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Measuring Motivation to Change in Sexual Offenders From Institutional Intake to Community Treatment

Marianne Barrett,[1] Robin J. Wilson,[1,2] and Carmen Long[1]

Changes in motivational levels occurring during various stages of treatment (institutional and community) were measured among 101 federally sentenced sexual offenders in the Ontario region. Motivation was conceptualized as a dynamic process that can be construed from behavioral referents and more global evaluations of internal features/readiness/psychological stance. Five motivational indices were examined: acceptance of guilt for the offense; acceptance of personal responsibility for the offense; disclosure of personal information; motivation to change behavior; and participation in treatment. Offender scores on these indices were evaluated using the Goal Attainment Scaling protocol (T. Hogue, 1994), at four stages of the treatment process: (1) at institutional assessment, (2) following institutional treatment, (3) upon conditional release to the community, and (4) following a 12-week period of community treatment. Results showed that motivation to change sexually deviant behavior was higher at the end of institutional treatment relative to the initial assessment. However, levels of motivation decreased upon conditional release to the community, with few offenders making significant rebounds following 12 weeks of community treatment. Admission of guilt and acceptance of personal responsibility (measured at community treatment) were both significantly associated with treatment outcome.

KEY WORDS: sexual offenders; motivation; goal attainment scaling; relapse prevention; treatment outcome.

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INTRODUCTION

The notion that motivation is an important component in the change process is not new. Many studies have examined the issue of motivation as it relates to the outcome of psychotherapy (Karoly, 1980; Miller, 1985). However, few studies have examined motivation as it relates to clients who are mandated to treatment, or have examined motivational issues as they relate specifically to sexual offenders (Garland & Dougher, 1991; Jenkins-Hall, 1994). This general lack of research regarding motivation to change in sexual offenders may be the result of a lack of conceptual clarity regarding the construct "motivation" (Rosenbaum & Horowitz, 1983), as well as being complicated by the heterogeneity of the population. However, these issues should not preclude systematic study of motivation to change among sexual offenders.

Understanding the dynamics of motivation to change among sexual offenders has significant implications for treatment design and delivery, as well as in enhancing outcome. Traditionally, sexual offenders have not been considered amenable to treatment unless they acknowledge the offense, recognize their sexual offending as a problem they want to change, and are willing to enter into and fully participate in treatment (McGrath, 1991). These exclusionary criteria have received less support in the recent literature, particularly, as denial does not necessarily impede treatment progress (Marshall, Thornton, Marshall, Fernandez, & Mann, 2001). This perspective also illustrates a lack of understanding about motivation—it is dynamic and can be positively influenced. Furthermore, by using these elements as exclusionary criteria, especially denial of the offense, treatment may not be offered to some of the most dangerous offenders (Marshall, 1994). It is theoretically supported (Miller, 1985; Rosenbaum & Horowitz, 1983) and clinically imperative for the effective treatment of sexual offenders that motivation be considered dynamic, and that it be seen as dependent on external events and internal experiences.

Motivation to Change—Conceptualization

Many of the studies that have examined motivation have been criticized because the definitions and criteria used to measure this construct were not clearly operationalized. A review of the literature suggests that motivation was initially defined from a psychodynamic trait model (Sifneos, 1968; Silverman, 1964), but later reflected greater emphasis of behavioral referents as indices of motivation (Miller & Rolnick, 1991; Rosenbaum & Horowitz, 1983; Serin & Kennedy, 1997). Stirpe, Wilson, and Long (2001; see also Prochaska & DiClemente, 1986) asserted that motivation is a dynamic process that changes over the course of treatment. The current study endeavored to examine the dynamic nature of motivation using behavioral and attitudinal indicators of the construct.

Motivation to Change—Operationalization

In this investigation, motivation was conceptualized as a complex, multidimensional dynamic factor that can be evaluated using behavioral indices measuring active participation in a change program. Relative to other treatment modalities, cognitive–behavioral programs are currently preferable in reducing recidivism in sexual offenders (Hall, 1995; Marshall, Jones, Ward, Johnson, & Barbaree, 1991). Most cognitive–behavioral group programs for sexual offenders have a largely relapse prevention orientation (Pithers, 1990). Successful completion is reliant on the offender's ability to maintain motivation throughout the program. Serin and Kennedy (1997) suggested that treatment motivation can be measured by attendance, attrition rates, and participation levels (including willingness to complete homework assignments, and disclosure in sessions).

The Goal Attainment Scaling protocol (GAS—Hogue, 1994) for sexual offenders was developed to provide an objective evaluation of the extent to which offenders meet clinical goals in treatment. Initial validation work showed that the GAS provides a reliable measure of clinical change (Hogue, 1994), and this was further demonstrated by Stirpe et al. (2001). Using this protocol, clinicians can specifically examine offender adherence to the cognitive–behavioral change program offered in institutional and community sex offender programs. The present study sought to measure changes in motivational levels among sex offenders during the course of their progression from institutional intake to community treatment.

METHOD

Subjects

Subjects were 101 federally sentenced male sexual offenders on conditional release to the Greater Toronto Area over a 7-year period. Subjects were classified as belonging to one of the following three groups: pedophiles, nonpedophilic child molesters (largely incest-type offenders), or sexual aggressives (largely rapists and other sexual offenders against female adults), according to criteria commonly reported in the literature (see Knight & Prentky, 1990; Wilson, 1999). A second rater with expertise in the field of sexual offenders (i.e., the third author) independently classified the typology of each offender. Any offender with both child and adult victims was excluded from the study. Decisions regarding pedophilic status were made based on phallometric results.

Offenders included in the study were drawn from two community-based treatment programs: (1) a structured program offered at a local psychiatric hospital, and (2) a relapse prevention maintenance program. All subjects had previously been involved in institutional sex offender treatment programming. Administrative consent to use offender file information was obtained from the Correctional

Service of Canada (Research Branch). All necessary precautions were taken to ensure confidentiality and offender anonymity.

As a means to establish relative risk for reoffense posed by the three subject groups, scores on conventional risk assessment indices were recorded. Rapid Risk Assessment for Sex Offender Recidivism (RRASOR—Hanson, 1997) scores were recorded as an actuarial measure of sexual offense risk potential. Psychopathy Checklist-Revised (PCL-R—Hare, 1991) scores were recorded as a predictor of violent recidivism. Scores on each of the General Statistical Information on Recidivism Scale (GSIR—Nuffield, 1982) and the Level of Service Inventory-Revised (LSI-R—Andrews & Bonta, 1995) were recorded as actuarial measures of risk for general recidivism. Because file reports do not necessarily report an actual score (i.e., a risk rating is reported), PCL-R and LSI-R scores were coded according to the following scheme: *low risk* = 1, *moderate risk* = 2, or *high risk* = 3.

Procedure

Materials

All data was collected from psychology files held at the Central Ontario District Office or from data maintained on the Offender Management System (OMS—an electronic database of offender files). The following file documents were examined for the purposes of data collection: (1) pretreatment assessment report completed at the intake assessment unit, or any other institution where the offender was assessed pretreatment; (2) institutional posttreatment report; (3) initial community assessment report; and (4) community progress reports completed after an initial three month period of involvement in a community-based sex offender treatment program.

Goal Attainment Scaling

Treatment reports were rated using the Goal Attainment Scaling protocol (GAS—Hogue, 1994) specifically designed for sexual offenders. This protocol provides clinicians with a framework for rating offender progress on 12 dimensions. Six of the 12 GAS subscales measure nonrelapse prevention clinical dimensions (acceptance of guilt for the offence, showing insight into victim issues, showing empathy for their victims, acceptance of personal responsibility, recognizing cognitive distortions, and minimization of consequences). Three additional subscales measure relapse prevention clinical dimensions (understanding lifestyle dynamics, understanding offence cycle, and identification of relapse prevention concepts). The remaining three subscales measure motivational dimensions

(disclosure of personal information, participation in treatment, and motivation to change behavior). A set of five measurable indices is outlined for each of the 12 subscales, ranging from the most unfavorable outcome (−2) to the best possible treatment outcome (+2). Minimum successful completion of any goal is rated zero.

The present study employed the GAS motivational subscales: (1) disclosure of personal information; (2) participation in treatment; and (3) motivation to change behavior. Additionally, two other subscales were used: (1) admission of guilt for the offense; and (2) acceptance of personal responsibility for the offense. These additional subscales were included because they represent a significant factor when examining adherence to the cognitive–behavioral change program, as motivation to change is often inextricably linked to denial and minimization (Knopp, 1984; Marshall, 1994). These measures are consistent with the conceptualization of motivation in terms of active engagement (Rosenbaum & Horowitz, 1983) and a probability of participating in a strategy of change (Miller, 1985; Miller & Rolnick, 1991)

Reports were assessed and coded by the first author using the five subscales of the GAS in random order, and were not read consecutively (to reduce possible researcher bias). A set of five measurable indices is outlined for each of the subscales, ranging from the most unfavorable outcome (−2) to the best possible outcome (+2), in a Likert-type format. The second rater noted above also evaluated a random sample of 20 offender reports, using the GAS, to provide an estimate of interrater reliability.

RESULTS

Interrater Concordance

Interrater agreement for classification of offenders according to type was found to be 97%. A Spearman correlation coefficient was calculated as a measure of interrater concordance for the subsample of GAS evaluations, and revealed high interrater reliability ($r = 0.7108$, $p < .001$). These results are similar to those reported recently by Stirpe et al. (2001).

Analysis of Group Differences

Subject groups were compared for differences based on demographic variables (see Table I). The sexual aggressives differed significantly from the other two groups (pedophiles and nonpedophilic child molesters) on a number of variables, including criminal history, number of suspensions, the risk assessment indices (RRASOR, PCL-R, LSI-R, GSIR), and age. From an overall perspective, results revealed that this group tended to be younger and more criminally oriented than both groups of child sexual abusers. Regarding RRASOR scores, the

Table I. Comparison of Demographic Variables

	Pedophiles ($N = 29$)	Child molesters ($N = 35$)	Sexual aggressives ($N = 37$)
Age*	49.8 (10.5)	52.0 (8.2)	38.6 (11.0)
Victims			
Number**	3.70 (4.02)	1.69 (1.21)	2.14 (3.70)
Female only	64.3%	94.3%	97.4%
Sentence length (days)	1435 (542)	1462 (713)	1834 (1041)
Length of release (days)	841.2 (448.3)	879.9 (496.8)	770.3 (516.0)
RRASOR score**	1.19 (1.00)	0.34 (0.64)	1.37 (0.91)
LSI score**	1.15 (0.56)	1.10 (0.32)	1.78 (0.89)
PCL-R score**	1.27 (0.80)	1.14 (0.47)	1.66 (0.73)
GSIR score**	13.92 (10.31)	15.52 (6.81)	3.42 (10.32)
Number of suspensions*	0.14 (0.35)	0.14 (0.33)	0.58 (0.83)

*$p < .05$. **$p < .01$.

pedophiles were also at significantly higher actuarial risk than the nonpedophilic child molesters.

Motivation GAS Subscale Scores—Descriptive

The means and standard deviations for all subjects on the GAS subscales: acceptance of personal responsibility; acceptance of guilt for the offense; disclosure of personal information; motivation to change behavior; and participation in treatment are presented in Table II. These include scores on the five subscales at the four stages of treatment, and demonstrate overall trends for each subject group at each stage of treatment. These data sets are also graphically represented in Figs. 1–5.

At institutional assessment, all three groups were relatively equal in terms of their motivational measures, with all mean scores being below the minimum acceptable clinical level (score of 0). For each group, there was a substantial increase in each of the five motivational measures following institutional treatment. However, despite the increase, mean scores were only slightly better than the minimum acceptable clinical level and, for the sexual aggressives and pedophiles, the mean scores for both admission of guilt and acceptance of personal responsibility still fell below the minimum acceptable level. The most substantial increase was found in the child molester group. At community assessment, decreases were observed in motivational levels for all groups, with the largest decrease being found in the child molester group. However, following a 3-month period of community treatment, this group regained its motivational levels (compared to institutional treatment). The pedophiles and sexual aggressives showed either a slight increase or a maintenance of community assessment motivational levels following the 3-month period of community treatment, although they did not reach those motivational levels achieved during institutional treatment.

Table II. Mean (Standard Deviation) Scores on the GAS Subscales as a Function of Group by Stage of Treatment

GAS subscale score	Pedophiles	Child molesters	Sexual aggressives
1. Admission of guilt[a,b]			
Institution pretreatment	−0.93 (0.70)	−0.97 (0.63)	−1.14 (0.65)
Institution posttreatment	−0.20 (0.76)	0.31 (0.86)	−0.06 (0.70)
Community assessment	−0.32 (0.97)	−0.23 (0.88)	−0.41 (0.80)
Community treatment	−0.28 (0.92)	0.14 (0.91)	−0.32 (0.71)
2. Acceptance of responsibility[a,b]			
Institution pretreatment	−1.17 (0.76)	−1.26 (0.66)	−1.13 (0.63)
Institution posttreatment	−0.40 (0.76)	0.34 (0.87)	−0.18 (0.72)
Community assessment	−0.52 (0.91)	−0.17 (0.89)	−0.54 (0.69)
Community treatment	−0.38 (0.94)	0.11 (0.90)	−0.46 (0.69)
3. Disclosure of personal information[a,b]			
Institution pretreatment	−0.17 (0.53)	−0.29 (0.63)	−0.23 (0.43)
Institution posttreatment	0.44 (0.51)	0.53 (0.67)	0.45 (0.67)
Community assessment	0.00 (0.65)	0.20 (0.47)	−0.16 (0.69)
Community treatment	0.07 (0.88)	0.37 (0.69)	−0.19 (0.73)
4. Participation in treatment[a]			
Institution pretreatment	−0.17 (0.54)	−0.26 (0.62)	−0.23 (0.43)
Institution posttreatment	0.28 (0.74)	0.56 (0.62)	0.45 (0.67)
Community assessment	0.03 (0.73)	0.20 (0.47)	−0.08 (0.68)
Community treatment	0.10 (0.90)	0.40 (0.69)	−0.08 (0.72)
5. Motivation to change behavior[a]			
Institution pretreatment	−0.37 (0.68)	−0.47 (0.61)	−0.57 (0.92)
Institution posttreatment	0.36 (0.64)	0.75 (0.57)	0.39 (0.83)
Community assessment	−0.04 (0.94)	0.14 (0.85)	−0.22 (0.85)
Community treatment	0.00 (1.00)	0.34 (0.91)	−0.19 (0.94)

[a] Main effect of stage of treatment ($p < .05$).
[b] Group by stage interaction ($p < .05$).

Motivation GAS Subscale Scores—MANOVA

A repeated measures multivariate analysis of variance was conducted in order to test the significance of the effects displayed in Figs. 1–5. As motivation is a

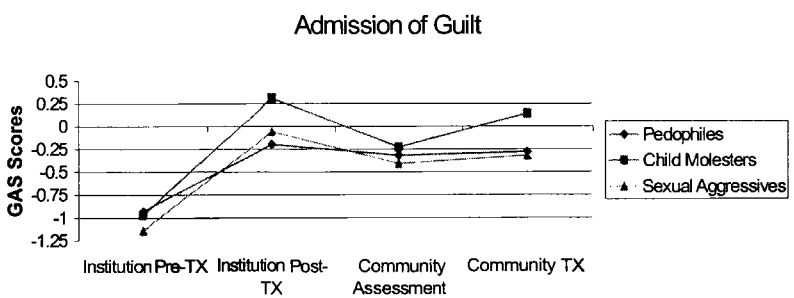

Fig. 1. GAS Scores-Admission of Guilt.

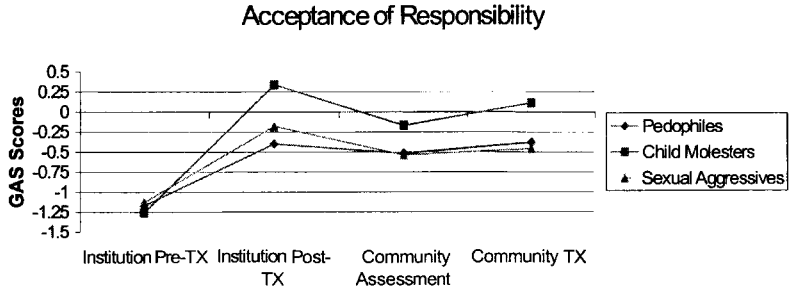

Fig. 2. GAS Scores-Acceptance of Responsibility.

complex construct that is multidimensional in nature (Rosenbaum & Horowitz, 1983), analyses of the five motivational measures were conducted individually, rather than as a composite score. Combining items into a single overall motivational score may have obscured the presence of significant changes within individual dimensions relevant to changes in motivation.

The within-subject variable for each test was Stage of Treatment (institutional assessment, institutional posttreatment, community assessment, and community treatment). The between-subject variable was type of offenders (groups were pedophiles, child molesters, and sexual aggressives). The dependent variable was the subject's score on each of the motivational measures. The following results are also found in Table II.

Acceptance of Guilt

The results of the MANOVA for acceptance of guilt showed a significant main effect for stage of treatment, $F(3, 255) = 64.48$, $p < .001$, and a significant

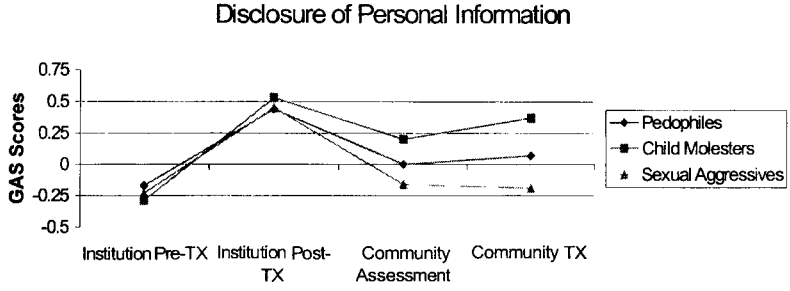

Fig. 3. GAS Scores-Disclosure of Personal Information.

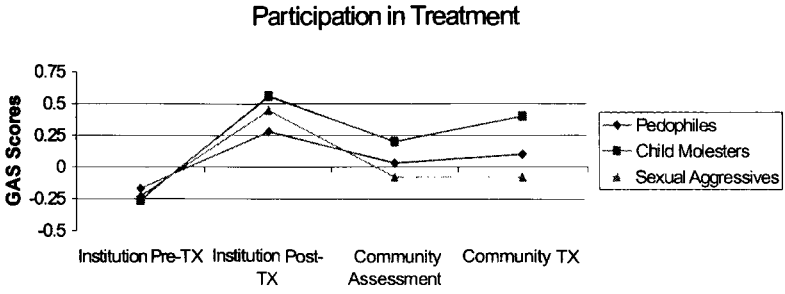

Fig. 4. GAS Scores-Participation in Treatment.

group by stage interaction, $F(6, 255) = 2.29$, $p < .05$. There was no statistically significant main effect for type of sexual offender.

Acceptance of Responsibility

The results of the MANOVA for acceptance of responsibility for the offense showed a significant main effect for stage, $F(3, 255) = 89.19$, $p < .001$, and a significant type by stage interaction, $F(6, 255) = 4.26$, $p < .001$. The main effect for group was not significant but it approached significance, $F(2, 85) = 3.00$, $p < 0.06$.

Disclosure of Personal Information

The results of the MANOVA for disclosure of personal information were similar to the previous two motivational measures, in that there was a significant main effect for stage of treatment, $F(3, 255) = 68.48$, $p < .001$ and a significant group by stage interaction, $F(6, 255) = 2.29$, $p < .05$, but no significant main effect for group.

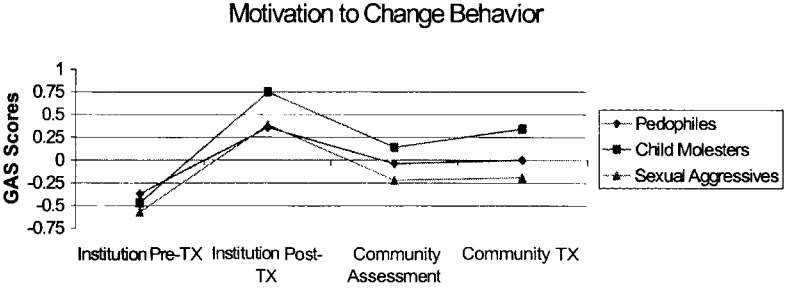

Fig. 5. GAS Scores-Motivation to Change Behavior.

Participation in Treatment

The results of the MANOVA for willingness to participate in treatment showed a significant main effect for stage of treatment, $F(3, 255) = 23.02$, $p < .001$, but neither a significant main effect for group, nor a group by stage interaction.

Motivation to Change Behavior

The results of the MANOVA for motivation to change behavior were similar to those found with respect to participation. A significant main effect was only observed for stage of treatment, $F(3, 255) = 33.44$, $p < .001$.

Treatment Outcome

Treatment or release outcome was divided into five categories: successful outcome, sex related suspensions/revocations, nonsex related suspensions/revocations, new nonsexual offense, and new sexual offense. Treatment outcome results are presented in Table III. A chi-square analysis of treatment outcome approached significance ($p < .06$), with the sexual aggressives having a greater tendency to be suspended/revoked or to recidivate in a nonsexual manner.

Correlation analysis was completed regarding demographic, actuarial, and motivational variables and treatment outcome. Age, LSI-R, GSIR, and prior criminal history were all significantly correlated with treatment outcome at the $p < .05$ level, which is consistent with findings generally reported in the correctional literature. Regarding motivational measures, only acceptance of responsibility and acceptance of guilt, as measured at community treatment, were correlated with treatment outcome ($p < .05$). Correlations of treatment outcome with the other motivational variables (disclosure of personal information, motivation to change behavior, and participation in treatment) at this stage approached significance ($p < .10$). Motivational scores at all other stages of treatment were not correlated with treatment outcome.

Table III. Treatment Outcome

	All subjects	Pedophiles	Child molesters	Sexual aggressives
Successful outcome	72.3%	79.3%	80.0%	59.5%
Suspension/revocation nonsex related	10.9%	0.0%	14.3%	16.2%
Suspension/revocation sex related	5.9%	10.3%	2.9%	5.4%
New nonsex offense	7.9%	3.4%	2.9%	16.2%
New sex offense	3.0%	6.9%	0.0%	2.7%

Note. Mean follow-up = 2.3 years; recidivism determined as charge or conviction.

DISCUSSION

Historically, motivation has been conceptualized as a static personality trait. However, contemporary research has emphasized the need to consider the dynamic nature of motivation (Miller, 1985; Miller & Rolnick, 1991). The results of the current study showed that the five motivational measures changed over the course of treatment, which supports the conceptualization of motivation as a fluctuating variable. Motivation increased significantly from institutional assessment to institutional posttreatment, suggesting that the institutional treatment protocol had an impact on participants' motivational levels. However, other factors, such as a desire to achieve conditional release, may have biased the results to a degree. Indeed, the influence of conditional release may be surmised from the finding that motivation decreased for all types of sexual offenders upon community release. Motivation is dynamic and may be impacted by internal, external, and alliance variables. There are many things that could have contributed to the decreases observed here. One possibility is that motivation might have decreased when offenders were placed in new groups with new treatment providers. It is reasonable to postulate that some individuals may take a more defensive stance until they become more familiar with the new providers and program.

Overall, motivation levels measured upon arrival in the community remained above those found at institutional assessment but, for the most part, levels recorded at institutional posttreatment were not maintained in the community. Despite an increase in some motivational levels following community treatment, the levels attained during institutional treatment were not recovered, suggesting an influence of environmental determinants on motivation. This may be because many offenders are not aware that they will have to continue formal sex offender programming in the community upon release. In fact, many are quite disillusioned and frustrated with such requirements, and believe that they do not require further programming in the community.

Specific community environmental determinants need to be identified in terms of their role in motivational levels. These may include life-related stressors, such as unemployment, conflicted relationships, financial problems, and the like. Future research might attempt to document the impact of stressors on motivation to change and participation in community-based treatment programs. Also, studying offenders who voluntarily present for treatment without involvement of the courts would be a valuable addition to the literature.

The results of this study clearly show that clinicians in community settings should expect to have difficulty re-engaging offenders in the treatment process and should not assume that a positive institutional report will be reflected in a client's attitude and behavior in the community. Treatment engagement, whether in the institution or community, must focus on the therapeutic alliance and assist offenders in developing a cost-benefit analysis (Preston & Murphy, 1997). Community

clinicians need to provide the offender with information that illuminates the benefits of continued treatment in the community.

One of the areas addressed in this investigation was the extent to which taxonomy influenced motivational levels. In other words, do motivational levels systematically differ among different types of sex offenders? The results revealed that type, in and of itself, did not determine motivational levels. However, there were type by stage interactions for three of the five motivational measures: admission of guilt, acceptance of personal responsibility, and disclosure of personal information. It was not expected that motivational levels among the three types of sex offenders would differ significantly at institutional assessment, and the results confirmed this hypothesis. This finding is consistent with other research in the area (e.g., Langevin, Wright, & Handy, 1988; Stirpe et al., 2001).

Encouragingly, nonpedophilic child molesters increased motivational levels following community treatment. Sexual aggressives and pedophiles made slight gains or maintained their community assessment motivational levels. These results indicate that child molesters were different from both pedophiles and sexual aggressives in terms of their motivation to change. Pedophiles and child molesters did not differ significantly with respect to age, previous criminal history, LSI-R, GSIR, and PCL-R scores. The only significant difference in terms of descriptive variables was the number of victims—pedophiles had significantly more victims. The fact that these two groups differed in terms of motivational levels provides preliminary evidence that an underlying paraphilic motivation to commit sexual offenses against children may affect the offender's motivation to change his sexual behavior. In current correctional research and practice, paraphilic individuals are considered higher risk to recidivate; however, these results indicate that modifications in programming may be needed to help a paraphilic individual maintain his motivation to lead an offense free lifestyle following release to the community.

Conclusions regarding the rapist category are more problematic. The sexual aggressives were younger, had a more varied and extensive criminal history, and exhibited more psychopathic personality and behavioral tendencies than both groups of child sexual abusers. In general, the sexual aggressives appear to be a qualitatively different type of sexual offender than either group of child sexual abusers. They tend to be more criminally oriented, which is consistent with other research showing that sexual aggressives have more extensive criminal records (Gordon & Porporino, 1990). In addition, sexual aggressives were not divided on the basis of the presence or absence of a paraphilia. Future research may need to examine sexual aggressives as an exclusive group rather than comparing them to child sexual abusers. One implication of the results of this study is that the clinical needs of the sexual aggressives are currently not being met in the correctional system. Sexual aggressives were not able to maintain their posttreatment motivational levels and they had the highest number of suspensions and nonsexual reoffenses. It may be prudent to focus on the general antisocial tendencies of rapists prior

to engaging them in sex offender programming. To do so would be consistent with the work Wong, Nicholaichuk, Gordon, and Olver (2000) have done on the Violence Risk Scale: Sex Offender Version (VRS:SO). In their framework, three overarching factors contribute to risk: sexual deviance, criminality, and antisocial attitudes and beliefs. The specific dynamics of rapists, in comparison to other sexual offenders, are different and our motivational enhancement strategies may have to reflect those differences.

Denial and minimization, along with cognitive distortions (Abel et al., 1989), are common among offenders (Serin & Kennedy, 1997). It was expected that the majority of the offenders in this study would demonstrate these tendencies upon admittance to an institution, but that treatment programming would have a beneficial effect. This, too, was supported by the results of the investigation. The mean values for all five motivational measures increased following institutional treatment for all types of sex offenders, with the nonpedophilic child molesters achieving the most substantial gains in motivational levels, as measured at institutional posttreatment.

The GAS motivational scores were assessed based on file information. Direct observation and subject self-report may provide a more valid measure of motivation. This should be considered for future research. The reports used to assess motivation were written by several different clinicians who may have been biased about the motivational levels of their participants. In addition, the reports varied in content and detail. The majority of reports made specific comments regarding the offenders' participation rates, disclosure of information, and denial and minimization. Reports often discussed "motivation" but its conceptualization was often ambiguous in that there was contradictory information. An offender might be described as putting little effort into the required assignments and disclosing little information, yet elsewhere in the report he would be described as well-motivated to change his behavior. To improve the delivery and evaluation of correctional programs, standardized assessment and progress reports may be required, as well as a standardized assessment of motivation components. Improving program design and delivery to increase motivational levels may decrease future victims of both sexual and nonsexual crimes.

The treatment outcome data presented in Table III is consistent with Canadian data published earlier (Barbaree, Seto, & Maric, 1996; Motiuk & Brown, 1996; Wilson, Stewart, Stirpe, Barrett, & Cripps, 2000) demonstrating relatively lower recidivism rates in comparison to international norms (Hanson & Bussière, 1998). Wilson et al. (2000), using essentially the same data set as we did here, suggested that this was due to a supervision strategy combining community-based sexual offender treatment and dynamic case management supervision. That acceptance of guilt and responsibility, measured at the community treatment stage, were significantly correlated with treatment outcome further suggests that an integrated sexual offender management protocol can contribute to successful outcome.

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