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Goal Attainment Scaling with Sexual Offenders: A Measure of Clinical Impact at Posttreatment and at Community Follow-Up

Tania Simone Stirpe,[1,2] Robin J. Wilson,[1] and Carmen Long[1]

The impact of cognitive–behavioral interventions was assessed for 28 low–moderate risk and 20 high-risk sexual offenders on conditional release to the Greater Toronto Area. Goal Attainment Scaling (GAS—T. Hogue, 1994) for sexual offenders was used to rate clinical and motivational elements of treatment taken from reports written at pretreatment, posttreatment, and after 3 months of community follow-up. Results indicated that both groups of offenders benefited from treatment, although low–moderate risk offenders showed consistently better results on all measures. Performance along nonrelapse prevention related dimensions increased from pretreatment to posttreatment and remained relatively steady in the community. Relapse prevention related treatment components showed a steady increase from pretreatment throughout follow-up in the community for low–moderate risk offenders, but not for high-risk offenders. Both groups improved substantially in level of motivation from pretreatment to posttreatment; however, only those in the low–moderate risk group maintained their motivation levels once released to the community. These results are discussed with respect to the effectiveness of cognitive–behavioral treatment of sexual offenders.

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

INTRODUCTION

The factors that contribute to sexual offending, and the therapeutic techniques that are effective at changing offending behavior, have been extensively studied in recent years. There is a growing consensus in the literature that the most effective

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treatment programs for sexual offenders are those which are cognitive–behavioral in orientation, specifically those which are relapse prevention-based (Marshall, Jones, Ward, Johnston, & Barbaree, 1991; Marshall & Pithers, 1994; Watson & Stermac, 1994). However, there has been little systematic work to develop clinical measures of dynamic risk, and this has been seen as one of the main challenges facing the field of sex offender treatment (Hogue, 1994; Maletzky, 1993; Marques, Nelson, West, & Day, 1994).

Murphy (1990) has suggested that restructuring cognitions provides offenders with an explanation of the role of thought in maintaining their sexually assaultive behavior. This process provides corrective information and education around victim issues, as well as a method to assist clients in identifying their personal cognitive distortions. Cognitive distortions are often indicative of an offender's insufficient level of acceptance of responsibility for his actions, with the responsibility frequently being projected onto the victim(s).

Most sex offender treatment providers recognize that acceptance of responsibility, along with the development of victim understanding and empathy, requires considerable motivation on the part of the offender. Motivation for treatment includes an individual's willingness to disclose personal information, to participate in individual and therapy groups as required, to accept that change is required, and to be willing to change their behavior in a way that will reduce risk to others in the future. Motivation for treatment seems logically tied to the individual's acceptance of guilt or lack of denial; however, how this translates into reductions in recidivism is not presently clear. Nonetheless, denial and minimization are seen as dynamic factors, motivation may also be seen as a target for clinical change tied to other clinical goals. Barbaree, Seto, and Maric (1996) examined the relationship between motivation and outcome, and found that individuals who reported more positive attitudes and expectations regarding treatment were more likely to complete the program. In general, offenders who complete treatment are less likely to recidivate than those who drop out (Hanson & Bussière, 1998). (Note: This was not replicated with a larger sample. With more subjects, there was no difference between refusers and completers).

Comprehensive treatment programs involve different stages. In the beginning stages of treatment, it is necessary to couple level of supervision with the appropriate level of intensity of programming. As an offender demonstrates commitment to treatment, an understanding of his relapse prevention plan, and a degree of change, a gradual reduction in program control may be contemplated. This is likely to maximize the offender's own sense of responsibility for daily life management (Green, 1995; Marshall, Eccles, & Barbaree, 1993). Subsequently, the offender may then be moved from higher to lower security, with eventual release to the community for follow-up treatment, provided indicators of treatment efficacy and community safety are evident (Barbaree & Marshall, 1995).

Evidence suggests that the selection and implementation of interventions responsive to the sex offender's changing needs over time is an essential element of

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an effective therapeutic intervention (Andrews et al., 1990; Marshall & Pithers, 1994; Pithers, 1990). Release from incarceration only at the end of an offender's sentence (i.e., Warrant Expiry Date—WED) does not allow professional support persons to monitor the offender's activities in the community. WED release also does not offer treatment providers an opportunity to assist in reintegration by supervising the offender's adaptation of relapse prevention skills or by monitoring his performance in terms of risk to reoffend. Additionally, motivation has often been observed to wane after release to the community, which further serves to underpin the necessity of supervision and maintenance programming in the reduction of risk to the community (Williams, 1996).

Few studies have measured clinical change among sexual offenders. The Goal Attainment Scaling (GAS) for Sexual Offenders (Hogue, 1994) was developed to provide a structured and objective evaluation of the extent to which sex offenders meet clinical goals in treatment. A number of the basic clinical goals included in this scale are incorporated in most comprehensive relapse prevention-based sexual offender treatment programs. These goals are also consistent with those set out in national treatment standards by the Correctional Service of Canada (Correctional Service of Canada [CSC], 1996). Initial validation work has shown that the GAS provides a reliable measure of clinical change (Hogue, 1994).

The present study examined the impact of clinical interventions on sexual offenders at institutional posttreatment and at community follow-up. It is hoped that the GAS will provide a measure of treatment effectiveness to increase understanding of the variables associated with treatment responsiveness, as well as the relative impact afforded by various treatment program components. This study endeavored to assess whether there is a demonstrable transference of skills acquired in treatment to the setting where those skills are to be implemented. Further, attention is paid to the relative benefit of continued treatment combined with increased exposure to the community.

METHOD

Subjects

Subjects were 48 federally sentenced male sexual offenders on conditional release to the Greater Toronto Area (GTA) between January 1995 and June 1996. These offenders were drawn from two community-based sex offender treatment programs: (1) a structured program (Group 1, $n = 20$) designed to treat offenders judged to be at relatively high-risk, in comparison with other offenders being afforded conditional release, and (2) a relapse prevention maintenance program (Group 2) designed to treat offenders judged to be at comparatively low to moderate risk ($n = 28$). Sexual offenders who had not participated in sexual-offender-specific treatment in the institution, or who did not participate in a community

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program in the GTA, were excluded from the study. The reader is directed to Wilson, Stewart, Stirpe, Barrett, and Cripps (2000) for further information regarding these offender groups.

Group 1

Subjects in Group 1 were those offenders judged by standard risk assessment procedures (such as those suggested by Hanson, 2000) to be at relatively high-risk in comparison to most conditionally released sexual offenders. Group 1 members typically had longer histories of sexual offending, possessed deviant sexual interests, had significant issues regarding denial and minimization, and had failed to make substantial gains in institutional treatment. The program was offered in the forensic division of a local psychiatric hospital, and was multidisciplinary in focus, including access to psychiatry, psychology, nursing, social work, and other health-related disciplines. Offenders were seen in both group and individual sessions, according to individual client needs; weekly contact hours vary from 2–3 hr. The program's orientation is cognitive–behavioral and is relapse prevention based with a focus on skills development (e.g., victim empathy, offense chains, relapse prevention planning, etc.). The program has an established policies and procedures guidebook, which is available from the authors.

Group 2

Subjects in Group 2 were assessed, by the same process noted earlier, as being of comparatively low risk among conditionally released sexual offenders. This program was housed at a Community Correctional Centre, and was offered by CSC staff (generally a psychologist and a senior intern) to those offenders with limited sexual offense histories, generally conventional sexual interests, and who were judged to have achieved substantial institutional treatment gains. Although the primary service was group psychotherapy, those offenders with acute personal difficulties were also seen in individual psychotherapy. Two-hour group sessions were offered initially on a weekly basis (6 months), with subsequent biweekly involvement (usually 6–8 months, tied to performance in the community), and eventual monitoring in a long-term follow-up group until WED. All three groups targeted maintenance of relapse prevention learning with a focus on risk in the community, usually in an open discussion format. This program adheres to the *Standards and Guidelines for the Provision of Services to Sex Offenders* (CSC, 1996; also available at *www.csc-scc.gc.ca*).

Procedure

All data were collected from psychology files held at the district parole office, and were derived from three particular file documents: (1) a pretreatment

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assessment report completed at the intake unit, or any other institution where the offender was assessed pretreatment; (2) posttreatment reports from the institution where the offender completed his final institutionally based sex offender treatment program; and (3) treatment reports completed 3 months after initiation of involvement in community-based follow-up treatment. Permission for use of these data was granted by CSCs Research Branch. All identifying information was removed from the reports to ensure anonymity and confidentiality.

Goal Attainment Scaling

Treatment reports were rated using Goal Attainment Scaling (GAS—Hogue, 1994) specifically designed for sexual offenders. A set of five measurable indexes 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 Structured Interview for Sex Offender Risk Assessment, also designed by Hogue to assist interviewers in making ratings, was used as a guide for scoring the subjects on the GAS.

Six of the 12 GAS subscales measured 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 subscales measured relapse prevention clinical dimensions (understanding lifestyle dynamics, understanding offence cycle, and identification of relapse prevention concepts). The remaining three subscales measured motivational dimensions (disclosure of personal information, participation in treatment, and motivation to change behavior).

To minimize researcher bias, the reports were assessed and coded using the GAS in a random order (i.e., reports on the offender's file were not read consecutively). Following coding, the separate reports for each offender were put together for the purpose of analysis. Information on offender age, education level, and offender–victim relationship was also collected. A second rater, who was also familiar with the GAS rating system, rated a randomly selected subsample of offender reports (15 from Group 1 and 16 from Group 2) so that an estimate of interrater reliability could be calculated (Spearman $r = .80881$, $p < .001$). The *Statistical Package for the Social Sciences* (SPSS, 1999) program was used to conduct analyses of the data.

RESULTS

Subjects were compared for demographic and crime-specific differences. Mean age of all subjects was 46.1 years, and there were no differences between the groups. Group differences in education level approached significance, $F(1, 47) = 2.86$, $p < .098$, with higher levels of education reported in Group 2.

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The mean sentence length imposed on all subjects was 4.28 years; there was no statistically significant difference between the two groups. Group differences with respect to victim type were also not significant, $F(1, 47) = 1.48$, $p < .230$.

The means and standard deviations for the GAS subscale scores for the two groups are presented in Table I. These include scores on the 12 subscale measures for the three stages of treatment (pretreatment, posttreatment, and follow-up in the community). Scores on each of the 12 subscale measures had a possible range of -2 to $+2$. Data presented in Table II show scores for GAS total and the three domains (nonrelapse prevention, relapse prevention, and motivation) for the three stages of treatment (pretreatment, posttreatment, and follow-up in the community). The clinical nonrelapse prevention treatment domain had a possible range of -12 to $+12$ and the relapse prevention treatment and motivation categories each had a possible range of -6 to $+6$. The GAS total score had a possible range of -24 to $+24$; these data are graphically represented in Fig. 1.

Repeated measures analyses of variance were conducted to test the significance of effects displayed in the tables and the figure. The results of the first ANOVA (GAS total score) indicated the presence of significant main effects for group ($F[1, 46] = 7.70$, $p < .01$) and stage of treatment ($F[2, 92] = 67.15$, $p < .001$), as well as a significant group by stage interaction ($F[2, 92] = 10.35$, $p < .001$). The results of the second ANOVA (nonrelapse prevention scores) also showed significant main effects for group ($F[1, 46] = 6.85$, $p < .01$) and stage of treatment ($F[2, 92] = 61.75$, $p < .001$), in addition to a significant group by stage interaction ($F[2, 92] = 10.65$, $p < .001$). Similarly, the third ANOVA (relapse prevention scores) showed significant main effects for group ($F[1, 46] = 8.92$, $p < .01$) and stage of treatment ($F[2, 92] = 81.34$, $p < .001$), as well as a significant group by stage interaction ($F[2, 92] = 7.21$, $p < .001$). The results of

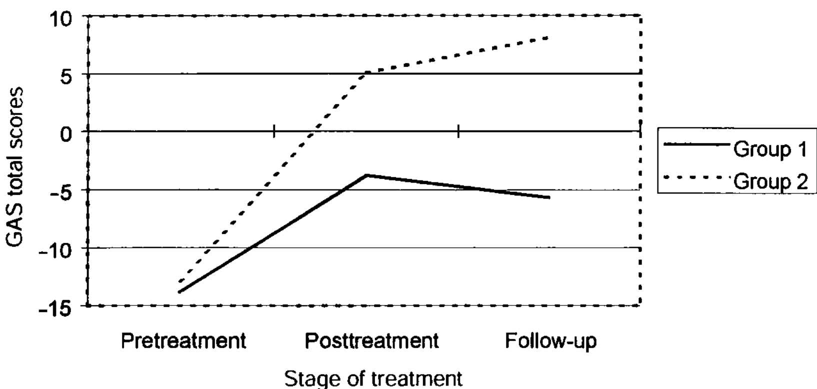

Fig. 1. GAS total scores across stages of treatment.

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

GAS subscale score	Group 1	Group 2
1. Acceptance of guilt for the offence		
Pretreatment	−0.90(1.07)	−1.07(0.54)
Posttreatment	−0.15(1.42)	0.29(1.05)
Follow-up	−0.50(1.36)	0.61(0.99)
2. Show insight into victim issues		
Pretreatment	−1.30(0.98)	−1.14(0.93)
Posttreatment	−0.40(1.39)	0.43(1.03)
Follow-up	−0.55(1.23)	0.61(1.03)
3. Show empathy for their victims		
Pretreatment	−1.35(0.93)	−1.10(0.96)
Posttreatment	−0.45(1.47)	0.39(1.07)
Follow-up	−0.65(1.27)	0.61(0.50)
4. Accept personal responsibility		
Pretreatment	−1.05(1.19)	−1.21(0.69)
Posttreatment	−0.30(1.56)	0.46(1.07)
Follow-up	−0.50(1.50)	0.57(1.07)
5. Recognize cognitive distortions		
Pretreatment	−1.40(0.88)	−1.29(0.71)
Posttreatment	−0.70(1.26)	0.43(0.96)
Follow-up	−0.65(1.18)	0.57(1.07)
6. Minimize consequence		
Pretreatment	−1.25(0.91)	−1.07(0.86)
Posttreatment	−0.50(1.40)	0.46(1.04)
Follow-up	−0.60(1.39)	0.57(1.07)
7. Understand life style dynamics		
Pretreatment	−1.35(0.81)	−1.18(0.61)
Posttreatment	−0.30(1.34)	0.43(1.07)
Follow-up	−0.30(1.03)	0.93(1.09)
8. Understand offence cycle		
Pretreatment	−1.40(0.82)	−1.25(0.75)
Posttreatment	−0.30(1.38)	0.43(1.10)
Follow-up	−0.30(1.17)	0.93(0.98)
9. Identify relapse prevention concepts		
Pretreatment	−1.45(0.83)	−1.29(0.71)
Posttreatment	−0.35(1.27)	0.50(1.00)
Follow-up	−0.20(1.15)	1.00(0.94)
10. Disclose personal information		
Pretreatment	−0.85(0.99)	−0.57(0.84)
Posttreatment	−0.10(1.41)	0.39(0.99)
Follow-up	−0.40(1.23)	0.57(0.79)
11. Participate in treatment		
Pretreatment	−0.75(0.91)	−0.75(0.70)
Posttreatment	−0.25(1.33)	0.39(0.96)
Follow-up	−0.55(1.23)	0.57(0.79)
12. Motivation to change behavior		
Pretreatment	−0.80(1.11)	−0.96(0.79)
Posttreatment	0.00(1.45)	0.46(0.96)
Follow-up	−0.50(1.10)	0.57(0.84)

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Table II. Mean (SD) GAS Scores as a Function of Group by Stage of Treatment

GAS scores	Group 1	Group 2
Total score		
Pretreatment	−13.85(10.16)	−12.89(7.65)
Posttreatment	−3.80(14.96)	5.07(11.46)*
Follow-up	−5.70(13.06)	8.12(10.12)**
Nonrelapse prevention score		
Pretreatment	−7.25(5.23)	−6.89(4.21)
Posttreatment	−2.50(7.71)	2.46(5.92)*
Follow-up	−3.45(7.47)	3.54(6.04)**
Relapse prevention score		
Pretreatment	−4.20(2.40)	−3.71(1.96)
Posttreatment	−0.95(3.95)	1.36(3.14)*
Follow-up	−0.80(3.25)	2.86(2.94)**
Motivation score		
Pretereatment	−2.40(2.87)	−2.29(2.09)
Posttreatment	−0.35(4.06)	1.25(2.80)
Follow-up	−1.45(3.50)	1.71(2.26)**

*$p < .05$.
**$p < .001$.

the final ANOVA (motivation category scores) showed significant main effects for group ($F[1, 46] = 5.97$, $p < .025$) and stage of treatment ($F[2, 92] = 22.05$, $p < .001$), and a significant group by stage interaction ($F[2, 92] = 5.48$, $p < .01$).

A number of planned comparisons were conducted to better isolate the effects reported earlier. The groups were compared at each of the three stages of treatment; the results of these analyses are also found in Table II. In addition, an analysis of trend from pretreatment to posttreatment, from posttreatment to follow-up, and from pretreatment to follow-up was conducted independently for each group for nonrelapse prevention, relapse prevention, and motivation scores. In terms of GAS total scores, the results confirmed the visual impression that although the groups were not significantly different at pretreatment, Group 2 performed significantly better once treatment began (i.e., at both posttreatment and community follow-up). The results also confirmed that both groups made overall improvements from pretreatment to follow-up in the community. However, only Group 2 showed an added gain from posttreatment to community follow-up. In regard to nonrelapse prevention clinical performance, Group 1 demonstrated only general maintenance of institutional treatment gains.

Although similar during pretreatment, the members of Group 2 did much better in regard to the nonrelapse prevention components than did their counterparts in Group 1, both at posttreatment and at community follow-up. However, Group 1 did achieve overall improvement from pretreatment to follow-up in the community. As expected, the nonrelapse prevention component scores of both groups remained steady from posttreatment to community follow-up.

On the relapse prevention components of treatment, the groups were not significantly different at pretreatment, although Group 2 did much better once

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treatment began (i.e., at posttreatment and at community follow-up). The results also confirmed that both groups of offenders improved overall from pretreatment to follow-up in the community. Again, scores of Group 1 remained in the negative range. As expected, scores of Group 2 on the relapse prevention components of treatment improved from posttreatment to follow-up. Discouragingly, Group 1 did not show a comparable improvement upon release into the community.

With respect to motivation, both groups were again not significantly different at pretreatment, but the difference between groups at posttreatment approached significance ($F[1, 46] = 2.62$, $p < .11$). The biggest difference between the groups, in terms of motivation, was at community follow-up, where Group 2 did considerably better. Both groups showed an improvement from pretreatment to posttreatment, but only Group 2 showed an overall improvement with treatment. Group 2's motivation did not wane once conditional release was achieved; however, Group 1's motivation level returned to pretreatment levels after release.

DISCUSSION

The results of the present study support the notion that both higher and lower risk sexual offenders can benefit from cognitive–behavioral interventions. It appears that, as a whole, the offenders in Group 2 were effectively meeting the expectations of institutional and community-based sex offender treatment programs for the CSC. However, the offenders in Group 1 were not consistent in adequately meeting these goals. Nonetheless, a substantial number of these high-risk offenders did achieve a degree of success. This adds to the growing literature suggesting that both high- and low-risk sexual offenders can, and do, benefit from treatment.

Treatment in the community did not appear to enhance the nonrelapse prevention clinical elements for either group (see 1–6, Table I). This was likely because the community-based programming did not involve strategies requiring active rehearsal in a realistic/community setting. Although there was no apparent added gain to community-based treatment in terms of these goals, there was community maintenance of institutional treatment gains for both groups of offenders. Researchers and clinicians have argued that community-based sex offender programs are essential for maintenance of treatment gains (Green, 1995; Welfling, 1987; Williams, 1996).

An implication of the present study is the notion that nonrelapse prevention components of treatment (e.g., denial and minimization) may be considered dynamic factors amenable to treatment. Thus, offenders who initially deny their offences or minimize the consequences of their behavior should not necessarily be excluded from programming. Indeed, overcoming denial and minimization may be crucial first steps in treatment, ultimately leading to the accomplishment of other goals (Barbaree, 1991; Barbaree et al., 1996; Green, 1995; Laflen & Sturm, 1994; Marshall, 1994).

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Treatment in the community appeared to enhance the relapse prevention clinical elements for some offenders, because they involved strategies that needed to be actively rehearsed in a genuine setting. As a group, Group 2 displayed an added gain to pre-WED release in terms of these goals, whereas Group 1 did not. Encouragingly, Group 2 appeared to maintain their treatment gains following release from the secure setting of the institution. In general, the results of this study support the argument that treatment in the community may serve as a vehicle for easing the transition between the artificial living arrangements of the institution to the realistic living arrangements in the community (Steele, 1995). Further, systems that offer transitional/community programs facilitate the evaluation of offender responses to real life challenges, such as responding to unexpected frustrations and being exposed to old temptations (Andrews et al., 1990; Pithers, 1990; Steele, 1995). Although a comparison group of offenders held until WED was not included in this study, recent results (Wilson, Kirkegaard, & Heise, 2000) suggest that WED offenders provided community facilitation reoffend at a rate considerably below that predicted by Static-99 (Hanson & Thorton, 1999). This further supports the proposition made earlier that offenders who are afforded community support following release may be at a reduced risk for reoffense.

Motivation for treatment demonstrated by both groups increased substantially from pretreatment to posttreatment. However, although motivation remained steady for Group 2 once they were released into the community, motivation levels for Group 1 decreased. The difference in motivation between groups may reflect an actual difference in the desire for treatment. Conversely, this may be a reflection of the likelihood that high-risk offenders have undertaken a great deal more treatment and are subject to more stringent supervision conditions in the community, resulting in increased frustration and defensive posturing.

An implication from the motivation data is that offenders who initially express or display poor motivation for treatment should not be excluded from programs because of the apparent success of cognitive–behavioral treatment in enhancing motivation for some of these offenders. Future research should attempt to sort out motivation factors as they relate to the accomplishment of other treatment goals, and should delineate ways to enhance motivation in sexual offenders. Asking offenders which treatment mode they prefer and involving them in the planning stages may be an appropriate starting point (Langevin, Wright, & Handy, 1988).

It is still unclear as to how factors considered in the GAS, such as motivation for treatment and denial, would impact recidivism rates, as this question was not precisely addressed in the present study. Hanson and Bussiere (1998) found, in their meta-analysis of predictors of sexual offender recidivism, that lack of motivation for cooperation during treatment was the only significant dynamic (changeable) factor associated with sexual recidivism. Generally, they found that historical risk factors (e.g., prior sexual offences) or stable risk factors (e.g., personality disorders, especially psychopathy) were much better predictors of sexual offender

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recidivism. Variables such as denial and low victim empathy were not associated with reductions in sexual recidivism. Further, Seto and Barbaree (1999) used a clinical rating scheme, including some items also found in the GAS, but noted that good treatment behavior (e.g., homework quality, motivation) was not associated with lower sexual recidivism. Furthermore, they found that sexual offenders scoring high in psychopathy, and who exhibited better treatment behavior, were most likely to reoffend. This suggests that, in their sample, the veracity of some clients' motivation and treatment compliance was compromised by personality orientation. More research is required to clarify the relationship between dynamic risk factors, treatment success, and recidivism.

Another implication of this study pertains to use of a "high risk" versus "low risk" labeling dichotomy with sexual offenders. Although the average GAS scores for Group 1 (high risk) fell below an acceptable clinical level, a relatively large proportion of these offenders did meet clinical goals. High-risk offenders are often deemed such largely due to historical or static variables; however, the present study indicated that such offenders can do well in treatment, in spite of their histories. In future, it would be beneficial to do a study similar to the present one, but rather than making group comparisons based on risk labels, comparisons should be made according to clinical level at postinstitutional treatment.

A further implication of this study has to do with the different stages of treatment available to sexual offenders within CSC. Researchers and clinicians have espoused the benefits of moving sexual offenders from higher to lower security institutions and then into the community as they demonstrate a commitment to treatment and evidence of change (Barbaree & Marshall, 1995; Green, 1995; Marshall et al., 1993). It is believed that the offenders and the community at large benefit from community-based offender supervision as the reintegration process occurs (Marshall et al., 1993; Steele, 1995; Welfling, 1987). The present study lends support to the notion that treatment in the community enhances effectiveness for goals related to relapse prevention, and that other goals of cognitive–behavioral programs (e.g., reducing cognitive distortions, increasing victim empathy) are maintained in the community.

There are limitations to the present study. First, generalizability of results must be considered. The subjects in the present study were federally sentenced sexual offenders; their provincial counterparts are likely to be offenders of comparatively lower risk and, thus, may be even more responsive to treatment interventions. Secondly, the study only included offenders who agreed to participate in both institutional and community-based sex offender-specific programs. Treatment refusers, who may be less amenable to clinical change, were excluded. Another potential problem is that only those offenders who achieved conditional release were included, suggesting that the subjects in the present study met some acceptable level of risk or treatment satisfaction as a prerequisite to being considered for release. Finally, offenders who were returned to custody prior to the 3-month follow-up report were not included in this study.

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Other weaknesses of the present study are in relation to the file review process. The GAS scores used in this study were dependent solely on post hoc file review material, without the influence of direct observation by the assessor. The actual reports were written by a number of different clinicians, whose reports were subject to individual biases regarding treatment goals and treatment effectiveness. Reports also varied in detail and content. Nonetheless, ratings by two independent assessors yielded very good interrater concordance.

Future research should endeavor to isolate which treatment factors are crucial in treatment and at which stage they should be introduced. For example, should one even begin relapse prevention components of treatment if denial and minimization have not as yet been adequately addressed? As noted earlier, meeting clinical goals should be related to other outcome measures, such as performance on conditional release and long-term recidivism rates. The present investigation was intended to broaden the scope of research examining the nature of clinical change in sexual offenders. The aim of such research is to develop indexes of treatment effectiveness, so as to better understand which offenders respond effectively to treatment, which components of treatment have the greatest impact at certain points, and which offenders can safely be released to the community. Of course, the ultimate goal of any such research and treatment efforts is a reduction in the number of women and children who are victimized.

REFERENCES

Andrews, D. A., Zinger, I., Hoge, R., Bonta, W., Gendreau, P., & Cullen, F. (1990). Does correctional treatment work? A psychologically informed meta-analysis. *Criminology, 28,* 369–404.

Barbaree, H. (1991). Denial and minimization among sex offenders: Assessment and treatment outcome. *Forum on Corrections Research, 3,* 30–33.

Barbaree, H., & Marshall, W. (1995). Treatment of the sexual offender. In L. Stewart, L. Stermac, & C. Webster (Eds.), *Proceedings of the Second Conference on Clinical Criminology,* 87–109.

Barbaree, H., Seto, M., & Maric, A. (1996). Working papers in impulsivity research. *Sex offenders characteristics, response to treatment, and correctional decisions at warkworth sexual behaviour clinic.* Toronto, ON: Clarke Institute of Psychiatry.

Correctional Service of Canada (1996). *Standards and guidelines for the provision of services to sex offenders.* Ottawa, ON: Correctional Service of Canada.

Green, R. (1995). Comprehensive treatment planning for sex offenders. In B. K. Schwartz & H. R. Cellini (Eds.), *The Sex Offender: Corrections, treatment, and legal practice.* Kingston, NJ: Civic Research Institute, Inc.

Hanson, R. K. (2000). *Risk assessment.* Beaverton, OR: Association for the Treatment of Sexual Abusers.

Hanson, R. K., & Bussiere, M. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66,* 348–362.

Hanson, R. K., & Thornton, D. (1999). *Static-99: Improving actuarial risk assessments for sex offenders* (User Report 99-02). Ottawa: Department of the Solicitor General of Canada.

Hogue, T. (1994). Goal Attainment Scaling: A measure of clinical impact and risk assessment. *Issues in Criminological and Legal Psychology, 21,* 96–102.

Laflen, B., & Sturm, W. R. (1994). Understanding and working with denial in sexual offenders. *Journal of Child Sexual Abuse, 3,* 19–36.

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Langevin, R., Wright, P., & Handy, L. (1988). What treatment do sex offenders want? *Annals of Sex Research, 1,* 363–385.

Maletzky, B. (1993). Factors associated with success and failure in the behavioral and cognitive treatment of sexual offenders. *Annals of Sex Research, 6,* 241–258.

Marshall, W. (1994). Treatment effects on denial and minimization in incarcerated sex offenders. *Behaviour Research & Therapy, 32,* 559–564.

Marshall, W., Eccles, A., & Barbaree, H. (1993). A three-tiered approach to the rehabilitation of incarcerated sex offenders. *Behavioral Sciences and the Law, 11,* 441–455.

Marshall, W., Jones, R., Ward, T., Johnston, P., & Barbaree, H. (1991). Treatment outcome with sex offenders. *Clinical Psychology Review, 11,* 465–485.

Marshall, W., & Pithers, W. (1994). A reconsideration of treatment outcome studies with sexual offenders. *Criminal Justice and Behavior, 21,* 10–27.

Marques, J., Nelson, C., West, M., & Day, D. (1994). The relationship between treatment goals and recidivism among child molesters. *Behavior Research and Therapy, 32,* 577–588.

Murphy, W. D. (1990). Assessment and the modification of cognitive distortions in sex offenders. In W. L. Marshall, D. R. Laws, & H. E. Barbaree (Eds.), *Handbook of sexual assault,* New York: Plenum.

Pithers, W. (1990). Relapse prevention with sexual aggressors: A method for maintaining therapeutic gain and enhancing external supervision. In W. L. Marshall, D. R. Laws, & H. E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories, and treatment of the offender.* New York: Plenum.

Seto, M., & Barbaree, H. (1999). Psychopathy, treatment behaviour, and sex offender recidivism. *Journal of Interpersonal Violence, 14,* 1235–1248.

Statistical Package for the Social Sciences [computer software]. (1999). Chicago, IL: SPSS Inc.

Steele, N. (1995). Aftercare treatment programs. In B. K. Schwartz & H. R. Cellini (Eds.), *The sex offender: Corrections, treatment and legal practice.* Kingston, NJ: Civic Research Institute, Inc.

Watson, R. J., & Stermac, L. (1994). Cognitive group counseling for sexual offenders. *International Journal of Offender Therapy and Comparative Criminology, 38,* 259–270.

Welfling, M. (1987). *Follow-up study of untreated sex offenders.* Unpublished report. St Paul, MN: Minnesota Department of Corrections.

Williams, S. (1996). A national strategy for managing sex offenders. *Forum on Corrections Research, 8,* 33–35.

Wilson, R. J., Kirkegaard, H., & Heise, E. (2000, May). *Circles of Support: A restorative justice initiative.* Paper presented at the 6th International Conference on the Treatment of Sex Offenders, Toronto, ON.

Wilson, R. J., Stewart, L., Stirpe, T., Barrett, M., & Cripps, J. E. (2000). Community-based sex offender management: Combining parole supervision and treatment to reduce recidivism. *Canadian Journal of Criminology, 42,* 177–188.

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