AN EXPLORATORY STUDY OF THE ASSOCIATION BETWEEN THE STATIC VARIABLES OF THE STATIC-99 AND SUCCESSFUL OR UNSUCCESSFUL TREATMENT COMPLETION

by

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Abstract

The purpose of this research was to investigate the extent to which successful or unsuccessful completion of an outpatient adult sexual offender treatment program is influenced by the risk for sexual or violent recidivism. The findings suggest that this research study was able to differentiate the background of completers and non-completers of an outpatient sex offender therapy program. Completers had the following characteristics, which differed from non-completers: (a) most are aged 24.99 and up, (b) most had an intimate adult relationship of 2 years duration, (c) a significant number of completers did not have a separate conviction for a non-sexual violent offence, and (d) they were more likely to have low risk for sexual and violent recidivism.

Dedication

I dedicate this dissertation to my mother and step-father whose faithful prayers enabled me to complete my education. I am also thankful to them for taking care of my children so that I could attend school events. In addition, I am grateful to my children who have had to sacrifice much while I worked on my educational goals. Finally, to my husband who has always believed in me.

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CHAPTER 1. INTRODUCTION

Background of the Study

Sex offenses are among the crimes that evoke the most public concern. Therefore, it is not surprising that exceptional policies have been directed toward individuals who have committed such offenses (Hanson & Mourton-Bourgon, 2004). Recent legislative changes and sentencing practices increase the likelihood and length of incarceration for convicted sex offenders. Conduct that was once tolerated is now criminally prosecuted. In fact, more than eight times more people were incarcerated for lower grades of sexual assault in 1992 than in 1980 (Lane Council of Governments, 2003). The effective administration of such policies requires evaluation of offenders' recidivism risk. Not all sexual offenders are equally likely to reoffend; therefore, interventions directed at the highest risk offenders are most likely to contribute to public safety.

Of the offenses examined in one study, 16% were against children, 11% were classified as violent, 40% were against a child, and violent and 33% categorized as other (Bianchi & Lawrence, 2006). According to Bianchi and Lawrence (2006), 97.4% of total sex offenders are male. Bianchi and Lawrence also found 30% of registered sex offenders were considered level 1 (lowest risk), 57% were considered level 2 (moderate risk), and 13% were considered level 3 (highest risk). In addition, sex offenders are 6% of the parole population and 20% of the probation supervision.

Although there is a great deal of publicity surrounding sex offenders, much is still unknown about how well treatment works to prevent recidivism. Even less is known about who may be successful or unsuccessful in completing treatment programs. It has

been suggested that an individual who does not successfully complete treatment is 2 to 6 times more likely to reoffend than those who complete treatment (Gordon & Hover, 1998).

How do we define successful and unsuccessful treatment? Furthermore, do those who are successful and unsuccessful share similar characteristics Geer, Becker, Gray, and Krauss (2001) found that more years of education, no history of sexual victimization, and lower levels of cognitive distortions predicted treatment completion. In addition, because treatment is primarily focused on increasing adaptive behaviors and reducing maladaptive behaviors, success is most commonly measured by the reduction or elimination of the maladaptive behavior. Failure can be measured by the manifestation of the maladaptive behavior. An individual who has been successful in treatment will also have understood, integrated, and internalized the program's material thereby demonstrating accountability, empathy, prosocial behavior, and an overall understanding of his own deviant cycle and potential for relapse (Moore, Bergman, & Knox, 1999).

Sex offender treatment dropout is very common in outpatient settings (Geer et al., 2001). Shaw, Herkow, and Greer (1995) found that as much as 86% of incarcerated sex offenders in sex offender treatment were terminated in the evaluation stage. Given this information, is there a way to predict who will be successful in an outpatient treatment program? The ability to predict successful treatment completion would have implications for resources, staffing, funding, and ultimately the prevention of further victimization by former offenders. With this in mind, this study quantitatively and qualitatively examined the characteristics of those who were successful and unsuccessful in sex offender treatment completion. This researcher hopes that this study will help identify trends,

themes, or characteristics that can assist in identifying specific sex offenders who may not be amenable to treatment.

Statement of the Problem

How society intervenes with identified sex offenders has become an important public health issue. Community sentiment to "just lock 'em up and throw away the key" is prevalent. This approach does not consider the limited resources of many correctional systems. Prisons are overcrowded and sentencing structures allow most sex offenders to return to the community following incarceration. Reliance on incarceration as the sole solution ignores the reality that certain types of sex offenders present a relatively low risk of reoffending (McGrath, Hoke, & Vojtisek, 1998).

Those that are terminated from treatment may be at greater risk for reoffense than those who did not receive any treatment (Geer et al., 2001; Gordon & Hover, 1998). Therefore, it is important to determine how those who successfully complete treatment and those who unsuccessfully complete treatment are different. Decreasing unsuccessful treatment completion rates would subsequently reduce recidivism rates. In addition, effective treatment programs are ineffective for the entire population if the participants do not successfully complete them.

Purpose of the Study

The purpose of this study was to investigate the extent to which successful completion of an outpatient adult sexual offender treatment program relates to the risk for sexual or violent recidivism. This research may have an effect on treatment and the way in which sex offenders are assessed and treated. This exploratory correlational study

examined the relationship between offenders' risk level on the Static-99 of and successful completion of a specific outpatient adult sexual offender treatment program. The researcher hopes that this study could assist treatment programs by helping to identify sex offenders who are not amenable to treatment early on, thereby reserving limited resources for those who are amenable to treatment. In addition, the results of this study might help prevent further victims by identifying those who may not amenable to treatment early on. Potentially, with knowledge of this in court, these sex offenders could then face tougher sentencing laws.

Nature of the Study

This exploratory correlational study examined the association between adult sex offenders' characteristics and their success in completing treatment in an outpatient group therapy program that uses cognitive behavioral and relapse prevention interventions. This study was primarily an exploratory archival study with hard data of the individual sex offender treatment program under review.

Significance of the Study

There has been much publicity surrounding sex offenders, but little is known about the effectiveness of treatment. In addition, even less is known about who is more likely to complete treatment programs and who is not likely to complete specific treatment programs. There is a great concern that those who do not complete treatment are 2 to 6 times more likely to reoffend than those who complete sex offender specific

treatment (Gordon & Hover, 1998). Shaw et al. (1995) found that 86% of incarcerated sex offenders in sex offender specific treatment were terminated in the evaluation stage.

According to Marques, Day, Nelson, and West (1994), individuals who do not complete treatment are 5 times more likely to sexually reoffend and 3 times as likely to reoffend non-sexually. Hanson and Bussiere (1998) also concluded that not completing treatment significantly predicted general and sexual recidivism.

By examining the relation between Static-99 risk levels and treatment outcome, it may be possible to identify which risk level predicts participant outcome in a treatment program. In addition, by identifying which risk level can contribute to offenders' successfully completing a treatment program, it may be possible to tailor the treatment program to fit the needs of the offender based upon those variables. Those who may have more difficulty successfully completing a treatment program may require a different level of care or more intense scrutiny by the treatment provider. However, a treatment provider may be more willing to provide services to those who are more likely to successfully complete treatment.

The information gained from this study may provide a way to predict failure in treatment for outpatient sexual offenders. If there is a way to predict, there may be other important implications regarding resources, including alternative treatments, staffing, time, funding, and the incarceration of offenders who are not amenable to treatment.

Definition of Terms

Sex offender – Gebhard, Gagnon, Pomeroy, and Christenson (1965) defined sex offenders as individuals who are ultimately convicted for committing overt acts for their

immediate sexual gratification that are contrary to the prevailing sexual mores of their society and thus are legally punishable.

Cognitive-Behavioral Therapy – The Center for Sex Offender Management (1992) defined the cognitive behavioral model of sex offender treatment as,

> A comprehensive, structured treatment approach based on sexual learning theory using cognitive restructuring methods and behavioral techniques. Behavioral methods are primarily directed at reducing arousal and increasing pro-social skills. The cognitive behavioral approach employs peer groups and educational classes, and uses a variety of counseling theories. (p. 22)

Relapse prevention – A process of self-control that teaches individuals who genuinely desire to change their maladaptive behaviors how to prepare for and cope with relapsing (Marlatt & George, 1984).

Static-99 - The Static-99 is an instrument designed to assist in the prediction of sexual and violent recidivism for sexual offenders. It was developed by Hanson and Thornton (1999) based on follow-up studies from Canada and the United Kingdom with a sample 1,301 sexual offenders.

Successful and unsuccessful treatment completion - *Success* is measured by the reduction or elimination of the maladaptive behavior. *Unsuccessful* may be measured by the manifestation of maladaptive behavior. It is hoped that if an individual is successful in treatment, he will have understood, internalized, and applied the concepts of treatment programs material, thereby demonstrating accountability, empathy, prosocial behavior, and an understanding of his own deviant cycle and potential for relapse (Moore et al., 1999).

Assumptions

It was assumed that the clients who successfully completed treatment met all of the requirements for successful treatment completion, as determined by the treatment program. The treatment program's therapists would have already determined that these clients demonstrated the goals of the treatment program prior to their completion. In addition, the individuals that were unsuccessfully terminated from the treatment program did not meet the requirements for successful completion and they were terminated prior to completion of the program. It was also assumed that the participants were reasonably representative of adult sex offenders in outpatient group therapy and that the treatment program was reasonably representative of outpatient group therapy for adult sex offenders. In addition, the researcher assumed that consistent standards were adhered to across therapists and that the therapists consistently applied these standards across clients. Similarly, the researcher also assumed the same standards were used when administering the Static-99 and that it was a valid measure of risk.

Limitations of the Study

This field study examined the records kept at a small outpatient treatment program for adjudicated adult sexual offenders. One major limitation of this study was that it involved offenders from only one outpatient treatment program in one small central Illinois city. Therefore, it may be difficult to generalize the findings of this study to sex offenders participating in other outpatient treatment programs. This challenge was addressed by ensuring that the program met the minimum standards of practice in the outpatient treatment of adult sexual offenders.

A second limitation of this study was that the delivery of the treatment and the method of termination were not standardized. The lack of program specific training may allow the possibility of individual biases in the implementation of treatment interventions. These individual biases may result in therapists using personal judgment to determine a participant's termination. This limitation is addressed in the discussion section of this dissertation.

Finally, while in group therapy, participants were not differentiated by age or offense, therefore, group composition varied. Some offenders may be influenced by other group members and may not progress as far as they could if they were in smaller, risk potential, or offense specific groups. The results of this study may assist in best practice recommendations for this limitation.

CHAPTER 2. LITERATURE REVIEW

The following is a review of the literature on sex offenders, sex offender treatment, and sex offender risk assessment. It includes a discussion of the types of sex offender treatment provided to participants in the outpatient treatment program being studied. In addition, this chapter includes an examination of the association between treatment outcomes and recidivism. Finally, a review of the research on actuarial assessment is provided.

The Sex Offender Defined

The definition of a sex offender includes legal, moral, cultural, and psychiatric considerations. Morally, or religiously, some may be considered offenders if they are sexually active without the intentions of creating another life. Others may engage in sexual acts, with consenting partners, when the acts themselves are not allowed in their culture.

Sex offenders are not a homogenous group. They come from varied socioeconomic backgrounds, live in diverse communities, and engage in a range of occupations. Though the background of the sex offender can be varied, they can be categorized based upon the type of offense they committed. These categories include people who commit rape, statutory offences, extrafamilial child and intrafamilial child molestation and incest. The person who rapes has had a victim at least 14 years of age, the act occurred against the objections of the individual and/or the individual was not of sound mind to consent to the sexual activity. The statutory offender has had consensual sexual contact with an unrelated victim between the ages of 13 and 17. The person who

engages in extrafamilial child molestation has had victims under the age of 13 and touched them in an inappropriate manner. A person who engages in intrafamilial child molestation and incest has victims that are related to them under the age of 13.

The American Psychiatric Association (APA) classified sex offenders into four mental health categories (APA, 1999). The first category consists of individuals who have no mental or physical abnormality. The second category includes individuals who have a mental disorder or physical injury that limits cognitive functioning, such as mental retardation or a traumatic brain injury. The third category consists of individuals who have a diagnosable sexual paraphilia, such as exhibitionism or pedophilia. Finally, the fourth category includes individuals with another mental health condition that may indirectly affect their sexual behavior. These offenders may be diagnosed with a personality, psychotic, or impulse control disorder (APA, 1999).

Sex offenders may be clinically diagnosed with a paraphilia, which is defined by the *Diagnostic and Statistical Manual of Mental Disorders-Text Revision* (2000) as "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors" (p. 566) that may involve inanimate objects, the physical pain, or humiliation of others and/or oneself, or children. One example of a paraphilia is pedophilia, which involves fantasy or sexual activity with children. However, our society is governed by laws and no one can be considered a sex offender based on thoughts or beliefs alone. Paraphilia is not a sex offense by itself. If someone suffering from paraphilia acts upon on their thoughts and sexually abuses a child, they are engaging in illegal activity. For the purposes of this study, sex offenders are defined as those who have been arrested and convicted for an illegal sexual act. The subjects of this study committed at least one of the offenses

previously outlined. Those who committed such offenses and have gone unreported or unfounded were not included in this study.

Sex Offender Treatment

In the United States, more than 75% of sex offender treatment providers use the cognitive-behavioral approach or relapse prevention treatment model as their primary approach (Freeman-Longo, Bird, Stevenson, & Fiske, 1995). In addition, almost all of the cognitive-behavioral treatment approaches attempt to treat the lack of victim empathy, cognitive distortions, denial, minimization of responsibility, and deviant sexual preferences (Marshall, 1999). Cognitive-behavioral treatment is delivered through group therapy, which is recognized as the most appropriate and effective way of delivering sex offender treatment. This is primarily because sex offenders may more easily manipulate their treatment providers to see their point of view in individual treatment (Fisher & Beech, 1999).

Initially, relapse prevention was used as a maintenance strategy to prevent drug addicts, alcoholics, and smokers from returning to using their initial substance (Laws, 1999). It was later adapted by Pithers, Marques, Gibat, and Marlatt (1983) to address sexual offending. According to the model, sex offenders must be committed to abstinence from sexual offending. They are then taught about *seemingly unimportant decisions (SUDS)* that may place them in high-risk situations. These situations might provide the opportunity to commit a new sex offense. Some SUDS can include going to restaurants, or recreation centers where children gather, keeping catalogs that display children in

bathing suits, or underwear, fantasies about exposing private parts to women in public settings, or buying pornographic material.

The self-regulation model suggests that sexual offending behaviors can occur through three distinct pathways: (a) disinhibition, (b) misregulation, and (c) purposeful (Ward, Hudson, & Keenan, 1998). Disinhibition involves sexually deviant urges and acts that result from situation or emotional triggers, such as anxiety, loneliness, low self-esteem, and chance contact with a potential victim. Misregulation involves efforts to control deviant sexual urges through counterproductive strategies, such as masturbating to deviant fantasies, resulting in offenders having less control, thus committing sex crimes. Finally, the purposeful pathway involves carefully planning the sex crimes and believing that sexual assaults are appropriate because of apparent attitudes, such as women want to be raped. With the purposeful pathway, sex offenders may experience positive affect or be frustrated that their goals of deviant sexual contact are thwarted.

Several behavioral treatments apply operant and classical conditioning principles to reduce deviant sexual urges, preferences, and fantasies (Heilbrun, Nezu, Keeney, Chung, & Wasserman, 1998; Marshall & Barbaree, 1978). These types of treatment assume that deviant sexual arousal and fantasies are formed through experiential learning and reinforcement. Behavioral treatments are typically used as adjunct treatments for sex offenders who express deviant sexual arousal patterns, fantasies, or preferences. For example, covert sensitization involves patients imagining that they are performing behaviors that have led to prior sex offenses and then interrupt the imagery before the offense occurs through an adverse consequence, such as being caught.

Defining "Successful" and "Unsuccessful" Treatment

Treatment for sex offenders is generally focused on the increase of adaptive behaviors and the reduction of maladaptive behaviors. Success is often measured by the reduction of or complete elimination of the maladaptive behavior. On the other hand, *unsuccessful* may be measured by the continuation or manifestation of maladaptive behavior. If an individual is successful in treatment, he will understand, internalize, and apply the treatment concepts, thereby demonstrating accountability, empathy, prosocial behavior, and an understanding of his deviant cycle and potential for relapse (Moore et al., 1999). However, the best indicator of successful treatment is for the offender to have no additional victims in his lifetime. This could be a difficult to measure. Therefore, in this study success was measured by the therapist's indication that an individual successfully completed treatment and that recidivism risk decreased significantly.

Predicting Treatment Outcome

Many variables predict of successful treatment completion, including both internal and external issues (Andrews & Bonta, 1998, 2003; Craissanti & Beech, 2001). Abel, Mittleman, Becker, and Rathner (1988) found that Antisocial Personality Disorder was associated with treatment dropout. However, others found no association between Antisocial Personality Disorder and treatment completion (Shaw et al., 1995). Individuals who are convicted of rape are less likely to accept responsibility for their behavior. Individuals who are convicted of incest and pedophilia tend to be more resistant to treatment (Marques et al., 1994). In addition, Craissanti and Beech (2004) found that individuals who rape were also less likely to participate in treatment and 57% of them

were rated by their therapists as being treatment non-compliant. The type of crime committed can predict treatment outcome.

Research over the last several decades examined whether or not sex offender treatment is effective, in addition to who is most likely to complete treatment successfully. Abel et al. (1988) studied child molesters and found that sex offenders who were not diagnosed with Antisocial Personality Disorder were most likely to complete a community-based treatment program. Of those who dropped out in this study, approximately 89% had assaulted both males and females in both contact (e.g., molestation, sexual penetration) and non-contact offenses (e.g., Internet porn, exhibitionism) prior to treatment. In addition, the study participants offended against both young children and adolescents (Abel et al., 1988).

Brown, Foreman, and Middleton (1998) studied 96 sex offenders in a community treatment group. They found that 60 offenders stayed in treatment and 36 dropped out. A checklist of nine factors was created after identifying the risk characteristics of those 36 offenders. The researchers used Thornton's (1999) Structured Anchored Clinical Judgment Scale (SACJ) and the risk factors to develop their hypotheses. The researchers hypothesized that there would be a positive relationship between the incidence of those risk factors and of treatment drop-out. The second hypothesis was that those that dropped out of treatment would score higher on the SACJ than those who remained in treatment (Brown et al., 1998).

The risk factors identified on the SACJ include sexual arousal to children; cognitive distortions; empathy deficits; emotional loneliness; views self as primary victim; relapse prevention deficits; unhelpful attitudes of significant victim; and

involvement in additional crimes. Using a discriminant factor analysis to analyze their data, they found support for the second hypothesis, but not the first (Browne et al., 1998).

The SACJ differs from the Static-99 in that it uses several steps to evaluate the offender's risk level and incorporates dynamic risk factors to determine risk. The dynamic factors are those factors that have the potential to change and when changed, are associated with corresponding increases, or decreases in recidivism (Hanson, 1998). The Static-99 uses only objective, static data. Static variables are things that are not likely to change much over a lifetime, such as engaging in criminal activity in adolescence. Because it contains only objective static variables, the Static-99 is a better assessment tool for the purposes of this study.

Research suggests that treatment completion is also related to the age and intelligence of the offender; the older and more intelligent the offender, the more likely he is to complete outpatient sex offender treatment, thus reducing individual recidivism (Geer et al., 2001). Sex offenders who dropped out of treatment had a history of sexual abuse, prior sexual and/or violent assaults before their index offense, and victimized both strangers and acquaintances (Craissanti & Beech, 2001; Craissanti, Falla, McClurg, & Beech, 2002). According to Marques et al. (1994), individuals who do not complete treatment are 5 times more likely to sexually reoffend and three times as likely to reoffend non-sexually. Hanson and Bussiere (1998) also concluded that not completing treatment significantly predicted both general and sexual recidivism.

Differences in treatment resistance and recidivism suggest that the ability to identify these differences could help clinicians distribute services and resources. In this regard highly motivated, high risk offenders would receive the greatest amount of

treatment resources because they would benefit the most from their treatment. In addition, clinicians and researchers could further develop and tailor treatment interventions for offenders not interested in receiving treatment (Langevin et al., 2004).

Sex Offender Risk Assessment

Assessing sex offenders for the risk of reoffense can pose a challenge. Sexual offending is different from other crimes because the risk factors for violence and general crime recidivism may not be the same as those for sexual recidivism. In 1998, Hanson and Bussiere conducted a meta-analysis of 87 articles based on 61 data sets. They found that in addition to general criminal history, deviant sexual arousal, deviant sexual attitudes, number of prior sex offenses, victimization of a stranger, victimization of an unrelated person, victimization of a male, and never being married predicted sexual recidivism (Hanson & Bussiere, 1998). Hanson and Morton-Bourgon (2004) replicated these findings in an updated meta-analysis, with additional clarification regarding deviant sexual arousal and attitudes. Many of the predictors identified by these researchers were included as variables on the Static-99.

According to Laws, Hudson, and Ward (2000), risk prediction is an essential part of the assessment process. Risk assessment is defined by Doren (2002) as the evaluation of an offender's likelihood that he will behave in a specific manner in the future. Since the completion of Meehl's work in 1954, actuarial risk prediction has proven far more effective than clinical prediction. Meehl's work, over a period of 40 years and in several different contexts, confirmed that clinical/subjective judgment is as good as, but often worse than, actuarial methods (Grove & Meehl, 1996; Janus & Meehl, 1997). Several

studies since 1954 supported the use of actuarial procedures to predict risk. These same studies suggest reliance on clinical prediction alone would be considered an unethical professional practice (Grove & Meehl, 1996; Hanson & Boussiere, 199; Mossman, 1994).

A large amount of literature over the past several decades supported the use of actuarial prediction over clinical prediction in decision-making (Harris, Rice, & Quinsey, 1993; Jones, 1998). For instance, research has demonstrated that mental health professionals possess no expertise in predicting violence and that the sole reliance on clinical judgment can result in inaccurate predictions of violent recidivism (Rice & Harris, 1995). However, the courts have upheld the constitutionality of laws that rely on clinical prediction, even when such predictions have low accuracy. According to Monahan (1996), the solution to improved violence prediction is the same as the solution to improved clinical predictions- the use of actuarial assessment.

Currently there is agreement that it is possible to predict general criminal recidivism with moderate accuracy by using an objective risk scale that specifies the risk factors to be considered and assigns relative weights to each of these factors (Hanson, 1997; Jones, 1998; Quinsey, Harris, Rice & Cormier, 1998).

Research indicates that while risk scales effectively predict general recidivism and non-sexual violent recidivism among sex offenders, the scales are not as effective at predicting sexual recidivism (Hanson, 1997). In their meta-analysis, Hanson and Bussier (1996) found that sexual recidivism could best be predicted by a different set of factors than those that predict general or non-sexual recidivism. Because of this finding, Hanson (1997) developed the Rapid Risk Assessment of Sex Offender Recidivism (RRASOR), a

brief risk scale designed to categorize sex offender into risk levels using items selected from his meta-analysis.

Several standardized instruments have been developed to assess the risk of sexual recidivism. The RRASOR is the most popular risk assessment tool in the United States and Canada and combines four characteristics in an additive fashion (Hanson & Thornton, 2000). The RRASOR considers male victim, unrelated victim, prior sex offenses and being released from prison (or inpatient secured institution) before the age of 25. A shortcoming of the RRASOR is that it relies only on official criminal history and ignores prior undetected crimes to probation officers or treatment providers.

The Structured Anchored Clinical Judgement-Minimum Version (SACJ-MIN) uses a two-step scoring system (Hanson & Thornton, 2000). The five characteristics that are scored first are: (a) any current sexual offense, (b) any prior sexual offense, (c) any current nonsexual offense, (d) any prior non-sexual offense, and (e) four or more previous sentences. The second step involves raising risk one category higher if an offender has two or more of the following eight characteristics: (a) any stranger victims, (b) any male victims, (c) never married, (d) convictions for hands-off sex offenses, (e) substance abuse, (f) placement in residential care as a child, (g) deviant sexual arousal, and (h) psychopathy.

The Static-99 combines the RRASOR and the SACJ-MIN. It has better predictive accuracy than the RRASOR or the SACJ-MIN alone (Hanson & Thornton, 2000). The Static-99 was developed in 1999 and it includes only static variables. Bonta, Law, and Hanson (1998) suggested that most of the predictive power of risk comes from static factors (e.g., age of offender, criminal history, relationship history, and victim type)

because these factors are least likely to be influenced by individual situation occurrences. These variables are valuable for predicting long-term sexual recidivism.

Few studies have focused on the use of actuarial assessment to determine which sex offenders will be successful or unsuccessful in treatment. This researcher contributed to this specific area of research by exploring the factors that are common among adult and child sex offenders. The following chapter outlines the research tools that were used and explains the research methodology and hypotheses.

CHAPTER 3. METHODS

Research Design

The purpose of this research was to investigate the extent to which successful completion of an outpatient adult sexual offender treatment program relates to the risk for sexual or violent recidivism. Specifically, completers and non-completers of the therapy program were compared in terms of each risk factor, overall risk score, and nominal risk category as determined by the Static-99. For the purposes of this study, non-completers were those sex offenders who voluntarily dropped out of treatment or were terminated from treatment by their treatment provider.

This study utilized a descriptive, non-experimental research design and a descriptive quantitative approach to analyze the data. A descriptive design was appropriate because this researcher aimed to determine participants' extent of risk for sexual and violent recidivism without the manipulation of independent variables. The sexual recidivism construct was assessed using a single measure at a single moment in time. Responses were analyzed using quantitative approaches, specifically descriptive and inferential statistical methods.

Research Questions and Hypotheses

The following research questions, with their corresponding null and alternative hypotheses, were addressed in this study:

Research Question 1: Is there a significant difference between completers and non-completers of an outpatient sex offender therapy program in their extent of risk for

sexual and violent recidivism?

Null Hypothesis 1: There is no significant difference between completers and non-completers of an outpatient sex offender therapy program in their extent of risk for sexual and violent recidivism.

Alternative Hypothesis 1: There is a significant difference between completers and non-completers of an outpatient sex offender therapy program in their extent of risk for sexual and violent recidivism. Sex offenders who have not completed the therapy program have significantly higher risks for sexual and violent recidivism compared to those who successfully completed the program. In terms of the nominal risk categories in the Static-99 questionnaire, non-completers will be labeled with risk categories that denote higher risks for sexual reoffending compared to completers of the treatment program.

Research Question 2: What are the common characteristics on the Static-99 of sex offenders who do not complete the outpatient sex offender treatment program?

Research Hypothesis 2: Sex offenders who have not completed the outpatient sex offender treatment program will have a greater tendency to have the following risk factors from the Static-99 for sexual and violent recidivism: (a) age less than 25 years old; (b) have never lived with an intimate partner for 2 years; (c) have committed a current non-sexual violent offense; (d) have a history of non-sexual violence; (e) presence of prior sexual offenses; (f) four or more previous sentencing dates; (g) have a history of non-contact sex offenses; and (h) have unrelated, stranger, and male victims.

Variables of the Study

For the first research question, the independent variable was the treatment status (i.e., completer or non-completer). This variable yielded categorical or nominal data, where the order of the data is purely arbitrary. For the *t*-test analysis, the dependent variable was the overall risk score for sexual reoffending on the Static-99. This variable yielded continuous or interval data. For the chi-square analysis, the dependent variable was the risk categories (i.e., high, moderate-high, moderate-low, or low), which yielded nominal or categorical data.

For the second research question, the independent variable for each of the chi-square tests was also the treatment status (i.e., completer or non-completer). The dependent variables were each of the risk factors for sexual recidivism.

Target Population

The target population was adult male sex offenders adjudicated to participate in specific outpatient sex offender therapy. Files of approximately 10 successful and 20 unsuccessful participants ranging in age from 18 to 80 were selected. This number is representative of the small number of individuals who completed treatment in the selected outpatient sex offender treatment program. The participants were in the outpatient treatment program from January 1, 2002 until December 31, 2007 and came from several central Illinois communities. A power analysis was not performed to determine an adequate sample size because the study was exploratory in nature.

Several outpatient treatment programs were contacted to participate in this study. Most refused to participate due to concerns about confidentiality or not having the

resources to participate. One agency that was contacted refused to participate because they were using all of their client data to present at an upcoming Association for the Treatment of Sexual Abusers (ATSA) conference. Only data from one program was used in the study, as the Program Director of this outpatient treatment program agreed to participate.

The treatment program selected uses a combination of cognitive/behavior and relapse prevention techniques to treat the offenders. In Illinois, this is the standard for the treatment of sexual offenders. The program serves all of the outpatient sex offenders for several central Illinois counties. All counseling staff had a Master's degree and a state license to conduct treatment. In addition, all staff received additional training in the assessment and treatment of sexual offenders. Staff are registered by the state Sex Offender Management Board (SOMB) as competent to assess and treat sex offenders. The counselors routinely used the Static-99 as part of the intake assessment for sex offenders entering the treatment program.

Selection of Participants

Participants consisted of adult male sex offenders who were previously treated and terminated from an adult sex offender outpatient counseling program in a small central Illinois city. These offenders were mandated to undergo outpatient therapy, referred by probation and parole. The treatment program also offers services to female sex offenders, but because females are a small percentage of the total sex offender population, they were excluded from this study. The program director selected files by looking through the filing cabinet that contained the discharged client files. If the file did

not contain the standard discharge paperwork, the file was excluded from the study. The files contained the standard discharge paperwork indicating if the client was successfully or unsuccessfully discharged from group therapy. The discharged client was considered as a participant in this study if the discharge report was complete because this indicates the client is not expected to return to treatment.

Only those clients involved in group therapy were included in this study. In some situations, clients were referred to individual therapy, or changed from group to individual therapy. These referral or changes were uncommon, therefore this study only utilized files from offenders who were referred to and terminated from group therapy.

Confidentiality was maintained because the researcher did not have access to the clients' files. Only the program director had access to the files containing identifying information. The researcher only used the data required to complete the analyses. No personal identifiers were provided to the researcher; such information was removed prior to the researcher receiving the data.

Instrumentation

Static-99

The Static-99 is designed help predict sexual and violent recidivism for sexual offenders. It was developed by Hanson and Thornton (1999) based on follow-up studies in Canada and the United Kingdom with a sample of 1,301 sexual offenders. According to Hanson and Thornton (1999), the Static-99 showed moderate predictive accuracy for both sexual recidivism (r = .33, ROC area = .71) and violent (including sexual) recidivism (r = .32, ROC area = .69). In addition, the Static-99 identified a substantial

subsample (12%) of offenders whose long-term risk for sexual recidivism was greater than 50%. The recidivism rates for the minimum entrant into the high risk category (score of 6) was 37%, 44% and 51% after 5, 10 and 15 years post release. However, most of the offenders were in the lower risk categories, with a long-term recidivism risk of 10% to 20%.

The Static-99 consists of 10 items and estimates future risk based upon the number of risk factors. The risk factors included on instrument are: (a) the presence of prior sexual offenses; (b) having committed a current non-sexual violent offense; (c) having a history of non-sexual violence; (d) the number of previous sentencing dates, age less than 25 years old; (e) having male victims; (f) having never lived with a lover for 2 years; (g) having a history of non-contact sex offenses; (h) having unrelated victims; and, (i) having victims that are strangers (Harris, Phenix, Hanson, & Thornton, 2003).

Treatment research found that those in the high risk category may be more difficult to treat and are at a higher risk to reoffend (Stirpe, Wilson, & Longe, 2001). Because of this finding, one of this researcher's hypotheses was that sex offenders who do not complete treatment would have a significantly higher risk for reoffending (as measured by the Static-99 questionnaire) compared to those who successfully completed treatment.

Procedures

The data was collected from client archival files located at the treatment program. All of the files of clients terminated between January 1, 2002 and December 31, 2007 were reviewed using a systematic review technique. The review began with the first file

in the cabinet. Files were classified by successful (complete) and unsuccessful (non-complete) termination. Those files that did not contain the Static-99 coding form, or a standard discharge report, were excluded from the study. Thus, only 36 client files were considered for this study.

The Static-99 Coding Form from each of the selected files was photocopied by the facility staff. A code was written on the back of each sheet such that S = successful and U = unsuccessful. This coding better enabled the researcher to distinguish the completers or non-completers. Clients' identifying information was removed to ensure their confidentiality. The Program Director mailed the forms to the researcher, who reviewed the forms to ensure they were all coded correctly. The data was then given to a statistician to input the data into SPSS version 17. Upon completion of the data entry, the forms were returned to the researcher for qualitative analysis. The results were then recorded and will be discussed later.

Data Collection

Security Procedures and Confidentiality

The facility Program Director accessed the file cabinet to select participants using a systematic sampling technique. In accordance with human subjects regulations, the researcher did not code any of the data. All identifying information was eliminated by the facility staff during the photo copying process, prior to forms being sent to the researcher. The researcher did not have access to the identity of the participants in the study.

Data Storage

The de-identified data was stored in a sealed envelope, marked confidential, and kept in a locked file cabinet when not in use. The researcher is the only one who possesses a key to the cabinet. After the data was analyzed, the data was locked in a secure file cabinet where it will be stored for a period of 10 years after which it will be shredded.

Data Analyses

SPSS version 17 was used to conduct the statistical analysis. The data was analyzed using descriptive and inferential statistics. First, descriptive statistics were used to summarize each of the risk factors, the total risk score, and the nominal risk categories for the Static-99 questionnaire. Then, a combination of descriptive and inferential statistics was used to address each of the research questions. Inferential statistics can be used to test hypotheses about differences or relationships in the population based on measurements from a sample of participants (Tabachnick & Fidell, 2007). All statistical conclusions were derived using an alpha level of .05.

An independent samples *t*-test was used to address research question 1. The *t*-test was used to compare the means obtained from the two groups of sexual offenders (i.e., completers and non-completers) to determine if there were any statistically significant differences between them (Mertens, 2005; Tabachnick & Fidell, 2007). The means represented the overall risk score for sexual reoffending. A Pearson chi-square test was calculated to compare the two groups of sexual offenders in their Static-99 nominal risk categories (i.e., high, moderate-high, moderate-low, or low). Cramer's *V* coefficient was

also calculated to investigate the extent of association between treatment status and risk category.

Descriptive statistics were used to address research question 2 and summarize the common characteristics of the non-completers for each risk factors in the Static-99 questionnaire. Next, Pearson chi-square tests were calculated to compare non-completers to completers of the program for each of the risk factors in the Static-99 questionnaire. Phi coefficients were also calculated to investigate the extent of association between treatment status and each of the risk factors for sexual reoffending.

Expected Findings

It was expected that the adult sexual offenders with a lower recidivism risk level, based on the 10 risk factors coded on the Static-99, would be more likely to complete the outpatient program. The offenders with the highest risk level were expected to be terminated or drop out of the program before completing treatment.

CHAPTER 4. RESULTS

The purpose of this study was to explore the extent to which unsuccessful completion of an outpatient adult sexual offender treatment program correlated with the risk for sexual or violent recidivism. In this chapter, the researcher presents the results of the data analysis, including the descriptive and inferential statistics to address the research questions.

Description of the Sample

Thirty six adult male sex offenders were selected to be part of the study. This number is representative of the small number of individuals who completed treatment in the selected sex offender treatment program. These participants were in the outpatient treatment program from January 1st, 2002 until December 31st 2007. A power analysis was not calculated in this study because study was exploratory. According to Tabachnick and Fidell (2007), when using inferential statistics, the data should be cleaned to remove univariate outliers. For univariate outliers, the dependent variable scores (i.e., the Static-99 risk total scores) were transformed into *z* scores. Cases with *z*-scores greater than 3.29 were considered univariate outliers. No univariate outlier were found and all 36 participants were included in the analyses.

Descriptive Statistics

The descriptive statistics for the entire sample of 36 adult male sex offenders can be found in Table 1. Descriptive statistics were calculated for each of the risk factors, the total risk score, and the nominal risk categories for the Static-99 questionnaire. Nearly

two-thirds (61.1%) of the participants did not complete the adult sexual offender treatment program and were considered non-completers in this study. Almost two-thirds (60%) of the participants were older (i.e., aged 25 or older). Nearly two-thirds (61.1%) of the participants had an intimate adult relationship of 2 years or more duration. None of the participants had a separate conviction for a non-sexual violent offence, or co-occurring offence, at the same time they were convicted of their index offence. Co-occurring offence is defined as the co-occurrence of a non-sexual violent offence and an index offence within the same period or phase. Meanwhile, the index offence is defined as the offence that the participant was convicted of leading to his/her detention. As such, this risk factor was not included in any further analyses.

In terms of prior convictions of non-sexual violence, about one third (30.6%) of the sex offenders' criminal records showed a separate conviction for a non-sexual violent offence. In terms of prior sex offences, most (77.8%) of the participants did not have prior charges or convictions of a sexual nature. However, close to a fifth (19.4%) of the sample had between one and two prior charges of a sexual nature, and one conviction. The majority (77.8%) of the sex offenders had three or fewer prior separate sentencing dates. Most (88.6%) of the participants' criminal records did not indicate a separate conviction for a non-contact sexual offence. Just over two-thirds (66.7%) of the participants had victims of sexual offences outside their immediate family. In addition, most (82.9%) participants knew the victim for at least 24 hours prior to the offence. Finally, only 2 of the 36 (5.6%) male participants had male victims, the rest of the victims were female.

The average total risk score on the Static-99 for all of the participants

corresponded to a risk category of moderate-low (M = 2.58, SD = 1.71). Nearly half (47.2%) of the participants scored moderate-low risk for sexual and violent recidivism. More than a quarter (27.8%) of the sex offenders scored low risk for sexual and violent recidivism. Almost a quarter (22.2%) of the sample scored in the moderate-high risk category. Only one participant scored in the high risk category for sexual and violent recidivism.

Table 1. Frequencies and Percentages of Study Variables (N = 36)

Variable	Frequency	%
Sex Offender Treatment Program Status		
Completer or Successful	14	38.9
Non-Completer or Unsuccessful	22	61.1
Young (i.e., Age Group)		
Aged 18 to 24.99	14	38.9
Aged 25 or older	22	61.1
Ever Lived with an Intimate Partner – 2 years		
Yes	22	61.1
No	14	38.9
Index Non-Sexual Violence – Any Convictions		
Yes	0	0.0
No	36	100.0
Prior Non-Sexual Violence – Any Convictions		
Yes	11	30.6
No	25	69.4
Prior Sex Offences		
No Charges, No Convictions	28	77.8
1 to 2 Charges, 1 Conviction	7	19.4
6+ Charges, 4+ Convictions	1	2.8

Table 1. Frequencies and Percentages of Study Variables (continued)

Variable	Frequency	%
Any Convictions for Non-Contact Sex Offences		
Yes	4	11.4
No	32	88.6
Any Unrelated Victims		
Yes	24	66.7
No	12	33.3
Any Stranger Victims		
Yes	6	17.1
No	30	82.9
Any Male Victims		
Yes	2	5.6
No	34	94.4
Risk Category		
High	1	2.8
Moderate - High	8	22.2
Moderate - Low	17	47.2
Low	10	27.8
Prior Sentencing Dates		
3 or Less	28	77.8
4 or more	8	22.2

Main Analyses

Research Question 1

The first research question asked, "Is there a significant difference between completers and non-completers of an outpatient sex offender therapy program in their extent of risk for sexual and violent recidivism?" Two statistical procedures were

conducted to address this research question. The first analysis involved an independent samples *t*-test to compare completers and non-completers' Static-99 total risk scores. The result of this analysis is presented in Table 2. The *t* statistic was significant, $t(34) = 4.14$, $p < .001$. This indicates a significant difference in the risk total scores of completers and non-completers of the program. Non-completers ($M = 3.36$, moderate-low risk) had significantly higher total risk scores compared to completers of the program ($M = 1.36$, low risk). According to the Static-99, participants who did not complete the therapy program had a higher risk for reoffending compared to those who successfully completed the program.

The second analysis was a chi-square test to explore if there is a significant difference between completers and non-completers' Static-99 risk category: high, moderate-high, moderate-low, or low. The results of the analysis are presented in Table 3. The chi-square analysis yielded a significant result, $\chi^2(3) = 12.93$, $p < .01$. This indicates a significant difference between completers and non-completers' risk categories. Based on the percentages (see Table 3), non-completers of the therapy program were more likely to have moderate-high and moderate-low risks for sexual and violent recidivism. In contrast, completers of the program were more likely to have low risks for sexual and violent recidivism.

Following a significant chi-square, an odds ratio was calculated as a post-hoc analysis to compare the probability of completers and non-completers in having either moderate-low or low risks for reoffending. An odds ratio was not calculated for the moderate-high and high risk categories because there were no completers of the sample who qualified for these labels. The odds ratio was 7.33. This means that non-completers

of the therapy program were 7 times more likely to score in the moderate-low risk for reoffending than participants who completed the program. In contrast, completers of the therapy program were 7 times more likely to score in the low risk for reoffending than their non-completer of the peers.

The association between treatment status and risk category was also assessed using a Cramer's *V* coefficient and the correlation was significant, Cramer's $V = .60$, $p < .01$. Using Cohen's (1988) guidelines for interpreting the magnitude of correlation coefficients, the obtained Cramer's *V* is large. Thus, there was a significantly strong association between being a completer or non-completer of the therapy program, and their risk category for reoffending. The higher the risk score, the more likely the participant would not have completed treatment. The result also indicates that a sexual offender's treatment status explains 36% of the variance in recidivism risk categories.

Table 2. Independent Samples t – Test Comparing the Overall Risk of Sexual Re-Offending of Completers and Non-Completers of an Outpatient Sex Offender Therapy Program ($N = 36$)

	Successful		Unsuccessful				
Variable	*M*	*SD*	*M*	*SD*	*df*	*t*	*p*
Overall Risk Score	1.36	1.28	3.36	1.50	34	4.14	.001

Note. *M* = mean. *SD* = standard deviation.

Research Question 2

The second research question asked, "What are the common characteristics on the

Static-99 of sex offenders who do not complete outpatient sex offender treatment program?"

To address this research question, descriptive statistics were first presented for the non-completers of an outpatient sex offender therapy program for each of the risk factors in the Static-99 questionnaire (see Table 3). More than half (57.1%) of non-completers were in the younger age group (i.e., aged 18 to 24.99). Slightly more than half (54.5%) of the non-completers ever had an intimate adult relationship of 2 years duration. Almost half (45.5%) of the non-completers' criminal records show a separate conviction for a non-sexual violent offence. These findings separate the group of participants who did not complete treatment from those who had. A majority of the program completers in this study were in the older age group (85.7%), had lived with an intimate partner 2 years or more (85.7%), and did not have prior non-sexual convictions (92.9%).

A second set of statistical analyses was used to explore the significance of the differences between the participants in the study. This process involved chi-square tests to compare non-completers of the therapy program to completers of the program for each of the risk factors in the Static-99 questionnaire. Results of these comparisons, including frequencies and percentages for each group, are presented in Table 3.

The first chi-square test explored if there is a significant difference between non-completers and completers by their age group: aged 18 to 24.99 and aged 25 or older. The chi-square analysis yielded a significant result, $\chi^2(1) = 6.43$, $p < .05$. This result means that there is a significant difference in age grouping between non-completers and completers. Non-completers of the therapy program were more likely to be in the younger age group compared to completers of the program (see Table 3). As a post-hoc

analysis to a significant chi-square, odds ratio was calculated to compare the probability of non-completers and completers of the therapy program in their age group. The odds ratio was 8. This means that non-completers of the therapy program were 8 times more likely to be in the younger age group (i.e., aged 18 to 24.99) versus the older age group (i.e., aged 25 or older) compared to completers of the program. The association between treatment status and age group was also assessed using a Phi coefficient and the correlation was significant, $Phi = .43$, $p < .05$. Using Cohen's (1988) guidelines for interpreting the magnitude of correlation coefficients, the obtained Phi is moderate. Thus, there was a significantly moderate association between being a completer or non-completer of the therapy program and age. The result also indicates that sexual offenders' treatment status explains 18% of the variance in age group.

The second chi-square test explored if there is a significant difference between non-completers and completers in their history of prolonged intimate connection with a partner. The chi-square analysis yielded a significant result, $\chi^2(1) = 5.84$, $p < .05$. This result indicates a significant difference between non-completers and completers of the therapy program in their history of prolonged intimate connection with a partner. Non-completers of the therapy program were more likely to not have had an intimate adult relationship of 2 years duration (see Table 3). As a post-hoc analysis to a significant chi-square, odds ratio was calculated to compare the probability of non-completers and completers of the therapy program in their history of prolonged intimate relationship. The odds ratio was 7.2. Non-completers of the therapy program were 7 times more likely to have never had an intimate adult relationship of 2 years duration compared to completers of the program. The association between treatment status and intimate relationship

history was also assessed using a Phi coefficient and the correlation was significant, *Phi* = .40, $p < .05$. Using Cohen's (1988) guidelines for interpreting the magnitude of correlation coefficients, the obtained Phi is moderate. Thus, there was a significantly moderate association between being a completer or non-completer of the therapy program, and their history of prolonged intimate relationship. The result also indicates that sexual offenders' treatment status explains 16% of the variance in history of prolonged intimate relationship.

The third chi-square test explored if there is a significant difference between non-completers and completers in their history of convictions of non-sexual violence. The chi-square analysis yielded a significant result, $\chi^2(1) = 5.92$, $p < .05$. This result means that there is a significant difference in their history of convictions of on-sexual violence between non-completers and completers of the therapy program. Non-completers of the therapy program had a higher percentage of criminal records indicating a separate conviction for a non-sexual violent offence (see Table 3). As a post-hoc analysis to a significant chi-square, an odds ratio was calculated to compare the probability of non-completers and completers of the therapy program in their history of convictions of non-sexual violence. The odds ratio was 10.83. This indicates that non-completers of the therapy program were about 11 times more likely to have criminal records that show a separate conviction for a non-sexual violent offence compared to completers of the program. The association between treatment status and non-sexual violence conviction history was also assessed using a Phi coefficient and the correlation was significant, *Phi* = .41, $p < .05$. Using Cohen's (1988) guidelines for interpreting the magnitude of correlation coefficients, the obtained Phi is moderate. Thus, there was a significantly

moderate association between being a completer or non-completer of the therapy program, and their history of convictions of non-sexual violence. The result also indicates that sexual offenders' treatment status explains 17% of the variance in history of convictions of non-sexual violence.

The fourth chi-square test explored if there is a significant difference between non-completers and completers in their prior sex offences. The chi-square analysis yielded an insignificant result, $\chi^2(2) = 3.09$, $p = .21$. This result means that there is no significant difference between non-completers and completers of the therapy program in their history of charges or convictions of a sexual nature. Most of the sexual offenders in both groups did not have prior charges and convictions of a sexual nature.

The fifth chi-square test explored if there is a significant difference between non-completers and completers in their number of prior sentencing dates. The chi-square analysis yielded an insignificant result, $\chi^2(1) = 3.01$, $p = .08$. This result means that there is no significant difference between non-completers and completers of the therapy program in their number of prior sentencing dates. Most of the sexual offenders in both groups had three or less prior sentencing dates.

The sixth chi-square test explored if there is a significant difference between non-completers and completers in their convictions for non-contact sex offences. The chi-square analysis yielded an insignificant result, $\chi^2(1) = 0.32$, $p = .57$. This result means that there is no significant difference between non-completers and completers of the therapy program in their history of separate convictions for non-contact sexual offences. Most of the sexual offenders in both groups did not have prior convictions for non-contact sexual offences.

The seventh chi-square test explored if there is a significant difference between non-completers and completers of an in their history of offence against unrelated victims. The chi-square analysis yielded an insignificant result, $\chi^2(1) = 2.86$, $p = .09$. This result means that there is no significant difference between non-completers and completers of the therapy program in their history of having victims of sexual offences outside their immediate family.

The eighth chi-square test explored if there is a significant difference between non-completers and completers in their history of offence against stranger victims. The chi-square analysis yielded an insignificant result, $\chi^2(1) = 0.13$, $p = .71$. This result means that there is no significant difference between non-completers and completers of the therapy program in their history of having victims of sexual offences who are not known to them for at least 24 hours prior to the offence. Most of the sexual offenders in both groups had victims who were known to them for at least 24 hours before the offence.

The ninth chi-square test explored if there is a significant difference between non-completers and completers in their history of offence against male victims. The chi-square analysis yielded an insignificant result, $\chi^2(1) = 0.11$, $p = .74$. This result means that there is no significant difference between non-completers and completers of the therapy program in their history of having male victims of sexual offences. Most of the sexual offenders in both groups had female victims.

In general, sexual offenders who did not successfully complete the outpatient sex offender treatment had the following common characteristics, which were significantly different from those who have completed the therapy program: (a) most are aged 18 to 24.99; (b) most have never had an intimate adult relationship of 2 years or more duration;

(c) there was a significant number of non-completers who had a prior conviction for a non-sexual violent offence; and (d) more likely to have moderate-low, moderate-high, and high risks for sexual and violent recidivism based on the Static-99.

Table 3. Chi-Square Tests Comparing Completers and Non-Completers of an Outpatient Sex Offender Therapy Program in the STATIC-99 Risk Factors and Categories ($N = 36$)

Variable	Completers		Non-Completers				
	f	%	*f*	%	*df*	χ^2	*p*
Young (i.e., Age Group)					1	6.43	.011
Aged 18 to 24.99	2	14.3	12	57.1			
Aged 25 or older	12	85.7	9	42.9			
Ever Lived w/ Intimate Partner					1	5.84	.016
Yes	12	85.7	10	45.5			
No	2	14.3	12	54.5			
Prior Non-Sexual Violence – Any Convictions					1	5.92	.015
Yes	1	7.1	10	45.5			
No	13	92.9	12	54.5			
Prior Sex Offences					2	3.09	.213
No Charges, No Convictions	13	92.9	15	68.2			
1 to 2 Charges, 1 Conviction	1	7.1	6	27.3			
6+ Charges, 4+ Convictions	0	0.0	1	4.5			
Prior Sentencing Dates					1	3.01	.083
3 or Less	13	92.9	15	68.2			
4 or more	1	7.1	7	31.8			
Any Convictions for Non-Contact Sex Offences					1	0.32	.572
Yes	2	15.4	2	9.1			
No	11	84.6	20	90.9			

Table 3. *Chi-Square Tests Comparing Completers and Non-Completers of an Outpatient Sex Offender Therapy Program in the STATIC-99 Risk Factors and Categories* (continued)

	Completers		Non-Completers				
Variable	*f*	%	*f*	%	*df*	χ^2	*p*
Any Unrelated Victims					1	2.86	.091
Yes	7	50.0	17	77.3			
No	7	50.0	5	22.7			
Any Stranger Victims					1	0.13	.714
Yes	2	14.3	4	19.0			
No	12	85.7	17	81.0			
Any Male Victims					1	0.11	.740
Yes	1	7.1	1	4.5			
No	13	92.9	21	95.5			
Risk Category					3	12.93	.005
High	0	0.0	1	4.5			
Moderate - High	0	0.0	8	36.4			
Moderate - Low	6	42.9	11	50.0			
Low	8	57.1	2	9.1			

Note. % represents percentages within treatment status.

CHAPTER 5. RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

Discussion

The purpose of this research was to investigate the extent to which unsuccessful completion of an outpatient adult sexual offender treatment program is related to the risk for sexual or violent recidivism. Specifically, completers and non-completers of the therapy program were compared in terms of each risk factor measured, overall risk score, and nominal risk category as determined by the Static-99 questionnaire. It was expected that the adult sexual offenders with a lower recidivism risk level based on the ten risk factors coded on the Static-99 would be more likely to successfully complete the outpatient program. The offenders with the highest risk level assigned would be more likely to be terminated or drop out of the treatment program. The study findings are discussed in the following paragraphs.

There is a significant difference between completers and non-completers of an outpatient sex offender therapy program in their extent of risk for sexual and violent recidivism. This hypothesis was supported, suggesting that the Static-99 risk score may be related to treatment completion. Two statistical procedures were conducted to address the research question. The first analysis involved an independent samples *t*-test to compare the risk total scores of treatment completers and non-completers. The means represented the overall risk score for sexual reoffending. The results showed that non-completers of the outpatient sex offender therapy program had significantly higher total risk scores than completers of the program, that there is a significant difference between completers and non-completers' overall risk categories, and that they were more likely to

have moderate-high and moderate-low risks for sexual and violent recidivism compared to completers of the program.

The outpatient sex offender therapy program used in this study is based on relapse prevention. Relapse prevention was used as a maintenance strategy to prevent sexual offenders from sexual offending. They are then taught about seemingly unimportant decisions (SUDS) that may place them in high-risk situations. These situations might provide the opportunity to commit a new sex offense. Some seemingly unimportant decisions can include going to restaurants, or recreation centers where children gather, keeping catalogs that display children in bathing suits, or underwear, fantasies about exposing private parts to women in public settings, or buying pornographic material and so forth. Therefore, non-completers have not committed to abstinence and have not learned and practiced SUDS, which may place them in high-risk situations. The non-completers of the therapy program were 7 times more likely to have moderate-low risks for reoffending compared to the completers of the program. Completers of the program were in a low risk category and they received the SUDS skills.

The descriptive statistics suggest that in terms of the nominal risk categories, half (50%) of non-completers received a label of moderate-low risk for sexual and violent recidivism. Moreover, a third (36.4%) of non-completers had moderate-high risk for sexual and violent recidivism. This implies that 86.4% of non-completers pose risks for sexual and violent recidivism. In other words, the males with the greatest risk for reoffending received the least amount of treatment by dropping out early and not completing the treatment program. This makes it critical to encourage moderate-high risk sexual offenders to complete their programs.

The next hypothesis was that sex offenders who have not completed the outpatient sex offender treatment program will have a greater tendency to have the following risk factors for sexual and violent recidivism: (a) age less than 25 years old; (b) have never lived with an intimate partner for 2 continuous years; (c) have committed a current non-sexual violent offense; (d) have a history of non-sexual violence; presence of prior sexual offenses; (e) four or more previous sentencing dates; (f) have a history of non-contact sex offenses; and have unrelated, stranger, and male victims. To address this hypothesis, descriptive statistics were presented for the non-completers of the program for each of the risk factors in the Static-99 questionnaire. A statistical analysis was then conducted using chi-square tests to compare non-completers to completers for each of the risk factors in the Static-99 questionnaire. The first chi-square test revealed that there is a significant difference between non-completers and completers in their Static-99 age group. Based on the percentages, non-completers were more likely to be in the younger age group than completers of the program. Non-completers were 8 times more likely to be in the younger age group than the completers of the program. Using a Phi coefficient, the analysis showed that there was a significantly moderate association between being a completer or non-completer of the therapy program and their age group. The descriptive statistics suggest that more than half (57.1%) of non-completers are in the younger age group (i.e., aged 18 to 24.99) while the rest (42.9%) are aged 25 or older.

In terms of prolonged intimate connection with a partner, more than half (54.5%) of the non-completers have never had an intimate adult relationship of 2 years duration. However, close to half (45.5%) have had an intimate adult relationship of 2 years duration. The second chi-square test explored if there is a significant difference between

non-completers and completers of an outpatient sex offender therapy program in their history of prolonged intimate connection with a partner and yielded a significant result, suggesting that there is a significant difference between non-completers and completers of the therapy program in their history of prolonged intimate connection with a partner. Non-completers were more likely to have never had an intimate adult relationship of 2 years duration compared to completers. Non-completers were also 7 times more likely to have never had an intimate adult relationship of 2 years duration compared to completers of the program. There was a significant moderate association between being a completer of the therapy program, and their history of prolonged intimate relationship.

Considering the results of the first two chi-square analyses, it appears that age and intimate relationships do not define non-completers. However, it defines patients who complete the sex offender therapy program. Only a few completers did not have an intimate 2-year relationship and only few completers were in the younger age group. Analyzing this further, one could conclude that older sex offenders have more time to spend in intimate relationships. This also brings about a higher level of maturity on the part of the patient. Moreover, older patients tend to stay in one area to complete their programs while younger patients are more likely to move which would affect their completion of the program.

The third chi-square test explored if there is a significant difference between non-completers and completers in their history of convictions of non-sexual violence and yielded a significant result, suggesting a significant difference between non-completers and completers' history of convictions of non-sexual violence. Non-completers had a higher percentage of having criminal records that show a separate conviction for a non-

sexual violent offence and were about 11 times more likely to have criminal records that show a separate conviction for a non-sexual violent offence compared to completers of the program. There was a significantly moderate association between being a completer or non-completer of the therapy program and history of convictions of non-sexual violence. The significant difference implies that sex offenders who have history of convictions of non-sexual violence do not deem the sex offender therapy program as an effective means to change their perspective about offenses. These patients do not complete their therapy program because they do not find it valuable. It is also possible that sexual offenders who have other non-sexual offenses should have a different therapy program. This program should focus on all other offenses such that the patient understands the implications of his/her offenses in general.

The fourth chi-square test explored whether there is a significant difference between non-completers and completers' prior sex offences and yielded an insignificant result. This suggests that there is no significant difference between non-completers and completers of the therapy program in their history of charges, or convictions of a sexual nature. Most of the sexual offenders in both groups did not have prior charges and convictions of a sexual nature.

The fifth chi-square test explored if there is a significant difference between non-completers and completers of an outpatient sex offender therapy program in their number of prior sentencing dates and yielded an insignificant result. This suggests that there is no significant difference between non-completers and completers' number of prior sentencing dates. Most of the sexual offenders in both groups did not have three or less prior sentencing dates. Therefore, the sentences to offenders do not affect their decision

to accept relapse prevention.

The sixth chi-square test explored if there is a significant difference between non-completers and completers' convictions for non-contact sex offences and yielded an insignificant result. This suggests that there is no significant difference between non-completers and completers' history of separate convictions for non-contact sexual offences. In fact, most of the sexual offenders in both groups did not have prior convictions for non-contact sexual offences, which are common among sexual offenders (Craissanti & Beech, 2001). Prior sex offense charges and convictions can also affect one's risk of reoffense; however little is known regarding the implications for sex offender treatment. In this study, the descriptive statistics suggest that more than half (54.5%) of the non-completers' criminal records show a separate conviction for a non-sexual violent offence. Thus, it could be observed that violence, in general, affects the completion of sex offenders. Patients who have a separate conviction for non-sexual violent offence do not see the importance of the therapy program. This makes them more difficult to treat.

In terms of prior sex offences, most (68.2%) of the non-completers did not have charges or convictions of a sexual nature, however more than a quarter (27.3%) of the non-completers had between one and two charges, and one conviction of a sexual nature. Most (68.2%) of the non-completers had three or fewer separate sentencing dates and the majority (90.9%) of the non-completers' criminal records did not indicate a separate conviction for a non-contact sexual offence. This further strengthens the previous conclusion that prior engagement in other offences makes it more difficult for patients to appreciate the value of the programs. Multiple incarcerations can indicate a greater level

antisocial behavior and criminal thinking (Bianchi & Lawrence, 2006). The more incarcerations, the more likely antisocial behavior and thinking become entrenched. Treatment success for these individuals is also more unlikely.

Moore et al. (1999) found in their comparison of treatment completers and non-completers, a diagnosis of Antisocial Personality Disorder often interfered with treatment completion. When an individual is diagnosed with a personality disorder, they may be less capable of flexible thinking, less likely to access support, and less likely to follow the rules. Antisocial offenders are also more likely to have a complex level of criminal thinking and criminogenic needs. Sex offender treatment only addresses one area of need for these offenders. It is possible that this treatment is unable to meet the criminogenic needs of the non-completers. It not known whether any of these offenders were diagnosed with Antisocial Personality Disorder. However, it may be that non-completers were more likely to possess antisocial characteristics, which rendered them more likely to disobey the rules. This is consistent with Abel et al.'s (1988) findings that Antisocial Personality Disorder is associated with treatment dropout.

The eighth chi-square test explored if there is a significant difference between non-completers and completers ' history of offence against stranger victims and yielded an insignificant result. There was no significant difference between non-completers and completers' history of having victims of sexual offences who are not known to them for at least 24 hours prior to the offence. Pertinent to the characteristics of the victims, most (77.3%) non-completers had victims outside their immediate family, which means that 33.3% of the non-completers perpetrated against a family victim. This percentage is close to Waterhous, Carnie, and Dobash's (1993) finding that 40% of the offenders were

related to their victim. This percentage may be reflective of all sex offenders who have difficulty in completing the therapy program.

The Static-99 suggests that those who offend against a family member may pose less of a risk to reoffend (Hanson & Thornton, 2003). This finding may be important because if it is believed that they are at less risk to reoffend, an offender may be more willing to change their cognitive distortions. Most pedophiles who offend within the family will justify their offending with distortions. In addition, Marshall (1997) noted that child molesters often make an effort to restrain empathy for their victims in order to sexually abuse them. Marshall believes that by continually engaging in restraint, it leads to entrenchment of a lack of empathy toward similar populations to their victims. Because of this entrenchment, these men may be difficult to treat.

Men who abuse or rape their spouses may also justify their offenses with cognitive distortions. Because these offenses are more likely to be motivated by interpersonal reasons or emotions, it is less likely that a stranger or a friend could evoke the same emotions that a family member can. In addition, sometimes family members will support the offender, minimizing his actions and responsibility. Therefore, when he is not held accountable, he may not succeed in treatment. Like violence, offenders who have a family member as their victim were less likely to complete their program. The findings from this study suggest that violence in any other offense and offenses against family members contribute to non-completion of therapy programs. This finding is important because it suggests that a different approach is necessary for such sexual offenders.

Both types of offenders may make a concerted effort to maintain their cognitive

distortions. Geer et al. (2001) found that lower levels of distortions predicted treatment completion, so it seems likely that the opposite would be true. More specifically, sex offenders with high levels of cognitive distortions would be less likely to complete treatment.

The ninth and final chi-square test explored if there is a significant difference between non-completers and completers' history of offence against male victims. The chi-square analysis yielded an insignificant result. It is of little surprise that most of the victims were female. What is surprising, however, is that while research shows treatment failures and perpetrators with male victims are at greater risk to recidivate, this study found that non-completers were mostly perpetrators against women. Although, the Static-99 demonstrates that sex offenders who perpetrate against males are at a greater risk to reoffend, there is very little known about the relationship between the gender of the victim and the efficacy of treatment.

The media objectification and sexualization of women may be a contributing factor to this phenomenon. In addition, portrayals in the media may perpetuate distortions that blame the victim. These distortions are often maintained in society, giving offenders support or justification for their actions and consequently they do not take responsibility for their actions. Feminist theory argues that sexual abuse, primarily rape of women, reinforces stereotypical gender roles (Donat & D'Emilio, 1992). Consequently, sexual abuse of females is as a mechanism of social control that affects how the sexual abuse is defined and how the victims are perceived and treated. As a result, a rape culture is ultimately created.

If rape is considered a social norm, or even ignored, what are sexual abusers of

women in treatment for? This may be one of the most difficult distortions to treat and to change because this becomes a part of the culture. If the sexual abuse of females becomes a norm in society, it would be meaningless to exert effort in treating sexual offenders. In this case, it is important to negate stereotypical gender roles by convicting offenders and ensuring that they understand the consequences of this action. Moreover, they should be aware that sexual abuse does not add to their masculinity, instead, it degrades their status in society (Moore et al., 1999).

In summary, the findings of this study suggest that the sexual offenders who successfully completed the sex offender treatment were significantly different from those who did not completed the therapy program in the following ways: (a) most are aged 24.99 and up; (b) most had an intimate adult relationship of 2 years duration; (c) a significant number of completers did not have a separate conviction for a non-sexual violent offence; and (d) they were more likely to have low risk for sexual and violent recidivism.

Limitations of the Study

This study was able to identify specific findings related to sex offenders who are successful and not successful in treatment completion. However, there are some limitations to this study. One common problem of archival data is the lack of complete information for each participant. Only a limited number of things can be done when this occurs, including data substitution or removing the participant from the analysis. Because the most important data for this study involved the Static-99 and a complete discharge summary, it was necessary condition to include the participant in the samples.

A second limitation was the small sample size. This limits an adequate evaluation of the predictive utility of the measure. A larger sample size would have increased the statistical power of the study. There were some correlations between the assigned risk levels and treatment outcome and it is possible that these correlations suggest a predictive relationship. However, because this study was not concerned with predictive measures, the sample size for this study was sufficient to answer the research questions. In the case of the Static-99, there are currently no other studies that have revealed a relationship between an individual's risk level and treatment outcome.

One final limitation similar is the short duration of the study. If this study included participants in treatment beyond over the 5-year period that was selected, the sample size would have increased. There would have been a larger number of offenders who did not complete, as well has a larger number of offenders who did complete, allowing for a larger comparison group. This could enhance the study's findings.

This research study also considered only one outpatient sex offender therapy program. In future studies, it would be more valuable to explore different programs to determine how the findings of this study are relevant to a larger population. Moreover, would provide a means to generalize the therapy programs for specific types of sexual offenders.

Implications for Professional Practice

The findings presented in this study have important implications with regard to the assessment and treatment of adult sex offenders in an outpatient therapy program. One possibility is that sex offenders with different risk levels might benefit from different

treatment strategies. For example, those who possess higher risk levels and associated characteristics and are just beginning treatment could be placed in a common group to break down similar cognitive distortions in the first few months of treatment. This would ensure that each group is at the same stage of their therapy. Moreover, the patients could identify with their fellow patients such that they could help one another commit to complete the outpatient sexual offender therapy program.

It is important to note that it can be difficult to identify, or even predict who may or may not complete sex offender treatment. However, knowing the history of an offender may help to provide pertinent information about their chances of being successful in treatment. By knowing which offenders may be at risk to not complete treatment, they may be identified earlier in treatment and given additional supportive programming. For example, the at-risk offender may be assigned to a primary clinician who is involved in all aspects of programming (i.e., sex offender treatment, mental health, substance abuse, etc.). In addition, a peer who is successful in treatment could be assigned as an offender's "mentor" to aid in participation and to serve as a positive role model. Knowing patients' status could help match appropriate programs to ensure that they could complete the program. The significant correlations identified through this study could provide a means to develop specific programs for specific groups or types of sexual offenders.

Recommendations for Future Research

There are a number of areas for future research with regard to sex offenders in outpatient therapy. Perhaps one of the most important areas for future research is to

conduct the research study using a much larger sample. This could possibly involve sexual offenders in different programs to expand the generalizability of the study to different programs. A larger sample size could allow deeper sets of analyses and insights. This could also ensure that the findings of the study are generalizable to the population. Moreover, including a wider range of programs could determine whether the type of program affects completion and non-completion in order to enhance the current programs to ensure completion amongst majority of the sexual offenders.

Another area of research that could be expanded is how therapists provide treatment. If there was a way to identify whether or not treatment is provided objectively and consistently to each individual, some of the dynamic factors in treatment could be eliminated or reduced. If the goal is for the offender to be successful in treatment, it would be important to address bias, on the part of either the offender or the provider, through supportive confrontation, continuous supervision, and training. How the therapist provides treatment and handles each offender's issues is an important area of research.

The demographic profiles of individuals could also be gathered. This includes the socioeconomic status, ethnicity, and educational level to determine whether these factors affect success rate. The affect of demographic characteristics on program completion could be determined. The contribution of this expansion in the field of research could provide a means for institutions to classify patients and appropriately match their needs through program activities.

Conclusion

This research study was able to differentiate the background of completers and

non-completers of an outpatient sex offender therapy program. Completers had the following characteristics, which differed from non-completers: (a) most are aged 24.99 and up, (b) most had an intimate adult relationship of 2 years duration, (c) a significant number of completers did not have a separate conviction for a non-sexual violent offence, and (d) they were more likely to have low risk for sexual and violent recidivism.

This study contributes to further understanding the assessment and treatment of adult sex offenders in an outpatient therapy program. The results of this study may encourage using specific treatment strategies based on the patients' characteristics to ensure that they complete the treatment program. There are many areas that could be expanded in this research study. This includes a larger sample size, the consideration of different sex offender treatment programs, and the consideration of other demographic variables. This could enhance the application of the findings to the target population.

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APPENDIX. STATIC-99 CODING FORM

STATIC-99 Coding Form

Question Number	Risk Factor	Codes	Score
1	Young (S9909)	Aged 25 or older Aged 18 – 24.99	0 1
2	Ever Lived With (S9910)	Ever lived with lover for at least two years? Yes No	 0 1
3	Index non-sexual violence - Any Convictions (S9904)	No Yes	0 1
4	Prior non-sexual violence - Any Convictions (S9905)	No Yes	0 1
5	Prior Sex Offences (S9901)	Charges / Convictions None / None 1-2 / 1 3-5 / 2-3 6+ / 4+	 0 1 2 3
6	Prior sentencing dates (excluding index) (S9902)	3 or less 4 or more	0 1
7	Any convictions for non-contact sex offences (S9903)	No Yes	0 1
8	Any Unrelated Victims (S9906)	No Yes	0 1
9	Any Stranger Victims (S9907)	No Yes	0 1
10	Any Male Victims (S9908)	No Yes	0 1
	Total Score	**Add up scores from individual risk factors**	

TRANSLATING STATIC 99 SCORES INTO RISK CATEGORIES

Score	Label for Risk Category
0,1	Low
2,3	Moderate-Low
4,5	Moderate-High
6 plus	High