

Sex-Offender Risk Assessment and Disposition Planning: A Review of Empirical and Clinical Findings

Robert J. McGrath

Abstract: The primary goal of intervention with sex offenders is to protect the community from further sexual aggression. As the availability of jail beds decreases, it is imperative that professionals discriminate between those offenders who must be incarcerated to protect the public and those offenders who can be supervised with reasonable safety in community settings. This article will review the research on variables related to sex offender recidivism which is a critical factor to consider in making these decisions. In addition, criteria for determining an offender's amenability to treatment will be examined and guidelines for formulating disposition plans will be outlined.

INTRODUCTION

During the last decade, there has been a dramatic increase in the number of sex offenders who have come to the attention of the courts, correctional agencies, social service organizations, and mental health professionals. What to do with these offenders has become a vitally important societal question. The availability of ever-expensive jail beds continues to decrease while public demands for community safety may be at an all-time high. Those who find themselves faced with the responsibility of making risk-assessment and disposition-planning decisions about sex offenders indeed confront a challenging task. A number of researchers have provided assistance by detailing the information that should be elicited from offenders and collaterals (Barnard, Fuller, Robbins, & Shaw, 1989; Groth & Birnbaum, 1979; O'Connell, Leberg, & Donaldson, 1990) and recommending specialized interview techniques (McGrath, 1990). To date, however, specific guidance on risk assessment and disposition planning with this population has generally been limited to summaries of clinical impressions (e.g., Groth, Hobson, & Gary, 1982; Knopp, 1984) or empirical studies of circumscribed populations. A review and integration of these findings can be of benefit to both researchers and practitioners.

The goal of this article is to provide professionals who are responsible for managing sex offenders with information that can enhance their

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risk-assessment and disposition-planning skills. The article is divided into three sections. The first two, on rehabilitation and risk factors, provide the reader with background information necessary for disposition planning, which is covered in the final section. Since most risk-management and disposition-planning research with this population has been conducted with males convicted of rape, child molestation, and exhibitionism, discussion is limited to these populations.

REHABILITATION: AMENABILITY TO TREATMENT

Specialized sex-offender treatment is a common disposition option and can reduce an offender's risk to reoffend. Disposition plans that incorporate rehabilitation components must take several factors into consideration. Treatment programs vary in their effectiveness, and no rehabilitation program can expect to be 100% effective. In addition, some individuals who suffer from psychological disturbances are not amenable to psychological intervention. Those who make decisions concerning rehabilitation should have at least a rudimentary knowledge of sex-offender treatment efficacy, accepted intervention components, and standard admission criteria.

While some would argue that sex offenders do not deserve treatment services, Prentky and Burgess (1990) underscore the fact that the primary goal of sex-offender treatment is actually reduction of victimization rates. Their recent research also suggests that rehabilitation efforts are cost effective even when treatment reduces recidivism rates by only a small degree.

Although the knowledgeable skeptic would be justified in questioning the ability of mental health professionals to rehabilitate sex offenders (Furby, Weinrott, & Blackshaw, 1989), several recent outcome studies of specialized sex-offender treatment have offered encouraging results. Estimates by the United States Department of Justice (1988a) suggest that the recidivism rate of untreated sex offenders is about 60% within 3 years of release from incarcerated settings, while recidivism among those who have completed specialized treatment within these institutions is about 15% to 20%. The efficacy of some specialized community based treatment programs for sex offenders has likewise shown very promising results (Maletsky, 1990; Marshall & Barbaree, 1988; Pithers & Cumming, 1989).

A variety of components commonly comprise effective sex-offender treatment programs. It is worth noting that there is little to suggest that analytic or other insight-oriented psychotherapies alone are effective with this population (Lanyon, 1986; Quinsey, 1990; Salter, 1988). Rather, the vast majority of specialized programs employ a combination of psycho-

educational, cognitive-behavioral, and family-system intervention strategies (Knopp & Stevenson, 1988). Psychoeducational interventions assist offenders in acquiring knowledge in areas such as sex education, sexual assault cycles, and victimology. Cognitive-behavioral interventions incorporate treatment components designed to alter deviant arousal patterns, improve appropriate sexual functioning, increase social competence, and correct distorted thinking (Marshall & Barbaree, 1990). Family therapy seems to be an especially critical treatment component in incest cases (Giarretto, 1982; Trepper & Barrett, 1989). Recent applications of relapse prevention strategies designed to assist clients in maintaining treatment benefits over time have also proved to be promising (Marques, Day, Nelson, & Miner, 1989; Pithers & Cumming, 1989). Intensive probation supervision of sex offenders, coupled with these above psychological interventions, makes good intuitive sense and may further reduce recidivism rates (Romero & Williams, 1985).

With respect to decisions about which sex offenders can be considered amenable to treatment, at least three factors seem important. (It should be noted that "amenability" refers to the offender's ability to engage in treatment, but is neither a judgment about the setting in which treatment should take place nor a prediction about the effectiveness of treatment.) First, the offender must acknowledge that he committed a sexual offense and accept responsibility for his behavior. Such acknowledgment is critical since treatment interventions rely fundamentally on the offender's ability to identify and later modify the types of feelings, thoughts, situations, and behaviors that were proximal to his sexually aggressive act. An offender obviously cannot identify the precursors to an offense that he states he did not commit.

Second, he must consider his sexual offending to be a problem behavior that he wants to stop. Ideally, the offender would wish to stop offending for the sake of future victims; however, at least initially, motivation based on reasons that are more self-serving can open the door to treatment.

Last, the offender must be willing to enter into and fully participate in treatment. This willingness can be formalized through a written treatment contract that describes the components of treatment and alerts the offender to any risks that may be involved. The offender's informed consent is essential for purposes of clarity and is in keeping with good ethical practice.

Risk assessments and disposition plans must take into consideration the fact that amenability to treatment is not a static variable. Offenders who initially deny committing their offense may later accept responsibility and desire treatment. Conversely, offenders who are initially found amenable and begin treatment may later decide that rehabilitation is too demanding and drop out.

RISK ASSESSMENT: SAFETY OF THE COMMUNITY

After a determination has been made as to whether or not an offender is amenable to treatment, several other variables must be examined to ascertain the degree of risk that the offender poses to the community. This risk assessment will help identify the types of controls that must be established to protect the community from the offender.

Predicting risk to commit violence in general and sexual aggression in particular is an extremely difficult task (Hall, 1990; Monahan, 1981; Quinsey, 1983). Although explication of the complexities of predicting risk per se is not the purpose of this article, the following brief caveats are warranted. Due to the low base rates of some types of sexual aggression, and also to political pressure to avoid making false-positive decision errors, clinicians must guard against a tendency to overpredict violence (Melton, Petrila, Poythress, & Slobogin, 1987). In addition, predictions of dangerousness are only as good as the data upon which they are based. The tendency of offenders to lie about, deny, and minimize their sexual deviancy requires evaluators to be thorough and gather data from a variety of collateral sources. Last, professionals often overestimate their clinical decision-making ability (Turk & Salovey, 1988) and must remember that actuarial methods of prediction generally outperform clinical ones (Sawyer, 1966).

Despite the difficulties inherent in predicting risk, those who work with sex offenders are forced to assess dangerousness on a regular basis. It is imperative that decisions that can affect the liberty of offenders and the safety of the community are based not only on clinical experience but on empirical findings as well.

Since 1980, there have been a large number of studies investigating factors associated with risk to recidivate among known sex offenders. Table 1 summarizes the essential findings from a number of these recent studies. The consistency with which various risk factors emerge in this literature is particularly noteworthy in light of the many differences among the studies reviewed. In addition, it is important to consider a number of other risk factors that are based on clinical impression and have not as yet been adequately researched.

LEVEL OF DENIAL

Given that an offender's acceptance of at least some responsibility for his offenses is a prerequisite for acceptance into virtually all specialized sex-offender treatment programs, and given that adequately treated sex offenders are less likely to recidivate, those offenders who deny their offenses and remain untreated can be viewed as a higher risk for recidivism. Researchers have found that low levels of denial are positively correlated

TABLE 1
FACTORS COMMONLY ASSOCIATED WITH SEXUAL OFFENSE RECIDIVISM

Study	Sample	Follow-Up	Recidivism Criteria	Risk Factors ¹									
				UEMP	UREL	PARA	CRIM	SEXC	MALE	FORC	UMAR	DEVI	
Abel, Mittleman, Becker, Rathner, & Rouleau (1988)	98 treated outpatient child molesters	12 mos	self-report of sex offense	0	+							+	
Barbaree & Marshall (1988)	35 untreated outpatient child molesters	12-117 mos	reconviction or unofficial record for sex offense	+				0					+
Hanson, Steffy, & Gauthier (1990)	106 treated incarcerated child molesters	10-23 yrs	reconviction for sex offense		+			+					+
Maletsky (1990)	3,995 treated outpatient sex offenders	1-17 yrs	reconviction sex offense or failed treatment goals	+	+			+				+	+
Rice, Harris, & Quinisey (1989a)	136 treated incarcerated nonfamilial child molesters	6.3 yrs mean	reconviction for sex offense					+				+	+

with favorable treatment progress (Simkins, Ward, Bowman, & Rinck, 1989). Interestingly enough however, among those offenders who remain untreated, it appears that there may be no difference in reoffense rates between deniers and admitters (Marshall & Barbaree, 1988).

TYPE OF OFFENSE

The type of sexual offense is related to the probability of recidivism. I found only two studies that compared three or more offense types in a single sample (Frisbie & Dondis, 1965, cited in Quinsey, 1977; Romero & Williams, 1985). These studies allow a comparison of the relative reoffense rates among various offenders by type of offense, in a single geographic area during a prescribed period. This is an improvement over studies that compare offender recidivism among different studies conducted in different locales and at different time periods where, for example, variability of reporting, arrest, and clearance rates may affect subject comparability.

Romero and Williams (1985) conducted a 10-year follow-up on a sample of 231 convicted sex offenders who were randomly assigned either to group psychotherapy and probation or to probation only, in Philadelphia between 1966 and 1969. Twenty-six men (11.3%) had been rearrested for a sex offense at follow-up. Only 6.2% of the 39 convicted of pedophilia reoffended, whereas 10.4% of the 144 convicted of sexual assault reoffended. The highest reoffense rate, 20.5%, was found among the 48 convicted of exhibitionism.

Frisbie and Dondis (1965, cited in Quinsey, 1977) found similar reoffense relationships when examining the type of offense. They studied a sample of 1,760 "sexual psychopaths" who were treated and released from Atascadero State Hospital in California between 1954 and 1960. Over the 1 to 6-year follow-up period, those convicted of exhibitionism had the highest reoffense rate, at 40.7%. The rate of reoffense for those convicted of sexual aggression was 35.6%. The child molesters in this study were grouped according to the sex and relatedness of their victims. Of father-daughter and father-stepdaughter incest offenders, 10.2% recidivated, whereas 21.5% of men who molested minor nonrelated females reoffended. Those who molested underage males had the highest reoffense rate, 34.5%.

The findings suggested by these two studies are generally supported by others. Untreated exhibitionists are consistently reported to have the highest recidivism rates (20%–41%) among all sex offenders (Blair & Lanyon, 1981; Cox, 1980). The recidivism rates of rapists range between a low of 7.7% (U.S. Department of Justice, 1989) to a high of 35.6% as reported in Frisbie and Dondis (1965, cited in Quinsey, 1977). Among nonfamilial child molesters, the reoffense rates of those who molest boys (13%–40%) tend to be much higher than of those who molest girls (10%–29%) (Fitch, 1962;

Radzinowicz, 1957). Incest offenders display the lowest untreated recidivism, generally 10% or less (Gibbins, Soothill, & Way, 1979, 1981).

While these studies may provide helpful comparative information about the differential risk of recidivism according to the type of offense, the true reoffense rates for the subjects in each of the previous studies are likely to be much higher. In general, the skill with which most offenders avoid detection seriously compromises our ability to assess actual recidivism rates (Abel, Becker, Cunningham-Rathner, Rouleau, & Murphy, 1987; Groth, Longo, & McFadin, 1982; Marshall & Barbaree, 1988).

MULTIPLE PARAPHILIAS

The foregoing discussion of recidivism based on the type of offense could be taken to suggest that offenders limit themselves to a single class of deviant behavior. In reality, however, many offenders have multiple paraphilias, and those who do so are at increased risk to reoffend.

Longo and Groth (1983) found that as many as 35% of their sample of incarcerated rapists and child molesters actually began their deviant sexual histories committing hands-off sex offenses such as exhibitionism and voyeurism, before progressing to hands-on offenses. In another study (Abel, Becker, Cunningham-Rathner, Mittleman, & Rouleau, 1988), researchers who assured confidentiality to 561 nonincarcerated paraphiliacs found that the child molesters, rapists, and exhibitionists averaged between 3.3 and 4.2 paraphilias each.

One hundred and ninety-two of these child molesters later volunteered to enroll in a structured treatment program with Abel and his colleagues (Abel, Mittleman, Becker, Rathner, & Rouleau, 1988). The researchers found that the number of age and gender categories into which the subject's victims fell were powerful predictors of recidivism. For instance, the overall reoffense rate for the 98 subjects who were followed up 1 year after treatment was 12.2% ($n = 12$). Of those offenders who targeted both males and females and both children and adolescents, 75% recidivated ($n = 9$). This variable alone correctly classified 83.7% of both recidivists and nonrecidivists in the study. In addition, offenders whose pretreatment sexual offense history included hands-off offenses, reoffended at a higher rate than offenders without such a history.

Romero and Williams' (1985) analysis of recidivism among their sample of 231 assaulters, pedophiles, and exhibitionists supports this association between a history of hands-off offenses and subsequent recidivism for a sexual offense. Of 26 recidivists in their study, 16 reported a prior history of indecent exposure, and of this group 30.4% were rearrested. Only 9.1% of the entire sample who reported no such history of indecent exposure reoffended. More recently, Maletsky (1990) found that

those offenders with histories of multiple paraphilias were over five times more likely to be treatment failures or recidivate than those who did not have multiple paraphilias.

CRIMINALITY

A prior criminal record, both for sexual and nonsexual crimes, has consistently proven to be one of the best predictors of future sexual criminal behavior. For example, Danish researcher Christiansen (1965, cited in Tracy, Donnelly, Morgenbesser, & Macdonald, 1983) conducted a 12 to 24-year follow-up of 2,934 sex offenders from 1929 to 1939. Those offenders with criminal records recidivated at a rate of 38.6%, compared to 18.6% for first offenders. Romero and Williams (1985) found that the prior sex offense arrest rate was the single best predictor of sexual recidivism in their 10-year follow-up study of 231 sex offenders. Specifically, of offenders whose prior adult sex-offense rate was low (zero to one arrest every 3 years), only 7.9% reoffended sexually. Conversely, for offenders whose prior arrest rate was higher (greater than one arrest every 3 years), the sex offense recidivism rate was 26.2%.

Criminal personality traits have also been associated with recidivism, as well as with treatment failure. Rapists appear to have more deeply ingrained sociopathy than do child molesters. In a study of 411 outpatient sex offenders conducted by Abel, Mittelman, and Becker (1985), 29.2% of the rapists were given a diagnosis of antisocial personality disorder, whereas only 11.6% of the child molesters were so diagnosed. Abel and his colleagues (Abel, Mittelman, Becker, Rathner, & Rouleau, 1988) later treated 192 of the child molesters on a voluntary basis. A diagnosis of antisocial personality was predictive of eventual drop out: Of the 19 child molesters so diagnosed, over half (10) dropped out during treatment and an additional 5 dropped out during follow-up. A DSM III-R diagnosis of antisocial personality disorder was not, however, predictive of sexual recidivism during the 1 year of follow-up.

Using longer follow-up periods and a more restrictive definition of antisocial character traits, Rice, Harris, and Quinsey (1989b) found that high scores on the Psychopathy Checklist (Hare, 1980) were powerful predictors of both sexual recidivism and violence recidivism among a group of 54 incarcerated rapists.

SEXUAL AROUSAL PATTERNS

The assessment of sexual arousal patterns by phallometric measurements has become an accepted and common element in a significant proportion of sex-offender treatment programs (Knopp, 1984; Knopp & Stevenson, 1990). The results of such assessment procedures are generally

predictive of subsequent reoffense among identified sex offenders. Given the controversy that often surrounds this assessment procedure, each of the seven studies located for this review will be briefly examined.

Quinsey, Chaplin, and Carrigan (1980) provided behavioral treatment to a group of 30 child molesters in a psychiatric institution. At follow-up (average of 29 months), posttreatment penile response data proved to be a small but significant predictor of recidivism, in that it differentiated the 6 recidivists from nonrecidivists. Subsequently the sample size was increased to 132 offenders and the length of follow-up period extended to an average of 34 months. Under these conditions, there was no relationship between posttreatment arousal measures and recidivism (Quinsey & Marshall, 1983). Interestingly enough, however, the initial arousal data from the first 100 treated and untreated child molesters did prove to be significantly related to recidivism.

In a community-based study, Barbaree and Marshall (1988) followed 35 extrafamilial child molesters for an average of almost 4 years after their assessment and, using penile response data correctly predicted the treatment outcome of just over 75% of the sample with respect to recidivism. From among a large number of variables, inappropriate age preference ratios as measured by plethysmography were the strongest predictors of treatment failure. When they increased their sample size to 126 and the follow-up period up to as long as 11 years, neither pretreatment, posttreatment, nor pre/post changes in pedophile indexes predicted outcome (Marshall & Barbaree, 1988).

Rice, Quinsey, and Harris (1989a) determined the recidivism rates of 136 extrafamilial child molesters in a maximum security psychiatric institution over an average 6.3-year follow-up period. Deviant pedophile indexes at intake were positively correlated with reconviction for a sexual offense. Given the propensity of sex offenders to deny the extent of their deviant sexual interests, however, it is not surprising that subjects' self-report of their arousal preferences were not predictive of reconviction. Studies conducted at the same facility on a group of 54 rapists found that sexual recidivism and violent recidivism were predicted by phallometric measures of sexual interest in nonsexual violence, to an even greater extent than arousal to rape per se (Rice, Harris, & Quinsey, 1989b).

Most recently, Maletsky (1990) reported on his 1 to 17 year follow-up of almost 4,000 outpatient sex offenders. Almost three-fifths (57.8%) of his sample who evidenced pretreatment deviant arousal greater than 80% became treatment failures, whereas only 18.9% of the treatment successes evidenced such an arousal pattern. His definition of treatment success was an individual who completed all treatment sessions, did not evidence deviant arousal at the end of treatment, and had not been arrested for a sexual offense at follow-up. Unfortunately, Maletsky did not break his

sample down by offense type or report the actual number of arrests or convictions.

Of the seven studies located for this review, six show positive correlations between deviant sexual arousal and reoffense. Although phallometric measures should never stand alone as predictors of sexual recidivism, in combination with other variables they provide an important data source.

IMPULSIVITY

Impulsivity has long been known to be a stable and robust predictor of reoffending among the general criminal population (Pritchard, 1979). Only recently has this variable been carefully examined in a sex-offender population. Prentky (1990) determined the recidivism rates of 106 rapists over a period of 25 years following their discharge from a maximum security treatment facility. His subjects were assessed as having either high and low lifestyle impulsivity. Decision criteria for impulsivity have been described in detail elsewhere (Prentky, Cohen, & Seghorn, 1985; Prentky & Knight, 1986); briefly, however, high impulsivity includes hyperactivity and behavior management problems beginning in late childhood, and instability in relationships, jobs, and living situations. Rapists in the high-impulsivity group were almost three times more likely to be convicted of new sexual offenses than those who were judged to be in the low-impulsivity group. The ability of this variable to have differentiated between recidivists and nonrecidivists is even more striking when one considers that the sample consisted of a fairly homogeneous group of highly repetitive rapists.

ALCOHOL ABUSE

Sexual aggression and alcohol are closely associated. Studies suggest that about half of all of sex offenses are committed by offenders who consumed alcohol at the time of their offense, and that about half of all sex offenders are alcoholic (e.g., Rada, 1976 Rada, Kellner, Laws, & Winslow, 1979). According to these studies, incest offenders tend to have the highest rate of drinking at the time of offense (63%). While male-oriented pedophiles drink alcohol less often than other sex offenders prior to committing offenses (38%), there seems to be little difference in the rates of offense-related drinking among extrafamilial female-target child molesters, rapists, and exhibitionists (57%, 57%, and 55%, respectively).

Alcohol can reduce inhibitions and social controls, as well as increase sexual arousal. Abel and colleagues (1985) found that 30% of the child molesters they studied reported that alcohol use increased their sexual arousal to children, and 45% of rapists reported a connection between alcohol use and increased urges to rape. These connections notwithstanding, in a recent thorough review of the literature on alcohol and human

sexuality, Crowe and George (1989) conclude, "There is no suggestion that alcohol causes sexual aggression; rather, alcohol can facilitate a preexisting inclination to sexual aggression" (p. 384). Of course, many offenders do blame their deviant sexual behavior on alcohol, partly in an effort to avoid legal and other external consequences but also in an attempt to define themselves as "normal" people (McCaghy, 1968). Understandably, most individuals would rather be viewed as alcoholics than as sexual deviants.

PSYCHOPATHOLOGY

Besides sociopathy and substance abuse, sex offenders occasionally suffer from other forms of mental disorder. Knopp's (1984) review suggests that 5% to 8% percent of sex offenders have psychotic illnesses. Few studies examine recidivism rates for these offenders; however, Tracy and colleagues (1983) contend that recidivist sex offenders are generally not found to be psychotic.

Of course, common sense would suggest that a convicted dually diagnosed schizophrenic sex offender who is again hearing auditory hallucinations from the devil commanding him to rape women is at high risk to reoffend. Likewise, individuals with a history of sexually aggressive behavior who experience hypersexuality as a symptom of their manic-depressive illness are also at high risk to reoffend during the active manic phase of their illness. Appropriate psychotropic medication may greatly reduce the risk of reoffense for both of these types of conditions.

USE OF FORCE

There is ample evidence that offenders who use force in committing their offenses recidivate at a higher rate than those offenders who do not use force (Barbaree & Marshall, 1988; Gebhard, Gagnon, Pomeroy, & Christenson, 1965; Maletsky, 1990). Particularly prone to recidivate may be those offenders whose sexual arousal is fused with aggression or sadism (Groth & Birnbaum, 1979; Hazelwood, Reboussin, & Warren, 1989; Rice et al., 1989b). Plethysmographic data may help identify offenders with these predispositions (Rice et al., 1989a).

An exception to these generalizations are the high rates of recidivism found among individuals who commit hands-off offenses such as exhibitionism, who, as mentioned earlier, are more likely to reoffend than other types of sex offenders. Nevertheless, from a practical point of view, society clearly seems much more willing to risk allowing a compulsive exhibitionist to remain in the community under supervision than to take a similar gamble with an offender whose first conviction has been for a violent sexual offense.

SOCIAL SUPPORTS

Especially in incest cases, the reactions of the offender's family and support network to the abuse can have a profound influence on his recovery process. If, for example, the offender's spouse sides with him in blaming the victim, denies his need for treatment and supervision, or believes that the abuse did not occur, it will be more difficult for the offender to take responsibility for his behavior, follow probation or parole conditions, and actively engage in treatment. Family and friends who continue to value their relationship with the offender, but at the same time hold him accountable for avoiding high-risk behaviors, can be a stabilizing and beneficial resource.

Offenders who do not, either through choice or circumstance, have a stable, supportive social network may be at a higher risk to reoffend. There are a number of studies that have found that convicted child molesters who are unmarried reoffend at a slight higher rate than offenders who are married (Abel, Mittleman, & Becker, 1985; Fitch, 1962; Maletsky, 1990).

EMPLOYMENT STATUS

Employment can be another stabilizing and positive influence on offenders. For example, Maletsky (1990) followed almost 4,000 outpatient sex offenders for between 1 and 17 years. Men who had worked at three or more jobs during the 3 years preceding their offense or were unemployed at the time of their offense were almost four times more likely to be treatment failures than men with more stable employment patterns. Maletsky defined treatment failure as not completing treatment, maintaining a deviant arousal pattern throughout treatment, or being arrested for a sexual offense.

OFFENDER AGE

Analysis of the Uniform Crime Reports for the United States (U.S. Department of Justice, 1988c) clearly reveals that rape is generally committed by young adult males. Men in the 20 to 29-year-old age bracket accounted for a larger proportion of arrests for rape (41.5%) than those in any other similar age span. Overall, men under the age of 40 accounted for 88.2% of all rape arrests. Unfortunately, other types of sexual offenses are not broken down by category in the Uniform Crime Reports, and one must rely on analysis of geographically limited studies. Studies reviewed by Blair and Lanyon (1981) suggest that exhibitionism, like rape, tends to be perpetrated by males in their late teens or twenties, and there seem to be relatively few males over age 40 who publicly expose themselves. The age at which incest offenders typically commit their offenses is not surprising; it

seems to coincide with their parenting years, between the ages of 30 and 45 (Williams & Finkelhor, 1990).

These age ranges found to be typical of rapists and incest offenders are supported by the findings of Frisbie (1969), who in addition studied nonfamilial child molesters. In her sample of 91 men who had molested nonrelated minor females, she found that 42% were under the age of 30, whereas only 35% percent of the 55 men who had molested nonrelated minor males were under the age of 30. Further analysis of her findings suggests that molestation of nonrelated children of both sexes, but especially of male children, is perpetrated by offenders across the age span.

The courts customarily look askance at basing sentencing decisions on an offender's age, reasoning that this variable, like race, is outside the offender's control and is inherently prejudicial. Nevertheless, offender age appears to be related to the likelihood of recommitting an offense, so it should apply at least to decisions concerning intensity of supervision.

GROOMING OR ATTACK BEHAVIOR

The method that an offender uses to gain access to his victims may be related to risk of reoffense and is clearly related to the supervisability of the offender. Those offenders who develop lengthy preoffense relationships with their victims, as in the case of many child molesters, may provide a protracted window of opportunity for probation or parole officers and others to identify precursive offense behaviors and intervene with the offender prior to the commission of an actual offense. On the other hand, offenders whose prodromal phase is relatively brief, as is the case with many rapists, may give those that supervise them few observable warning signs.

Pithers, Buell, Kashima, Cumming, and Beal (1987) have identified a variety of emotional states that typically precede relapse among sex offenders. Child molesters commonly report feeling anxiety and depression prior to relapse, whereas rapists almost universally report feeling angry. Anger tends to be a relatively intense emotion that can be aroused quite quickly, so it may be comparatively more difficult for offenders to control than feelings of anxiety and depression, which tend to be less intense and often have a more gradual onset.

Studies by Barbaree and Marshall (1988) found that offenders whose sexual abuse of children had proceeded through the grooming process to the point of genital-to-genital contact had higher recidivism rates than those offenders who limited their sexual abuse to less intrusive behaviors.

VICTIM CHARACTERISTICS

Sexual abuse and assault is by definition the taking advantage of a weaker, more vulnerable person. Unfortunately, some offenders choose

victims who are at such an extreme disadvantage that they cannot effectively fight back, even after being attacked. Offenders who assault very young children, or persons with mental illness or mental retardation or others with compromised intellectual and communication abilities are assaulting victims who cannot effectively report their abuse or provide credible testimony in court. Whether offenders who select these disadvantaged victims present an increased risk for reoffense remains an unanswered empirical question. At any rate, such offenders can be considered more dangerous in that their reoffenses may be more difficult to detect and certainly more difficult to prosecute.

LENGTH OF TIME AT RISK

Although recidivism rates continue to climb the longer sex offenders remain at risk in the community, the pace of recidivism seems to vary by offender type. For example, Frisbie (1969) found that, among her sample of formerly incarcerated rapists, reoffenses were more likely to occur during the first year following release and that the yearly rate of reoffense continued to decrease each year thereafter. The U.S. Department of Justice (1989) statistics indicate that slightly over half of all rapists released in 1983 were rearrested within three years and that they were 10.5 times more likely than other released felons to be rearrested for rape. Studies conducted on child molesters suggest that their reoffense curves are more gradual than those of rapists (Frisbie, 1969; Hanson et al., 1990).

ENVIRONMENTAL FACTORS

The preceding risk factors have all pertained directly to the offender himself, yet some environmental factors also appear to influence sexual aggression. Like the previous discussion of the length of time at risk, information from the following studies can be useful in directing supervision practices of sex offenders, but would not be germane to sentencing decisions.

Michael and Zumpe (1983) and the Uniform Crime Reports (U.S. Department of Justice, 1988c) have found large and statistically significant seasonal variations in the commission of rapes, with the maxima occurring in the summer months, even in states with consistently moderate climates. Cox (1980) has noted similar findings among exhibitionists. Time of day also seems to be an important factor among rapists: U.S. Department of Justice (1985) studies highlight that two-thirds of all rapes and rape attempts occur at night.

SUPERVISION AND TREATMENT RESOURCES

Another variable that may be outside an offender's control, but must also be considered a risk factor, is the availability of quality treatment and

supervision resources. A relatively high-risk offender who is convicted in a jurisdiction in which there is a comprehensive outpatient sex-offender treatment program and a highly trained and well-equipped probation department may be considered appropriate for community probation. Yet a similarly high-risk offender who is convicted in a jurisdiction without these resources may not be able to be managed safely in the community.

MULTIPLE VARIABLES

Professionals who assess offender risk can benefit from examination of each of the forementioned individual variables. Unfortunately, generating a comprehensive risk-assessment tool by assigning the proper weight to each of these variables is a difficult task, as only a few researchers have undertaken the study of multivariate models of risk prediction with sex offenders.

Hall (1988) found that the combination of the factors of age, offense history, IQ, and MMPI scores resulted in improved accuracy in identifying sex offenders most likely to reoffend. Researchers in Canada (Rice et al., 1989a, 1989b) identified the combination of deviant arousal patterns and scores on the Psychopathy Checklist (Hare, 1980) as powerful predictors of recidivism among both rapists and child molesters. Factor analytic studies conducted by Barbaree and Marshall (1988) determined that a group of variables labeled "sexual deviance" correctly classified approximately 70% of successes and failures in their outpatient treatment program for child molesters. This cluster was comprised of deviant sexual arousal, amount of force, whether or not the offender had intercourse with the victim(s), and the number of previous victims. A number of ongoing research projects are attempting to identify the predictive ability of combinations of variables relative to sex offender recidivism (Bemus & Smith, 1988; Doke, 1989; Prentky, 1989).

DISPOSITION PLANNING: COMMUNITY OR INCARCERATED PLACEMENT

The two central issues that must be examined in order to formulate a sex-offender disposition plan—amenability to treatment and risk factors—have been described in the first two sections of this article. Based on this information, evaluators typically have four general disposition options: incarceration without treatment, incarceration with treatment, community supervision with treatment, and community supervision without treatment.

Whether or not an offender is amenable to treatment is a relatively clear-cut issue and has been discussed. Whether to place a convicted sex offender initially in a secure setting, such as a jail, hospital, or halfway

house, or in a community setting under the supervision of probation or parole, is a more difficult decision. Placement decisions are by necessity subjective determinations as to the relative risk that different offenders present to the community. The degree of risk tolerated in different locales varies considerably. For example, according to United States Department of Justice (1988b) statistics, during 1984 in both Vermont and Minnesota, for each offender who was in a jail or prison, approximately eight offenders lived in the community under the supervision of probation or parole. This one-to-eight ratio contrasts significantly with the approximately one-to-two ratio found in states such as Arizona and Alabama. The latter states appear to rely more frequently on incarceration for community protection, as well as perhaps for reasons of punishment and deterrence. These examples are offered to highlight the fact that guidelines for disposition are profoundly influenced by local laws, mores, and conventions.

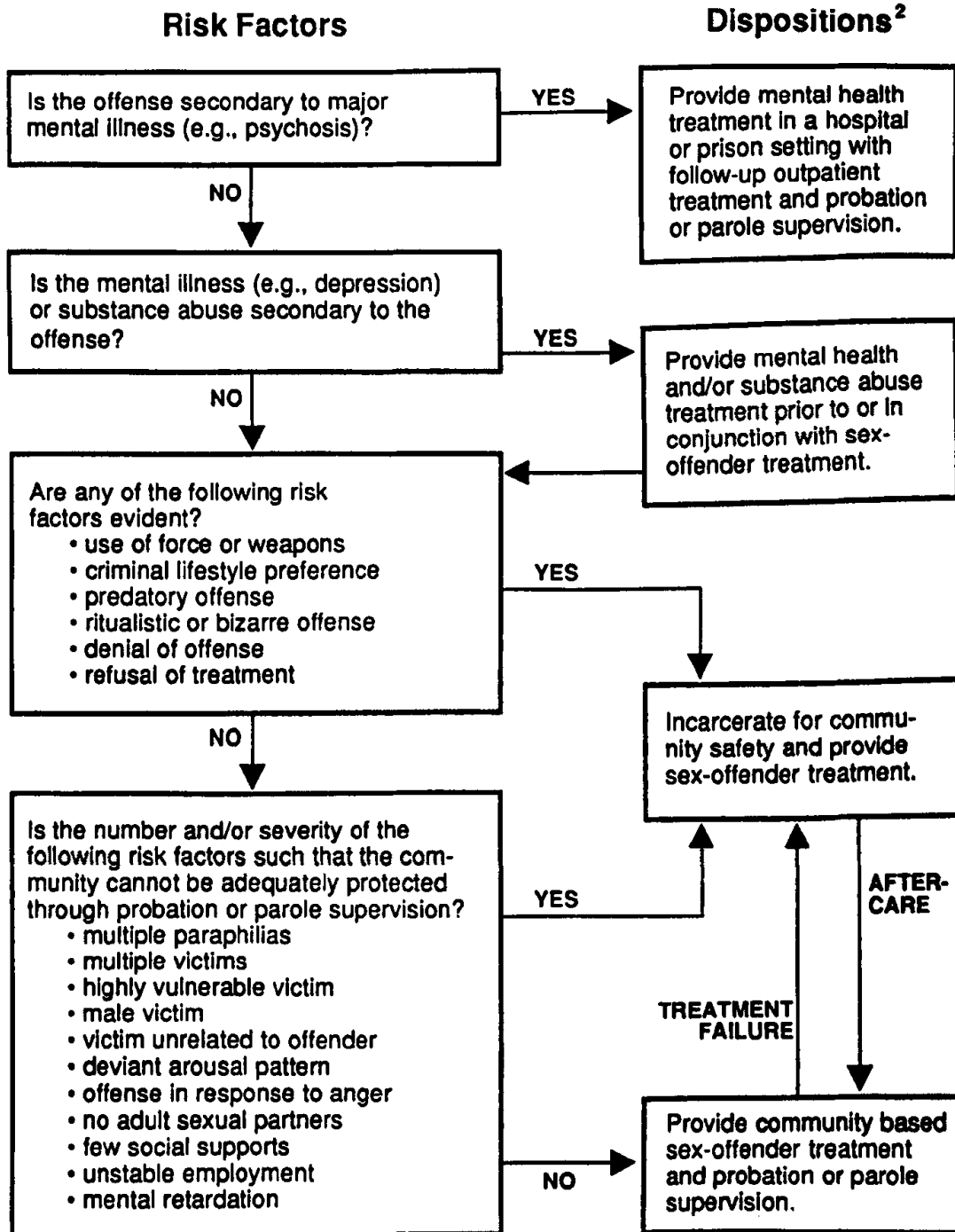
Since empirically validated multivariate risk-assessment instruments have yet to be developed, disposition decisions can be facilitated by consideration of the empirical and clinical variables outlined in the preceding sections of this paper. In addition, the following suggestions and the decision tree in Figure 1 incorporate and are in concert with clinically and intuitively based guidelines formulated by others (Groth, Hobson, & Gary, 1982; Knopp, 1984).

Offenders who are not considered amenable to treatment are generally recommended for incarceration. Certainly this is well justified for high-risk offenders, but decisions to incarcerate nonamenable offenders who are low recidivism risks pose a more difficult challenge. Nevertheless, it is important to consider that low-risk offenders who are ambivalent about rehabilitation efforts may become motivated to enroll in treatment if they are aware that failure to do so will result in more severe punishments.

Other offender variables that are considered contraindications for community placement include history of using extensive violence, force, or weapons in the commission of offenses. Offenders whose sexual interests are fixated on illegal behaviors, such as sex with children and other nonconsensual sexual activity, and who have no history of consensual adult sexual functioning, may also be considered poor risks for community placement. Likewise, offenders who commit ritualistic or bizarre offenses should be placed in a secure setting. Extensive criminality and predatoriness are other poor risk factors.

Evaluators who assess dually diagnosed sex offenders should investigate carefully the primacy of each disorder. Sex offenders who suffer from a psychotic illness may require psychiatric hospitalization and psychotropic medication, but may not need specialized sex offender treatment. Intervention with alcoholic sex offenders may consist of either inpatient alcohol treatment or outpatient alcohol services. In any case, abstinence from

Disposition Planning with Sex Offenders¹



1. The purpose of this decision tree is to aid professionals in developing disposition plans that address the sentencing goals of community safety and rehabilitation. The decision tree does not address the sentencing goals of punishment or deterrence.
2. If the offender is not amenable to treatment or fails to make adequate progress in treatment, he should be incapacitated by incarceration or community supervision measures to reduce his opportunity to reoffend.

Figure 1

alcohol must be mandatory with this population and should occur prior to initiating treatment of sexual deviancy. Individuals with mental retardation vary considerably in their functional ability and therefore must be assessed thoroughly at the beginning of treatment, to determine their capacity to control their deviant sexual behavior in the community.

Clearly, offenders who have a history of multiple convictions for sexual and nonsexual offenses need incarceration to control their behavior. Offenders who reoffend despite having completed specialized sex offender treatment presumably require incarceration or, at a minimum, more intensive outpatient treatment and supervision.

Sex offenders whose lives are chaotic and unstable may be poor community placement risks. These individuals are often difficult to supervise and require assistance with employment, housing, and other social supports prior to treatment for their sexual deviancy.

Almost all convicted sex offenders eventually return to the community and a significant number never serve any jail time. The crafting of appropriate probation and parole conditions is another critical component of disposition planning for offenders. Model conditions have been developed (Oregon Department of Corrections, 1988) and should address risk factors specific to each offender (Pithers et al., 1987). Generally conditions should include requirements to enroll in and successfully complete specialized sex offender treatment, to refrain from establishing any type of contact with potential victims, to avoid high-risk behaviors (e.g., pornography use, hitchhiking, and alcohol use), and to allow monitoring of one's behavior (e.g., drug testing and property searches).

CONCLUSION

Disposition planning with sex offenders encompasses a number of important decisions that can profoundly influence the rehabilitation of the offender and the safety of the community. Effective decision making with this population is based on a thorough evaluation of an offender's strengths and risk factors and on an analysis of available treatment and supervision resources. Since the expertise that is required in making these types of decisions rarely rests within any one individual or discipline, the courts, correctional agencies, social service organizations, and mental health professionals must work cooperatively in order to make informed and professional judgments. Disposition plans should not be influenced by misinformation, politics, or fear, but should be solidly grounded in clinical experience, empirical knowledge, and availability of specialized resources. Rehabilitation of offenders who show potential for change is imperative, while protection of the community must remain a continual priority.

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Robert J. McGrath, M.A.
Director, Sex Offender Treatment
Counseling Service of Addison County
89 Main Street
Middlebury, Vermont 05753
USA