Cognitive Group Counselling for Sexual Offenders

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Abstract: *Cognitive group counselling was employed with two populations of sexual offenders against children, one in a psychiatric setting, the other in a correctional institution. Both groups were assessed pre- and post-treatment using a psychometric package, which included the Sexual Myths (SM) subscale of the Sexual Knowledge and Attitude Test (SKAT), the Abel Cognition Scales (child sexual abuse—COG-C; rape—COG-R), the Hostility Towards Women Scale, a 15-point contributing factors list, and self-report measures of motivation and potential for counseling. Significant positive treatment effects were observed in both groups on the SM, COG-C, and COG-R. This is interpreted as indicating that cognitive group counselling can be effective in helping child sexual abusers to reevaluate and remodel their cognitions about their victims and offenses. Further, it is noted that this method can be useful in both psychiatric and correctional facilities.*

For many years, the issue of what to do with sex offenders has been at the emotional forefront of the media and public opinion (Kosky, 1989; Langevin & Lang, 1985).

Various theoretically based interventions have been advocated for sex offenders. One school argues that sex offenders are violent criminals and should be treated as such with long prison terms, or by even more radical methods. Other schools believe that sex offenders may suffer from degrees of neuropsychological impairment or psychiatric difficulties (Berlin, 1983; Gaffney & Berlin, 1984; Langevin, Hucker, Ben-Aron, Purins, & Hook, 1985). The deviant behavior paterns that result can be diagnosed and treated by physiological means such as medroxyprogestrone acetate (Provera), cyproterone acetate (Androcur), and other sex-drive reducing agents (e.g., Berlin & Meinecke, 1981; Freund, 1980). Castration as a long-term treatment technique for sex offenders has been suggested (Wille & Beier, 1988). This admittedly extreme option has yet to be seriously investigated in North America.

Other hypotheses contend that sex offenses are a result of social factors rather than individual psychopathology—incest is offered as an example. It has been reported in the professional literature that as few as 20% to 25%

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of offenders against female children within a familial context may actually be pedophilic (Freund, Watson, & Dickey, 1991; Langevin & Lang, 1988). A number of different hypotheses (see review in Dwyer, 1987) have been advanced as to the reasons why nonparaphilic men might commit sexual offenses, including drug and alcohol abuse, stress, family difficulties, and inappropriate socialization.

The idea that sexual offending results from deviant or inappropriate socialization has led to the development of various treatment programs that focus on these issues (Dwyer, 1987; Whitman & Quinsey, 1981). Regardless of whether one views sexual offenders as cognitively and socially deficient or organically impaired, most clinicians agree that any successful treatment program for sex offenders must address social issues. Accordingly, many treatment programs involve such cognitive and behavioral techniques as covert sensitization (Maletsky, 1974), individual psychotherapy, and group psychotherapy (Langevin & Lang, 1985). Some success has been reported in using combined cognitive-behavioral and pharmacological therapies (Stermac & Hucker, 1988). Many sex offender treatment centers in North America are now using relapse prevention models, and are reporting successes (see Pithers, 1990).

Langevin, Wright, and Handy (1988) administered a questionnaire to 87 sex offenders and assessed their treatment methods of choice. Although individual psychotherapy was the overwhelming favorite of the subjects in their study, of the 16 remaining options, social skills training, sex education, anger management, and group therapy were rated in the top quarter. Treatment methods deemed to be unacceptable by these individuals were those that would normally be seen as more invasive and medically oriented (e.g., castration, sex drive reducing medication, aversive conditioning).

The present study was designed to examine attitudes and beliefs about sexual offending among two groups of child molesters, and to determine the effects of cognitive group counselling on these attitudes within both a psychiatric and a correctional facility. Specifically, this study assessed knowledge, attitudes, and beliefs in sex offenders against children, particularly "cognitive distortions" (Abel, Becker, Cunningham-Rathner, 1984; Abel, Becker, Cunningham-Rather, Rouleau, et al., 1984; Stermac & Segal, 1989). These distortions include such opinions as: (1) children are informed and can consent to sexual interaction with adults, (2) prohibition of sexual interaction between adults and children is the result of an arbitrary social policy, and (3) sexual interaction between children and adults will not cause any harm to the child unless force is used. It has been postulated that these cognitive distortions tend to increase as child molestation behavior continues (Abel, Gore, Holland, Camp, et al., 1989).

METHOD

SUBJECTS

Subjects in this study consisted of a total of two groups totalling 27 male sex offenders against children. Group 1 was comprised of 15 men who participated in the Clarke Institute of Psychiatry's Sex Offender Treatment Program (SOTP); Group 2 was comprised of 12 men who participated in similar treatment at the Ontario Correctional Institute (OCITP). Information on group characteristics for these two subject groups is presented in Table 1.

PROCEDURE

Clarke Institute of Psychiatry Sex Offender Treatment Program (SOTP). The SOTP is a 16-week comprehensive inpatient counselling program designed to assess and treat sexual offenders or individuals with sexually deviant interests. The program consists of an initial ten-day assessment for treatment suitability, during which potential participants are interviewed and assessed. Patients must be voluntary treatment admissions who have a previous conviction for a sexual offense. Although individuals without previous charges are admitted, they were not part of the research here reported. Subjects were allowed to enter the program at any point following conviction. Potential participants on parole, mandatory supervi-

TABLE 1
GROUP CHARACTERISTICS

	SOTP	OCITP
N	15	12
M age	38.6	39.3
SD age	11.7	9.8
Median occupation[a]	SSL	SSL
Median education	8<Ed<12	8<ED<12
Marital status		
Single	3	3
Married/common law	6	7
Divorced/separated	6	2
Victim type		
Familial child	5	4
Nonfamilial child	7	7
Familial & Nonfamilial children	3	1

Note. SSL = semiskilled labor, 8<Ed<12 = greater than 8 grades, but less than 12.
[a]Hollingshead and Redlich, 1958.

sion, or a temporary absence program were eligible if they voluntarily requested counselling.

Subjects admitted to the SOTP participated in a treatment program consisting of six group counselling modules, individual counselling, and ward milieu. All subjects participate in each aspect. The groups were conducted on a 16-week modular basis and consisted of: (1) Anger Awareness Training for Sexually Assaultive Men, (2) Anger Control, (3) Sexuality, (4) Social Skills, (5) Substance Abuse Treatment for Sexually Assaultive Men, and (6) Relapse Prevention: Self Control for Sexual Assaulters.

Ontario Correctional Institute Treatment Program (OCITP). The OCITP is also a group and individual counselling program. Residents throughout the Ontario provincial corrections system are eligible for admission to this treatment facility, although inmates with psychiatric disorders and sexual offenders are given priority. Admission to the sex offender program is based upon treatment needs and motivation. Assessment procedures attempt to identify residents with high motivation. Treatment is optional and any resident not wishing to participate in the program can request a transfer.

Offenders are housed in three specialized units where they attend groups and reside in a therapeutic community. The average time in counselling for residents is approximately four months. As in the SOTP, treatment participants engage in group counselling, individual counselling, and ward milieu. Groups deal specifically with sexual offenses and accepting responsibility for behavior. Residents also participate in off-ward group counselling programs with other nonsex offender residents. Groups are cognitive-behavioral and include anger management, assertiveness training, sexual education, and stress management.

QUESTIONNAIRES

Persons admitted to the SOTP and the analogous OCITP program were routinely administered a psychometric package when entering the program and upon termination. A number of the indices focus specifically on cognitions and attitudes surrounding sexual offenses and other related issues. Participation in any research associated with either program was completely voluntary. Informed consent was obtained from all participants and confidentiality was maintained.

Cognition Scales. Two cognition scales were used in this study, COG-C and COG-R (Abel, Becker, Cunningham-Rathner, 1984; Abel, Becker, Cunningham-Rathner, Rouleau, et al., 1984). The first was a 29-item instrument designed for use with child molesters (COG-C), and is comprised of a number of statements reflecting values about child sexual abuse. Items are scored on a five-point Likert scale, all in the same direction. A

greater proclivity toward permissiveness in regard to adult–child sexual relations is reflected in a lower score. Gore (1988) has reported test-retest reliability for this scale at .76 (three week interval). Alpha reliabilities range from .59 to .82 for six identified subscales (Abel et al., 1989). Child molesters have been shown to score significantly higher on this scale than normal controls (Abel et al., 1989). The second of these cognition scales is similar except that it addresses ideas concerning sexual abuse directed towards female adults (e.g., rape–COG-R).

Sex Knowledge and Attitude Test (SKAT). The SKAT consists of four attitude scales (heterosexual relations, sexual myths, abortion, and masturbation) and a Knowledge Scale (Miller & Lief, 1976, 1979). Only the Sexual Myths scale, which consists of nine items to which subjects respond on a five-step Likert-type scale, was used in this study. A low score on the scale indicates that the subject endorses various commonly held sexual misconceptions. Sexual myths concerning sexual education, homosexuality, oral sex, and the basics of sex drive and responsiveness are included. Miller and Lief (1976) have reported that the attitude subscales of the SKAT have internal consistency alphas ranging from .68 to .86.

Hostility Toward Women Scale (HTWS). The HTWS is a 30-item trait measure of male hostility directed toward women (Check, 1984; Check, Malamuth, Elias, & Barton, 1985). Subjects respond to the questions in the scale as "true" or "false." The authors have contended that the scale can consistently predict a number of self-reported rape-related attitudes, motivations, and behaviors. Scores of lower than 5 indicate below average hostility toward women, while scores of 6 to 11 and more than 11 indicate average and above average hostility respectively. The normative average score, obtained from a sample of 305 male college students was 8.79. Check (1984) has reported that the scale has a KR-20 reliability of over .80 and a one-week, test-retest reliability of .83.

Contributing Factors Checklist. Each participant in each setting was asked to rate each of 15 potential contributing factors as to the degree to which these factors may have had a role in their offense(s) (Pollock, 1987). The items are listed in Table 3.

Motivation and Treatment Potential. Individuals in each program were also asked to rank, on scales ranging from "1" to "7," their motivation for counselling and their expected degree of success. Admission to treatment program was *not* contingent on responses to *these* scales; however, individuals with overall low motivation for treatment were not accepted into either program.

STATISTICAL PROCEDURES

All statistical comparisons were accomplished using the Statistical Package for the Social Science (SPSS, 1991). For comparisons of group

demographics: age was assessed by ANOVA and Tukey's honestly significant difference multiple range tests; education and occupational status (Hollingshead & Redlich, 1958) were assessed by Kruskal-Wallis and Mann-Whitney *U* tests. The effects of counselling on measures of sexual knowledge, beliefs, and attitudes were assessed in a repeated measures MANOVA design. Group differences, treatment effects, and group by treatment interactions were investigated in this analysis. In all cases, statistical significance was observed at $p < .05$.

RESULTS

Group Demographics. There were no differences between the two groups in regard to age, education, or occupational status (see Table 1). The groups were quite similar regarding victim types—familial, nonfamilial, or both. The SOTP sample contained a slightly greater percentage of persons who were divorced or separated.

Cognition Questionnaires. Although subjects in both groups expressed cognitive distortions, the OCITP group expressed cognitive distortions about their interactions with children (COG-C) significantly more often than did their counterparts in the SOTP group: $F(1, 25) = 7.32$, $p < .02$. However, both groups showed significant treatment effects over time: $F(1, 25) = 6.00$, $p < .03$.

Both groups of subjects also showed a significant treatment effect in regard to cognitive distortions expressed about "rape" situations (COG-R): $F(1, 25) = 16.29$, $p < .001$.

Sexual Myths. Subjects in both groups showed significant decreases, pretreatment to posttreatment, in the degree to which they espoused sexual myths (SM): $F(1, 25) = 6.81$, $p < .02$.

Hostility Towards Women Scale. Neither group showed any significant differences, pretreatment to posttreatment, in their responses to the questions contained in the HTWS. The results above are summarized in Table 2.

Contributing Factors Checklist. The subjects in the SOTP group were significantly more inclined on the whole to acknowledge that the items listed may have contributed to their offenses than were the members of the OCITP group: $F(1, 25) = 8.13$, $p < .01$. A summary of these comparisons is presented in Table 3.

Motivation and Treatment Potential. Both groups of subjects responded similarly on the motivation for treatment and expectation of treatment success self-report scales. Median *motivation* scores were 7 and 6.5 for the SOTP and OCITP groups respectively, while median *potential* scores were 6 for both groups.

TABLE 2
PRETREATMENT AND POSTTREATMENT MEAN SCORES (*SD*) ON PSYCHOMETRIC INDICES

	SOTP	OCITP
Sexual Myths[b]		
Pre-treatment	32.5 (5.4)	32.8 (8.4)
Post-treatment	35.3 (6.0)	35.5 (5.2)
Cognition-child[a,b]		
Pre-treatment	137.9 (8.7)	126.0 (17.7)
Post-treatment	140.5 (5.6)	135.0 (5.8)
Cognition-rape[b]		
Pre-treatment	84.3 (12.1)	92.2 (18.1)
Post-treatment	76.9 (8.1)	84.5 (17.0)
HTWS[c]		
Pre-treatment	8.4 (5.9)	4.4 (5.2)
Post-treatment	7.3 (6.3)	5.5 (6.1)

[a]Group difference.
[b]Treatment effect (repeated measures MANOVA, p .05).
[c]HTWS = Hostility Toward Women Scale.

TABLE 3
PRETREATMENT AND POSTTREATMENT MEAN (*SD*) SELF-REPORTED RATINGS OF FACTORS CONTRIBUTING TO OFFENDING

	SOTP	OCITP
Lack of sexual knowledge[a]		
Pretreatment	3.1 (1.4)	2.0 (1.0)
Posttreatment	3.3 (1.3)	2.6 (1.2)
Anger[a,b]		
Pretreatment	2.7 (1.6)	1.2 (0.6)
Posttreatment	3.9 (1.0)	2.1 (1.2)
Beliefs and feelings about women[a]		
Pretreatment	3.3 (1.4)	2.0 (1.3)
Posttreatment	3.5 (1.3)	2.3 (1.4)
Emotional problems (depression, anxiety)		
Pretreatment	3.6 (1.4)	3.2 (1.7)
Posttreatment	3.9 (1.4)	3.1 (1.4)
Abnormal sexual desires		
Pretreatment	3.3 (1.7)	2.2 (1.6)
Posttreatment	3.3 (1.5)	2.3 (1.5)
Alcohol abuse		
Pretreatment	1.7 (1.2)	2.4 (1.8)
Posttreatment	2.3 (1.6)	2.4 (1.8)

(continued)

TABLE 3 *(continued)*

	SOTP	OCITP
Beliefs and feelings about children		
Pretreatment	2.5 (1.8)	2.3 (1.7)
Posttreatment	2.7 (1.5)	1.8 (1.4)
Drug abuse		
Pretreatment	1.5 (1.0)	1.6 (1.4)
Posttreatment	1.5 (1.2)	1.6 (1.4)
Poor social skills[a]		
Pretreatment	3.1 (1.4)	2.3 (1.3)
Posttreatment	3.5 (1.5)	2.1 (1.2)
Sexual attitudes[a]		
Pretreatment	3.4 (1.5)	2.3 (1.7)
Posttreatment	3.6 (1.5)	2.4 (1.3)
Job stress		
Pretreatment	2.7 (1.4)	1.6 (0.9)
Posttreatment	2.4 (1.5)	2.0 (1.1)
Not caring enough about other people[a,c]		
Pretreatment	3.0 (1.6)	2.5 (1.6)
Posttreatment	3.9 (1.5)	2.0 (1.2)
Problems with sexual performance[a]		
Pretreatment	2.6 (1.5)	1.8 (1.1)
Posttreatment	2.7 (1.3)	1.8 (1.1)
Family stress		
Pretreatment	3.3 (1.3)	2.6 (1.6)
Posttreatment	3.3 (1.3)	2.6 (1.5)
Not caring about the law		
Pretreatment	2.0 (1.4)	1.8 (1.3)
Posttreatment	2.5 (1.6)	1.5 (1.0)

Note. Subjects were asked to rate items on a five-point Likert scale as to the degree to which they believed they may have contributed to their offense(s).

[a]Group difference.

[b]Treatment effect.

[c]Group by treatment interaction (repeated measures MANOVA, $p < .05$).

DISCUSSION

The results of this investigation indicate that cognitively oriented group counselling may be profitably used in the treatment of sex offenders against children. This type of counselling may help clients to reevaluate inappropriate sexual beliefs (cognitive distortions) and increase their level of sexual knowledge. The results of this study indicate that this treatment plan would be successful in both correctional and psychiatric settings.

Though the two subject groups in this study were similar in age,

education, and other social aspects, they were, at times, different in their responses to the questions contained in the tests administered. This may be due to the differences between offenders in psychiatric versus correctional settings. It can be argued that persons who commit sexual offenses against children and who are incarcerated as a result of their actions are generally of a lower socioeconomic status than those who are given the option to seek help at a noncorrectional facility. This bias is likely a reflection of the beliefs and attitudes of those working in the judicial system.

With the notable exceptions of drug and alcohol abuse, the subjects seen at the Clarke Institute (SOTP) acknowledged, in relative terms, the effects of each of the items listed in the Contributing Factors Checklist more than did their counterparts in the OCITP group.

Both groups examined in this study exhibited several positive treatment effects. However, in light of results obtained by other researchers (see reviews in Furby, Weinrott, & Blackshaw, 1989; Hanson, Cox, & Woszczyna, 1991), and also taking into account the influences of demand situation on the individuals sampled (Orne, 1962), this finding suggests that the outcome includes a significant effect due to education (e.g., both treatment programs emphasize increase in sexual knowledge and reevaluation of sexual attitudes, precisely the things being measured by the indices investigated in this report).

It would be reasonable to contend that the subjects in this investigation were merely answering the post-treatment questionnaires favorable so as to give the impression that they were no successfully "cured" of their difficulties. This contention is supported by the high responses of the two groups on the motivation and potential self-report scales. Abel et al. (1989) have noted that the Abel Cognition Scales are overly transparent (see also Langevin, 1991). Nonetheless, the mere fact that the offenders in this study are now apparently more aware of what are regarded by the general populace to be the "correct" answers supports the interpretation of an educational effect.

The finding that the HTWS did not show any positive treatment effects may be reflective of this scale's measurement of hostility towards women, while the victims of the offenders in this study were, as far as we know, exclusively children.

The real test of a sex offender treatment program's effectiveness is in looking at its long-term strengths and weaknesses (e.g., recidivism rates); the major problem being whether new skills learned in counselling can be generalized to the "real world." Furby et al. (1989) have presented a thorough review of the literature with respect to recidivism rates, and note that various treatment programs have had varying degrees of success, the most successful generating recidivism rates as low as 0% while less effective programs have yielded rates of greater than 50%. Research has indicated

that therapy programs that include a variety of treatment modes (e.g., psychotherapy and pharmacotherapy—Stermac & Hucker, 1988) have shown some success. Proponents of relapse prevention oriented treatment programs (e.g., Pithers, 1990) believe that the process is an ongoing one where the offender must continually monitor his risk situations and cognitions. In these programs, the initial part of the process essentially teaches the individual to "program" himself not to become involved in illicit relationships with children. Despite the claims of many offenders that they are "cured" once they have finished their first treatment program, it is important to stress (to caregivers and receivers alike) that this is only the first step in a long and difficult process. Although "halo" effects may be observed in hospital populations, they may be less likely in prison populations (the strong "machismo" culture developed by inmates does not support better attitudes right out of prison).

The SOTP and OCITP have been in progress for over two years. As such, the two-year postgraduation mark is approaching for the first sizable group of posttreatment offenders. Results of recidivism investigations for these two programs will be reported in the future. Preliminary estimates, however, are that the recidivism rate is in the 20% to 25% range.

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