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Identification of Dynamic Risk Predictors of Sexual Recidivists on Community Supervision in Maricopa County

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IDENTIFICATION OF DYNAMIC RISK PREDICTORS OF SEXUAL RECIDIVISTS ON COMMUNITY SUPERVISION IN MARICOPA COUNTY

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An Abstract Presented to the Faculty of the Graduate School of Lindenwood College in Partial Fulfillment of the Requirements for the Degree of Master of Arts
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Abstract

Identification of risk factors that place one sexual offender at a greater risk for recidivism than another has value to those in the criminal justice field as well as therapists who might work with these offenders. To date, the majority of risk factors have been based on historical information. As a sexual offender progresses through treatment, or regresses, changeable or dynamic risk factors need to be identified. In this study sexual offenders on probation with Maricopa County were compared to sexual recidivists who committed another sexual crime while on the same type of supervision. Information was obtained from case files and through probation officers who supervise sexual offenders. Sexual recidivists were more often discharged from treatment, had a higher instance of alcohol and drug abuse, had less stable employment, and tended to live with minors present in their residence.

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1998

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Introduction

Sexual aggression towards another person is a crime that happens all too often in todays society. In fact, between 1 in 10 and 1 in 4 adult women have been raped or sexually assaulted during adulthood (Koss, 1993) and these figures are similar for children who are victims of sexual aggression (Finkelhor, 1984). Abel, Becker, Mittelman, Cunninham-Rathner, Rouleau, and Murphy (1987) interviewed 561 sexual offenders about their sexual paraphilias and victims. The 561 offenders reported 291,737 "paraphiliac acts" against 195, 407 victims under the age of 18. This number of victims is staggering coming from a mere 561 offenders.

Once sexual offenders are convicted in the criminal justice system they are often required to attend treatment and, for the most part, are returned to the community after some period of incarceration (Hall, 1995). While in the community it is up to the members of society who have contact with the offender to watch for any subsequent deviant behavior. These people include, but are not limited to, family members, members of law enforcement, and therapists who interact with the offender. While prediction of recidivism is important for any type of crime, the ability to recognize factors that may indicate another offense may occur against another human appears to be especially important.

Unfortunately recidivism for sexual offenders has been found to be as great as 41% (Caul & Huot, 1995).

While some studies have found this rate to be much lower (Hanson & Brussiere, 1996), these studies are usually conducted over a shorter period of time, about five years. It is realistic to hypothesize that all sexual offenders commit another sexual offense sometime in their lifetime (Abel, 1981). The statistics for recidivism are collected from offenders who either self report another crime, or who are convicted in the criminal justice system. It is possible that all offenders commit another crime, but only 13.4% to 41% actually get caught. While the possibility that all offenders will recidivate is disheartening, there do appear to be some factors that may help predict who is at higher risk to commit these crimes (Hanson & Brussiere, 1996; Hall, 1995; Quinsey, Lalumiere, Rice, & Harris, 1995; Prentky, Knight, & Lee, 1997; Hanson, Steffy, & Gauthier, 1993; Rice, Quinsey, & Harris, 1991).

Purpose

Historical risk predictors have been identified in regard to sex offender recidivism. The goal of this study is to find dynamic predictors that may be present prior to the commission of a new sexual offense by a convicted sex offender. Convicted sexual offenders on probation with Maricopa County Adult Probation Department (MCAPD) will be compared to sexual offenders who were

on probation with MCAPD yet committed another sexual offense.

An instrument was developed based on a review of the literature to use as the standard of measure between these two groups. Information on seven factors will be obtained and compared with the recidivist and non-recidivist group. It is hypothesized that relative to the control group of non-recidivists the recidivist group will:

1. Have a higher incidence of treatment failure, or non-attendance in mandatory sex offender treatment.
2. Show a higher rate of unemployment, or underemployment.
3. Live in less stable environments characterized by living alone, living with friends, or living on the streets/homeless.
4. Have a higher rate of living with minor children.
5. Be perceived as socially isolated.
6. Have a higher rate of alcohol use and/or illegal drug use.
7. Have more inappropriate physiological arousal as measured by a phallometric instrument (plethysmograph).

Chapter II

Literature Review

There are several theories about how a person develops a sexual deviance and maintains this deviance as an adult (Finkelhor, 1984; Marshall & Barbaree, 1990). An examination of the possible causality of sexual deviant behavior can lead to increased effectiveness in treatment, and in a more accurate mode of predicting future acting out behavior. Several studies have looked at historical factors that are common in sexual offenders. Historical factors include any type of similarities in the upbringing or life experiences of offenders. One of these factors may possibly be attachment styles. Attachment styles in sexual offenders has been found to be deficient in many studies (Hudson & Ward, 1997; Ward, Hudson, Marshall & Siegert, 1995; Marshall, 1989,1993).

Bartholomew (1990) has extended the traditional model of secure/insecure attachment into a model that incorporates four attachment styles. The preferred type of attachment is thought to be a secure attachment. In this attachment style the individual reflects a positive view of self and of others (Bartholomew, 1990). An insecure attachment style is broken down into preoccupied, fearful type, and dismissing type. In a preoccupied style a negative view of self but a positive view of others held. A fearful type of attachment results in both a negative view of self

and others. Those who engage in a fearful attachment style tend to desire social contact but avoid these situations as a result of their fear of rejection (Collins & Read, 1990; Hazan & Shaver, 1987). Another result of a fearful attachment style is a lack of empathy toward victims, most likely as a result of their negative view of others. A dismissing type of attachment will often led people to place little value on relationships. These people will often be viewed as independent, although they may be lonely and fear intimacy (Hudson & Ward, 1997).

A preoccupied type of attachment has been theorized to correlate higher with sexual offenders (Shaver & Hazan, 1988). Preoccupied individuals are prone to seek the approval of others in an excessive way. In addition, these individuals may be sexually preoccupied and use sexuality to fulfill the need for security and affection. This type of relationship will most likely be unsatisfactory, with high levels of loneliness and low levels of aggression (Bartholomew & Horowitz, 1991).

Another form of insecure attachment, anxious/ambivalent, is also theorized to contribute to sexually acting out behavior (Ward, Hudson, Marshall, and Siegert, 1995). In this style the individual desires intimacy but is anxious about adult relationships. As a result of this anxiety a partner is located that can be controled. This type of relationship is often devoid of intimacy so the offender will look for another outlet, often children to fulfill this need. Over a period of time a

"relationship" will be formed with the child. This relationship replaces the lack of intimacy he has with his partner. During this phase many cognitive distortions and deviant fantasies are used to perpetuate the relationship in the offender's mind. The result of the failure to attain an intimate adult relationship is the sexual offense against a child who has fulfilled this need for the offender. This type of pattern is seen most by offenders who pick an interfamilia victim.

Within the same framework presented by Ward et. al. (1995) another insecure attachment style is the avoidant I, or fearful type. This person will desire an intimate relationship, but is fearful of rejection. A partner is located whom will not reject the offender however, the relationship is greatly lacking in closeness. The offender will continue to keep emotionally and socially distant from others and remains self-focused. Sexual contact with others serves as a replacement for the closeness or intimacy lacking in the offender's life. This contact will usually be very impersonal. The resulting sexual offending behavior manifested is nonviolent and impersonal. These behaviors often include exhibitionism, voyeurism, or an offense against a child who is an acquaintance or stranger.

Prentky, Knight, & Lee (1997) state that attachment disorders may be characterized by intense anxiety, distrust of others, insecurity, dysfunctional anger, and failure to develop normal age appropriate social skills. Those with these interpersonal deficiencies are more likely to turn to children to meet their

psychosexual needs. Marshall (1989, 1993, 1995) also believes a failure to develop secure attachment bonds in childhood results in a failure to learn the interpersonal skills needed to form secure and intimate relationships with other adults. He in turn concludes that this failure to become securely attached results in gaining intimacy with others mostly by sexual contact. Other empirical research has shown that a lack of intimacy is a significant distinguishing feature of sexual offenders. (Garlick, 1989; Seidman, Marshall, Hudson, & Robertson, 1994).

While the development of an insecure attachment style fosters cognitive distortions and a unhealthy pattern of interaction, the lack of intimacy due to this faulty attachment has also been found to be a factor in sexual offending behavior (Ward, McCormick, & Hudson, 1997). Neubeck (1974) found that the desire to achieve a feeling of satisfaction through intimacy was one of the primary motives for engaging in sexually offensive behavior. In addition, Marshall (1989) suggested that a possible consequence of a lack of intimacy is emotional loneliness. This loneliness may be compensated for through sexual relations and fantasies. These relations and fantasies can become increasingly deviant as intimacy continues to be absent.

This failure to achieve intimacy in adult relationships can lead to other behavioral and thinking errors. Many researches have observed offenders are

socially and emotionally isolated (Tingle, Barnard, Robbin, Newman, & Hutchinson, 1986). Even those offenders who appear to have many social relationships report these to be superficial and lacking intimacy (Marshall, 1989). Numerous other studies have also found inadequate social and interpersonal skills, under assertiveness, and poor self -esteem among offenders. These social competence deficiencies have been well documented with convicted child molesters (Araji & Finkelhor, 1985; Marshall, Barbaree, & Fernandez, 1995; Marshall & Mazzucco, 1995; Pithers, Beal, Armstrong, & Petty, 1989; Segal & Marshall, 1985; Segal & Marshall, 1986). Tingle et. al. (1986) reported that 74% of child molesters studied had few or no friends while growing up. Also along these lines Awad, Saunders, & Levene, 1984; Garlick,(1991) found loneliness to be a common experience for sexual offenders when compared to other offending groups and control groups. Robertson (1994) compared sexual offenders to violent nonsexual offenders and a control group. These findings also support the idea that sexual offenders report more loneliness and intimacy deficits that nonsexual offenders.

Ward et. al. (1997) came to several conclusions regarding to sexual offenders and intimacy. Child molesters were found to be less satisfied in sexual relationships than other groups, including other types of sex offenders such as rapists. This coupled with the reported lack of intimacy could mean that offenders

correlate sexual relationships with intimacy. If they attempt to use sex as a way of coping with emotional loneliness, sex may become a habitual way of coping with their negative feelings associated with a lack of intimacy.

There are numerous other historical, developmental, cognitive, and behavioral factors that have also been hypothesized to contribute to sexual deviant interests. These factors are used to help determine what treatment will be the most effective with sexual offenders. Some of these factors have been researched in more depth than others; however several theories tend to be the most promising.

Allen (1940) proposed that sexual conditioning physically influences the hypothalamus and this in turn affects the endocrine mechanisms. McGuire, Carlisle, and Young (1965) theorized that sexual deviant practices stem from masturbation practices. If deviant themes are reinforced by masturbation, they may result in actual sexual practice. In addition, as the masturbation continues more bizarre fantasies can occur. These themes eventually become acceptable to the person engaging in the masturbation. Some therapy techniques evolve around behavior modification of masturbation practices. Satiation therapies are one of these techniques (Marshall & Lippens, 1977; Marshall & Barbaree, 1978; Marshall, 1979; Abel & Annon, 1982).

Satiation therapies require the person to masturbate to an appropriate sexual fantasy until ejaculation. After this they are to continue to masturbate for a period

from fifty minutes to two hours while verbalizing deviant fantasies (Cellini & Schwartz, 1995). Olfactory conditioning is another behavioral technique to help reduce deviant arousal. In this therapy inappropriate slides or audio tapes are presented to the offender followed by a noxious odor. This odor in turn will eliminate arousal and associate this negative reinforcer to the inappropriate stimuli (Cellini & Schwartz, 1995). Behavioral techniques are used only to decrease deviant arousal, and they are a focal point in many sex offender programs as this arousal is believed to be a factor in sexually abusive behavior (Laws & Osborn, 1983; Quinsey & Marshall, 1983; Finkelhor, 1984).

A phallometric device known as the plethysmograph was developed to measure physical arousal of a male during the presentation of different stimuli (Malcolm, Andrews & Quinsey, 1993). This device has been shown to have the capability of discriminating between known groups of sexual deviants and non-deviants (Quinsey & Chaplin, 1988; Quinsey, Steinman, Bergersen, & Holmes, 1975). The plethysmograph is a tool often used in therapy to confirm the self report of offenders. It is to often the case the offender will either delete or grossly minimize deviant sexual interest. Sex offenders are notorious for misrepresenting their true sexual fantasies and desires. At the onset of therapy it is common for offenders to minimize offense behaviors to the therapist and peers (Pithers & Laws, 1996). This device enables the therapists to obtain specific information

about offenders progress in treatment and further needs that should be addressed.

In addition, the plethysmograph has also gained success in predicting future deviant sexual behavior (Barbaree & Marshall, 1988). In a follow up of 54 rapists over a 46 month period Quinsey (1990) found phallometrically measured sexual interest in sadism and inappropriate age selection to be an excellent predictor of sexual recidivism. Again, Quinsey (1991) studied a sample of 136 child molesters and followed them up over an average period of 6.3 years. Of these 136 58% were arrested for an offense of some kind or returned to an institution. Inappropriate sexual arousal in regard to age measured by the plethysmograph was correlated to new convictions for sexual offenses. Quinsey defines inappropriate age selection as a juvenile 15 and under, or if the offender is a juvenile as a person 5 years younger. Hanson & Brussiere (1996) found erections to children according to the plethysmograph to be the greatest predictor of sexual recidivism.

Cognitive-behavioral theories also help in explaining how a sexual deviant behavior is developed and maintained. This theory explores how self talk results in action. The sexual offender may set up negative emotional states by interpreting experiences in a negative way. In order to alleviate this emotional state deviant fantasy may be used. If these fantasies become uncomfortable the offender may engage in cognitive distortions to continue in the fantasies or acting

out behaviors (Cellini and Schwartz, 1995). Another cognitive theorist, Samenow (1984), identified the cognitive distortions among criminals of rationalization and victim stance. If cognitive distortions are maintained sexual deviant behavior can be sustained as well. According to the Association for the Treatment of Sexual Abusers (1997) "cognitive therapy must address dysfunctional core beliefs, as well as current cognition that promote maladaptive behaviors and emotions" (p. 23). If cognitive distortions continue they allow the offender to minimize, justify and rationalize the deviant behavior. These distortions eventually allow the offender to cross over from deviant fantasy to acting out against another person.

Ward, Hudson, and Marshall (1995) have used the theory of cognitive deconstructionist to help explain the minimization, blaming, covert planning, intimacy and social deficits, lack of empathy, and other justifications often employed by sexual offenders. Ward et. al. (1995) note that sex offenders often deny all aspects of their sexual offense despite overwhelming evidence that they did commit the offense. In addition, many offenders will attempt to shift responsibility for the offense from themselves to the victim, or to another factor such as alcohol or drug use. Another common reaction of the offender may be to shift the blame not to the victim, but to their partner claiming they were being neglected and had to turn to a sexual offense to get their needs met. Another cognitive error on the part of the offender include the way in which they view

reactions by the victims during the assault. Some offenders may view children as sexually provocative, interpreting normal childhood behavior with adult themes. If a child sits in a way that exposes their underwear this is viewed as having sexual intent. Similarly a child who sits on the lap of an offender may be viewed as a flirt or as a person who wants sexual contact. These types of cognitive distortions are encountered all to often with the offender. During the sexual assault itself the child or victim is often seen as an active participant. If the victim does not actively resist, the offender often will perceive these actions as a willing participant in the deviant act. Other offenders such as exhibitionist will view the shocked responses of their victims not as repulsiveness or fear, but rather as attraction or approval of their sexual organs.

Seemingly irrelevant decisions (SIDs) are described by Laws (1989) as steps involved in the planning of a sexual offense that the offender passes off as accidental. This covert planning helps the offender rationalize that they did not play a large part in the circumstances leading to the assault. An example of this could be making arrangements to be alone with a child, then after the assault claiming that they did not want to be there in the first place.

Finally, Meichenbaum (1977) noted sexual offenders suspend self-regulation during their offense cycle. The realization of long term consequences are suspended in order to meet the short term gratification of the offense. A result of

this thinking is the failure of the offender to understand the distress caused to the victim initially and long term. In a cognitively deconstructed state for a sex offender the focus is on the here and now and concrete levels of thinking are concentrated on. This means the offender does not evaluate his actions in a negative way, but rather on the positive he is getting at that specific point in time. This could be the positive associated with sexual arousal or the anticipated pleasure he will receive upon orgasm.

Ward et. at. (1995) have also concluded there are several cognitive distortions that accompany a cognitive deconstructed state of the offender. One of these is the common perception by offenders that victims enjoy the assault while it is occurring. A result of this belief is the distortion that there will be no negative consequences from the assault because there was not assault at all. In addition, if the offender views the victim as enjoying the offense, he can not consider the short and long term effects of the behavior on the victim. This may lead to a lack of victim empathy on the part of the offender. This deconstructed state may not be in place at all times for the offender, but rather only in regard to the sexual offense. Marshall, Jones, Hudson, and McDonald (1994) found that child molesters can be just as empathetic as other men, even though they are quite unempathetic towards specific victims.

A review of historical factors common among sexual offenders is a way to

dissect what to look for in recidivism prediction. The factors reviewed so far have to do with the personal history of the offender or the cognitive and behavioral deficits often theorized to contribute to sexual offense. The next step is to explore what factors are related to recidivism in sexual offending.

The factors that have been most correlated with recidivism include erections to children, MMPI masculinity-feminity 5 scale, the presence of a severe psychiatric disorder, deviant sexual preferences, prior sexual offenses, if the victim is a stranger, erections to boys, if the victim is a male child, anger problems, any prior criminal offense, and age (Hanson & Brussiere, 1996). The study by Hanson & Brussiere (1996) was a meta-analysis of 61 sets of data involving 28,972 sex offenders with a median follow-up of 4 years. Of this set of data erections to children, prior sexual offense, victim is a male child, any prior offense, and age represented factors that were statisticly significant and had the most references supporting these factors as risk factors of recidivism. Other factors were found to have some statistical significance, but due to the limited literature to support these other factors they were not considered.

Other studies have found similar results to the massive meta-analysis by Hanson & Brussiere (1996). Prentky, Knight, & Lee (1997) found some factors that have statistical significance in the prediction of a sexual re-offense. These include psychopathy (as measured by The Hare Psychopathy Checklist-Revised,

PCL-R), prior criminal history, and deviant arousal as measured by phallometric assessment. Quinsey, Lalmuiere, Rice, & Harris, (1995) concluded after a study of 219 men who had assaulted an adult female or a child, that the best statistical predictors of recidivism were prior criminal history, psychopathy scores, and phallometric assessment of deviant arousal. Turvey (1997) also found phallometric assessment of deviant arousal and psychopathy useful in prediction of another sexual offense.

A review of the literature on risk factors associated with sex offender recidivism continues to find these similar factors over many times. The best predictors to date are prior criminal history, level of psychopathy, and the use of phallometric measurement. Two of these factors, criminal history and psychopathy, are unchangeable or static factors. Response on a phallometric device has been shown to be changeable with intervention. Historical factors are very useful in initial classification for law enforcement personnel and therapists. However, after this initial assessment no reassessment can be made with dynamic factors that might change over the course of an offender's life, except for arousal on a phallometric device. In fact, there has been little research that has linked changeable risk factors to recidivism (Hanson, Steffy, & Gauthier, 1993; Hanson & Brussiere, 1996; Quinsey, Lalumiere, Rice, & Harris, 1995; Prentky, Knight, & Lee, 1997). It is iimportant for these dynamic factors that need to be identified

and focused on in treatment, because they involve issues that can be modified to reduce the risk of recidivism for the offender (Quinsey et. al., 1995).

Some dynamic factors are starting to give an indication that they can predict risk. A recent study presented by Hanson (1997), identified substance use, mood, psychiatric symptoms, social environment, employment, attitude, life stress, victim access, and offender cooperation with supervision as possible dynamic factors. Other studies (Quinsey et. al., 1995 & Hanson, Steffy, & Gauthier, 1993) found the offender's marital status to be a risk indicator. Offender success or participation in treatment has also been examined at as a possible risk indicator. Furby, Weinrott, and Blackshaw (1989) found that attendance in treatment did not reduce the risk of recidivism in sexual offenders. However, Marshall, Jones, Ward, Johnston, and Barbaress (1991) did find that offenders who attended treatment had lower recidivism rates. Finally there have even been conflicting reports on the use of substance use by sexual offenders as a dynamic risk factor. Prentky, Knight and Lee (1997) did not find the use of alcohol as a dynamic risk factor (it should be noted that illicit drug use was not mentioned). However, Hanson (1997) found substance use to be a possible dynamic risk factor.

Recent studies have focused even more on dynamic risk factors to help fill the void of research. Harris (1997) conducted a study that examined only dynamic factors. His findings are broken down into five categories: 1) information during a

basic interview 2) psychological adjustment 3) attitudes 4) self management and sexual risk factors 5) pro-social influence. During the basic interview a dynamic factor that correlated with recidivism was the use of alcohol or drugs at the time of the new offense. In the psychological adjustment category three factors were present. Feeling low, psychiatric symptoms, and feelings of anger were all related to recidivism. Attitudes only measured one factor, this was classified as a general change for the worse. No specific information about this bad attitude was listed in the literature, but it correlated with recidivism. Under self management and sexual risk factors three factors were present. These include if the offender views himself as no risk to the community, if he engages in sexual risk factors such as deviant fantasy or excessive masturbation, or if he has access to his target victims. Finally pro-social influence finds four factors that correlate with recidivism. Manipulative behavior on behalf of the offender, no show (not defined), disengaged, and if the offender initiates dysfunctional relationships all correlated with sexual recidivism.

Information Hansen (1997) presented at the ATSA conference in Washington D.C. also identifies dynamic risk factors. Hansen (1997) studied 400 offenders, 200 recidivists and 200 non-recidivists. These offenders were under some type of community supervision at the time of the re-offense or non-offense. When discussing dynamic factors Hansen (1997) has broken these into two types, stable

and acute. Stable factors are such things as marital status, a deviant sexual preference or a personality disorder. Acute factors change rapidly such as negative mood or drunkenness. Hansen listed 11 dynamic factors related to recidivism: substance abuse, mood, psychiatric symptoms, social, employment, attitude, life stress, victim access, self-management, supervision cooperation, and miscellaneous.

Pithers (1998) also identified dynamic risk factors at the 1998 Winter Institute of the American Probation and Parole Association. According to Pithers there are four domains of risk factors, dispositional, historical, contextual, and clinical. Dynamic factors are located in dispositional, contextual, and clinical domains. These factors include arousal to abusive fantasy, substance abuse, cognitive distortions, global anger, impaired interpersonal relationships, and lifestyle impulsiveness. Prentky & Knight (1993) also use impulsiveness as a possible risk factor, and find that a history of impulsive and antisocial behavior has been a well-documented risk factor consistent in child molesters.

As can be seen identification of static factors has remained consistent across studies with prior sexual criminal history and elevated PCL-R scores as the two best static predictors. Research on dynamic factors shows some similar outcomes, however different factors can be identified depending on what study is reviewed. One consistent dynamic factor across studies is deviant arousal according to

phallometric measurement. Other factors that show some consistency are social isolation, failure in treatment, accessability to victims, and substance abuse.

Identification of these static and dynamic risk factors are important when attempting to predict any type of criminal activity, but even more so for a crime that immensely impacts the victim and their family members. The percent of offenders who do recidivate often varies depending on the type of sexual offense or who the offense was committed against. Quinesy et. al. (1995) found incest offenders to have the lowest rate of re-offense with a rate of 10%. As the offense moved outside the family and toward children in general the re-offense rate increased dramatically. Heterosexual child molester had a re-offense rate of 22%, while homosexual offenders had a rate of 35%. Frisbe (1969) conducted a study of 887 men convicted of a sexual offense against a minor. Of this sample 75% were heterosexual offenses. After a 3.5 year follow up 15% of these offenders had been convicted of a new sexual offense. Frisbie concluded through the use of follow-up interviews the contributing factors associated with these re-offenses were alcohol abuse, unorthodox ethical values, problems in establishing meaningful relationships with adult females, and the desire for physically immature females as sexual objects. The latter could possibly be correlated to deviant arousal on the plethysmograph.

Quinsey, Rice, and Harris (1991) followed 136 extra familial child molesters

released prior to 1983. Offenses were against males 16 years old and younger and females 14 years old and younger. The follow up period had an average of 6.3 years. Of this group 31% had a subsequent conviction for a sexual offense, and 43% had a subsequent arrest for any type of violent offense (including sexual offenses). The recidivists in this study were less likely to be married, more likely to have been diagnosed with a personality disorder, had a more serious offense history, and showed more deviant arousal on the plethysmograph.

Recidivism rates for rapists differs from that of offenders who assault children. Rice, Harris, and Quinsey (1990) studied 54 offenders who had sexually assaulted females 14 or older. These offenders were released prior to 1983 and were followed for an average of 4 years. This group had a reconviction rate for a sexual offense of 28%, and 43% had a conviction for any offense. The sexual recidivists of this group had more serious offense histories, higher psychopathy scores, and more sexual interest in nonsexual violence against women as measure by the plethysmograph. When the psychopathy score and plethysmograph were the only two tools used to predict re-offense they were able to accurately classify 77% of this sample of recidivists or non-recidivists.

The samples presented have all used official reports as the basis for recidivism. Barbaree and Marshall (1988) followed 35 extra familial sex offenders who had victims under the age of 16. When both official and unofficial reports were used

to determine recidivism 43% of this sample re-offended sexually within a 4 year follow-up period. This sample found three large categories that contributed to sexual re-offense. These include: 1)sexual deviance determined by deviant arousal on the plethysmograph, use of force, intercourse with the victim, and number of victims, 2) social status comprised of intelligence quotient and socioeconomic status, 3) offender age that looked at the offenders age and the victims age. Of these factors sexual deviance was accurate in predicting recidivism in 71% of this sample. The most striking statistic of this study is how recidivism increases when unofficial reports are also considered.

Prentky, Knight, and Lee (1997) reviewed recidivism rates of 251 repetitive offenders released from the Massachusetts Treatment Center for Sexually Dangerous Persons. Of this sample 25% were convicted of a new sexual offense after an average release period of 3.98 years. This sample included convicted child molesters and rapists. More importantly is the extended follow up period of 25 years used in this study. At the end of this follow up 52% of the offenders had been charged with a new sexual offense, and 41% had been convicted. Prentky et. al. (1997) points out that if a follow up uses results after 2-5 years 30% of the recidivists will be missed. The survival rate for offenders progressed consistently over his 25 year follow up period. One could hypothesize that if the follow up period had been extended the survival rate would have ended up being zero

indicating all offenders recidivate.

In regard to risk factors Prentky et. al. (1997) found degree of sexual fixation with children, presence of multiple paraphilias, and number of prior sexual offenses to predict recidivism most accurately. The only dynamic factor indicated is the degree of fixation with children. This has been shown to change over time. Alcohol history and social competence were not found to be factors, although other studies have found differently. Recidivism was accurately predicted 75% of the time using the two static and one dynamic factor.

A review of the literature reveals consistent historical risk factors to help identify recidivism risk with a sexual offender. The identification of dynamic predictors is still under study, and will be the focus of this research. Dynamic indicators will aid in helping therapists and other professionals to decide how to engage a sexual offender. As life changes so does risk for recidivism. This study examined possible risk factors in men over the age of 18 who are on probation with MCAPD for a sexual offense. The recidivism rate of this program has been much lower than other programs, most likely due to strict community supervision and mandatory treatment. The overall recidivism rate for offenders supervised in a specialized sex offender unit has been under 2%.

Chapter III

Method

Subjects

The offenders studied came entirely from Maricopa County Superior Court. Two groups were represented, recidivists and non-recidivists. Access to files and information was granted by MCAPD as all offenders studied are either on supervised probation or were on supervised probation at the time of their re-offense. All offenders, except one, were convicted of a sexual crime that was a felony. The one exception was convicted of felony aggravated assault, a date rape case. As with all the other offenders studied this offender also had sex offender terms and was supervised by a specialized sex offender unit in MCAPD.

The non-recidivist group consisted of 16 cases who are actively under supervision by MCAPD in a specialized sex offender unit in the east valley of Maricopa County. This unit is comprised of five probation officers, two surveillance officers, and one supervisor. Total active cases currently supervised by this unit is 309. Each one of these offenders are required to follow specialized sex offender terms that include, but are not limited to, no contact with minors (person <18), mandatory attendance in sex offender treatment, and participation in

the penile plethysmograph and polygraph. This sample group consisted of males with age ranges from 20 to 48 (mean 34.2). The time spent on probation to date ranged from 10 months to 120 months (mean 52.2 months). All subjects were still on supervision at the time of this study.

A variety of sexual offenses were examined in this sample and no distinction was made between a sexual crime against a child or an adult. In addition, no distinction was made between inter familia and extra familia offenders. Also the offense did not have to be a "hands on offense." Felony indecent exposure cases were also included in this sample.

The sexual recidivist group consisted of 14 cases that had committed another sexual crime while on supervision with MCAPD. Total number of cases in the sex offender unit has only been tracked since 1993, with a total of 1,514 sexually motivated crimes in the unit to date through out MCAPD. Of this total there have been 24 sexual recidivists, however information was only available on 14 of these cases.

The age range of this group was from 18 to 60 (mean 34). From the time they were placed on supervised probation to the time of the new sexual offense had a range of 3 months to 90 months (mean 23.9 months). One case had a span of 84 months between initial conviction and re-offense, however this was not included in the statistics. Upon interview with the victim in the new offense she stated the

offender had been sexually assaulting her the entire time he was on probation.

Instrument

Based on a review of the literature concerning what dynamic predictors appear to predict recidivism most accurately a short questionnaire was developed (Appendix A). Seven factors were selected to be compared between the recidivists group and the control group. The first of these factors was participation in treatment. Several studies have shown that offenders who participate in sex offender treatment have lower rates of sexual recidivism. Marshall & Pithers (1994) found that sex offenders who participated in specialized treatment had lower recidivism rates when compared to offenders who did not participate. Gordon, Holden & Leis (1997) followed 25 men who did not complete a sex offender treatment program and compared them to those who did. Of those who did not complete treatment 53% were incarcerated again, compared to a recidivism rate of 32% for those who did complete treatment. Finally, Hall (1995) compared the effectiveness of treatment programs on recidivism. Overall the recidivism rate was 19% for those in treatment compared to 27% for those who were not. For the questionnaire used in this study three choices were given for the question "participation in treatment." These included attending as required, not attending, and unsuccessfully discharged.

Social and emotional isolation has also been considered a possible dynamic

risk factor. Married individuals have been shown to have lower rates of recidivism when compared to single offenders (Pithers, 1998). Gary (1997) believes offenders who do not have a stable and supportive social network present a higher risk to re-offend. Maletsky (1990) concluded that men who were unemployed at the time of their offense were four times more likely to be treatment failures. Living arrangements and employment status were the next two sets of data on the questionnaire. This information can be linked to social and emotional isolation as those who live alone and are unemployed will most likely have less social interaction and support. A specific question was added in regard to living with minors. While not all the offenders in this study had victims who are minors, 59% of the official convictions for recidivists and non-recidivists sample indicated the crime was against a person under the age of 18.

Indication of current use of alcohol or illicit drugs was also chosen for the questionnaire. Hanson & Bussiere (1996) concluded offenders were at a higher risk for general recidivism if they had a current alcohol problem or if they were intoxicated at the time of the offense. Illegal drug use and alcohol use both impair judgement and often allow an offender to justify their actions. The questionnaire left a blank space so the specific substance could be listed if the offender was using any type of substance.

Finally arousal as measured by the plethysmograph was used as the final

variable. The effectiveness of a phallometric device in the prediction of a new sexual crime has been well documented. In addition to the 6 factors offender age, time on probation, and time on probation to new offense were also collected. The questionnaire used forced choice answers on all questions except for #5 substance abuse so the substance could be listed. No other instruments were used to gather the information obtained from the recidivist group and the control group.

Design

The focus of the study was to determine differences, if any, between the dynamic factors of sexual recidivists and non-recidivists. The experimental group was therefor the sexual recidivists. A sexual recidivist for this study was a person who while on probation supervision with MCAPD was charged with another sex crime. This charge resulted in the termination of probation in each case and a return to court for the offender. The members of the sexual recidivists are no longer on probation supervision and for the most part are incarcerated in the Department of Corrections (DOC) in the state of Arizona. Many of the probation officers who initially supervised these offenders are no longer with MCAPD or have taken other assignments within the department. As stated earlier there have been 24 sexual recidivists over the past 10 years that have resulted in new charges. However, in most cases prior to 1993 files were not kept once the offender was sentenced to DOC. Only 14 case files were located that contained

enough material to answer the questions on the instrument used. These files contained presentence reports of the initial sexual offense, progress notes from treatment providers, progress notes from probation officers, court memos and documents pertaining to the offense, drug screens and results, in some cases polygraphs around sexual history, and in some cases plethysmographs. They also contained police reports and probation violation reports around the new sexual offense. The offenders in these cases were supervised by MCAPD in the sex offender unit. They were given sex offender terms in addition to standard terms of probation. These 14 files were used to gather the relevant information for this study.

A control group was used of 16 sexual offenders currently on probation with MCAPD's sex offender unit for similar crimes as the recidivists group. These offenders are also expected to follow specialized sex offender terms of probation as well as standard terms. These cases were randomly selected by the probation officers who currently supervise them. In addition to all file material, the probation officer who personally meets with the offender was available to assist with the relevant information.

Procedure

Information on the recidivists was collected from the MCAPD case files. All information was collected and interpreted by this writer in order to maintain

consistency. Since the non-recidivists were still on active supervision three probation officers were selected and asked to randomly select cases from their case files. The only restrictions given on choosing a file was that they could not be in violation of probation at the present time. These officers were given the survey and instructions on how to fill in each question. For question 1 attending as required was defined as any person who was currently in group therapy. Not attending was defined as any offender who had not started treatment, and unsuccessfully discharged was for any offender who was asked to leave group for non-compliance or non-attendance. The remainder of the questions were not explained in any greater detail than what was presented on the survey. If an officer had an individual question it was answered by this writer.

Chapter IV

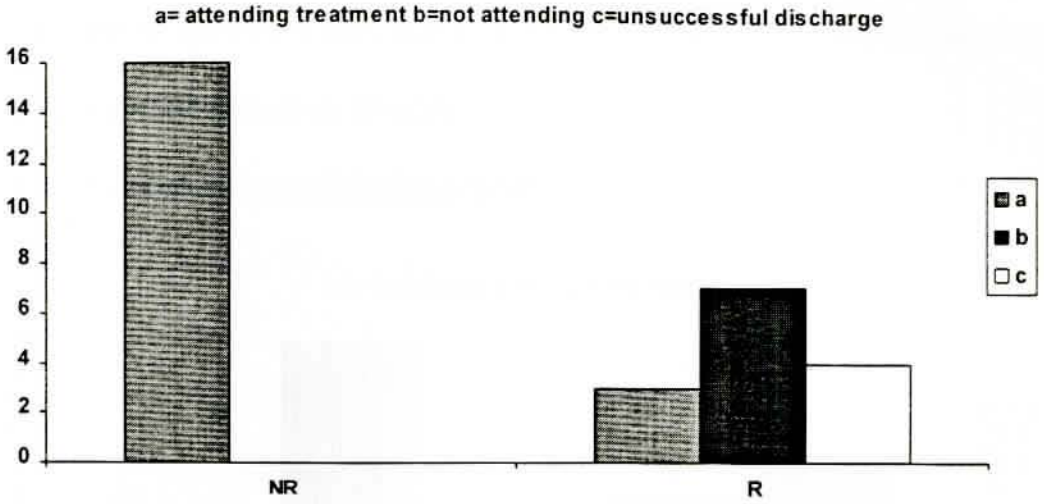
Results

Considerable differences were found between the recidivist (R) and non-recidivists (NR) groups on 4 of the 7 factors measured. The greatest difference between the two groups was in reference to question 1, participation in treatment (Figure 2). Of the non-recidivists 100% were attending treatment as required (n=16). This is a term of probation that is strictly enforced by MCAPD and therapists. Total compliance for those chosen as not in violation by the supervising probation officers is not entirely surprising. Sexual recidivists had a much different response to treatment when given a court order to attend. Of this group 20% (n=3) were attending as required at the time of their new sexual offense, 47% (n=7) were not attending any treatment at the time of their new sexual offense, and 27% (n=4) had been unsuccessfully discharged from treatment at the time of their new sexual offense. Combining the offenders who were not in treatment either for unsuccessful discharge or for not attending showed that 73% (n=11) were not attending treatment regardless of the reason.

Figure 1. Responses to questionnaire

	Non-recidivists (NR) n=16	Recidivists (R) n=14
Participation in treatment		
A. Attending as required	100%	21%
B. Not attending	-	50%
C. Unsuccessfully discharged	-	29%
Employment		
A. Unemployed	-	29%
B. Unemployed-retired	-	-
C. Unemployed less than 30 days	-	-
D. Part time less than 30 hours	-	-
E. Full time employed	100%	71%
D. Missing data	-	
Living arrangement		
A. Living alone	37%	33%
B. Living with a spouse	37%	27%
C. Living with parents	19%	13%
D. Living with friends/roommates	6%	7%
E. Living in a group home	-	7%
F. Living on the street/homeless	-	7%
G. Missing data	-	-
Living with minors in the residence		
A. Yes	6%	33%
B. No	94%	53%
C. Missing data	-	-
Is the probationer socially isolated		
A. Yes	50%	-
B. No	50%	-
Missing data	-	-
Is the probationer currently using any type of drug/alcohol		
A. Yes	0%	43%
B. No	100%	57%
C. Missing data	-	
Type of sexual arousal/interest according to plethysmograph		
A. Responding to preadolescent females	13%	-
B. Responding to preadolescent males	6%	-
C. Responding to prepubescent females	29%	7%
D. Responding to prepubescent males	6%	7%
E. Responding to adolescent females	63%	7%
F. Responding to adolescent males	19%	13%
G. Responding to adult females	56%	13%
H. Responding to adult males	13%	-
I. Flatline	6%	7%
J. None taken	-	67%

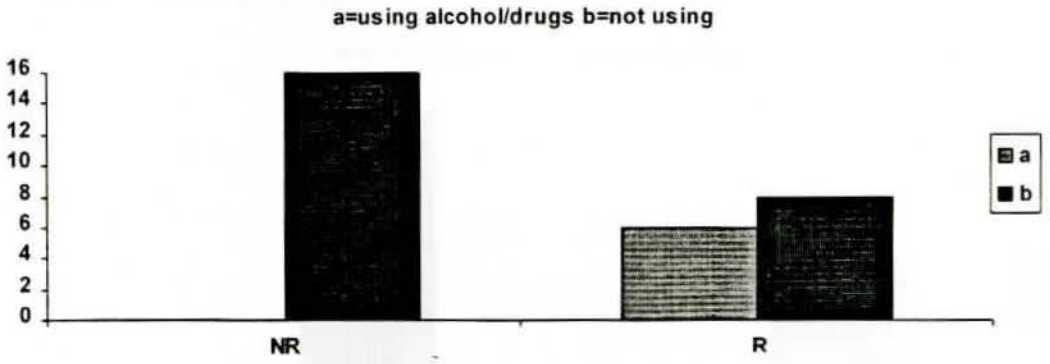
Figure 2. Comparison of treatment success/attendance



Item 6 on the survey addressed the presence of illegal substance use or alcohol use by both groups (Figure 3). Persons on supervised probation are required to participate in drug screening, and breathalyser testing while on supervision. If alcohol has been a problem in the past, or was a factor in the initial sexual offense a term of probation of "no alcohol" is often added by the court. Of the non-recidivists 100% (n=16) were scored as not currently using any illegal drug or alcohol. This determination was made by drug screen and breathalyser results. If no drug screens or breathalysers were administered a score was given by the impression of the probation officer in regard to usage. Of the 14 sexual recidivists substance use appeared to be a much larger problem. An alarming 43% (n=6) were using a substance of some kind around the time of their sexual re-offense. Of these 6 offenders 2 were using methamphetamine, 2 were using marijuana and

alcohol, 1 was using methamphetamine and alcohol, and 1 had missing data. The use of these substances was verified in the case file by either an admission of the offender or by a drug screen report.

Figure 3. Comparison of alcohol/drug use

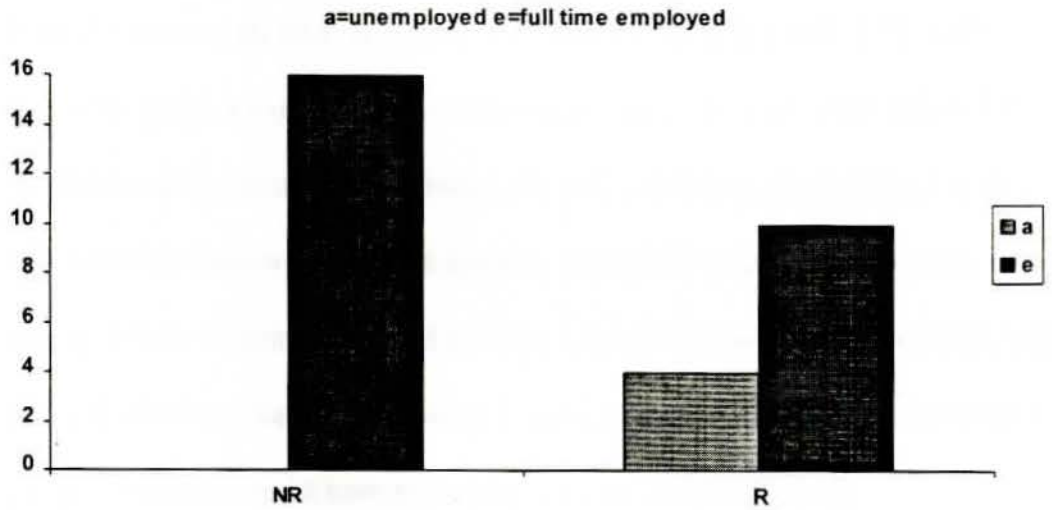


The accessability to minors that a sexual offender has was also found to be different when comparing recidivists to non-recidivist. Of the non-recidivists 94% (n=15) were not living with minors. Recidivists were living with a minor in 33% (n=5) of the cases reviewed. The majority 53% (n=8) were not living with a minor, and 7% (n=1) had missing data in reference to this factor. While this difference is not as great as participation in treatment and substance use, it still appears significant.

Employment is often a sign of stability in a person's life and was the second factor measured between these two groups (Figure 4). Non-recidivists were working full time (at least 32 hours per week) 100% (n=16) of the time. Again

this is also a term of probation that each group was expected to follow when initially placed on supervised probation. The recidivists were full time employed in 71% (n=10) of the case files reviewed. The remaining 29% (n=4) were totally unemployed at the time of their new sexual offense.

Figure 4. Comparison of employment



There were two remaining factors that data was collected for on the surveys, level of social isolation and results on the plethysmograph. Of the non-recidivists 50% (n=8) were scored as socially isolated and 50% (n=8) were scored as not socially isolated. No data was collected in reference to this question on the sexual recidivists. Attempting to make a determination of social isolation from a written case file was not possible. Notes from probation officers, therapist progress notes, official court documents, and other assessments did not offer the specific information needed to accurately score this question. If a specific assessment had

been given prior to the re-offense this information could have possibly been collected.

A measure of sexual arousal was obtained in 13 of the non-recidivists cases. The remaining three had results from an Abel screen. The Abel is a measurement of sexual interest and has been correlated with the plethysmograph so the results from this assessment were included. The results were as follows: 13% (n=2) arousal to preadolescent females, 6% (n=1) arousal to preadolescent males, 29% (n=4) arousal to prepubescent females, 6% (n=1) arousal to prepubescent males, 63% (n=10) arousal to adolescent females, 19% (n=3) arousal to adolescent males, 56% (n=9) arousal to adult females, 13% (n=2) arousal to adult males, and 6% (n=1) flatlined the test (no arousal to any category). It should also be noted one non-recidivist could have more than one area of arousal on the plethysmograph. All significant areas of arousal were recorded, not just the highest. Of the recidivist group only 3 had a plethysmograph on file, 10 had no test, and one had a flatline during the test. Of the three that did complete this assessment 7% (n=1) arousal to prepubescent females, 7% (n=1) arousal to prepubescent males, 7% (n=1) arousal to adolescent females, 13% (n=2) arousal to adolescent males, and 13% (n=3) arousal to adult females. No striking differences were noted between these two groups of offenders. The outcome on this factor may have been different if more information was available.

The mean age for both groups of offenders were surprisingly similar. Non-recidivists had a mean age of 34.2, while the recidivists had a mean age of 34.0. Average time on probation however reflected noticeable differences. The non-recidivists have been on supervised probation for an average of 52.2 months (range 10 months to 131 months) with no known new sexual crime. The recidivist group overall was not successful on supervised probation as long before they committed a new sexual crime. The mean time between conviction of the original sexual offense and the charge of a new sexual offense was 29.3 months (range 3 months to 90 months). As noted earlier one offender was not counted in this average as his victim informed MCAPD he had been sexually assaulting her the entire time he was on supervision.

The results of this study indicate treatment failure/non-attendance, substance abuse, unemployment, and easy accessability to minors are more likely to be present in sexual recidivists on probation with MCAPD when compared to non-recidivists that had similar offenses and supervision requirements. Age was not related to recidivism, but time on supervision to re-offense also appears to be. The majority of offenders are charged with a new sexual offense within 30 months of the original conviction.

Chapter V

Discussion

This study yielded some useful results for those who deal with sexual offenders. The most substantial finding has to do with treatment failure in a sexual recidivists population. Offenders supervised by MCAPD are required under terms of probation to attend cognitive/behavioral therapy. Without mandatory therapy offenders do not learn the internal controls needed to manage a sexual deviance they have already demonstrated exists. Sheen (1996) found that incarceration without the benefit of treatment results in offenders who return to the community with lower self-esteem, increased anger, and less coping abilities. Eventually these offenders return to their dysfunctional coping strategies that include deviant sexual behavior.

Jackson County conducted a study on the effects of treatment and sexual recidivism. Of the 170 offenders who completed the mandatory treatment successfully only one had a subsequent felony conviction for a sexual offense (.58%). A second group from this county consisted of 157 offenders who failed to successfully complete treatment for a variety of reasons. Of this group 17 individuals were convicted of a new sexual offense (10.82%). These results are consistent with this study, failure to complete sex offender treatment increases the probability for a new sexual offense.

It is noted that not all offenders being supervised by MCAPD are attending treatment. From the sample given by supervising officers it appears that those who are not in violation status are attending. Some offenders who have not re-offended are not in treatment. This does not mean they should be arrested immediately, however perhaps an increase of other external controls should be used until compliance in treatment has been achieved.

Results of this study also confirm the effectiveness of a cognitive/behavioral approach to therapy for sexual offenders. MCAPD offenders are required to participate in group counseling exclusively with other sexual offenders. There is no confidentiality in these groups to ensure the team of therapists, probation officers, and family members are aware of all issues. Offenders are required to confront mistaken beliefs about sex and their sexual offense, participate in minimal arousal conditioning, learn red flags, disclose all sexual history and fantasy, and are not to live with minors unless they have an approved chaperon or it is approved by an official court order. This type of required treatment may be necessary as sexual offenders typically have little motivation to change their established behavior without significant intervention.

If offender's do attend treatment it is usually not voluntarily (Jensen & Jewell, 1988). Salter (1988) states the clinical environment for sexual offenders must be different from a traditional approach. Increased controls, less trust, and less

confidentiality are all needed. Insight oriented treatment without behavioral tools to decrease deviant arousal falls short of the goal to reduce deviant sexual behavior. Gendreau (1996) found the following to reduce recidivism in regard to a treatment program: intensive services, cognitive/behavioral approach, teaching of new social skills, structured setting that was enforced in a firm fair manner, and the programs activities could be related to the real word. Finally, Lockhardt, Saunders, and Cleveland (1989) concluded a cognitive-behavioral approach including masturbatory satiation, covert sensitization, heterosocial skills training, cognitive restructuring, and antiandrogen drug therapy to be the most promising for use with the sexual offender. For the sexual recidivists in this study 73% were either not in treatment or unsuccessful in treatment. This figure validates the need for treatment, and the lack of participation in treatment as a dynamic risk indicator for recidivism.

The use of illegal substances or the use of alcohol impairs judgement in all users. It therefore stands to reason that sexual offenders who engage in new criminal activity are often using these substances. In a large sample pool of offenders placed on probation with MCAPD only a small percentage have been charged with a new sexual offense. Of this small sample 43% were using substances around the time of the new sexual offense. Compared with 0% of the non-recidivists that were randomly sampled this percentage is significant. A

common justification for offenders at the time of the initial sexual offense is to pass their actions off to being "drunk" or "high" therefore they are not really sure what happened. This places the responsibility away from the offender and onto the substance. Using substances may also increase the occurrence of deviant fantasy, increasing the chance of taking this fantasy to the real world. Finally, if an offender has been attending treatment and is serious about monitoring behavior the use of substances can nullify any gains from treatment. An offender under the influence will most likely be less able or unwilling to utilize the skills they have learned.

In the sample studies there does not appear to be a drug/alcohol more likely to led to re-offense. Of the recidivist group marijuana was used twice, methamphetamine was used three times, and alcohol was used three times. The use of a stimulant, depressant, or mild hallucinogen does not seem to produce different outcomes. This is especially important in reference to alcohol abuse, a legal substance for most people who are not under court orders. Therapists, family members, and social agencies should discourage the use of alcohol by any sexual offender. It appears to be detrimental to the goal of treatment, and a risk factor for sexual recidivism.

Originally one factor to be measured for both groups was the perceived level of social isolation of an offender. It was hypothesized that an offender who was

isolated would have a higher rate of sexual recidivism. As the study progressed and material was gathered from the case files of the recidivists group, it became apparent that a determination of this factor could not be made with the information at hand. Of the non-recidivists group probation officers were able to give their impression of the level of social isolation an offender. The results were a perfect split, 50% not socially isolated, 50% socially isolated. The only conclusion to draw from this is that sexual offenders have few social outlets. It is also important to note that this is a rating from the probation officer. Perhaps if each offender was asked if they are socially isolated the numbers would be much different. One can also only speculate on what the numbers would have shown for the sexual recidivists in terms of social isolation.

For many people social outlets are found in the workplace. The recidivists group did have 27% of the sample unemployed. At the very least this does show a difference in some type of stability between the two groups. Lower rates of employment could also mean a diminished social network to draw support from. An increase of stress related to unemployment might possibly increase escapism in the form of deviant sexual fantasy. This added stress coupled with other risk factors found in the recidivists group such as lack of or no treatment and substance use can make for a very high risk offender. These life changes should be taken into consideration when working with a sexual offender.

Living arrangements did not appear to be different between the two groups. If the recidivist group tended to live alone/homeless more than the non-recidivist group an even stronger argument could be made for a lack of social support for the recidivist group. One commonality to consider is that the majority of sexual offenders' victims are either family members or someone they know. Perhaps an offender with many associates has a larger potential victim pool to draw from, thus increasing the chance of a new sexual crime. Living with a minor in the residence however was a risk factor for the recidivist group. Continued exposure to a minor could increase the occurrence of deviant thoughts or fantasy. Of the non-recidivist group 94% did not live with a minor while 33% of the recidivists did. It is important to remember that of this sample not all offenders were convicted of a crime against children. The recidivist group may have been living with children more often, but a child under the age of 18 may not have been their deviant sexual interest. If an offender is allowed to live with a child while on probation it is because they have an approved chaperon (and have been successful in treatment), have a specific court order to live with a minor, or their offense was not against a minor. In fact, 4 of the 10 recidivists were not convicted of a crime against children and could have been allowed to live with a minor. This could account for 4 of the 5 recidivists living with children.

One downfall of this study was the small sample of sexual recidivists on

probation with MCAPD. However, there were a large number of sexual offenders to begin with, and of the small sample size common factors were identified when compared to a sample of non-recidivists. It is important to keep in perspective that not all sexual crimes are detected, in fact the majority are not reported or discovered at all. It is possible that a very large number of probationers have committed a new sexual offense and have never been caught. Studies have also shown that offenders remain at risk for re-offense their entire lives. In fact Hansen & Bussiere (1996) found that follow up of sexual offenders after 15 to 30 years indicate a new sexual offense in 42% of offenders. This continual risk of the sexual offender substantiates the need for this study and others like it. Dynamic risk factors need to be identified in order to increase/decrease resources for each particular offender. Quinsey, et. al. (1995) note that the most important need is the identification and evaluation of dynamic predictors. These can be situational predictors, such as employment or lack of, changes in mood, treatment induced changes such as skill acquisition, and compliance with supervision.

This study was successful in distinguishing characteristics between recidivists and non-recidivist sexual offenders on probation in Maricopa County. While it is highly doubtful there will ever be a 100% effective way to predict who will commit another sexual crime commonalities across offenders can determine who is at a higher risk to do so.

Appendix A

Probationer Data at the time of new offense

Name:
Assigned number:
Age of offender at time of offense:
Date placed on probation:

1. Participation in treatment
   A. Attending as required
   B. Not attending
   C. Unsuccessfully dicharged

2. Employment
   A. Unemployed
   B. Unemployed
   C. Unemployed less than 30 days
   D. Part time employment less than 30 hours per week
   E. Full time employed
   F. Missing data

3. Living arrangement
   A. Living alone
   B. Living with a spouse/significant other
   C. Living with parents
   D. Living with friends
   E. Living on the street/homeless
   F. Missing data

4. Living with minors in the residence
   A. Yes
   B. No
   C. Missing data

5. Is the probationer socially isolated?
   A. Yes-no outside freinds from the home

B. No-activities with others outside home
C. Missing data

6. Alcohol/drug use
   A. Yes What_____
   B. No
   C. Missing data

7. Type of arousal according to plethysmograph
   A. Responding to preadolescent females
   B. Responding to preadolescent males
   C. Responding to prepubescent females
   D. Responding to prepubescent males
   E. Responding to adolescent females
   F. Responding to adolescent males
   G. Responding to adult females
   H. Respoding to adult males
   I. Flatlined
   J. Missing data

Time on probation until new offense in months_____

Appendix B

Maricopa County Adult Probation
Attention: Lori Scott, Supervisor unit 12-sex offender unit

I am requesting permission to use casefile information and to solicit information from probation officer's regarding client progress. This informatin will be used to complete a study on dynamic risk predictors of the sexual recidivist that have been on supervision with Maricopa County. The information obtained will be used for satistical purposes only. All files will be assigned a number, as will all other data collected. There will be no confidentiality issues. By completing this study I will gain valuable information on how to better supervise offenders on probation for a sex offense, and I will meet requirements to complete my Master of Arts Degree.

Thank You,

Boyd Frick
Adult Probation Officer, II
IPS Unit 7

References

Abel, G. G., & Annon, J. S. (1982). Reducing deviant sexual arousal through satiation. Workshop presented at the 4th National Conference on Sexual Aggression, Denver.

Abel, G. G., Becker, J. V., Mittleman, M.S., Cunningham-Rathner, J., Rouleau, J.L., & Murphy, W.D. (1987). Self reported sex crimes of nonincarcerated paraphilics. Journal of Interpersonal Violence, 2, 130-148.

Araji, S. & Finkelhor, D. (1985). Explanations of pedophilia: Review of empirical research. Bulletin of the American Academy of Psychiatry and the Law, 13, 17-37.

Awad, G., Saunders, E., & Levene, J. (1984). A clinical study of male sex offenders. International Journal of Offender Therapy and Comparative Criminology, 28, 105-115.

Barbaree, H. E., & Marshall, W.L. (1988). Deviant sexual arousal, offense, history, and demographic variables as predictors of re-offense among child molesters. Behavioral Science and the Law, 6, 267-280.

Bartholomew, K. (1990). Avoidance of intimacy: An attachment perspective. Journal of Social and Pesonal Relationships, 7, 147-148.

Bartholomew, K., & Horowitz, L.M. (1991). Attachment styles among adults:

A test of a four catagory model. Journal of Personality and Social Psychology, 61, 226-244.

Collins, N. L., & Read, S. J. (1990). Cognitive representations of attachment: The structure and functions of working models. In D. Perlman & K. Bartholomew (Eds.), Advances in personal relationships, vol. 5: Attachment processess in adulthood (pp 53-90). London: Jessica Kingley.

Finkelhor, D. (1984). Child sexual abuse: New theory and research. New York: The Free Press.

Furby, L. Weinrott, M.R., & Blackshaw, L. (1989). Sex offender recidivism: A review. Psychological Bulletin, 105, 3-30.

Garlick, Y. (1989). Intimacy, loneliness, and attributions of responsibility in sex offenders, Unpublished masters thesis. London: University of London.

Hall, G. C. (1995). Sexual offender recidivism revisted: A meta-analysis of recent treatment studies. Consulting and Clinical Psychology, 2 (5), 105-112.

Hansen, K. R. (1997). Presented at ATSA conference, Washington, D.C.

Hansen, K.R., & Bussiere, M.T. (1996). Predictors of sexual offender recidivism: A meta-analysis. Public Works and Government Services, Canada.

Hansen, K.R., & Harris, A. J. R. (1997). Dynamic predictors of sexual reoffense project 1997. Presented at the Association for the Treatment of Sexual Abusers Conference, Arlington, VA.

Hansen, K. R., Steffy, R. A., & Gauthier, R. (1993). Long-term recidivism of child molesters. Journal of Consulting and Clinical Psychology, 61, 646-652.

Hazen, C. & Shaver, P. (1987). Romantic love conceptualized as an attachment process. Journal of Personality and Social Psychology, 52, 511-524.

Hudson, S. M., & Ward, T. (1997). Intimacy, loneliness, and attachment style in sexual offenders. Journal of Interpersonal Violence, 12 (3), 220-238.

Jensen, S., & Jewell, C. (1988). The sex offender experts. The Prosecuter. Fall, 1988. Alexandria, VI.

Koss, M.P. (1993). Rape: Scope, impact, interventions, and public policy responses. American Psychologist, 48, 1062-1069.

Laws, D. R. (Ed.) (1989). Relapse prevention with sexual offenders. New York: Guilford Press.

Laws, D. R., and Osborn, C. A. (1982). A procedure to assess incest offenders. Proposal submitted to research committee. Atascadero State Hospital, Atascadero, CA.

Marshall, W. L. (1979). Satiation therapy: A procedure for reducing deviant sexual arousal. Journal of Applied Behavior Analysis, 12, 10-22.

Marshall, W.L. (1993). The role of attachment, intimacy, and loneliness in the eitology and amintenance of sexual offending. Sexual and Marital Therapy, 8, 109-121.

Marshall, W.L. (1989). Invited essay: Intimacy, loneliness, and sexual offenders. Behavior Research and Therapy, 27, 491-503.

Marshall, E. L., & Lippens, K. (1977). The clinical value of boredom: A procedure for reducing inappropriate sexual interests. Journal of Nervous and Mental Disease, 165, 283-287.

Marshall, W. L. & Barbaree, H. E. (1990). An intergrated theory of the aetiology of sexual offending. In W. L. Marshall, D. R. Laws, & H. E. Barbaree (Eds.), Handbook of sexual assault: Issues, theories, and treatment of the offender (pp. 257-271). New York: Plenum.

Marshall, W. L., Barbaree, H.E., & Fernandez, M. (1995). Some aspects of social competence in sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 7, 113-127.

Marshall, W. L., Jones, R. L., Hudson, S. M., & McDonald, E. (1993). Generalized empathy in child molesters. Journal of Child Sexual Abuse, 2, 61-68.

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

Marshall, W. L., & Lippens, K. (1977). The clinical value of boredom: A procedure for reducing inappropriate sexual interests. Journal of Nervous and Mental Disease, 165, 283-287.

Marshall, W. L., & Pithers, W. D. (1994). A reconsideration of treatment

outcome with sex offenders. Criminal Justice and Behavior, 21, 10-25.

Meichenbaum, D. (1977). Cognitive-behavior modification: An intergrative approach. New York: Plenum Press.

Pithers, W. D., Beal, L. S., Armstrong, J., & Petty, J. (1989). Identification of risk factors through clinical interviews and analysis of records. Relapse prevention with sexual offenders. New York: The Guilford Press.

Prentky, R. A., Knight, R. A., & Lee, F. S. (1997). Child sexual molestation: Research issues. National Institute of Justice Research Report.

Neubeck, G. (1974). The myraid of motives for sex. In L. Gross (Ed.). Sexual aggression: Current issues. Flushing, New York, Spectrum.

Quinsey, V. L. & Chaplin, T. C. (1988). Penile responses to description of encounters with children involving sex and violence. Journal of Interpersonal Violence, 3, 259-274.

Quinsey, V. L., Chaplin, T. C., & Varney, G. (1981). A comparrison of rapists and non-sex offenders sexual preferences for mutually consenting sex, rape, and physical abuse of women. Behavioral Assessment, 3, 127-135.

Quinsey, V. L., Lalumiere, M. L., Rice, M. E., & Harris, G. T. (1995). Assessing dangerousness: Violence by sexual offenders, sexual batterers, and child abusers (pp. 114-137). Thousand Oaks, CA: Sage Publications.

Quinsey, V. L., Rice, M. E., & Harris, G. T. (1995). Actuarial prediction of

sexual recidivism. Journal of Interpersonal Violence, 10, 85-105.

Quinsey, V. L., Steinman, C. M., Bergersen, S. G., and Holmes, T. F. (1975). Penile circumference, skin conductance, and ranking responses of child molesters and normals to sexual and nonsexual visual stimuli. Behavior Therapies, 6, 213-219

Salter, A. C. (1988). Treating child sex offenders and victims. Newbury Park, CA: Sage Publications Inc.

Seidman, B., Marshall, W. L., Hudson, S. M., & Robertson, P. J. (1994). An examination of intimacy and loneliness in sex offenders. Journal of Interpersonal Violence, 9, 518-534.

Segal, Z. V., & Marshall, W. L. (1985). Heterosexual and social skills in a population of rapists and child molesters. Journal of Consulting and Clinical Psychology, 53, 55-63.

Segal, Z. V. & Marshall, W. L. (1986). Discrepancies between self-efficacy predictions and actual performance in a population of rapists and child molesters. Cognitive Therapy and Research, 10, 363-376.

Tingle, D., Barnard, G. W., Robbin, L., Newman, G., & Hutchinson, D. (1986). Childhood and adolescent characteristics of pedophiles and rapists. International Journal of Law and Psychiatry, 9, 103-116.

Turvey, B. E. (1997). Dangerousness: Predicting recidivism in violent sex

offenders, Microsoft Internet Explorer.

Ward, T., Hudson, S. M., & Marshall, W. L. (1995). Cognitive distortions and affective defecits in sex offenders: A cognitive deconstructionist interpretation. Sexual Abuse: A Journal of Research and Treatment, 7 (1), 67-83.

Ward, T., Hudson, S. M., Marshall, W. L., & Siegert, R. (1995). Attachment styles and intimacy deficits in sex offenders: A theoretical framework. Sexual Abuse, 7, 317-335.