced in establishing and maintaining an evidence-based group programme for the treatment of sex offenders with discussion of case studies as relevant. This article will conclude with recommendations about how service delivery can be improved for this often neglected section of the community, whereby custody and community-based treatment providers can better work together to provide a through-care model where the rehabilitation needs of offenders are addressed in the interests of community safety.

### Introduction

In recent decades, the clinical and empirical literature has burgeoned in relation to sex offenders. Consequently, knowledge is amassing with respect to the dynamics of sexual offending behaviour, the personalities and accurate risk assessment of sex offenders, the antecedents to sexual offending behaviour and the best and most effective methods of rehabilitating sexual offenders (e.g., Beech, Craig & Browne, 2009; Marshall et al., 2011). However, much of this knowledge has been gained through research and treatment carried out with incarcerated offenders. This is not surprising given that there is generally a greater capacity to deliver intensive and structured treatment in the relatively controlled environment of prison.

Given the workings of the Australian judicial system and the relatively low rates of disclosures in relation to sexual abuse (London, Bruck, Ceci & Shuman, 2005), the majority of sex offenders will not

serve custodial sentences for their offending. Rather, they will be managed in the community, ideally with supervision through community corrections. Therefore, the community represents an important site for the provision of sex offender specific intervention that has only been recently recognised in the literature (e.g., Losel, 2010). Providing treatment in the community is even more important when it is considered that offenders living in the community are ostensibly at risk of reoffending on an ongoing basis, which challenges the sometimes hypothetical nature of risk management intervention in custody and highlights the need for effective safety and self-regulation processes. Further to this, it is in the community where offenders have the greatest chance of actioning their “good lives” (Frost, Ware & Boer, 2009; Ward, 2002; Ward & Brown, 2004) by addressing the various aspects of their lifestyles and functioning that will lead to fulfilment and ultimately reduce the risk of reoffending (Ward & Maruna, 2007). This reinforces the importance of providing community-based intervention for the purposes of long-term rehabilitation of sex offenders and the long-term greater good of community safety.

In general, the literature suggests that treatment approaches that are cognitive behavioural in nature will be the most effective with forensic populations (Andrews & Bonta, 2007; Gendreau, 1996), including sex offenders (Allam & Browne, 1998). Further, the more recent focus on “good lives” initiatives in treatment are proving efficacious in rehabilitation and are generally consistent with the more humanistic approach of most “front line” therapists.

Group work particularly, is increasing in terms of its applicability to the treatment of sex offenders (Frost, Ware & Boer, 2009). Group therapy, generally speaking within the mental health field, is popular because it is time and resource effective (Toseland & Siporin, 1986) and provides a quick and effective means of promoting learning (Shaw, 1981). Further to this, groups have particular effectiveness in relation to interpersonal skills development (Rose, 1984; Schneider Corey & Corey, 2002), in addition to being effective for difficult clients for whom other forms of



intervention have failed to bring about change (Forsyth, 1999).

Within the forensic domain, group work has also been increasingly prioritised to some effect. According to Morgan & Flora (2002), in their meta-analytic reviews of correctional programmes, offenders who participated in group-based interventions demonstrated improvements in institutional adjustment, interpersonal skills and self-esteem, as well as reduced anger and anxiety levels. Further, even with the significant attrition rates in forensic group programmes, those that adhere to the Risk, Needs and Responsivity (RNR) principles espoused by Andrews and Bonta (2007), produced notable reductions in recidivism (Olver Stockdale & Wormith, 2011), which is the ultimate measure of effectiveness in forensic psychology.

As with other general forms of treatment, group work with sex offenders has focussed on cognitive behavioural principles (e.g., Marshall, Anderson & Fernandez, 1999; Marshall et al., 2006). Allam and Browne (1998) summarise the core components of a treatment programme for sex offenders based on such principles as addressing cognitive distortions, developing empathy for others (particularly for victims), improving social and interpersonal skills and improving the behavioural management of deviant arousal. This has also been couched within the broader rubric of Relapse Prevention, which has been applied in the rehabilitation of sex offenders for many years (Pithers, 1990), such that offenders are taught effective self-regulation skills in the pursuit of community, victim and personal safety.

Much of sex offender treatment is administered in a group work setting (Frost, Ware & Boer, 2009) and research has suggested that there are a number of important gains for sex offenders from participating in such treatment. This includes positive changes in identity (Collins & Nee, 2010), understanding of offence-related concepts (Collins, Brown & Lennings, 2010) and an awareness of others (Wakeling, Webster & Mann, 2005). Further, the provision of social support through group treatment cannot be understated for this client group (Day, 1999; Frost, Ware & Boer, 2009). This is not surprising when one considers the established link between intimacy deficits, emotional loneliness and sexual offending behaviour (e.g., Marshall, 1993; Seidman et al., 1994). It even appears that group-based therapy is effective for sex offenders with intellectual disabilities (Keeling, Rose & Beech, 2008; Murphy et al., 2010). Allam & Browne (1998) suggest that treatment gains for sex offenders who have participated in group-based treatment can be between 36 percent and 69 percent (e.g., see also Friendship, Mann & Beech, 2003), although other research has been less encouraging (e.g., Hanson, Broom & Stephenson, 2004). However, this does not change the

fact that the treatment of sex offenders is an important initiative that continues to be carried out in forensic settings in the interests of community safety and child protection.

Recently, literature into community-based treatment is increasing and has suggested that this has some efficacy in intervening with sexual offenders (Collins, Brown & Lennings, 2010; Kemshall & Wood, 2007), especially in relation to dynamic risk factors associated with interpersonal functioning (Collins, Peters & Lennings, 2009). Andrews et al (1990) suggested that community based treatment is more effective than that provided in institutions, consistent with our argument that treatment provided in the community is especially important in assisting offenders to manage their risks where they usually occur. That is, sex offenders living in the community are at risk on an ongoing basis (Allam & Brown, 1998) and if offenders can be assisted to lead fulfilling lives and manage their risks safely in the community through treatment, then the change produced by intervention is arguably more meaningful in a tangible sense both to the offender and to the community.

In New South Wales, the majority of treatment initiatives for sex offenders are provided by Government agencies. There are a handful of individual clinicians who also provide this work but the reality of practice as an individual means that group work is prohibitive for most. Consequently, services are few, resources are limited and waitlists are long, which results in many offenders going untreated. This has obvious implications, which, in our opinion are untenable. To this end, we have sought to address this need by providing a group-based treatment programme for sexual offenders within the structure of a small independent private practice.

Consistent with accepted best practice in this field (e.g., Allam & Browne, 1998; Beech, Craig & Browne, 2009; Marshall et al., 2006; 2011), our programme aims to address the core principles of effective sex offender intervention, in addition to taking into account the "Good Lives" concepts (e.g., Ward & Brown, 2004; Ward & Maruna, 2007) so that participants are taught to avoid and/or manage risks safely, in addition to leading fulfilling and healthy lives that should, ideally, prevent the recurrence of risk factors. Specifically, the programme aims to address the following core targets:

- Addressing the criminogenic needs associated with sexual offending behaviour,
- Addressing issues of sexual deviance,
- Developing an understanding of consent and sexual boundaries,
- Developing an appreciation of victim empathy,
- Challenging offence-related cognitions,

- Developing a comprehensive understanding of the sexual offending behaviour,
- Developing skills for managing safety within the community,
- Developing and maintaining an appropriate support system within the community.

The programme is run in an open group format whereby participants work through a series of assignments addressing the core issues of treatment, in addition to optional assignments that may target particular issues relevant to individual group members. This includes a specialised pathway for internet/technology-based offenders, who appear to be different in important ways from contact offenders (e.g., Sheldon & Howitt, 2007). These assignments are completed as homework, which appears to be an important component in effective treatment programmes both generally for forensic clientele and for sex offenders more specifically (Collins, Brown & Lennings, 2010; Morgan & Flora, 2002).

According to Allam & Browne (1998), effective community-based programmes should be transparent in their philosophy and objectives, in addition to having specially trained and supervised staff to facilitate treatment. This is important to us and enshrined in the manner in which we run our programme. These authors also highlight the need for treatment to be structured according to a programme, which would usually be in the form of a manual. Such manuals are unhelpful if overly prescriptive (Collins & Nee, 2010) and we have developed our manual in line with the suggestion of Mann (2009), who indicates that “good” manuals should focus on concrete and specific goals, set process as well as content standards that are amenable to being somewhat flexible and not overly scripted. Furthermore, given that both treatment facilitators are well experienced group therapists, the process-based work is prioritised, which works to facilitate disclosure and resolution of emotional/relational concerns (Frost, Ware & Boer, 2009).

Although we receive some independent referrals, most of our referrals come through the criminal justice system and as such, clients are generally externally motivated, at least at the beginning of treatment, which can adversely affect motivation and performance (e.g., Collins, Brown & Lennings, 2010; Ward et al., 2004). According to McMurrin & Ward (2004), there is no consensus as to what is meant by offenders’ motivation and no systematic examination of the factors that influence motivation in offenders. Despite this, we are expected to cater treatment for individuals with differing motivational levels, whilst bearing in mind the responsivity principle (Andrews and Bonta, 2007).

Our programme caters only to men and not all the participants are expected to have been adjudicated or

even charged for their abusive behaviour. Given the time and resource limitations, we cannot apply treatment strictly according to the RNR principles (Andrews & Bonta, 2007). For instance, as we are based in the community, the majority of our clients are at the lower end of the risk continuum. However, the open group format allows for variations in treatment dosage, whereby those offenders with fewer criminogenic needs or those who are higher functioning will progress through treatment more quickly, thereby reducing their dose.

Following, we wish to outline some of the challenges that we have faced in developing, implementing and maintaining this group programme within a private practice. This will include discussion of the implications of these concerns.

### **Resources/Time-Intensive**

It has been well-established in the literature that the treatment for sex offenders is typically long-term and resource intensive (Keeling, Rose & Beech, 2008, Mailloux et al., 2003), and given that group work is currently the treatment modality of choice for this client group, regular psychological intervention is required by a team of specialist clinicians. This is a challenge within private practice, where there are usually limited clinicians available to facilitate long-term individual or group interventions both due to the specialist skills required to do this work and because of the high level of commitment required to facilitate this treatment.

In our experience, to ensure that best practice treatment is offered in a group format, extensive resources are required. Some of these include the time involved for clinicians, the administrative efforts and support needed, office space (including a group room), report and case note writing required to document treatment progress and the liaison required between various supervising officers and other involved parties (such as child protection workers or mental health treatment providers) and ensuring treatment efficacy and consistency across the board. We have found that for each group session, several hours of additional time is required by each clinician in order to fulfil the basic administrative requirements of the programme, which does not include other time required when clients, referrers or supervising agencies contact the service. This also does not include the development of group materials and participation in research or other initiatives that are important in responsible clinical practice.

There are few clinicians who are likely to have the capacity to be able to personally fund such resources within private practice, where there is no financial, administrative or organisational support from government agencies or the public domain for these efforts. In essence, this means that group treatment is a

loss leader financially both for individual clinicians and for private practices as a whole. Therefore, even though the commitment, motivation and skill set/experience may be present in private practice, for such specialist treatment groups to operate effectively, the practical requirements often outweigh available resource and are hence prohibitive for clinicians.

### **Interagency Challenges**

As treating clinicians working with sex offenders, there is a baseline expectation that reinforces a sense of responsibility and obligation to balance the needs of the client, the law/community, and therapists. Often there is a tenuous balance for clinicians in being able to recognise and manage the rights of all parties invested in the care and protection of children in relation to sexual abuse. This challenge occurs in the context of an overarching model of community protection with sex offenders that prioritises surveillance and control in order to protect victims (Birgden, 2007; Centre for Sex Offender Management, 2000; Kemshall & Wood, 2007). The difficulty with this model is that it has limited effectiveness in preventing acts of sexual abuse (Gendreau et al., 2000; Gendreau, Goggin & Smith, 2000), whilst at the same time creating additional challenges in managing sex offenders within the complex rubric of multiple systems and services that may be relevant stakeholders. It is advised that this communication and interaction primarily serve the purpose of ensuring victim safety and client care.

As a result of recent policy and management initiatives, sex offenders in the community are required to work closely with several agencies such as community corrections, the Police, specialist community management services, child protective services and the local Registration/notification Law monitors. Treatment providers are in a unique and important position to assist in this process both in terms of assisting clients in communicating effectively with supervising officers and facilitating persons in position of authority being aware of salient risk issues that may be relevant to the offender. To this end, in the interests of reducing recidivism and facilitating both client management and community safety, it is important that clinicians communicate with the aforementioned agencies in order to ensure consistency and continuity of care, which also aims to hold clients accountable for their behaviour and assist them in developing prosocial routines and support networks.

In our experience within a private practice, the more closely treatment providers are able to work with other law enforcement agencies or professional agencies and significant others, the more efficacious the treatment and the individual client's responsiveness to change. The literature suggests that offenders who experience a supportive treatment team and environment have a

more positive experience of intervention and change (e.g., Collins, Brown & Lennings, 2010; Frost, Ware & Boer, 2009; Wakeling, Webster & Mann, 2005). However, there is little data to explore how this issue relates to the more recent community management of offender initiatives that, in our opinion, require greater inter-agency cooperation. Notwithstanding, the success of Circles of Support Initiatives in various jurisdictions in the community management of support and sex offenders goes some way to highlighting the usefulness of a cooperative and supportive approach with these clients (van Rensburg, in press; Wilson, Cortoni, & Vermani, 2007; Wilson et al., 2007; Wilson, Picheca & Prinzo, 2005; Wilson, Picheca, & Prinzo, 2007a; Wilson, Picheca & Prinzo, 2007b).

Working outside of the criminal justice system, we have experienced a number of communication problems such as not being kept "in the loop" in relation to our clients. At a minimum, this has meant that relevant information has not been communicated to us. At a maximum, we have been deliberately excluded from the process of managing our clients. Difficulties such as this, compromises the ability to treat a client effectively. The lack of interagency support and communication can contribute to increased resistance from clients, lack of accountability and, at times, an inconsistency of services or messages delivered to clients. This can result in clinicians having to write more reports, attend meetings or education of others involved in the case management of the clients' treatment and supervision, in order to ameliorate inconsistencies and ensure effective treatment. In large part, this is a function of the misperception of what constitutes risk by many members of the community, who are generally ill-informed about sexual offending behaviour (Bollinger, Seidler & Kemp, 2012; Mills & Kroner, 2006; Petrunik, 2002).

In order to compensate for some of these challenges, our service has attempted to incorporate research and training workshops in the area of sex offender risk, assessment treatment that have been open to various practitioners and stakeholders in the field. Additionally, provisional psychologists and supervisees often observe the group as a training forum, which has been fed back to us as most beneficial in terms of generalising knowledge to witnessing treatment.

Our treatment programme has yet to graduate enough participants to be able to do outcome research. However, we utilise the Therapist Rating Scale designed by Marshall et al. (2006) in order to measure therapeutic change in participants so as to ensure they are ready to complete treatment. Further to this, we are currently participating in an international research project in relation to the role of group process in sex offender intervention. Through this process, not only will the participants of the treatment programme

contribute to international data on treatment processes and outcomes, but we also anticipate gaining location specific outcome research as part of the data collection process.

### **Ethics/Balancing Treatment Integrity**

It is an unfortunate reality that for most clinicians in the field, treatments cannot readily be applied according to best practice guidelines. In the community, we have found that offering treatment to sexual offenders has created challenges that do not often exist, or at least, not in the same way as in the prison system. Firstly, offenders are living their lives in the community, whilst engaging in treatment and this means that they may often be interacting with people who may place them at risk. The common way this occurs is by offenders coming into contact with children in their extended family or social networks, which is not easy to control. Invitations to special occasions are the common way in which this manifests. In these cases, as clinicians, it is important for us to balance the risks the clients may pose to those in their lives with the need that they have for living an independent and fulfilling life, which has been highlighted so poignantly by the Good Lives Model.

It is not uncommon for offenders to make further disclosures through the process of treatment and often, this is encouraged by clinicians as part of the process of becoming honest and accountable, although this process, and the potential consequences thereof, are explained to the clients upfront as part of the informed consent process. These additional disclosures should then be passed on to the relevant authorities in whatever jurisdiction the clinician works. These disclosures always carry the threat of further criminal actions, however, when working in the community, making such disclosures carries the very real possibility of incarceration, which disrupts the treatment process, disturbs the offender in regaining their stability and interpersonal relationships and naturally also removes the source of support available to the offender through participating in treatment. This is difficult and often counter-productive therapeutically for the client but can also create challenges for the therapists in being able to support their client appropriately.

Lastly, balancing the demands of the Court process is an added challenge here, which often raises ethical issues for clinician in their practice.

Traditionally, in our State jurisdiction (NSW), reporting obligations have been required from private practitioners once an individual is convicted and about to be sentenced. However, we have realised that there is a growing number of people who are seeking treatment, engaging in treatment or being recommended by family or legal personnel to engage in treatment prior to their sentencing dates. This often means that we are required

to communicate our assessment of the sex offenders referred to us and their engagement in treatment and any challenges faced in this regard with a view to advising the Court about sentencing options and treatment needs. What this has meant is that specialist psychological intervention is now being considered as part of a Court function when sentencing offenders. This places increased demands on clinicians to provide updated reports to the Court, which again, have time and financial implications.

Previously, we have included offenders in group who were yet to be sentenced. This has proven to be effective in so far as the providing offenders an opportunity to commence addressing offence specific and other issues through therapy, in addition to gaining therapeutic and group support through the stressful experience of going through Court. We have also found the Court to be receptive to offence-focused intervention at this early stage, which has been taken into account by the Courts in imposing sentence. Whilst valuable in some respects however, allowing unsentenced offenders in to group treatment has created dilemmas in terms of disruptions to group process, premature and sudden termination of treatment and additional drain on therapist time through necessary report writing and time to give evidence in Court.

### **Victim/Offender Clashes**

The treatment of sex offenders is not only imperative for the individuals engaging in treatment but also to the community at large due to issues of safety and child/victim protection. We have a responsibility to ensure individuals in the community feel safe, while also balancing and respecting the needs of the clients we treat. We suggest that there should be a community responsibility to ensure that sex offenders are offered treatment in order to reduce future victimisation and provide safer community living. Despite recognising how important it would be for the community to encourage and resource sex offender treatment, there remains a strong negative social stigma associated with the treatment of sex offenders (Centre for Sex Offender Management, 2000; Hayes et al., 2009; Hollin, 1996) and the community remains generally resistant to therapeutic work with sex offenders, such that they would prefer to see them controlled and restricted rather than offered supportive intervention (e.g., Bollinger, Seidler & Kemp, 2012; Byrne & Taxman, 2006). This continues to limit resources and also means that we cannot service the amount of offenders referred to us, thereby leaving many sex offenders untreated and at increased risk in the community.

It is also part of our role as clinicians to communicate with sexual assault counsellors at times, particularly when victims have engaged in a compensation process. As clinicians treating offenders,

we recognise that this is a complex process, particularly when some sexual assault counsellors have misperceptions of “dangerousness” or “risk” that an offender poses, which can add to the “divide” between those in the offender and survivor fields. As therapists working with offenders, we are placed in a position where we are trying to balance the integrity and rights of our own clients, while also attempting to educate, liaise and assist therapists of victims, to ensure a less difficult process of healing for victims. When we are faced with difficulties in communication with sexual assault counsellors, we are reinforced about the need to provide further education and development to lay people and professionals, who continue to hold misperceptions of “dangerousness” or “risk” (e.g., Mills & Kroner, 2006), often believing offenders are at higher risk than they actually are. Furthermore, we understand that part of ensuring victim safety is to identify potential risks to past or future victims. If there are any risks, we are obligated to work with other agencies, authorities, professionals and family members to ensure these risks are managed and safety is maximised. When other agencies collaborate and work smoothly with us, we have found that clients are more responsive to treatment, trusting those they work with and becoming more motivated to change. This is consistent with the more humanistic work of Ward and colleagues in elucidating the Good Lives Model that discusses notions of client resistance and the reasons why this may be present in the traditional, somewhat adversarial, environment of correctional programming for sex offenders (e.g., Ward, 2002; Ward & Brown, 2004).

### **Funding**

The group programme run through our service operates on a weekly basis and as aforementioned, can be resource and time intensive. As a private practice, we do not receive funding from any other source but from the clients who attend the Service. Furthermore, the participants of the programme are typically disadvantaged and have limited means financially. Consequently, clients’ fees are usually discounted to allow them to contribute something to the costs of their treatment within whatever limited budget they have available to them. To date, the practice has been financially supporting the programme over the almost three years it has been running, as it continues to run at a loss for the business, which is untenable over time. We have made attempts at securing funding in a through-care model but to date, have been unsuccessful in this, which is understood within the context of community resistance (Hollin, 1996) to treatment initiatives for this client group, as well as the difficulties negotiating the complex socio-political environment in which sex offender treatment takes place.

Below is a deidentified case study that illustrates the multiple, complex and at times, competing demands that may be brought to bear on clinicians working with clients like the one referred to below in the community.

### **Case Study**

M was referred for treatment with our Service in relation to a number of technology-based offences. He was referred not long after being charged and initially commenced in individual treatment. M was highly anxious and required supportive counselling to assist him to settle and begin addressing his offending. Through initial individual sessions, it became apparent that M had a high level of deviancy and had offended in more ways than had been disclosed to police. These in-session disclosures required us to liaise with the police and this resulted in M being charged with further offences. Fortunately, we were able to work with M through this process and therapeutic rapport was maintained.

Through the process of M’s charges being finalised, concerns were raised by our State child protection service in relation to potential risks to adolescent children present in M’s home. Therefore, we were required to liaise by phone and email with child protection and to submit a report to them in relation to our assessment of M’s risk and how this might relate to those children in his life. This took up some time in between sessions and with the exception of the provision of the report, was not remunerated by M. Although, it was in M’s best interests, in addition to being important clinically in terms of M taking accountability and accepting the consequences of his offending behaviour. Further to this, it was somewhat difficult to negotiate the differences in accountability and disclosure requirements between that necessary for child protection compared to the criminal justice system.

M then commenced group treatment with us and although initially anxious and uncomfortable, he engaged well and demonstrated honesty, accountability and insight in relation to his offending behaviour. He was also a positive influence on other members of the group. One of the major challenges that was relevant to M’s treatment was assisting him in managing deviant arousal when in the community and in the presence of children. This was a significant issue that was placing M and children at risk on a regular basis. Assisting him in developing skills to manage his deviant arousal necessitated M attending both group and individual treatment sessions, in addition to liaising with a psychiatrist to facilitate medication treatment.

M continued to progress well in treatment but he has had Court appearances every few months and is awaiting sentencing. His anxiety understandably increases prior to each Court appearance, which has

taken a focus in treatment, as has assisting M in supporting his family to cope with the potential consequences for his offending. Given the nature of M's offending and the additional charges he is facing, it is likely that he will receive a custodial sentence. This has been difficult for him to come to terms with emotionally but it has also been disruptive for the group with the impending threat of losing M each time he goes before the Court. Although we have managed this well to date, this has obviously interrupted M's progress through treatment, in addition to affecting other group members emotionally.

This case study highlights that when there are several systems involved, the client can be considerably impacted, as too can the treatment process and progress of treatment, the clinicians and other group members.

### Summary and Recommendations

There is increasing recognition of the need to provide appropriate and evidence based treatments for sex offenders in the community. As outlined above however, there are several limitations in providing a high standard of treatment to this special needs and often difficult client group, including inadequate resources, interagency challenges, the ongoing difficulties of long waitlists and being unable to offer treatment to individuals who are motivated or require intervention in the short to medium term or those who are still going through Court processes. Furthermore, it is recommended that there is a strong need for policies to be reviewed to incorporate increased awareness of the meaning of "risk" in relation to sexual offenders. Increased awareness would enable clients' needs to be better met, thereby improving therapeutic change rather than meeting change with unnecessary resistance or obstacles to treatment efficacy. Encouraging a 'through-care' approach, with greater interagency openness and cooperation would serve to facilitate the treatment and management process, which, in our opinion, will serve to encourage more genuine engagement in the therapeutic process, ultimately hopefully also reducing recidivism in sexual offenders. Furthermore, it is recommended that governments need to be held responsible for providing a source of funding in order to subsidise treatment offered to sex offenders in the community. Many offenders cannot afford treatment and for the reasons outlined above, small private practices find it difficult to fund and manage the regular and intensive treatment required to best rehabilitate sex offenders and the resources only continue to be more and more limited within the difficult socio-political climate that impacts on this area of mental health treatment, the ramifications of which have substantial consequences for sections of the community.

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# **Whispering to Horses: Childhood Sexual Abuse, Depression and the Efficacy of Equine Facilitated Therapy**

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## **Abstract**

Experience of childhood sexual abuse (CSA) is both prevalent and under-reported in Australia as it is elsewhere in the world. The negative psychosocial and behavioural sequelae of such abuse may be severe and can often last for the lifetime of the individual if therapeutic intervention is not successful. Meta-analyses of treatment outcome evaluations suggest that Cognitive Behavioural Therapy based approaches tend to be the most successful in reducing psychological symptoms (such as PTSD, internalising and externalising disorders), however for some clients these approaches may not be appropriate or as efficacious due to variables such as cognitive maturity or ethnicity. The use of animals within therapy situations to help develop an effective therapeutic alliance is not new but methodologically strong evaluations of Animal Assisted Therapies (AAT) generally and Equine Facilitated Therapy (EFT) specifically are needed in order to provide a solid evidence base regarding for whom, and in what situations, these approaches are the most effective. The current study aimed to evaluate and compare the efficacy of an adjunct EFT program run by Phoenix House (a sexual assault referral centre in Queensland, Australia) for the reduction of depressive symptoms across three age cohorts of CSA victims (children, adolescents and adults). Participants included 15 children (aged 8-11 years), 15 adolescents (aged 12-17 years) and 14 adults (aged 19-50 years) with 10 of the 44 participants identifying as Indigenous Australians. A quasi-experimental, repeated measures design was used to evaluate changes in depressive symptoms with all participants responding on the Child Depression Index or Beck Depression Inventory (as appropriate) at three points in time. Comparisons of change scores between Time 1 (intake to service) and Time 2 (post in-clinic counselling) and Time 2 and Time 3 (post-EFT) indicated that regardless of age or ethnicity,

EFT proved to result in a greater decrement in depressive scores than that seen between Times 1 and 2. Implications of this and directions for future research are discussed

Child sexual abuse (CSA) is a serious social problem with statistics revealing that in Australian communities, it is at epidemic proportions. According to the Personal Safety Survey conducted by the Australian Bureau of Statistics (2005), it was found that 12% (956,600) of women and 4.5% (337,400) of men reported that they were sexually abused prior to age 15. In other words, a total of over 1.2 million Australian individuals reported suffering sexual abuse before the age of 15 in 2005. However, official Australian Institute of Health and Welfare (AIHW; 2012) child protection data reveals that only a small proportion of cases of CSA are formally substantiated through investigation (a total of 5,437 in 2010-2011). This considerable discrepancy between self-report and formal investigative data reveals, amongst other issues, the large levels of underreporting of CSA to authorities. It also suggests that AIHW data is not reflective of the actual number of incidents of CSA within Australian communities (Richards, 2011), and that the actual prevalence of CSA remains undetermined (Olafson, 2011).

As pointed out by Putnam (2003), sexual abuse in childhood is a complex life experience, not a diagnosis or mental health disorder. CSA can be defined as any sexual contact by an adult or significantly older person upon a child, for the purpose of sexual gratification on the part of the perpetrator (Hornor, 2010) and has been linked to psychiatric conditions, such as substance abuse, post-traumatic stress disorder (PTSD), obesity,

and borderline personality disorder (BPD) (Plotzker, Metzger, & Holmes, 2007; Putnam, 2003; Rohde et al., 2008; Zlotnick, Mattia, & Zimmerman, 2001). The relationship between CSA and depression is especially strong (Olafson, 2011) with numerous studies linking CSA to major depression from childhood and continuing through into adulthood.

In a longitudinal study by Fergusson and colleagues (1996, as cited in Putnam, 2003), a cohort of New Zealand children was studied at yearly intervals from birth to 16 years. Children with experience of non-contact, or contact non-intercourse, sexual abuse had an increased odds ratio (OR) of 4.6 for major depression compared to non-abused children. An increased OR of 8.1 for major depression and 11.8 for attempted suicide was reported for those children with experience of sexual abuse involving intercourse.

CSA appears to correlate with depression particularly strongly among females. In a study involving 279 female adolescents (40 reporting a history of sexual abuse), it was found that compared to those with low depression scores, females who scored highly on depression were more likely to also report a history of CSA. In addition, sexual abuse was the most powerful factor in predicting depression in this cohort, explaining 7.8% of the variance (Buzi, Weinman, & Smith, 2007). There is a similar pattern for adult women. Kendler, Kuhn and Prescott (2004) explored the effects of CSA and stress sensitivity in women. Results showed that women who had experienced sexual abuse were significantly more susceptible to the depressogenic effects of life stressors compared to those without a history of CSA, and that women who were exposed to more severe forms of abuse, showed the greatest increase in stress sensitivity.

Unsurprisingly, the depressogenic impact of CSA can often lead to problem behaviour in terms of coping mechanisms. Lee, Lyvers and Edwards (2008) examined the relationship between CSA, substance abuse, substance abuse relapse, depression and coping style. Results showed that compared to substance abusers without a history of CSA, those who had experienced sexual abuse in childhood were more severely depressed, utilised coping styles that were less optimistic and reported a greater likelihood of using drugs to mitigate negative emotional states. It was also found that individuals who reported being exposed to CSA at a younger age displayed more significant levels of depression as compared to those who reported experiencing CSA at an older age.

Results of these studies highlight the fact that having a history of CSA is a critical risk factor for the development of depression both during childhood and beyond. As major depression is seen as one of the leading social health problems, with high levels of occurrence and demonstrated links with morbidity and

mortality (Putnam, 2003), it is essential that individuals with a history of CSA who are showing depressive symptoms, receive effective treatment.

Currently, the psychological treatment of choice with the strongest evidence base for childhood trauma (e.g. CSA) is Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) for children (Olafson, 2011) and Cognitive Behavioural Therapy (CBT) for both children and adults (Putnam, 2003). TF-CBT utilises psychoeducation about CSA for both the care-giving (non-abusive) parent and the child, along with strategies to reduce and cope with stress, encouragement of affect expression/modulation and expression of trauma narratives through poetry, language or art work (Olafson, 2011). However, due to feelings of betrayal associated with the experience of CSA, many children tend not to trust relationships with adults in general (Parish-Plass, 2008). Research shows that it is generally individuals known and trusted to the child who perpetrate the abuse, such as family members, relatives or neighbours (Lee, et al., 2008) and as a result, abuse perpetrated in these relationships engenders a high level of distrust of adults, which may make it difficult to establish an effective therapeutic relationship. Therapies such as CBT, which are traditionally based around discussion between the client and therapist, therefore may not prove effective (Parish-Plass, 2008), particularly in the early stages of therapy.

Cultural differences between therapist and client are also an important consideration as ethnicity may impact the severity and type of symptoms shown following CSA (Cohen, Deblinger, Mannarino, & de Arellano, 2001). However, at present there is a dearth of information available on the effects of cultural differences in the therapeutic relationship, and whether these differences affect the efficacy of therapeutic interventions (Lalor & McElvaney, 2010). In regards to Indigenous Australians, it is noted that clinicians often have difficulty engaging with Aboriginal people in a way that makes sense due to a lack of cultural knowledge, social norms, local customs and language (Westerman, 2010). Gender differences may also impact the therapeutic relationship for Indigenous Australians, as intimate discussion with those of the opposite gender is often viewed as inappropriate. Such incompatibility between therapist and client is likely to lead to ineffective engagement and assessment of the client (Westerman, 2010).

Such problems in connecting with, and engaging traumatised children in traditional talk-therapy, led early clinicians to attempt the first serious use of animals as therapy tools in the 1960s (Parish-Plass, 2008). What is now known as Animal Assisted Therapy (AAT), can be defined as the purposeful addition of an animal as part of a therapeutic treatment plan (Nimer & Lundahl, 2007). AAT has been shown to lead to

positive outcomes for CSA survivors. For example, in a study of 157 children with substantiated CSA histories, children participated in one of three types of therapy (1) talk-therapy with no dogs; (2) dogs present for interaction only prior to therapy; and (3) inclusion of a story about each dog prior to therapy. Results showed that children in groups 2 and 3 recorded significant reductions in CSA symptoms such as depression, anxiety, anger, PTSD, sexual concerns and dissociation (Dietz, Davis & Pennings, 2012).

For children who have been traumatised by sexual abuse, it is essential that they feel safe and accepted (Dietz et al., 2012), and therapy animals can meet these needs. Animals, such as dogs and horses, offer unconditional acceptance, which can in turn, assist children to overcome their insecurities and fears (Parish-Plass, 2008), ease tension and anxieties (Reichert, 1994) and mitigate extreme behavioural issues. Interactions between child and animal allow the child the opportunity to feel in control of the animal and the situation, an experience which the child may never have felt in their family home (Parish-Plass, 2008).

Equine Facilitated Therapy (EFT) includes activities such as grooming, handling, and riding horses (Meinersmann, Bradberry, & Bright Robers, 2008), and is suggested to be of benefit to individuals of all ages (Nimer & Lundahl, 2007) and may be particularly useful with clients of an Indigenous background (e.g., Kemp, Signal, Botros, Taylor & Prentice, 2013). Horses are prey animals and as such, are extremely sensitive to changes in those around them through areas such as body language, breathing and vocalisations. If the client working with the horse is incongruent in their thoughts, feelings and behaviours, the horse will feel this and will see the client as potentially dangerous (Porter-Wenzlaff, 2007). It is not until the client is modelling calm, confident and leading qualities, that the horse will respond effectively (Burgon, 2011). One important goal of EFT is to get clients to recognise and understand the emotions they are experiencing and to focus on these, rather than trying to escape from them (Porter-Wenzlaff, 2007).

Having a large and powerful horse respond to commands in a calm and favourable manner can provide abuse victims with a sense of authority and validation (Trotter, Chandler, Goodwin-Bond, & Casey, 2008). Such feelings of control have been found to empower clients, increase problem-solving and conflict resolution abilities (Trotter, et al., 2008), as well as increase self-esteem, self-confidence, and create a more positive self-image (Parish-Plass, 2008). Outcomes regarding common psychological post-abuse symptoms, such as depression, are less well quantified, although some anecdotal and/or qualitative evidence is available. For example, in a qualitative assessment of an EFT intervention, seven young people between the ages of

11-21 interacted with horses over a two year period. Key themes that emerged from this study demonstrated that the EFT was effective in building confidence and self-esteem, a sense of mastery of the situation and empathy toward the horse (Burgon, 2011). In another study, Equine-Assisted Psychotherapy (EAP) was used with 63 children who had been witness to family violence situations and had been diagnosed with disorders such as ADHD, mood disturbances (including depression), PTSD and adjustment disorder. This study tested the efficacy of EAP over approximately 19 sessions and reported that all 63 showed significant improvement in their Global Assessment of Functioning (GAF) scores from pre- to post intervention (Shultz, Remick-Barlow & Robbins, 2006).

While these studies reveal that EFT shows promising psychosocial benefits when utilised as a post-abuse therapeutic tool (particularly with children), further research is needed in order to facilitate evidence-based practice. A common criticism of AAT and EFT is that evaluations of these approaches are often not sufficiently rigorous (e.g., lacking control groups, Marino, 2012) to provide reliable evidence of efficacy. As mentioned in Kemp et al., (2013), maintaining methodological rigour while also meeting the needs of a vulnerable group is attainable but using 'traditional' control vs. experimental group designs is often not ethically appropriate. Similar to Tsai, Friedman and Thomas (2010), Kemp et al. (2013), outline the use of a quasi-experimental, repeated measures design where psychometric tools are administered at three times for each individual (e.g., Intake into Service, Pre-Intervention and Post-Intervention) and changes between Time 1 and Time 2 are compared to those between Time 2 and Time 3 to account for extraneous variables (e.g., maturation, time since abuse cessation) that might otherwise mask the true efficacy of the EFT. Treatment effect sizes are calculated by comparing Time 2 and Time 3 mean scores divided by the standard deviation of the Time 3 scores for the whole cohort (Cooper, Hedges & Valentine, 2009). The current paper follows this approach and presents an extension of Kemp et al. (2013) using the same EFT design. That is, while we (Kemp et al., 2013) have previously reported on the efficacy of this EFT in regards to trauma and anxiety symptoms, the current paper presents an assessment of the efficacy of EFT as a treatment for depressive symptomology and compares this efficacy across three broad age bands (children, adolescent and adult). These three age cohorts, with Indigenous and non-Indigenous participants, were assessed in order to broaden existing concentrations in the literature, which predominantly assess EFT's with children.

It is hypothesised that, compared to data recorded at

Time 1 and 2, depressive symptoms recorded at Time 3 (post-EFT) will be significantly lower across all three age groups. As reported in Kemp et al (2013) for children and adolescents, it is expected that EFT will be equally effective with the Indigenous and non-Indigenous adult participants across all three age cohorts. It is also anticipated that the child and adolescent cohorts will show greater change from Time 2 to Time 3 (i.e., effect of EFT) than the adult cohort for whom 'traditional' therapy should have a greater effect (i.e., as seen in decrements in depression scores from Time 1 to Time 2).

## **Method**

### **Participants**

The participants were 15 children, 15 adolescents and 14 adult women who were referred to Phoenix House for treatment for sexual abuse; some were also victims of neglect and/or physical abuse. The 'child' group consisted of 9 females and 6 males aged eight to 11 years ( $M = 9.8$  years,  $SD = 1.3$ ), three identified as Indigenous (i.e., Aboriginal and/or Torres Strait Islander) and 9 were non-Indigenous. The 15 adolescents were all females, aged between 12 and 17 years ( $M = 15.5$  years,  $SD = 0.8$ ). Five adolescents identified as Indigenous and ten as non-Indigenous. Of the 14 adult women (aged 19 to 50 years,  $M = 37.0$  years,  $SD = 8.9$ ), two identified as Indigenous and 12 as non-Indigenous. All participants took part in an EFT program with Phoenix House between March 2010 and September 2011. Specific details of abuse were not available to the researchers. All participants agreed to take part in the EFT program as well as the research and the current guardians of the participants also signed consent forms where relevant. Ethical approval to evaluate the archival data gathered during the EFT program was granted by Central Queensland University.

### **Procedure**

All participants were assessed at three points in time: upon intake and prior to in-clinic counselling (Time 1), prior to commencing EFT but after in-clinic counselling (Time 2) and upon completion of EFT (Time 3). After the first assessment, the participants were engaged with in-clinic individual counselling once a week for the average of 6.6 weeks ( $SD$  10 days) for the 'child' group and 6.4 weeks ( $SD$  15.7 days) for the 'adolescent' group. The 'adult' group was much more variable in the time between T1 and T2 ranging from as little as two weeks through to more than 12 months.

If the participant and/or guardian agreed to take part in an EFT group program, the participants attended for 90 minutes once per week for 9–10 weeks. The 'Trails of Discovery' EFT program utilised in the current study

is based on the Equine Assisted Growth and Learning (EAGALA, 2012) model and experiential learning with the help of horses. The therapeutic team consists of two counsellors and four horses. All activities are ground based and incorporate learning basic horsemanship skills, such as backing up a horse, asking a horse yield their hind or front quarters, desensitizing a horse, asking a horse to circle around a person, jump over obstacles either on a loose rope or at liberty. Other activities are designed to create a metaphor between what occurs in the arena and the participant's every-day life and again are performed at liberty. What emerges during these activities are patterns of thinking, reactions/responses to different situations and outcomes, and reactions to dynamics within the family group or within the group of participants. Each exercise is designed to address issues such as: trust, communication, boundaries, observation, body language, attitude and self-perception and all activities are dynamic, not static, to accommodate the needs of each group of participants, be it their age, developmental stage, disability, current mental health status or their cultural background. Further details of EFT activities are available from the corresponding author.

### **Measures**

Different depression measures were used for the children compared to adolescent and adult participants in order to ensure the use of appropriate psychological tools. For the 'child' cohort, the Children's Depression Inventory was utilised, while the Beck Depression Inventory was used for the adolescent and adult cohorts. Archival data with code names only were supplied to the researchers to protect the identities of the participants and their families.

#### **Children's Depression Inventory (CDI)**

The CDI (Kovacs, 2003) was created from the Beck Depression Inventory with 21 items adjusted semantically for age appropriateness and another five items added to account for school and peer functioning. Total scores range from 0 to 54 with higher scores denoting increased depressive symptomatology. A longitudinal study by Cole and Martin (2005) found that the child self-report scale (used in the current study) measured state depressive symptoms. Test-retest reliability coefficients fall in the mid .70 s for retest intervals up to 4 weeks. According to Kovacs (2003), children recording a CDI of 13 or greater (when presenting within a clinical sample) are considered to be showing significant depressive symptomatology.

#### **Beck Depression Inventory (BDI)**

The BDI measures levels of depression in adults and

adolescents. All 21 items are measured on a 4 point Likert scale and higher scores represent more severe levels of depression (Carlson, 2012). The BDI has been found to have sound predictive validity and good two week test retest reliability ( $r = .72$ ; Beck et al. 1996). While scores on the CDI cannot, in and of themselves, be used for a clinical diagnosis, the following cut off scores are commonly used to indicate the severity of depressive symptoms; 0-9 minimal ('normal'), 10-18 mild, 19-29 moderate and 30-63 severe depression (Beck, Steer & Garbin, 1988).

## Results

### Data Analysis for Child Participants

A multivariate analysis of variance did not reveal any significant difference between gender and ethnicity within this group. A repeated-measures analysis of variance (ANOVA) was used to assess change scores between Time 1, Time 2 and Time 3, and to test the hypothesis that the EFT program was effective in decreasing depressive symptomatology in participants. The assumption of sphericity was violated, so the degrees of freedom were corrected using the Greenhouse-Geisser estimate. Results showed a significant main effect ( $F(1.13, 15.86) = 36.155$ ,  $p = .001$ , effect size = .721), revealing that depressive symptoms were significantly affected by treatment. Follow-up tests of within subject contrasts indicated that there was no significant change in reported symptoms of depression between data collected at Time 1 ( $M = 15.73$ ,  $SD = 6.72$ ) and Time 2 ( $M = 15.6$ ,  $SD = 8.1$ ), ( $F(1, 14) = .051$ , ns), whilst, CDI scores from Time 3 ( $M = 4.33$ ,  $SD = 3.37$ ) were significantly lower than those at Time 2, ( $F(1,14) = 33.5$ ,  $p = .001$ , effect size = 0.705), indicating a significant decrement in reported depressive symptoms. Worthy of particular note is the observation that the average score on the CDU for the children within this cohort scored is above the cut off for 'clinical' depression (i.e., CDI scores at or above 13) at Times 1 and 2 but falls well below this at Time 3 following the EFT program.

### Data Analysis for Adolescent Participants

To test the hypothesis that the EFT program was effective in treating adolescent participants for depression, a repeated-measures ANOVA of Time 1, Time 2 and Time 3 assessments was utilised. Results revealed that treatment had a significant overall main effect ( $F(2, 28) = 33.042$ ,  $p < .001$ , effect size = .736); however, no main effects were found for age or ethnicity. Importantly, tests of within subject contrasts showed that between Time 1 ( $M = 28.60$ ,  $SD = 11.24$ ) and Time 2 ( $M = 27.87$ ,  $SD = 10.75$ ) while there was a slight improvement in scores, there was no significant change in reported symptoms of depression ( $F(1, 14) =$

.185,  $p = .673$ , ns). In contrast, BDI scores from Time 3 ( $M = 13.07$ ,  $SD = 11.89$ ) were significantly lower than those at Time 2 ( $F(1,14) = 50.86$ ,  $p < .001$ , effect size = 0.886) indicating a significant improvement in reported depressive symptoms. Again worthy of comment is the fall from an average rating of 'moderate' depression at both Time 1 and Time 2 to 'mild' depression at Time 3 (ratings as per Beck et al., 1988)

### Data Analysis for Adult Participants

Similar to the analysis of both the child and adolescent cohorts, a repeated-measures ANOVA of the three temporal BDI measures was utilised for the adult group. The assumption of sphericity was violated, so the degrees of freedom were adjusted using the Greenhouse-Geisser test. Results showed a significant overall main effect of treatment ( $F(1.23, 15.97) = 77.763$ ,  $p < .001$ , effect size = 0.911). No significant differences by ethnicity or age were observed. Tests of within subject contrasts showed that there was significant change in reported symptoms of depression between data collected at Time 1 ( $M = 29.08$ ,  $SD = 10.02$ ) and Time 2 ( $F(1, 13) = 6.00$ ,  $p = .029$ , effect size = 0.562), as well as Time 2 and Time 3 ( $F(1,13) = 77.78$ ,  $p < .001$ , effect size = 0.926). However, mean BDI scores from Time 3 ( $M = 8.83$ ,  $SD = 6.54$ ) were a great deal lower than those at Time 2 ( $M = 27.07$ ,  $SD = 9.79$ ), indicating that EFT resulted in a larger reduction of reported depressive symptoms as compared to in-clinic counselling. Although not significant, a consistent trend was noted whereby the older the women in the 'adult' group, the larger the change in scores from Time 2 to Time 3. Average ratings of BDI scores shifted from 'moderate' at Time 1 and Time 2 to 'minimal' at Time 3 (ratings as per Beck et al., 1988).

### Comparing Efficacy Across Groups and Ethnicity

Presented in Table 1, for ease of comparison, are the mean values for the age-appropriate depression measures recorded at Times 1, 2 and 3 separated by ethnicity, caution does need to be taken with these due to the limited number of Indigenous participants in each cohort. Also presented are the effect sizes for the change in mean values from Time 1 to Time 2 and Time 2 to Time 3. Effect sizes for the change in symptomology from Time 1 to Time 2 were consistently lower than those seen for Time 2 to Time 3 for Indigenous and non-Indigenous participants across all three age groups. For non-Indigenous children and Indigenous adolescent's scores on the relevant depression measures showed a slight increase from Time 1 to Time 2. All effect sizes following EFT meet the criteria for large effect, including the smallest (0.68), which was observed for adult Indigenous women. Consistently, non-Indigenous participants

Table 1

*Indigenous and Non-Indigenous Child, Adolescent and Adult Data Showing the Differences Between Mean CDI/BDI Scores from Time 1, Time 2 and Time 3.*

Cohort		Time 1	Time 2	T1-T2 Effect	Time 3	T2-T3 Effect
		<i>M (SD)</i>	<i>M (SD)</i>		<i>M (SD)</i>	
Children	Indigenous	14.33 (0.67)	13.00 (1.00)	0.62	6.00 (1.73)	0.93
	Non-indigenous	16.08 (2.17)	16.25 (2.60)	-0.04	3.92 (1.00)	0.95
Adolescent	Indigenous	23.40 (6.10)	24.00 (5.79)	-0.05	10.00 (4.16)	0.81
	Non-indigenous	31.20 (3.02)	29.80 (3.05)	0.22	14.60 (4.17)	0.90
Adult	Indigenous	19.50 (12.51)	18.52 (11.55)	0.04	3.54 (0.51)	0.68
	Non-indigenous	30.68 (2.43)	28.50 (2.48)	0.41	9.72 (1.93)	0.97

scored more highly on the CDI/BDI at Times 1 and 2 (with adult, non-Indigenous, women meeting the cut off for severe depression), and more highly (i.e., greater depressive symptomology) at Time 3 with the exception of those within the child cohort.

### Discussion

The current paper had two main aims. Firstly to assess the efficacy of EFT as an adjunct therapy for depressive symptoms presenting in survivors of CSA, and secondly, to compare the relative efficacy of this approach across differing age groups, namely children, adolescents and adults. As hypothesised, when change scores between Time 1 and Time 2 (pre-EFT) were compared to those between Time 2 and Time 3 (post-EFT), EFT proved to result in significant and marked (i.e., large effect size) decrements in CDI (children) and BDI (adolescent/adult) scores. From a clinical perspective, these decrements resulted in changes from potentially impairing depressive symptomology (i.e., warranting professional intervention with attendant elevated risks for self-harm/suicide) to 'normal' or minimal scores.

Extant literature regarding treatment effects for internalising symptoms (such as depression) following CSA suggests that the current treatment effect sizes are much larger than seen following TF-CBT, at least for children and adolescents (e.g., Trask, Walsh & DiLillo, 2011). The literature regarding the efficacy of treatments for adult survivors of CSA is comparatively sparse. As Trask et al. (2011), point out in their meta-analysis of treatment effects for common sequelae of CSA, it is important to compare the results of quasi-experimental approaches, as used here, with the outcomes of similar designs, as within-subject designs can lead to elevated effect sizes compared to

randomised control trial type studies. In keeping with this, the current large effect sizes compare very favourably with the average 0.5 or medium effect size calculated by Trask et al. (2011) for internalising symptoms (including depression) within the within-subject reports included in the meta-analysis. Interestingly, Trask et al conclude that greater effects (from standard CBT style therapy) were seen with older children/adolescents potentially due to the heavy reliance on cognitive components that require a certain level of intellectual maturity. In contrast, participants within the child cohort in the current study evidenced the greatest average effect size following EFT, suggesting that this approach may be particularly effective in reaching younger clients. This further supports the argument that non-traditional approaches like EFT (and AAT more generally) work well with certain populations (such as young children) precisely because they do not have a linguistic and/or cognitive component in a traditional sense (e.g., Lidgerwood & Gillingham, 2012).

Similar to Kemp et al. (2013), and as reported in Trask et al.'s (2011), meta-analysis, there proved to be no systematic difference in CDI/BDI scores following EFT by participant ethnicity; that is EFT was equally effective for all. As mentioned previously there is a noticeable lack in the literature regarding the efficacy of standard CBT treatments for non-European clients (e.g., Lalor & McElvaney, 2010) with some researchers suggesting that CBT type approaches may not be appropriate for, or as effective with, Indigenous Australians (e.g., Westerman, 2010) for a number of culture-specific reasons. Although the current findings need to be treated with caution due to relatively the small number of participants identifying as Indigenous (three children, five adolescents and two adults), the

fact that significant decreases in CDI/BDI scores and large effect sizes were seen (with the exception of the adult women for the latter) is encouraging. This finding in particular warrants further investigation and replication. Follow-up measures several months after EFT would allow for further analysis regarding the efficacy of EFT as an effective approach for treating depressive symptoms resulting from CSA regardless of ethnicity. In the current study, across all three age groups, non-Indigenous participants scored more highly on the CDI/BDI scales than those identifying as Indigenous, although the large standard deviation recorded for adult Indigenous participants does suggest a larger sample size is needed before definitive conclusions can be drawn. Non-indigenous participants also showed larger relative decrements and larger effect sizes following EFT (Time 2 - Time 3). With some researchers suggesting that ethnicity may influence the severity and/or symptomology shown subsequent to CSA (e.g., Cohen et al., 2001), this finding suggests that a broader examination of potential sequelae (i.e., beyond depression) following CSA may be important when considering the efficacy of EFT for Indigenous clients. Trask et al., (2011) also highlight the need to extend CSA treatment outcome evaluations to considerations of affective, behavioural, cognitive and interpersonal functioning including beyond the commonly assessed PTSD and externalising/internalising outcomes. Further evaluations specifically addressing the outcomes of therapeutic interventions for adult survivors of CSA are also urgently needed given both the prevalence of CSA in the wider population and the under-reporting thereof.

While the results of the current investigation are promising, several limitations need to be noted, particularly the relatively small numbers of Indigenous participants and the lack of other ethnicities in the sample. In order to truly evaluate the cross-cultural efficacy of EFT approaches, there is a need to broaden investigations and include a greater variety of cultural backgrounds. For example, for some cultures the horse may prove more of an obstacle to therapy than others and this needs to be considered when planning any animal based interventions. Similarly, the appropriateness of using particular animals with specific groups needs to also be considered to ensure the welfare of the animals used (Evans & Gray, 2012). Greater inclusion of male CSA survivors would also be beneficial as would extending the investigation to measures of broader sequelae, such as those suggested by Trask et al., (2011) and potentially human-directed empathy – deficits in which may be an additional side effect of CSA (and related experience of family violence) and area that AAT is purported to be particularly effective in addressing (e.g., Geist, 2011). Although not possible with the current data due to the

archival nature of the investigation, follow-up assessment several months following completion of EFT would be useful as there is, to the knowledge of the authors, no existing EFT study looking at long-term effects and only limited CSA-specific (non-AAT) evidence of long term efficacy for standard CBT type therapy (Trask et al., 2011).

Future studies would also benefit from the inclusion of measures to assess animal wellbeing. Animal assisted therapies and interventions have considerable advantages but should not be considered without a full assessment of the appropriateness of the species used and consideration of how their own welfare will be monitored and assured throughout the therapies. There is a risk, given the success of AAT's, that they become over-utilised and driven solely by human concerns, which is problematic not only in terms of animal welfare but also in terms of modelling appropriate attitudes towards sentient creatures which, itself, has been shown to impact on the ways human treat each other (Evans & Gray, 2012).

In summary, the current outcome evaluation outlines the efficacy of an EFT approach in ameliorating depressive symptomology (as indicated by CDI/BDI scores) across three age groups and two ethnicities. Treatment effect sizes are large and not dependent on age, gender or ethnicity, and compare favourably with those reported in the literature. EFT is a promising approach that warrants further research attention to delineate exactly for whom and in what way it can be the most effective.

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## **Psychological and Behavioural Characteristics of Females who Sexually Offend: Insights from Psychotherapeutic Work in New Zealand**

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### **Abstract**

Increasingly there is acknowledgement in our society that sexual abuse is perpetrated by females as well as male offenders. This paper describes a number of case studies of female sexual offenders and discusses their psychological and behavioural characteristics within the context of existing theory. This paper explores the common characteristics that female sexual offenders may present with, and the psychotherapeutic dynamics and challenges of working with this population. The information in this report was collected through work with female sexual offenders in New Zealand, over a period of 20 years.

### **Case Study Confidentiality**

The current paper was not intended to be a research project but is instead based on case studies from clinical practice. No identifying details are included and pseudonyms have been used throughout. The cases are amalgams of past cases that do not mirror any one particular client.

### **Introduction**

With increased awareness, society has to some degree acknowledged that men can be sexually abusive. However, that females can also perpetrate such behaviours remains largely overlooked, and indications of female perpetrated sexual abuse are often ignored until the point of legal intervention. Sexual offending by men against children and/or adults can be difficult for many professionals to comprehend, but the idea that females may also sexually offend is, for many unfathomable. Women, of course, have always been capable of violent offences, including sexual offences, with victimisation, alcohol issues and mental illness often being significant contributing factors to their offending (Gannon & Cortoni, 2010). However, our Western society finds this difficult to accept for it confounds the norms of women as being nurturing, loving and caring. Females who sexually offend are only recently emerging in crime statistics but remain largely invisible, under-reported and untreated (Becker, Hall, & Stinson, 2001; Gannon & Cortoni, 2010).

Given the paucity of research regarding female sexual offenders, clinicians not specialised in this field may fail to pursue this possibility that females can offend or to ask challenging questions even when a client gives indications as to their offending during therapy. In addition, work with female sexual offenders in New Zealand has been greatly influenced by the attachment theory of John Bowlby (1969; 1999) and trauma theorists such as Judith Herman (1997), John Briere (1992), Babette Rothschild (2003). Attachment theory proposes that people's relationship styles are influenced by the emotional relationships they have with their primary caregivers when they are infants. If subjected to trauma during childhood, the developing brain could be damaged by neglect and trauma (Perry, 2002; Schore, 2001; Siegel, 1999). As adults, the victims can become hypervigilant, have intrusive memories and difficulty in trusting others as a result of experiencing emotional, physical and sexual trauma.

In the early 1990s, very little literature existed concerning female sexual offenders, there were no normed psychological tests for this population and the small numbers of women who were being referred for treatment, had usually committed more severe offending. Often they were incarcerated in prison and/or youth offending facilities and the treatment usually mirrored that used for males. In recent years this has changed significantly and considerably more research is being conducted on the prevalence and offending behaviour of female sexual offenders (e.g., Cortoni & Hanson, 2005; Fazel, Sjostedt, Grann & Langstrom, 2010; Wijkman, Bijleveld, & Hendriks, 2010). However, such studies continue to primarily involve women who are charged and awaiting sentencing, along with those who are incarcerated, as opposed to those still living in the community.

The purpose of this article is to provide some theoretical background of the psychological and behavioural characteristics of this population and to present several case reports involving child, adolescent and adult female sexual offenders.

### **Collection of Case Study Data**

The client data discussed in this paper is provided by one of the authors (Robson) and was collected over many years through her work providing therapy at the SAFE Network<sup>1</sup> and also in her private practice. Female clients with offending histories were rarely initially referred because of their sexual offending. With the intention of better understanding the reasons that women became sexually abusive, Dr. Robson collected relevant data over 20 years during her work with female sexual offenders, to see if any patterns emerged. The background data collected included offending behaviour, victimisation histories and family background. All clients seen by Dr Robson were included in this study and the material presented on clients in this paper is an amalgam of different cases.

### **Theoretical Background**

The theoretical foundations informing work with female sexual offenders are drawn from attachment theory (Bowlby, 1969; Friedrich, 1995), trauma theory (Briere & Scott, 2006) and dialectical behaviour therapy (Linehan, 1993). These theoretical models have informed the author's psychotherapeutic work with clients, assisting them to develop skills to deal more effectively with emotional dysregulation and stress intolerance, and to improve interpersonal relationships.

### **Attachment Theory**

According to Bowlby's attachment theory (1969, 1973, 1980), infants are biologically predisposed to form attachments with caregivers around 6-12 months of age. The function of this attachment system is to increase the infants' likelihood of surviving, allowing the infant to use the caregiver as a secure base from which to explore and learn from the environment thus ensuring physical and psychological security (Bowlby 1969). Based on a strange situation procedure conducted in the laboratory, which involved separating and reuniting infants with their mothers, Ainsworth, Blehar, Waters and Wall (1978) identified three styles of infant attachment: secure attachment and two types of insecure attachment, namely avoidant and anxious/ambivalent. More recently, researchers have proposed new attachment patterns such as disorganised attachment (Green, & Goldwyn, 2002) which is theorized to be the result of a pervasive paradox where the caregiver is the only source of comfort for the infant but also frightens the infant at the same time (van

Ijzendoorn, Schuengel, & Bakermans-Kranenburg, 1999).

According to attachment theorists, caregivers play a pivotal role in shaping an infant's attachment style (Ainsworth et al., 1978; Belsky, Rovine, & Taylor, 1984; Egeland & Farber, 1984), and that child abuse can produce insecure attachment styles (Crittenden & Ainsworth, 1989). Longitudinal research has found that infants who received high quality care were significantly more likely to present as securely attached compared to maltreated infants who were significantly more likely to be insecurely attached compared to non-maltreated infants (Cicchetti & Barnett, 1991; Schneider-Rosen, Braunwald). Additionally, research suggests that attached maltreated infants tended to shift into the insecure groups over time, suggesting that maltreatment increases the likelihood of insecure attachment (Cicchetti & Barnett, 1991; Schneider-Rosen et al., 1985).

Meta-analyses and review studies also support the higher prevalence of insecure attachment among maltreated infants (Baer & Martinez; 2006; Morton & Browne, 1998). Baer and Martinez (2006) found that there was an 80% greater likelihood of an individual in the maltreated group exhibiting an insecure attachment style compared with a 36% in the comparison control group (Baer & Martinez, 2006).

As with insecure attachment, disorganised attachment has been found to be significantly more prevalent among abused than non-abused samples (Barnett, Ganiban, & Cicchetti, 1999; Carlson, Cicchetti, Barnett, & Braunwald, 1989; Van Ijzendoorn et al., 1999). Barnett and colleagues (1999) found that only maltreatment contributed unique variance to the prediction of attachment security or disorganised attachment among the sample of children. Additionally, Van Ijzendoorn et al. (1999) found that maltreated subjects were three times more likely to be disorganised compared to comparison subjects, with effect sizes ranging from .03-.60.

Childhood maltreatment appears to have implications for attachment into adulthood. Kwako, Noll, Putnam and Trickett (2010) examined the link between childhood sexual abuse and attachment among a sample of mothers and found that those with a history of childhood sexual abuse were significantly more likely to be insecurely attached compared to controls, making no distinction between avoidant and anxious attachment. Furthermore, Limke, Showers and Zeigler-Hill (2010) found that emotionally maltreated and sexually maltreated tertiary students were both more avoidant and anxious compared to their non-maltreated comparisons.

The evidence that maltreated children are more likely to be insecurely attached and disorganised compared to non-maltreated children has important

<sup>1</sup> SAFE Network based in Auckland is New Zealand's largest community treatment programme. SAFE provides treatment for adult and adolescent males and females. It also has a programme for children who display sexualised behaviour.

implications for clinicians, as attachment is fundamental to individual functioning across the life-span (Finzi, Cohen, Sapir, & Weizman, 2000) and insecure and disorganised attachment is associated with a range of poor psychosocial outcomes later on in life (Carlson, 1998; Limke et al., 2010). Research indicates that changes in patterns of care during infancy and early childhood can lead to changes in attachment patterns (Schneider-Rosen et al., 1985), highlighting the importance of identifying abuse and intervening early to improve outcomes for children.

The importance of the client – therapist relationship in providing a place of healing cannot be underestimated. It is important in all therapy to ensure that clients feel safe and secure in both the therapy room and their living situation, and that they experience the therapeutic relationship as both positive and consistent.

Finally, while there may be commonalities in the clinical features that clients have presented with, it is essential that therapy is individualised and specifically targeted to the needs of each client. Psychotherapy for the clients discussed in this paper was tailored to develop the individual self capacity required by each client. As with any good therapeutic work, ‘one size does not fit all’.

### **Females Who Engage in Sexual Offending Behaviours**

Almost all of the women and girls who were seen came from dysfunctional and chaotic families with little consistent care and nurturing having taken place. These females reported childhood experiences of severe physical and sexual abuse in the home, often with several changes of accommodation and care, where exposure to alcohol, drugs and violence were normative. Furthermore, exposure to pornography and adult sexual activity were often reported as part of their experience and in turn influenced their behaviour.

These females reported no experience of caring relationships and role modelling of what are appropriate relationships to help learn healthy emotional self-regulation. Additionally, because of their experiences of neglect and trauma they had diminished opportunities to learn empathy. Their own abusers had told them they were ‘bad’, had been sexually seductive, and had asked to be sexually abused and that the sexual abuse they endured was their fault. Such powerful messages had changed their core beliefs about themselves and, in turn, the way they perceived others. The abuse experience also altered their sense of self as they had internalised a belief system that they were ‘bad’.

### **Psychological and Behavioral Characteristics of Children and Adolescent Offenders**

The children who were all referred by the New Zealand Child Welfare Service (Child Youth and Family), were not just sexualised or engaging in mutual sexual exploration but were all, according to Cavanagh-Johnson’s model of Sexualised Children, children who molest (Gil & Johnson, 1993). The youngest was a six year old European, while the oldest adolescent was 16 years old and of Maori ethnicity. All these clients had been extensively physically and sexually abused and came from highly dysfunctional and chaotic families with little consistent care and nurturing having taken place.

Their offending behaviour of this group was not isolated to sexually harmful behaviours and often included other behaviours such as cruelty and deliberate violence to animals, stealing and physical aggression towards others. Their aggressive sexual behaviour was typically targeted towards those younger than themselves. They had a poor sense of boundaries, often grabbing at adult breasts or behaving in a provocative manner around adult males, exhibited sexual behaviours characterised by impulsivity, and showed no empathy for others. It is of notable mention that all clients disclosed during counselling that they had tried to tell an adult caregiver about their own abuse, but that they were not heard or believed and consequently no steps were taken to stop the abuse and to keep them safe. Had they been supported by an adult and their abuse stopped it is possible that they may not have gone onto offend.

### **Case Study of Susan**

‘Susan’ was referred when she was eight years old. She had sexually abused a baby of her caregiver by sticking her finger and toys in the baby’s vagina. She also grabbed the breasts of the Social Worker when she was uplifting her to take her to another placement. She was diagnosed by the Psychiatrist as having Reactive Attachment Disorder. She was enuretic and consistently smeared her faeces over toilet walls. She was observed to steal, lie and exhibit no empathic response nor any ability to relate to others. One of the most difficult challenges faced in therapy with Susan was being unable to find a stable permanent living placement for her. Her placements were often only short-term as her behaviours were so extreme that caregivers found them too difficult to manage. She was extensively sexually abused by several of her mother’s partners and this was disclosed on an evidential video interview but then she later retracted this because she was told by her mother “she wasn’t supposed to tell”. Susan was sexually abused again on a school camp when she was 9 years old. She also sexually abused another younger girl in a foster home and was involved in forcible digital penetration and simulating sexual intercourse with the victim. Her offending appeared to be impulsive in

nature which made it very difficult for her caregivers to manage. Eventually however, she was placed with caregivers who gradually, and with good clear boundaries in a thorough behavioural management system, were able to help her develop self-control strategies. Susan began to admit to having sexual fantasies that involved force. Over several years she developed a sense of good and bad behaviour, some ability to concentrate at school, an ability to make pro-social behavioural choices and develop impulse control (e.g., she stopped poking other students at the same school desk, stealing their school property and criticising them). She developed some desire to please her foster parents and this included helping her foster father in the garden. It was more difficult for her to want to please her foster mother due to her internalised anger at her foster mother not being her biological mother. Susan had a fantasy construct of her biological mother which contradicted the reality that she had been physically violent, neglectful emotionally, erratic in her behaviour, allowed her partners to sexually abuse Susan and encouraged her to lie and steal.

There were several years where Susan did not exhibit any sexually inappropriate acting out and her sexual fantasies were seemingly more age appropriate. However, she continued to show no empathy for others or to initiate and maintain lasting friendships. As an adolescent, Susan's behaviour became increasingly sexualised towards older males. Furthermore, she appeared to 'obsess' about prospective partners rather than entertain 'crushes' as is normative for teenagers. This developed into stalking behaviour, both physically and also by cell phone. When she was a teenager, Susan met a much older man and ran away with him.

Therapy with Susan in the first instance consisted of reliable, consistent short meetings to begin to develop a trusting therapeutic relationship. As a therapist, I (M.R) realised this was a long-term goal. Susan commented that therapy in the playroom was too "over stimulating". Consequently, each session involved only one therapeutic game or conversation. Once her foster parents were involved, helping them to realise that loving and caring for Susan was necessary but not sufficient, and that consistent, reliable boundaries and interventions were vital.

The above case study of Susan highlights several common features seen in almost all of the young female offenders in this sample, with only seemingly very slight variations of clinical presentation being evident. Sometimes the young people had more anger and outward aggression in their sexual behaviour, and sometimes more covert and devious sexually harmful behaviours. Diagnoses typically encountered included Attention Deficit Hyperactivity Disorder, Foetal Alcohol Syndrome diagnoses, and Conduct Disorder. All of these children had very little ability to

satisfactorily self-regulate their emotions and all reported significant mood swings that were perceived as overwhelming, often resulting in rage, sadness, loneliness and fear. They seemed to align their management of strong emotional affect control with sexual acting out behaviours.

Young people who were placed with appropriate and stable caregivers, in safe placements with good boundary and limit setting, and who were taught more effective ways of managing strong emotions, significantly decreased and eventually stopped engagement in sexually harmful behaviours. A stable placement is therefore considered to be a key factor in their successful treatment as it provides the child with a predictable and stable environment that they may not have experienced previously.

### **Psychological and Behavioural Characteristics of Adult Offenders**

The following section will include two small vignettes of adult women who had sexually abused others (see Gannon and Cortoni, 2010) for further comment on this emerging field of clinical practice and forensic nursing).

Two of the adult clients that were seen belonged to the 'co-offender' typology as described by Atkinson (1996). These are offenders who are accompanied by men, represent the largest number of female sexual offenders, and are thought to participate more actively in the abuse and may in fact initiate the offending as the offending progresses. They both had a long history of severe childhood trauma and came from dysfunctional and chaotic families. One had been severely sexually abused over many years and the other woman denied sexual abuse, however her clinical presentation was one whereby she displayed symptoms of being a victim of extensive sexual abuse over many years, including Post-Traumatic Stress Disorder symptoms (PTSD) and sexualised behaviour. Their attachment styles could be classified as insecure-ambivalent (Friedrich, 1995) and they both exhibited extreme dependency and 'neediness' in their relationships with others. The younger woman, in her early 20s, who saw herself as plain, unattractive and having no friends, was in a relationship with a male 15 years older. She explained how flattered she was that he 'wanted' her and that she would do anything to keep him. This involved 'procuring' two young cousins to participate in mutual sexual games with her saying she was forced by him to actively participate in sexually abusing them. This client would fit into the 'Male-Coerced' typology. This group of offenders are thought to only participate in offending in the presence of a male co-offender and offend due to the fear of being abused themselves and/or due to their extreme emotional dependency on

the their male partner (Matthews, Matthews & Speltz, 1989).

The other woman was referred after she had served her prison sentence for sexual offending. The victim statements said that she had abused a number of prepubescent children, boys and girls, together with her partner. She also admitted to abusing further children by herself. Though she attributed her own abusive behaviour as occurring out of fear of her partner and was forced to do so, she was reported to have abused children under her own volition as well. She would be classified as an 'Accompanied' typology (Atkinson, 1996).

Of the other adult clients that were seen, only one did not have an Axis 1 or 2 psychiatric diagnosis (American Psychiatric Association [Diagnostic Statistical Manual-V], 1994) and she was a school teacher in her 30s who had a sexual relationship with a teenage female student. This client would fit the 'Teacher/Lover' typology (Matthews et al., 1989). Such offenders are more likely to view an adolescent as an 'adult', not to see their behaviour as abusive, and consider the victim to be a willing participant. This client had no history of being sexually abused as a child, had come from a stable liberal Christian family who had accepted her previous lesbian partner. She lost her job as a school teacher because the relationship became known, and ran away with the girl. She found it very difficult to accept the fact that what she had done was in fact abuse and wrong.

The other clients, as reported, all had Axis 1 and Axis 2 diagnoses, usually comprising of Depression, PTSD and/or Borderline Personality Disorder. All had a psychological diagnosis of possible Complex PTSD since they had, been severely sexually and physically abused as children. They often lived in dysfunctional and aversive parental homes and/or in numerous foster home placements, where many were again sexually and physically abused. These clients often tried to talk about their own abuse but reported not being heard or tried to stop the abuse from happening further. The woman often reported having little control over their bodies or their sexuality. They often referred to sex as being something 'done to them' and that by sexually abusing others they were able to control others and experience feelings of power.

One young woman had a negative interaction with her estranged mother and reported being so furiously angry that she wanted to hurt children in the same manner as she had been hurt. This client, who worked in an educational setting at the time, took two young girls into a toilet and sexually abused them. The client maintained that she had never sexually abused any other children until this time, and reported that the action made her feel powerful in comparison to the

powerlessness she had always felt with her mother and other men.

The other four adult women that will now be described exemplify the invisibility of female sexual abusive behaviour as women minimise their offending. These women had been attending therapy for their own sexual abuse. However, when asked during treatment whether they had sexually abused anyone else, they admitted to doing so and commented that it had been a very shameful and owning their abusive behaviour was an important part of their therapy and recovery from being a victim. In all of these cases they had perpetrated sexual abuse on young children in their own or extended family. Initially they reported being unsure if it was abusive as it grew out of cleaning and bathing routines. They loved the children they abused and had a close relationship with them but admitted to experiencing an erotic sexual pleasure from their abusive behaviour, which usually closely resembled that which they had experienced as child victims. They continued to engage in abusive behaviour, usually over long periods often with several different child victims. The children in all these cases had never reported the abuse and it was therefore in therapy that the offending by these women first came to light. This highlights the invisibility of sexually abusive behaviour by women and the fact that reporting of offending may not take place for many years, despite there often being obvious signs that it is taking place.

### **Implications for Clinical Practice**

Given the various clinical presentations of female clients who have engaged in sexually abusive behaviours, treatment needs to be individually planned and tailored specifically to the client. It is important to be aware of both the therapeutic tasks of sex offender specific treatment, as well as the therapeutic needs of sexual abuse survivors. Treatment must be multifaceted and focused on all the client's needs rather than just attending primarily to their sexually abusive behaviour. In the process of dealing with their own victimisation, clients need to develop a healthy 'sense of identity and self', which is often absent or distorted due to their extensive trauma histories. Learning the capacity to self-regulate their labile moods without resorting to destructive and abusive behaviours, such as drugs, alcohol and/or sexual abuse is crucial to ensure long term positive therapeutic outcomes for this client group. It is important for clinicians to assist clients in developing an understanding of gender development and healthy female sexuality, as well as an understanding of intimacy and empathy that can enable them to relate to others in healthy and respectful ways.

A safe and caring environment where clear boundaries are stipulated and in which the client is supported by caring and compassionate people who

assist them in making good life choices is considered here to be a critical aspect of therapy. During all therapeutic work, it is important to keep in mind models of offending and the reasons for their offending. As is evident from the case studies described in this paper, these women and girls have significant levels of post-trauma symptoms and the previously discussed therapeutic goals need to be addressed before clients can enact different choices about their problematic behaviours.

### **Conclusion**

It is apparent that generally, inclusive psychotherapeutic treatment plans work reasonably well with most of the clients described in this paper. However, this excluded the teacher who ran away with her young student and the ex-prisoner who was only funded for six months of treatment. All the other adult women made changes that were sufficient to enable them to reintegrate back into society in safe ways. Of the children and adolescents that were treated, all have made important therapeutic gains, were able to be reflective and had learnt skills concerning emotional dysregulation management. However, it is believed that individuals who have experienced significant trauma are likely to require further therapy during future developmental life stages. It is crucial that clients are in a stable, long-term placement with caregivers who agree to participate in and support the treatment programme, and that funding providers accept that treatment for this clientele needs to be long term due to their complex psychological needs. The best results with the young people in this paper were evident in cases when the entire support system around them including caregivers, parents where possible, social workers, teachers, teacher aides and educational psychologists if necessary, exhibited attunement to, and supported and understood the treatment plan. The adult women also needed a supportive system around them, in order to be motivated to receive treatment and to be funded to attend to the long term psychotherapeutic/relational interventions that were required.

It is difficult to extrapolate any defining clinical features from the cases discussed in this article, as each female client appeared to be somewhat unique in her pathway to offending and her treatment needs. However, all of the clients had insecure attachments which made relating to and having empathy for others difficult. Almost all had been extensively physically and sexually abused and had significant post-traumatic symptoms. Their sense of who they were (self-concept) was distorted in that they had beliefs that they were bad or dirty or deserving of being a victim of abuse. All lacked a sense of what constitutes normal sexuality, and for the adults and adolescents, their sense of being a

woman was distorted. Many believed they were ugly, unlovable, powerless, sexually unattractive, and that it was a woman's job is to sexually service men. The majority of the females, including the children, had mental health condition diagnoses (DSM-IV-TR, 1994).

An notable theme through all of the 25 clients was that when they tried to tell someone about their own sexual abuse, they were not listened to, which exacerbated their sense of isolation and helplessness. If the underreported and largely overlooked problem of females who sexually offend is to be addressed, then individuals would benefit from communities becoming educated that such behaviour exists and take steps to address those factors that place some females at risk to such offending.

### **Acknowledgements**

We would like to thank SAFE Network for their ongoing support and commitment to research.

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**Short Research Report:  
A Brief Report of the Characteristics of Adolescents  
with Identified Sexually Abusive Behaviours  
Referred to a Forensic Child and Youth Mental Health Service**

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**Abstract**

The current study explored individual, family and environmental characteristics of adolescents exhibiting sexually abusive behaviours referred to a child and youth forensic mental health service in Queensland. Client files were coded for mental health disorders, features of sexual behaviour and psychosocial circumstances. Results were comparable to international studies of the characteristics of adolescents who engage in sexually abusive behaviour, with a wide range of problems not specifically related to sex offending identified. Characteristics of the sample included high rates of removal from the family, physical and emotional abuse, learning and language difficulties, and social deficits. It was suggested that the sample might represent an early developmental stage in the pathway of sex offending, highlighting a unique opportunity to intervene and reduce the risk of both sexual and non-sexual recidivism. Longitudinal study of this population may assist to increase knowledge of factors influencing the development, prevention and treatment of sexually abusive behaviours in adolescents.

Sexually abusive behaviour by adolescents poses considerable concerns for their victims, families, as well as the young person him/herself. Young people who engage in sexually abusive behaviours tend to have family backgrounds characterised by severe family problems, out-of-home placements, and exposure to abuse and neglect (Caputo, Frick, & Brodsky, 1999; Kenny, Keogh, & Seidler, 2001). Physical abuse and family violence are particularly prevalent in the population of young people with sexual behaviour problems. (Drach, Wirntzen, & Ricci, 2001; van Wijk et al., 2006; van Wijk et al., 2005; Veneziano, Veneziano, & LeGrad, 2000; Worling, 1995). Mental health diagnoses are prominent among young people who engage in sexually abusive behaviours, especially

conduct disorder and attention deficit hyperactivity disorder, as well as depressive disorders (Becker, 1998; Becker, Kaplan, Tenke, & Tartaglini, 1991; Kenny, Keogh, Seidler, & Blaszczyński, 2000). Within the broader social context, sexually abusive adolescents tend to have a history of academic underachievement and behavioural problems, social skills deficits and isolation from peers (Kenny et al., 2000; van Wijk et al., 2005; Veneziano, & Veneziano, 2002).

Research with adolescents who engage in sexually abusive behaviour has typically focused on rates of recidivism and associated risk factors, and there has been comparably little focus on the clinical features of this population. While international evidence indicates that the age of onset for sexual behaviour problems is an important factor to consider in understanding sexual offending trajectories (Burton, 2000; Friedrich et al., 2005; van Wijk, Mali, Bullens, & Vermeiren, 2007), there is very little empirical information available concerning young people with sexually abusive behaviours who have minimal or no contact with criminal justice systems. Such information is central to the development of early intervention strategies aimed at preventing the onset of persistent sexual offending behaviour into adulthood, potentially representing an early stage in the developmental pathway to persistent sexual offending.

The current study extends previous research with sexually abusive adolescents by evaluating young people referred to a specialist forensic mental health service in Queensland, most of whom have not been adjudicated as sex offenders at Court. Based on previous research on the psychosocial characteristics of this client group (for example, see: Kenny et al., 2000; Smallbone, 2006), it was hypothesised that the target group would have extensive histories of victimisation,

including physical/sexual abuse and neglect, and high rates of family dysfunction and disadvantage. Within the educational context, it was hypothesised that most adolescents with sexually abusive behaviours would have had academic difficulties and peer relation problems. Finally, it was hypothesised that the target group would be characterised by diversity in the range of antisocial behaviours, as opposed to specialising in sexually abusive behaviours.

## **Method**

### **Participants and Measures**

The present study utilised a multiple case-study design. Data from Child and Youth Forensic Outreach Service (CYFOS) case files was collected retrospectively from consecutive referrals over a three year period. CYFOS is a consultation-liaison service that assists agencies working with young people with co-occurring mental health and offending behaviour concerns in child and youth mental health services and youth justice services across South East Queensland. The first author developed a coding instrument, in consultation with the project team, to measure individual, family, and environmental variables associated with the presentation of sexually abusive behaviours, as identified from a review of the literature. Inter-rater reliability was checked for 15 cases. These participants were coded by an independent researcher, who was blind to the study hypotheses and the second author. Average agreement across all variables was 82.41%, with average Kappa in the fair range,  $K=.49$  (Kaplan & Saccuzzo, 2013). For coding categories, agreement was good to excellent for most variables (agreement 77.73% to 92.33%,  $K = .43$  to  $.81$ ) though low for victim characteristics (M agreement 70.00%,  $K=.32$ ).

For eligibility into the study a CYFOS case file must have been opened between 31/12/2002 to 01/01/2005 inclusive, the individual must have been identified as displaying sexually abusive behaviours, and the case file must have contained sufficient information for coding. The final study sample selected consisted of 29 CYFOS referrals included 27 males and 2 females, with a mean age of 14.29 ( $SD = 1.41$  years).

### **Results**

The majority of study participants were males of Anglo-European heritage. The mean age of the first reported sexually abusive behaviour was 11.79 years, indicating a mean difference of 2.50 years between onset of sexually abusive behaviour and clinical referral. School transitions were frequent; 41.38% of participants had attended between four and more than seven schools in their academic careers. Youth worker supported accommodation was the primary residence for 31.03% of participants, 24.14% lived with one

biological parent, 13.79% in foster care, and 10.34% resided with extended family, while only one participant lived with both biological parents. In 58.62% of cases a biological parent was the young person's legal guardian, while in 34.48% of cases guardianship was held outside the biological family (e.g. child protection services).

Conduct disorder (37.93%) and attention deficit/hyperactivity disorder (34.48%) were the most frequently diagnosed mental health problems for participants. Comorbid diagnoses were common. Post-traumatic stress disorder (24.1%) and attachment disorder (20.69%) were the next most frequent diagnoses. Adjustment disorder and mixed disorder of conduct and emotion were both diagnosed in 13.79% of participants, and smaller proportion received diagnoses for anxiety disorder (6.90%) or depression (6.90%).

High levels of victimisation were found for the sample. Most of the participants were victims of familial physical abuse (79.31%), familial emotional abuse (89.66%) and/or had witnessed intra-familial violence (72.41%). One in four young people were victims of sexual abuse by a family member (27.58%) and equivalent rates were found for non-familial sexual abuse (27.58%). The majority of individuals had been removed from the family environment on at least one occasion (82.76%) by child protection services. Chronic/life/situation stressors were also common, including changed life circumstances (e.g. enduring physical illness, change in geographic location, change in schools), witnessing parental self-harm, or being subject to a false report of sexual assault (72.41%).

As displayed in Table 1, the family histories of the sample were characterised by high rates of multiple and often comorbid psychosocial problems and dysfunction. Overall, the family environments of the sample were often characterised by disorganisation in family structure (e.g., absent parents) and poor parenting practices.

Socio-educational problems were pronounced for the sample. Almost half of the sample had been victims of school bullying (44.83%). Within the educational context, many participants displayed learning difficulties (72.41%), language disorder (65.52%), low intelligence (48.27%), truancy and other problematic behaviours (37.93%), with a high rate of previous suspension or exclusion from school (62.07%).

As perpetrators of sexually abusive behaviours, three quarters of participants, knew their victim (72.42%), and in almost half of the cases, the victim was a family member (44.83%). In almost all cases, the perpetrator had a single victim per offence (93.10%), and although the difference was small, there were slightly more female (79.31%) than male victims (69.00%). The most prevalent forms of sexual behaviour within the sample were inappropriate

Table 1  
*Family History of the Sample*

Family History Variable	%
Disruption to Family Relationships	96.55
Disruption to Connections to Community	93.10
Biological Family History of Mental Illness	51.73
Non-Biological Family History of Mental Illness	13.80
Trans-Generational Abuse	34.48
Lack of Sexual Boundaries in Family	55.17
Biological Family History of Drug or Alcohol Abuse	48.28
Non-Biological Family History of Drug or Alcohol Abuse	6.90
Parental Supervision and Discipline	82.76
Negative or Hostile Family Communication Style	89.66
Mother's Prior History of Victimization	41.38
Father's Prior History of Victimization	17.24
Biological Parent Illness (Physical)	27.58

*Note:* Totals > 100 per cent due to the existence of multiple problems within individuals.

touching (82.76%), penetration (48.28%), inappropriate sexual language towards others (48.28%), and using pornography (48.28%). Deviant sexual fantasies or arousal as reported by the young person and recorded in the clinical file was evident for one in five young people (17.24%). Approximately half of the participants reported use of some form of coercion (verbal threats, physical threats, physical violence) (51.72%) in their offending. Cognitive distortions (24.14%) and deficits in sexual knowledge (24.14%) were not particularly evident, though almost half of the sample either denied or minimised their sexual behaviour problems (44.83%). Sexually abusive behaviours were displayed in the home, community and/or school context, with more than half of the young people displaying sexual behaviours in multiple settings (55.17%).

A considerable proportion of the sample had previous convictions for offending. One third of the participants had a history of sexual crimes, approximately 40% had a history of property crime, and one in five had a previous conviction for non-sexual violence. At the point of data collection, half of the sample had a current sexual offence charge or conviction. Beyond official justice statistics, the youth were involved in a variety of antisocial and other problematic behaviours reported by the youth themselves, the referral agency or the primary carer. Property damage (58.62%) and violence against persons (82.76%) were common. Abuse of at least one

substance was recorded for one in three young people. Cruelty to animals (31.03%), fire-setting (37.93%), self-harming and suicidal thoughts (55.17%) were also prevalent for a sizable proportion of the sample. One in five young people had previously attempted suicide. The behavioural problems of this sample extended across multiple environments including home, school and community.

### Discussion

The present study examined individual, family and environmental characteristics of young people with sexually abusive behaviours referred to a Child and Youth Forensic Outreach Service Queensland. Overall, this study revealed significant similarities between the current sample and existing Australian, North American and European samples of adolescent sex offenders (Hunter, Figueredo, Malamuth, & Becker, 2003; Nisbet & Seidler, 2001; Righthand & Welch, 2001; van Wijk et al., 2005; Veneziano & Veneziano, 2002).

As hypothesised, most participants in this study had experienced pervasive problems within the family context. The family was frequently the setting in which the adolescents were themselves victimized, and in turn, victimized others. While there are still many questions about the etiological factors impacting on adolescents that engage in sexually abusive behaviours, existing research strongly suggests that the family environment

and relationships play a significant role (Caputo, Frick & Brodsky 1999; Kenny, Keogh & Seidler 2001).

In comparison to physical abuse, sexual victimisation was less evident for the young people, either perpetrated within the family or extra-familially. The finding of high rates of problematic family environments, including physical abuse and violence, and relatively low rates of sexual abuse is consistent with the existing research that indicates that sexual abuse is not unique to the histories of children and adolescents who engage in sexually abusive behaviours (see van Wijk, Loeber, Vermeiren, Pradini, Bullens & Doreleijers 2005). It was likely however, that self-disclosure of sexual abuse is under-reported, necessitating caution.

Mental health diagnoses across the sample were consistent with previous studies that identified Conduct Disorder and Attention Deficit Hyperactivity Disorder as the most frequently diagnosed mental health problem in adolescent sexual offenders. As hypothesised, diversity in antisocial behaviour was particularly evident, including violence, property damage, animal cruelty and fire-setting. Of further concern is the prevalence of self-harm, suicide ideation and previous suicide attempts among the sample.

The current sample had marked difficulties in the educational environment as hypothesised, with high levels of learning difficulties, language disorders, and below average intelligence and behavioural problems. Previous studies have consistently identified academic under-achievement and behavioural problems as being common among adolescent sex offenders groups (e.g., Kenny et al., 2000; van Wijk et al., 2005).

Social problems were highly prevalent in the current sample with poor peer relationships and the lack of an identified peer group for many. Existing research has identified that adolescent sex offenders tend to experience poor social skills, conflict in intimate relationships, over-identification with young children, and high degrees of social isolation including victimisation by school bullies (Hunter & Chaffin, 2005; Kenny et al., 2001; van Wijk et al., 2005).

There are a number of limitations to the present study. Firstly, the present study was descriptive only and as such, associative relationships cannot be inferred from the results. Secondly, the sample size was small. As case files were selected based on the presence of sufficient information and documentation, the results may reflect the characteristics of the most severe cases of adolescents with sexually abusive behaviours referred to CYFOS.

Coding in this study was dependent upon the availability of information hence, it was likely that the frequencies of some characteristics were underestimated as it was not possible to obtain all documentation relevant to each case. This may have

resulted in the divergence of the present study results from those of previous studies in relation to cognitive distortions and sexual offending (Kenny et al., 2000). Further, this study included only two female participants limiting generalizability to females.

While the study was limited in relation to sample size and research design, the similarity of findings between the current sample and previous research with adolescent sex offenders highlights potential implications for practitioners. Firstly, adolescents may engage in sexually abusive behaviour for several years prior to being referred to specialist service. Such a delay means that young people are not receiving timely interventions that may attenuate the potential for ongoing harm. Secondly, interventions should be diverse in focus, targeting a range of antisocial and disruptive behaviours, mental health concerns and broader psychosocial factors, in addition to targeting sexually abusive behaviours. Interventions that have targeted multiple systems and are broad in scope have presented as the most promising interventions with sexually abusive adolescents (e.g., Letourneau et al., 2009; Worling, Littlejohn, & Bookalam, 2010). Thirdly, victims were most likely to be family members or otherwise previously known to the adolescents. Interventions should focus on increasing families' and residences' capacity to maximise supervision and reduce opportunities for further sexually abusive behaviours.

Overall, this study revealed significant similarities between the current sample and other research detailing the characteristics of Australian, North American and European samples of adolescent sex offenders. Adolescents with sexual behaviour problems and sexually abusive behaviours are a heterogeneous group experiencing multiple personal, educational, and psychosocial challenges. Similarities between the factors found in the histories of the current sample of young people, many of who are not yet in the justice system, and previous samples of identified adolescent sex offenders, highlights the need for earlier identification and intervention.

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## **A Review of the Evidence for the Use of Polygraphy in the Supervision and Management of Community Based Sexual Offenders: An Australian Context.**

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### **Abstract**

Polygraphy has in recent years been increasingly used in the treatment and supervision of community based sex offenders. In this context the polygraph has two main aims: to enhance treatment and to improve supervision. In terms of the former, it is claimed that polygraphy provides fuller and more accurate information about an offender's history, enabling treatment needs to be better identified and targeted. In respect of supervision, polygraphy is used to assist in monitoring behaviour and adherence to relapse-prevention plans, with supporters arguing that it acts as a deterrent to reoffending. The research evidence provides support for some of the claims made by proponents, and in 2012 the United Kingdom (UK) government made polygraph testing mandatory for sex offenders in the community. Polygraphy could well have a place in the supervision and management of high risk offenders in Australia. Particularly so, when considering the development of statutory schemes, such as the Dangerous Prisoners (Sexual Offenders) Act (2003) in Queensland. This article provides an overview of recent advances in the use of polygraphy with sex offenders.

### **Introduction**

The polygraph, often referred to as a 'lie detector', has been widely used in the United States over the last 80 years, where it has typically been utilized in criminal investigations and for employment vetting (Grubin & Madsen, 2005; National Research Council, 2003). More recently the polygraph has also been used in a post-conviction capacity in the treatment and supervision of sex offenders (Consigli, 2002; English, Jones, Pasini-Hill & Cooley-Towell, 2000a; Grubin, 2008, 2010). Proponents claim that, within this context, polygraph examinations assist with gaining additional information about an individual's background and current behaviour (Buschman, Wilcox, Krapohl, Oelrich & Hackett, 2010). The emerging research evidence whilst not definitive has generally been supportive of these claims (Grubin, 2010; Buschman et al., 2010), and largely due to this, in 2012 the United Kingdom (UK) made polygraph testing mandatory for community based sex offenders.

Polygraph testing of sex offenders is not used in Australia, though the recently passed legislation in the UK, suggests that it could well have a place in the management of high risk sex offenders. Particularly it would seem offenders subjected to legislation, such as Queensland's Dangerous Prisoners (Sexual Offenders) Act 2003 which authorizes the continued supervision of 'high risk' sexual offenders for the stated purposes of community protection. In current circumstances professionals involved with the implementation of such orders are typically reliant on the offender's self-report to gauge 'risk' and to determine whether they are complying with their order. An offender's self-report is of course affected by a range of biases, and as such, not always reliable. Other strategies, such as electronic monitoring, that are used to minimise the reliance on an offender's self report are arguably of limited value as such approaches only provide information about the offender's location and not their behaviour. The use of the polygraph in supervision and treatment of high risk sexual offenders potentially provides an elegant solution to these difficulties experienced by practitioners. In the UK and some places in the United States, the polygraph in this context is not used in isolation or as a stand alone technique, but rather as an additional tool that is embedded within a broader risk management framework (Grubin, 2010; English et al., 2000b).

The purpose of this article is to describe what post conviction sex offender polygraphy testing (PCSOT) is, and review the research evidence for its use. It will further argue that whilst the research is not definitive, the available evidence suggest that PCSOT can be a useful adjunct when used with consideration of its limitations to both the treatment and supervision of community based sexual offenders in Australia.

### **Pre- versus Post- Conviction Polygraph Testing**

Of course polygraphy is not without controversy, with longstanding arguments regarding its validity, usefulness and ethics (British Psychological Society,

2004; Fiedler, Schmid & Stahl, 2002; Grubin & Madsen, 2005; National Research Council, 2003). Much of the ongoing debate surrounding polygraphy however relates to its application in criminal investigations, in employee screening and security vetting (Grubin, 2010; Holden, 2000; Wilcox, 2000). Investigative polygraphy (as this is referred to) is confrontational and interrogative in nature and involves one-off examinations, typically with negative outcome associated with significant consequences such as going to prison, being made subject to further investigation, getting fired, or not getting a job. The aim in these tests is to obtain a confession or a clear 'pass' or 'fail'.

In contrast, sex offenders who undergo polygraph testing in the context of treatment and supervision have all been convicted of offences – hence the reference to this type of polygraph examination as Post Conviction Sex Offender Testing. Unlike the investigative environment, the focus is not on passing or failing the polygraph, but on facilitating disclosures that assist in treatment, supervision, and enhancing engagement (English et al., 2000b). The examiner is often considered part of a treatment team that includes the offender's therapist and case manager officer. These professionals collaborate to gather information regarding the offender, institute supervision strategies and treatment interventions to ensure that the offender remains at a low risk of re-offending (Dutton, 2000; English et al., 2000a). Thus, it is argued that within this context, the polygraph is not considered a 'test' per se but rather a treatment tool that is used in conjunction with other tools (Abrams, 1991; Buschmann et al., 2010; Chambers 1994; Williams, 1995).

There are several types of post-conviction polygraph examinations that are used at different times and stages of treatment and supervision (Blasingame, 1998).

*Sexual history or disclosure* examinations are usually utilized shortly after an offender has started treatment, and is specifically focused on the offender's previous sexual behaviours. The purpose of this test is to obtain a fuller account of an offender's sexual history, including the range of deviant behaviours in which he has engaged, the age at which these commenced, and a more accurate sex offence history. Although the offender provides a lengthy account, he is only questioned about selected aspects of it when attached to the polygraph. This information is useful both in enabling a better understanding of an offender's risk and in clarifying treatment targets.

*Specific issue tests* (sometimes also referred to as denial tests) are commonly used to determine the veracity of an offender's index of offence-related disclosures during treatment. Typically, such tests are used for offenders in denial or if their version of the crime varies substantially from the victim's version.

Finally, *monitoring or maintenance exams* focus upon the offender's current behaviour, and are used on a regular basis to monitor compliance with supervision and treatment conditions (English, Pullen & Jones, 1996; Holden, 2000). Maintenance tests cover a number of issues, and are repeated at regular intervals, with the aims of detecting any behaviours indicative of increased risk, and deterring the offender from engaging in risky behaviours in the first place. The primary purpose of maintenance testing is to prevent reoffending rather than to detect reoffences after they have occurred.

Therapeutically, advocates argue that sexual history and specific issue polygraph examinations enable clinicians to obtain more reliable sexual histories and more accurate offence behaviour descriptions, both of which assist in overcoming denial and improve the assessment of treatment need and risk of reoffending (Salter, 1995). In terms of supervision, it has been argued that maintenance polygraph exams have the potential to identify not only breaches in supervision and outright offences, but it also acts to deter offenders from engaging in problematic behaviour in the first place.

Much of the published literature on post-conviction polygraphy has been either theoretical or anecdotal in nature (e.g., Blasingame, 1998; English, 1998; Gannon, Beech, & Ward, 2002; Kokish, 2003; Wilcox, 2000), however, what research has been done has generally tended to be supportive of the value of PCSOT.

### **The Research Evidence for the Use of Polygraphy in Treatment and Supervision**

In one of the earliest published studies on post-conviction polygraphy, Emerick and Dutton (1993) compared an offender's assault history (i.e., number of victims and offences) on three occasions:

- What was known from file information;
- What was known after an intake interview; and finally,
- What was known after a polygraph examination.

The results showed that there was a dramatic increase in the known information after the polygraph examination. For example, the mean number of victims increased from 1.5 to 1.9 and then 2.8, whilst for number of offences it increased from 20.6 to 27 and then 76.6 after a polygraph examination. Emerick and Dutton (1993) concluded that the polygraph assisted with gaining significant amounts of additional information. The approach taken by Emerick and Dutton's study represents the typical methodology utilised to investigate the impact of polygraphy on admissions in sex offenders. Generally, other studies have reported findings consistent with these early results. In unpublished research, for instance,

O'Connell (1998) reviewed 127 archival clinical files of adult sex offenders. In this study an offender's admissions were compared on three different occasions:

- At the referral interview;
- After a clinical interview; and,
- After polygraph testing.

Again the results indicated significant increases in the incidence of sexually abusive behaviours and numbers of victims reported after a polygraph test. In another study, Chambers (1994) found that the mean number of known victims and offences increased by 5.8 and 13.9 respectively after a polygraph test. In another small study (n = 14) Wilcox, Sosnowski, Warberg and Beech (2005) found that the polygraph when compared to clinical interviews, assisted in gaining significant amounts of additional information. This included an increase in number of known contact (16 to 73) and non-contact (32 to 110) offences. A more recent study with first time internet offenders by Buschman et al. (2010) reported similar findings. After a polygraph test, offenders reported having accessed a broader range of explicit child abuse images, and did not deny masturbating to these images. A notable finding was that 55% of the sample (n = 38) disclosed previously unknown contact offending during the polygraph test.

In a study that includes a type of comparison group, Ahlmeyer, Heil, McKee and English (2000) compared the admissions of inmates and parolees on four different occasions during the course of treatment. Again consistent with the earlier studies, the results suggested that the polygraph assisted with gaining significant amounts of additional information in both groups. For example, the 35 inmates in this study initially reported a mean of 83 victims and 394 offences after completing a Sexual History questionnaire, these numbers increased to 183 and 528 respectively after polygraph testing. This effect was less apparent for parolees (whose pre-polygraph reporting consisted of 2 victims and 3 offences versus their post-polygraph reporting of 7 and 23 respectively). In a similar study, Heil, Ahlmeyer and Simons (2003) investigated the admissions of 'crossover' offending in a sample of inmate and parolee sex offenders participating in treatment and engaging in polygraph testing. They defined crossover offences as those in which victims were from multiple age, gender and relationship (familial versus non-familial) categories. Broadly speaking the results showed that overall the sample disclosed a greater amount of crossover offending after polygraph testing. For instance, pre-sentence investigation reports showed that 7% of the inmate sample (n = 223) had committed sexual offences against both children and adults; however, after polygraph testing 70% disclosed having done so. A similar pattern was observed for parolees.

Taken together the results from these studies are promising, however, the lack of true control groups makes it difficult to determine whether the polygraph is solely responsible for the additional disclosures. For instance, the possibility cannot be discounted that the offenders would have disclosed the same information if asked without the polygraph or during the course of treatment. Although in view of the extensive amounts of assessment, treatment and supervision offenders received before polygraph testing this kind of spontaneous openness would seem very improbable (O'Connell, 1998; Wilcox, 2002).

In an interesting study that attempts to overcome this problem, English et al. (2000a) compared sex offender treatment programs that were conducted with and without polygraph testing as well. The results showed that polygraphed offenders were more likely to report having offended against both male and female victims, and also against both juveniles and adults. These offenders generally disclosed greater amounts of sexually deviant activity than the offenders not required to complete a polygraph examination. This study also compared information known before and after a polygraph test. Again consistent with the research mentioned earlier, the findings suggested that significantly more information was gained from the polygraph test. In the sample of 180 sex offenders, for example, almost twice as many admitted to having male victims (20% to 36%) and three times as many admitted to perpetrating offenses against both sexes (10% to 29%) after a polygraph test. In a similar study, Hindman and Peters (2001) retrospectively compared the histories of sex offenders whose self-reports were verified by polygraph with those who did not take a polygraph. Consistent with English et al. (2000a), polygraphed offenders reported on average more victims (13.6 compared to 2.5) and a higher incidence of having offended as juveniles (68% compared to 22%). Notably, they also reported less history of having been sexually victimised themselves (32% compared to 65% previously).

The largest trial of PCSOT was conducted recently in England by Grubin (2010). This study introduced polygraph on a voluntary basis to sex offenders taking part in programmes in 10 probation areas, and compared them with sex offenders in four probation areas where polygraphy was not introduced. Over two years, 347 sex offenders agreed to testing, of which 33% (n = 116) were tested on two or more occasions. The testing uptake rate was 43%, and the retest rate 47%. Feedback from probation officers was received in respect to just over two thirds of all the tests that were carried out. The comparison sample comprised 180 offenders, which represented about 60% of sex offenders in treatment programmes in the non-polygraph sites.



In sum, probation officers reported that new disclosures relevant to treatment or supervision were made in 70% of first tests, which compared with 14% of non-polygraphed offenders making such disclosures over the previous six months. The admissions made by polygraphed offenders were rated as 'medium,' (that is, relating to behaviours indicative of increased risk) or 'high' (actual breaches or offences) in over 40% of cases. The odds of a polygraphed offender making a disclosure relevant to his treatment or supervision were 14 times greater than they were for non-polygraphed offenders. Because offenders in both groups were in similar stages of treatment, it was considered unlikely that this increase in disclosure related to progress in treatment.

The use of volunteers and the lack of a true control group in the Grubin study, limit the generalisability of these findings, however, the results are consistent with other findings and suggests that PCSOT assists with gaining valuable information about sex offenders above and beyond what is gained from 'business as usual'. Of course what really matters is whether PCSOT reduces recidivism. To date only six studies have been reported in the literature that attempt to answer this question.

#### **Does PCOST Reduce Risk Behaviour and Recidivism?**

Abrams and Ogard (1986) compared the recidivism rates of probationers required to take periodic polygraph tests for supervision with probationers for whom there was no polygraph requirement. Whilst the study did not specifically investigate sex offenders, it was reported that over a two-year period 69% of men who received periodic polygraph examinations remained offence-free, whereas only 26% who did not receive polygraphs successfully completed their supervision. However, because participants were not randomly allocated, and general criminality and previous treatment were not controlled for, it is unclear how much the polygraph actually contributed to a reduction of recidivism. The difference between the groups, for instance, may simply have been due to one being less criminal than the other.

In a retrospective study that specifically investigated sex offenders, Edson (1991) reported that 95% of 173 sex offenders on parole or probation, who were required to undertake periodic polygraph testing, did not reoffend over a nine-year period. Yet again the absence of a comparison group makes it difficult to conclude that the low recidivism rate was due to use of the polygraph for monitoring.

In a prospective study that does include comparison conditions, Grubin, Madsen, Parsons, Sosnowski and Warberg (2004) evaluated whether the expectation of a polygraph test would reduce the likelihood of offenders engaging in high-risk behaviour. In this study

conducted in the UK, a small sample of sex offenders ( $n = 49$ ) were seen on three occasions. On the first occasion offenders were placed into one of two conditions and four high-risk behaviours were identified. One group was told to expect a polygraph test focused on their specified high-risk behaviours ('Polygraph aware'), whilst the second group was not told to expect a polygraph test ('Polygraph unaware'). On the second occasion, three months later participants were again interviewed about their identified behaviours. However, all the offenders were then asked to submit to a polygraph test focused upon these behaviours. The offenders who had disclosed engaging in high-risk behaviours were then told to expect a polygraph test in three months' time, whilst the participants that did not disclose any high-risk behaviour and passed their polygraph were not.

At the initial polygraph the majority of offenders (67%) were deceptive regarding whether they had engaged in risk behaviour over the preceding three months. Indeed nearly all the offenders (97%) disclosed having engaged in at least one of their monitored risk behaviours. The majority of the behaviours reported involved masturbating to deviant fantasies. However, a significant portion also included more serious victim acquisition type behaviours, such as contact with previous victims. Comparison between the two conditions showed that there was no difference in the number of behaviours reported by men in the 'Polygraph aware' ( $M = 2.4$ ,  $SD = 1.6$ ) and the 'Polygraph unaware' conditions ( $M = 2.7$ ,  $SD = 1.9$ ). This suggests that knowledge of the polygraph test had not acted as deterrence for engaging in risk behaviour.

Because all but one of the offenders admitted to having engaged in risk behaviours, all were told to expect a polygraph examination. At the final polygraph only 28% of the sample failed the polygraph. Seventy-one percent reported engaging in risk behaviours; however, 29% reported no risk behaviour and passed their polygraph test. Of the participants who reported risk behaviours, 60% had already disclosed these to their supervisors compared with just 1 (3%) who had done so at the initial polygraph. The offenders that attended both polygraphs reported significantly less behaviour at Time Two (58 versus 33 behaviours), these were also evaluated as being less serious in nature (Madsen, Parsons & Grubin, 2004). The researchers speculated that because polygraphy was not integrated into the treatment and supervision process, and none of the offenders had experienced a polygraph previously, this unfamiliarity may have contributed to there being no difference between the two conditions at the initial polygraph test. It appears that the polygraph acted as a deterrent for offenders only after they had experienced a test.

Overall, whilst the results from the Grubin et al. (2004) study appear encouraging, the high attrition rate limits its value. Only 21 offenders completed the study, this represented only 42% of the original sample, and only 18% of the offenders were approached to take part in the study.

In a study that overcomes some of the problems experienced by Grubin et al. (2004), McGarth, Cumming and Burchard (2007) reported on one of the few comparative trials. This study compared a group of 104 adult male sex offenders who received community cognitive-behavioural treatment, correctional supervision, and periodic polygraph compliance exams with a matched group of 104 sex offenders who received the same type of treatment and supervision services but no polygraph exams. At 5-year follow-up periods, the number of individuals in the polygraph group charged with committing a new non-sexual violent offence was significantly lower than in the no polygraph group (2.9% versus 11.5%). However, there were no significant between-group differences for the number of individuals charged for new sexual (5.8% versus 6.7%), any sexual or violent (8.7% versus 16.3%), or any criminal offence (39.4% versus 34.6%). A notable limitation of McGrath et al. (2007) study is that offenders were polygraphed on average every 22 months. This is not consistent with the recommendations of the American Polygraph Association (2009) which suggests testing every six months. So whilst the methodology of the study was sound, the way that PCSOT was conducted was not, as such it is difficult to know what to make of the findings.

Finally, there are a number of questionnaire studies of note, which provide some complementary evidence of the polygraph's value in a post-conviction context. Harrison and Kirkpatrick (2000) asked a small sample of sex offenders ( $n = 28$ ) whether the polygraph assisted them in their treatment and with the problem of adhering to their probation conditions. A slight majority (57%) reported a general decrease in risk behaviours that they attributed to use of the polygraph. In a larger study ( $n = 95$ ) Kokish, Levenson and Blasingame (2005) found that 72% reported that periodic polygraph testing was helpful in avoiding high-risk behaviours and re-offences. Grubin and Madsen (2006) asked 114 sex offenders who were required to take biannual polygraph tests, whether the polygraph affected their behaviour. Slightly over half (56%) reported that the polygraph was 'moderately' to 'extremely' helpful in assisting them to remain offence-free, 64% found that it was useful in assisting them to avoid engaging in risk behaviours, and 67% found that it was generally helpful with respect to their treatment. Taken together, the results from these survey studies provide some support for the view that the polygraph has therapeutic value in the treatment and management of sex offenders.

In conclusion, the evidence demonstrating that PCSOT reduces recidivism rates is limited, and clearly additional research needs to be conducted that examines the long-term impact of periodic polygraph use on actual offending behaviour. That said, the general findings from studies that have attempted to investigate this issue are promising.

### **The Accuracy of PCSOT**

Within the literature proponents of post-conviction polygraphy have tended to ignore or dismiss the unease within the wider scientific community regarding the polygraph's accuracy, focusing instead on its potential utility. Whilst it may be correct to argue that these issues are theoretically distinct, they are very much related in practice. For example, the utility of the polygraph as a deterrent depends inherently on the offender's belief that the procedure will reveal any deceptions and that the costs of being judged deceptive are undesirable. If the polygraph is not particularly accurate, then offenders are not going to maintain a belief in its accuracy over time. The continued value of this technique would then greatly diminish. The long-term usefulness of post-conviction polygraphy depends intrinsically, therefore, upon the procedure being an accurate method of detecting deception.

A limited number of studies have attempted to evaluate the accuracy of the polygraph in a post-conviction context. In the previously mentioned survey by Kokish et al. (2005) subjects were asked about the accuracy of the polygraph tests they had completed whilst on probation. The offenders reported that the polygraph accurately identified truth-telling 92% and deception 82% of the time. In the Grubin and Madsen (2006) study the offenders' self-report indicated that the polygraph had accurately identified deception 84% and truth-telling 85% of the time. In the only experimental study, Grubin and Madsen (2006) found that the polygraph, when scored by 'blind' examiners, was reasonably accurate in identifying truth-telling (80%) and deception (100%) in a sample of community-based sex offenders. Findings from these studies suggest that the polygraph is reasonably accurate in this context.

The most definitive review of polygraphy testing to date, carried out on behalf of the National Academies of Science in the United States, concluded that "polygraph tests can discriminate lying from truth telling at rates well above chance, though well below perfection" (National Research Council, 2003, p.4); polygraph accuracy was estimated in this review to be in the region of 80 to 90%. Although the review argued that this level of accuracy is too poor for polygraphy to be used effectively as a means of security vetting, it was suggested that polygraphy is viable when the underlying rate of deception is 10% or higher – a rate which most observers, even those critical of

polygraphy, would accept is readily exceeded in sex offender populations (British Psychological Society, 2004).

### PCSOT in Australia

As highlighted earlier PCSOT is not used in Australia, although it could have application here. Practitioners in Australia struggle with the same complexities and difficulties with supervising and treating high risk offenders in the community as others do around the world. Indeed the recent implementation of statutory schemes, such as the Dangerous Prisoners (Sexual Offenders) Act (2003) in Queensland, specifically targets a subclass of incarcerated sexual offenders by either continued detention and/or vigorous supervision, which suggests a need exists for effective supervision strategies. Post conviction polygraph testing could be used with these high risk offenders, as it is done in the UK, not as a stand-alone technique but as an additional strategy embedded within a broader risk management framework. The research for its use in such a capacity, whilst not definitive, is supportive of PCSOT in terms of its utility in contributing in a positive approach to sex offender treatment and supervision, enabling probation officers to better monitor risk and to bring about more effective and timely interventions. Of course, the implementation of PCSOT is complex, and would need to be regulated and independently evaluated, as it was in the UK prior to it being made mandatory in 2012.

### Conclusion

Proponents of post-conviction polygraphy make a persuasive case for its introduction in the management of sex offenders. When used in this context, the polygraph has the potential to overcome limitations in current supervision practices, as well as generally improving the assessment and treatment of sex offenders. Its use in such a capacity has increased markedly over the last decade in the United States and more recently in the UK. This expansion is likely to continue as professional organisations and leading sex offender practitioners endorse its utility. Whilst enthusiasm to polygraph sex offenders is perhaps understandable, the empirical evidence demonstrating its value in these settings is still emerging. To date much of this research has been complicated by methodological problems, such as small sample sizes, retrospective methodologies, lack of comparison groups and the use of non sex-offender samples. Clearly additional research needs to be conducted that not only replicates the earlier research, but also examines the long-term impact of periodic polygraph use in a supervision and treatment context. Nonetheless, from studies that have been conducted we can be cautiously optimistic that polygraphy can make a valuable

contribution to the treatment and supervision of sexual offenders.

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## **Policing Indecent Images of Children. What are the Critical Issues Surrounding Police Risk Assessment?**

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### **Abstract**

This paper will explore the key issues associated with the assessment of risk posed by individuals suspected of accessing indecent images of children (IIOC). The key themes discussed involve the breadth of the problem, the reason for police involvement, the content of IIOC being accessed, the ramifications for child victims, the relationship between IIOC offenders and contact offenders, the current approaches to risk assessment and the available risk assessment tools that can help prioritise high and low risk offenders. Overall, there is little consensus across police services internationally regarding the method of risk assessment for IIOC offenders. It is possible that without further investigation into the methods of formal and information prioritisation of offenders, and the manner in which risk assessment tools are utilised, police may allocate resources incorrectly and potentially, overlook seemingly low risk individuals engaging in high risk contact offending. The implications for this are catastrophic for child victims of contact IIOC offenders as the offence may go undetected as a consequence. The need for collaboration across disciplines is called for.

### **The Size of the Problem**

There has been a significant increase in the volume and circulation of both pictures and videos of indecent images of children (IIOC) over the last decade that parallels the expansion of the Internet (Carr, 2004, Motivans & Kyckelhan, 2007, Wolak et al., 2011). In the 1990s, the Internet had less than 100 million users worldwide (Edelman, 2010) and the estimated individual hard-copy IIOC in circulation stood at 7,000 (Home Office, 2010). By June 2011, the Internet had 2.11 billion users (Internet World Stats, 2011) and police were seizing up to 2.5 million pornographic images in single collections alone; with the number of child victims depicted in the images amounting to the tens of thousands (CEOP, 2012; International Telecommunications Union, 2009). The number of individuals accessing IIOC has been suggested to run into the millions (National Center for Missing and Exploited Children, 2005) with 750,000 individuals

estimated to be accessing the material at any one time (Maalla, 2009). It is estimated that 200 new images are posted daily (Wellard, 2001) and that IIOC turn over ranges from \$3 billion to \$20 billion per year (Hoover, 2006; Ropelato, 2003). However, estimates concerning IIOC are often unreliable and unrepresentative of the problem given it is illegal cross-globally and largely goes undetected. Various estimates should be treated with scepticism given estimates are often recycled from one publication to the next and IIOC volume is growing with technological advances (Wortley & Smallbone, 2012).

As Wortley and Smallbone (2012) highlight, the features of the Internet that are beneficial to society when undertaking legitimate activities, such as online banking or networking, are the very features that provide the ideal environment for individuals undertaking illegitimate activities, such as accessing illegal pornography or grooming children in chat rooms. Overall, the Internet and associated technologies have revolutionised the production, distribution and viewing of IIOC and have exacerbated the problem by increasing the volume of IIOC available, and the ease at which it is accessed and managed (Wortley & Smallbone, 2012). Clearly, both the volume of material and the number of individuals accessing the material pose a problem for the police services responsible for investigating these offences.

### **The Importance of Police Investigation**

In Australia and New Zealand, all serious crime reported to the police, such as murder, rape or serious assault is investigated. However, crimes perceived as less important or lower risk such as vandalism for example, are not considered high priority as police do not have the resources to investigate all crimes thoroughly. Allocation of police resources is relevant to investigations of individuals suspected of downloading IIOC because the large number of suspected offences reported, have the potential to overwhelm police capacity. In order to contextualise police responses, we

begin by looking at five factors comprising the rationale for the investigation of these offences in the first instance.

First, accessing IIOC is an illegal activity which in itself predicates the investigation of the alleged crime to ensure compliance with the law. Second, IIOC may involve the direct physical victimisation of children and the perpetrators of this abuse should be held accountable. Third, accessing IIOC may signal a sexual interest in children and indicate that an individual may have engaged in contact offences, currently be conducting contact offences, or intending to commit contact offences. Fourth, exposure to IIOC may facilitate an interest in contact child sex offending that would have not otherwise occurred. Fifth, the distribution of IIOC may be unpleasant and distressing for the victims who are aware that indecent images of them exist, (with the ramifications for victims who are unaware still unclear).

Although, all five factors provide a rationale for investigating individuals suspected of accessing IIOC, different police services may consider certain factors as more important than others (as do the public) and their investigations may mirror this prioritisation. For example, more comprehensive investigations of IIOC image content, with an aim to identify potential victims, may be pursued within a police service that considers all IIOC offenders as potential contact offenders. In keeping with this theme, we will now discuss what is known about the content of IIOC in relation to risk.

### **Risk and IIOC Content**

Examining the content of the IIOC material being accessed by IIOC offenders helps aid in our understanding of their relative risk to children potentially. The Internet Watch Foundation (2010) found 73% of victims depicted in IIOC on the internet were younger than 10 years old. Two thirds of the images involved penetrative sexual activity between the victim and an adult. Wolak and colleagues (2005a, 2005b) examined images that were in the possession of offenders arrested for producing or possessing IIOC, and found 19% had images of children under 3 years of age, with 80% of the offenders possessing images of the sexual penetration of a child. Some have reported a trend toward more extreme, sadistic and violent IIOC. For example, the European Commission (2010) stated that penetrative abuse in images had risen 7.6% from 2008 to 2010.

Taylor and colleagues (2001) proposed three factors that are indicative of the level of severity within an IIOC collection: the size of the collection and the extent of its organisation; the presence of new and never seen before material (indicating the likelihood the offender has access to children, or is a producer of IIOC) and the age of the children (with IIOC containing younger

children as more severe). Psychometrically, the level of severity depicted in images is often assessed by the COPINE scale, ranking the severity of IIOC on levels 1-10 (1 = indicative; 10 = sadistic/bestiality) (Taylor, Quayle & Holland, 2001). However, the global prevalence or ratio of images found within these levels is, to our knowledge, unknown in publically available sources.

Further, as Beech et al. (2008) highlight, although the COPINE establishes a framework for IIOC collections to be forensically analysed, there is no clear evidence of a relationship between risk and the type of images in the collection. Hence, the frequency of images found at each level may not reflect the risk posed by that individual (Beech et al., 2008). For example, a person fantasising and masturbating about non-sexual images of fully clothed children may not be any less dangerous than a person fantasising and masturbating about sadism or bestiality (Beech et al., 2008). Hence, further research is required in order for us to better understand the risk associated with image content and perceived level of severity. What is emerging however is our understanding of the risk associated with individuals accessing IIOC in regards to contact offending. This relationship will now be discussed.

### **The Relationship Between IIOC Offending and Contact Offending**

Recent research has however focused on examining the critical relationship between individuals accessing IIOC and offline contact offences, and suggests an absence of a clear linear relationship. Seto, Hanson and Babchishin (2011) have addressed this issue by conducting the most comprehensive study to date. Their meta-analysis, comprising 21 different participant samples, indicated that approximately one in eight IIOC offenders have a history of contact sexual offending based on official records of arrests, charges or convictions. Specifically, the prevalence of contact sexual offending as indicated by official records was 12% with individual studies ranging from 0-43%, (this large range is likely to be attributed to sampling differences) (Wortley & Smallbone, 2012). In contrast, the prevalence of self-reported contact offences stood at 55%, which is consistent with suggestions that official records present conservative estimates of actual offending (Seto et al., 2011). Furthermore, many victims do not report abuse to authorities or, when they do, their allegations do not always result in police action.

In addition to the meta-analysis, nine follow-up studies were conducted by Seto and his colleagues (2011) which revealed only 4.6% of the IIOC offenders went on to commit new sexual offences during the 1.56 year follow-up. Of that group, 3.4% committed a new IIOC offence and 2% committed a new contact sexual

offence. Overall, these results indicate only a relatively small percentage of IIOC offenders are likely to engage in further online and offline offending. Even this might be an overestimate as the prioritisation of some offenders may mean that only the highest risk offenders are targeted.

Perhaps the most high risk group of IIOC offenders are those individuals with a history of contact offending. Seto and Eke (2008) found sexual recidivism rates for IIOC offenders with a history of contact offending were higher than the expected base rates for general sexual offenders (Harris & Hanson, 2004). Specifically, the recidivism rate for contact offenders stands at 14%, irrespective of IIOC use (Hanson & Bussiere, 1998, Hanson & Morton-Bourgon, 2005). This is much higher than the 4.6% recidivism rate found in the IIOC offender group. Acknowledging that not all new offences are detected and the observed recidivism rate is likely to increase over time, these results contradict the supposition that all IIOC offenders have a similar level of risk with regards to future contact offending (Seto et al., 2011).

There are however various factors that predict increased recidivism in IIOC offenders and general sex offenders (Seto & Eke, 2008). These factors include age, prior criminal history, substance use problems and relationship status (Seto & Eke, 2008). Research has implicated some unique risk factors for IIOC offenders, including self-admitted sexual interest in young adolescents and a larger ratio of IIOC content depicting boys than girls (Eke, Seto & Williams, 2011; Faust et al., 2009; Seto & Eke, 2005; Wakeling et al., 2011). Faust and colleagues (2009) identified a number of recidivism predictors in a follow-up study of 870 IIOC offenders. Relevant variables included lower education, being single, possessing sexual material depicting children aged 13-15 years and a history of prior treatment for sexual offending. These results support the view that offenders who are single, have hebephilic tendencies, possess more male versus female IIOC and have lower intelligence quotient with a history of sexual offending are considered higher risk in regards to reoffending (Faust et al., 2009). We will now consider the different types of individuals that access IIOC and whether, aside from demographic variables, the pattern of their behaviour can serve as a marker of risk.

### **Risk and Behavioural Typologies of IIOC Offenders**

Various typologies of IIOC offenders have been posited (e.g., Hartman, Burgess & Lanning, 1984; Sullivan & Beech, 2004; Alexy et al., 2005). The most comprehensive typology was developed by Krone (2004) who placed the offenders on a continuum of increasing seriousness, and suggested within group variation reflected different types of IIOC behaviour. For example, those he labelled 'producers', 'groomers',

and 'physical abusers' are he considered to be higher risk than those he labelled 'browsers', 'trawlers' and 'distributors'. However, as Wortley and Smallbone (2012) highlight, despite having face validity, these typologies have not been empirically validated. It is unclear if offenders graduate from lower to higher (more serious) levels of behaviour, remain at the same level or desist altogether (Wortley & Smallbone, 2012). For this reason, the percentage of offenders found within each typology group is unknown. Research has however indicated that lower level IIOC offenders who do not engage in contact offending (e.g. browsers) score higher in victim empathy, higher in sexual deviance, and lower in antisocial tendencies such as impulsivity, rejection of personal responsibility, substance abuse or antisocial behaviour (Babchishin et al., 2011). These lower level individuals are also more likely to have higher psychological self-control which may explain why, when compared with contact offenders they are have a lesser likelihood of reoffending (Seto et al., 2011).

Recently, the 'groomers' within the high risk group of IIOC offenders have received attention due to the expanding online communication platforms now available to children, resulting in an increased risk of potential harm being caused. 'Groomers', or 'online solicitation' offenders, cultivate online relationships with children and may send IIOC to them as part of the grooming process. These individuals may or may not be involved in wider networking with offenders, and may or may not be engaging in direct contact abuse (Krone, 2004).

A comprehensive study by Seto and his colleagues (2012) examined the characteristics and risk associated with these 'groomers', or solicitation offenders, in comparison with contact offenders and general IIOC offenders. Results indicated that solicitation offenders were the group most likely to be residing with a child, after the contact offenders, with the general IIOC offenders placing last. Further, solicitation offenders were more likely to have viewed IIOC than the contact offenders. They were also more likely to have unrelated and stranger victims than the contact offenders, but were less likely to have offended against a male. Solicitation offenders were also more likely to have problems in their capacity for relationship stability and less likely to have ever lived with a lover compared to the contact offenders.

Additional findings revealed that the solicitation offenders and general IIOC offenders had a higher level of education and did not differ in their prior criminal history, or on dynamic factors, such as antisociality compared to the contact offenders. However, the solicitation offenders were more likely to report hebephilic interests in pubescent children; with IIOC

offenders more likely to report paedophilic interests in prepubescent children (Seto et al., 2012).

It appears IIOC intra-group differences are becoming clearer however despite the growing research in the area the cross-over between each typology, or subgroup within the IIOC offending population, remains unclear and people rarely neatly fit into one 'type' or another. Specifically, the level of risk associated with each type of offender has not been established, nor have the implications for police practice been considered. For example, if individuals are considered low level by police because they present ostensibly as 'browsers', a less thorough investigation may ensue as the individual is not prioritised. This in turn, may prevent the identification of a contact-abused child victim that may have been identified with a more thorough investigation into the IIOC content. Thus, offences may go undetected due to an initial, inaccurate risk assessment based on typology. Further research into how police prioritise IIOC offenders is required, with a particular focus on how the behaviour contained within the offence, for example soliciting children versus collecting and organising images, can influence police prioritisation of risk. Anecdotally, police will use the perceived impact on the child victim portrayed in the IIOC as a marker of risk. Hence, the associated risk of IIOC production and distribution on child victims will be now be discussed.

### **Risk For Victims of IIOC**

The impact on children represented within IIOC is varied. However, in many cases for the production of IIOC to occur a child must be taped or photographed being sexually abused (Wortley & Smallbone, 2012). With regards to distribution, the child is further violated when that record of abuse or images of them are re-accessed by various IIOC users. The impact on victims of the dissemination and viewing of IIOC material is difficult to distinguish from the impact of contact sexual abuse, as the contact abuse occurrence may obscure or overshadow the effects of merely being represented in IIOC (Wortley & Smallbone, 2012).

When considering the effects of contact sexual abuse generally, two-thirds of children in a study by Svedin and Back (2003) were found to have serious psychological or behavioural problems 17 months after disclosing the sexual abuse, as indicated by their scores on the Child Behaviour Checklist and the Youth Self Report scale (CBCL and YSR respectively; Achenbach & Rescorla, 2001). The most prevalent behavioural problems were obstinacy, irritability, contrariness, demands for attention, being opinionated, excessive use of profanity and the preference for being alone (Svedin & Back, 2003).

When considering the effect of IIOC production generally, victims can feel distress years later by their

perceived compliance during the abuse, particularly if it is noncontact, for example undressing for the camera and smiling (Leonard, 2010). Victims represented in IIOC can also be distressed about the distribution and accessibility of the material for other, future IIOC users as it remains in circulation (Von Weiler, 2010). Victims can experience anxiety and fear surrounding the actual viewers of the images and their reasons for accessing them (Leonard, 2010; Von Weiler et al., 2010). For example, this statement was provided by a child victim of IIOC: "I won't walk on the street on my own because I'm scared other paedophiles will follow me. I am scared because there are photos of me on the internet and paedophiles might have them" (CEOP, 2012, p.6). Further research exploring the effects of noncontact victims represented in IIOC with contact victims represented in IIOC is required, in order to decipher the true impact of IIOC on the children represented. With a better understanding of the effects of IIOC production and distribution, more accurate and informed risk analyses can take place. The current approaches to analysing risk will now be explored.

### **Police Approaches to Risk Assessment**

Broadly speaking, there are three main approaches to risk assessment for predicting recidivism in the forensic arena: the clinical approach; the actuarial approach; and, more recently, the structured decision-making approach. These approaches will be considered in relation to police investigation of risk associated with IIOC offenders.

The clinical approach involves the assessor, for example a police officer, using clinical judgment to determine the level of risk an individual poses. Clinical judgment is informed by the combination of various sources of information such as interviews, case reports, and historical information that together create an estimate of associated risk for an individual. There have been a number of critiques of this approach (e.g., Grubin, 1998) that focus on the poor accuracy and reliability of clinical judgment. Indeed, a number of reviews indicate that, in many instances, clinical perceptions of risk are little better than chance (e.g., Douglas & Skeem, 2005). One reason for this may be that an assessor, or police officer, may unintentionally use subjective judgment in their assessment of risk. For example, they may take into consideration how likeable or attractive an individual is or, how affable they are and whether they fulfill the assessor's pre-established expectations of how an offender.

Another factor that may influence clinical judgment of an assessor, specifically a police officer, may be the repugnant nature of the IIOC content seized and the evoked repulsion from the officer. For example, the depravity depicted in an IIOC collection may result in an offender being assessed as high risk due to the



socially unacceptable and disturbing nature of the material, despite there being little evidence to suggest high levels of image depravity corresponds with a high level of risk. In contrast to the clinical approach, actuarial approaches to prioritisation of risk remove clinical judgment altogether. Actuarial risk is calculated from large datasets and identifies factors that are empirically researched as predicting risk. One example that utilises an actuarial approach is the Static-99 (Hanson & Thornton, 1999). This tool specifically examines the risk of sexual reoffending in convicted sex offenders by assimilating the information from historical and fixed, or static factors. These static factors include: demographic information, official criminal history, the victim's gender and the relationship between the victim and the offender. Another example of a risk assessment tool that utilises the actuarial approach in a similar way is the Risk Matrix 2000 (Thornton, 2007), a modification of the Static-99 (Hanson & Thornton, 1999). This tool was designed to assist police in assessing risk using their available information (e.g., age of offender, previous charges) versus information typically only available to corrective services (e.g., attitudes towards sex offending, empathy for victims)

The actuarial approach typically outperforms clinical judgment and is reasonably accurate in predicting risk (for a discussion see Beauregard & Mieczkowski, 2009). However, it is not without its limitations. There are problems with the low base rates of behaviour; in the cases of child-sex offenders, there are relatively few convictions or charges, meaning that if you simply say no one will re-offend you would usually be quite accurate.

Finally, we consider the third approach to risk assessment, structured decision-making, which has received particular consideration as of Structured decision-making typically involves analysing a variety of factors (e.g. mental status, attitudes towards victims) and using clinical judgment to determine if they are present or absent, to determine overall risk. An example of a structured decision-making tool related to sexual reoffending is the Sexual Violence Risk-20 (SVR-20, Barbaree, Langton, Blanchard & Boer, 2008) which contains 20 items assessing psychological adjustment, sex offences (e.g. density of offending) and future life-planning (Barbaree et al., (2008). The tool has some predictive validity for recidivism and has shown reasonable predictive accuracy, above that of the Static-99 in one study (De Vogel, De Ruiter, Van Beek & Mead, 2004).

There are advantages in using the structured decision-making approach. First, it provides an evidence base and audit trail for the decision-making process and second, it can be designed to ensure consistency of judgments. This allows for different

people to assess the offender in the same coherent way, which will help the offender to be rehabilitated and support public protection. Importantly as has been stated earlier, by guiding the collection and assessment of relevant information, these techniques, typically outperform unstructured judgments, improving both test-retest and inter-rater reliability. Of course, actuarial systems have all the above advantages and also the potential to be automated.

Overall, these are advantages and disadvantages of each approach, however the representation of each approach within police services across the world is largely unknown and uninvestigated.

### **Police Prioritisation of High Risk Offenders**

There is limited, reliable data concerning the usage of risk assessment tools by police for individuals suspected of downloading IIOC. In a study conducted by CEOP (2012), 21 of the 34 responding police forces across England and Wales - reported using some form of risk assessment tool to prioritise investigations of IIOC offenders. The police services noted that they usually prioritised suspects with access to children. This emphasises the ad-hoc approach to risk assessment of IIOC offenders cross-globally and highlights the lacking consensual approach to risk analysis across regions and jurisdictions. The need for a global, formalised assessment is highlighted here in the CEOP (2012, p. 10) state, "the questions asked and answered in order to prioritise reports are subjective between different forces, teams and individual officers. Formalising a system of risk assessment would provide consistency and defensible decision making across, and within, police forces."

At present, in the open literature, there is little evidence of an effective, clearway of identifying high risk IIOC offenders. One exception is a study by Wakeling, Howard and Barnett (2011) who examined the validity of two actuarial risk assessment tools on a group of sexual offenders convicted of internet offences across England and Wales. One was the Risk Matrix 2000 (Thornton, 2007), which is based on age, number of sex offences and number of previous non-sex offences, and the Offender Group Reconviction Scale 3 (Howard, Francis, Soothill, & Humphreys, 2009). Their sample contained 1,326 IIOC offenders at one year and were able to follow 994 of the previous 1,326 offenders two later. Proven reoffending was defined as any caution or conviction for a new offence. Reoffending rates were very low among this sample, and three quarters of sexual reoffending was internet related. The results indicate that all four tools had moderate to very good predictive accuracy (this was measured by Receiver Operating Characteristics statistics which were between .67 and .87).

The development of forensic risk assessment tools is increasing. Critically, a new tool prioritising individuals accessing IIOC according to risk of committing contact offences has recently been established (CEOP, 2012). The tool, entitled the Kent Internet Risk Assessment Tool (cited in CEOP, 2012) shares some features with the Matrix 2000 (e.g., using the number of previous sex offences to add to the understanding of risk) however at present it is not publically available and there is no publically available data to support its validity.

Overall, the utility of risk assessment tools has been demonstrated however the use and implementation of these tools in policing practice is yet to be established in a coherent, consensual way across states and jurisdictions across the world. There is limited research into the use of risk assessment tools within the IIOC offending population and so prioritisation of these offenders can result from a variety of clinical judgment, actuarial and decision-making approaches by police. Importantly, there is a possibility that risk assessment tools used by police, whether formal or informal, become self-fulfilling. As mentioned previously those identified as high-risk individuals are prioritised and found to be committing contact offences, and those identified as low risk offenders are not prioritised and thus not investigated or found to be committing offences. More extensive research examining the current formal and informal policing prioritisation methods would be beneficial to help identify the key gaps in practice that may be attributing to a potentially disorganised or invalid global approach to the investigation of IIOC offenders.

### Conclusion

The volume of IIOC available to internet users is expanding, as are the number of individuals accessing the material. We have highlighted the ramifications of the production and distribution of IIOC for child victims. We have identified the several gaps in the literature regarding the current knowledge of policing practices and the investigation of IIOC. We can conclude that there is seemingly no global, formal prioritisation of risk within policing departments across the globe. Further, there is a lack of consensus as to what characterises a risky individual and the method in which this risk is assessed. The psychometric properties of the existing risk assessment tools are not yet well-established but they do provide a foundation to help us close the gap between the current police practices and the evidence available to us on the emerging profile of high and low risk IIOC offenders. However, situational factors such as transitory access to vulnerable children will make this task difficult. In assessing high and low risk offenders as accurately as is possible (and acknowledging the limitations of risk assessment) police services can streamline their investigative

process, avoid wasting resources and potentially identify more child victims that are being subjected to abuse and otherwise undetected.

The emerging subgroups, within the IIOC offending population, serve to confuse the matter further and it is possible that different subgroups present differently according to risk, however this is largely unclear. The need for research within this area is apparent and the implications of this paper are far reaching. The need for cohesion across the disciplines of law enforcement, psychology and criminology is imperative for us to successfully protect children.

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