

## Victim Empathy Deficits Among Sex Offenders in Kajang Prison

### Mangsa Empati Defisit antara Pesalah Seks di Penjara Kajang

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#### ABSTRACT

*A high incidence of rape and incest is emerging in Malaysia, especially among middle and lower income families in remote rural and coastal communities. The researchers have abided by the legal definition of rape in Malaysia, in which rape is defined as the forced penetration of a penis into vagina. This means that cases of forced oral or anal penetration (generally categorized by the police, courts etc as 'molest' or 'outrage of modesty'), or in which that attacker used an object such as a stick to rape the victim (which in many countries would be classified as rape. Incest, defined as sexual relationship between closely related persons forbidden by law to marry, incest, however is more often a case of the male adult forcing himself on a minor relative, in many cases a child. The impact of rape and incest is widespread, affecting the victim, family, friends, and society. While the prevalence of them has become part of Malaysian consciousness in recent years, the Malaysian remains less aware that a large number of these abusive acts are perpetrated within familial relationships. These cases are some of the most extreme examples of violence against girls and women (VAW). So, shocking and disturbing were they that they grabbed headlines and sparked public outrage throughout the nation. Malaysia Police statistic for 2006 show that 581 cases of rape from January to April that increased around 127 cases from last year. The trauma of victims has been such that many have attempted suicide or run away. The most visible emotional scar, often for life, is the victim's difficulty in trusting and building relationships with other people. Most important, society must report and act on such happenings. But sex is not a subject that easily discussed in Malaysia even between husband and wife.*

*Keywords: Victim; empathy; deficits; sex offenders; Kajang Prison*

#### ABSTRAK

*Kejadian rogol dan sumbang mahram kini wujud di Malaysia, terutama dalam kalangan golongan pertengahan dan berpendapatan rendah di luar bandar. Takrif rogol menurut undang-undang Malaysia ialah penembusan zakar ke dalam faraj termasuk penembusan mulut dan dubur atau dengan menggunakan objek seperti kayu. Kebanyakan negara di dunia mendefinisikan sumbang mahram sebagai hubungan seksual di antara orang mempunyai hubungan keluarga yang dilarang oleh undang-undang. Sejak kebelakangan ini, kejadian sumbang mahram semakin meningkat di Malaysia yang merupakan kejadian keganasan terhadap kanak-kanak perempuan dan wanita (VAW). Oleh itu, kejadian ini mencetuskan kemarahan orang ramai di seluruh negara yang mana statistik Polis Diraja Malaysia pada tahun 2006 menunjukkan seramai 581 kes rogol dari bulan Januari sehingga April yang meningkat kira-kira 127 kes daripada tahun 2005. Akibatnya, mangsa menjadi trauma dan ramai yang telah membunuh diri dan lari daripada rumah. Kesan yang amat ketara ialah dari segi emosi, kesukaran mempercayai dan membina hubungan dengan orang lain. Kertas kerja ini ingin melihat aspek kasihan belas pelaku sumbang mahram kepada mangsa dari aspek psikologikal. Metodologi yang digunakan ialah interview dan borang soal selidik mangsa sumbang mahram di Penjara Kajang seramai 50 orang. Hasil dapatan kajian menunjukkan tiadanya aspek belas kasihan dalam kalangan pelaku sumbang mahram.*

*Kata kunci: Mangsa; empati; pesalah seks; Penjara Kajang*

#### INTRODUCTION

Over the year, public fear of sex offenders has led to serious misconceptions regarding sex offender treatment. The atrocious acts carried out by some sex offenders are very hard for the public to understand, and present society with complex challenges. Society often finds it easier to turn a blind eye to the crime, lock up the offender and throw away the key than

attempt to address the challenge appropriately. "Lock them up and throw away the key! That is a common response to the question," What should we do with sex offenders are some of the most hated offenders in our society. The media often portray sex offenders as remorseless, untreatable, heartless, dangerous monsters (Blanchard 1995; Marshal 1996). This lack of public understanding toward sex offenders has created the myth that sex offenders cannot be

treated, and therefore should never be returned to the community.

In the late 80s and early 90s sexual offenders were the fastest growing population within the criminal justice system in the United States (Schwartz & Celini 1995). The substantial; cost of persecuting, incarcerating, treating and supervising this growing population led to dramatic increases in legislation and research in an attempt to address this problem (Schwartz 2002). Until the last decade, theoretical ideas about the role of empathy in sexual offending differed little in sophistication from common sense or folk theory. Many people think that the only basis on which someone could knowingly inflict on another human being the harm associated with sexual abuse, would be because the perpetrator was indifferent to the consequences for the victim (Polaschek 2002). Therefore, it is appealing intuitively that sex offenders have empathy deficits, and that these deficits will have a causal role in their offending. This intuition has been widely accepted by treatment providers, with the inclusion of empathy-focused interventions in rehabilitation programs. However, advances in research over the past decade suggest that the relationship between empathy and sexual violence is much more interesting and complex than it first appears. Schwartz (1995) has pointed to a variety of research and meta-analysis that led to a "Nothing Works" movement that severely hampered program research and development throughout the 70s and 80s. Social awareness, legislative changes, and economic impact have countered the "Nothing Works" trend, and over the last 20 years, there has been a substantial increase in research and program development in this area (Prenky & Burgess 2000; Schwartz 2002; English Pullen & Jones 1996; Freeman-Longo & Blanchard 1998).

During the sexual offence, the offender lacks empathy for their victim and their level of social interest is low. Victim empathy is an important element in treating sex offenders (Pithers 1994; Hilderbrand & Pithers 1989; Marshall & Fernandez 2001; Hanson 1997). This is highlighted by 94% of the treatment programmes in the U.S. using victim empathy components, designed to encourage the offender to accept some greater understanding of the impact of their behaviour on others (Knopp et al. 1992, and Freeman-Longo et al. 1995). The reasons for incorporating victim empathy in treating sex offenders centre around the issues of taking responsibilities for the offence, the development of personal relationships and skills, and arousal control techniques. These factors act as inhibitors to acting out in a sexually aggressive manner in the future.

The practice of singling out certain sex offenders from the criminals as appropriate for treatment dates back to the 1930s. (St. Paul 1994). In the late 1930s and 1940s, Minnesota and most other states enacted sexual psychopath or mentally disordered sex offender statutes, which typically provided for indefinite civil commitment of sexually dangerous persons to mental health treatment in lieu of imprisonment. These laws were enacted to protect the public from potentially violent offenders and to provide treatment to those in need. They were based on a belief that sex offenders suffered from a mental disorder that may be treatable (Veneziano & Veneziano 1987). At the time, the assumptions underlying these laws were accepted uncritically and were not subjected to scientific testing. Also, significantly fewer sexual offenses were reported when these laws were in effect.

#### STATEMENT OF THE PROBLEM

The intent of this study was to determine the effectiveness of a sexual offender treatment program in reducing the sexual aggression among Kajang Prison Sexual Offenders of prisoners in Malaysia. Research has demonstrated that treatment can be effective in decreasing the sexual aggression among Sexual Offender in Malaysia like in overseas treatment that based on community-based program (Aytes et al. 2001; Qulnsey Khanna & Malcolm 1998; Loomen et al. 2000). As the population of sexual offenders residing in the community continues to rise, research has begun to focus on refinement of treatment and supervision in order to prevent a sexual abuse in Malaysia community. It has been noted that prosecution, incarceration, treatment and supervision require a greater level of cooperation and integration to be effective in preventing future victimization in the community (National Council of Juvenile and Family Court Judges 1993). But, in Malaysia this is not similar because sexual offender approach is still not have in Malaysia Prison.

By the way in America, the viability and affordability of treatment must be addressed in a similar collaborative approach in order if the system is to be effective in dealing with this specialized population (National Council of Juvenile and Family Court Judges 1993; American Psychiatric Association 1999).

#### OBJECTIVES

The objectives of the study are to study the prevalence of victim empathy deficits in sexual offender and

to study the relationship between empathy deficit and aggression. This study also hopes to study the relationship between socio-demographic factors and empathy deficits in Kajang Jail sexual offender prisoners and to study the effectiveness of the empathy deficits approach for the treatment of sexual offender among prisoners over a period of three months.

## METHOD

The research will be carried out in two phases; (1) population survey to examine the relationship between empathy deficit and aggression and (2) clinical research to test the effectiveness of Empathy Victim Deficits for the treatment of Sex Offender.

## CLASSIFICATION AND DIAGNOSIS OF EMPATHY

The history of empathy research has been marred by debate. Marred, rather than enhanced, because, as Hezewijk (2001) points out, these debates often seem endless and “if there end it is because they have evaporated instead of having been rationally decided upon. The arguments are about fundamentalist matters, they revolve about tacit presuppositions, about abstract assumptions and about definitions (p.101). Debate regarding definition; however, should not be seen as a worthless endeavor. Unless definitional agreement is achieved “we will not be able to understand each other” (Simon 1982: 333).

## CONCEPTIONS OF SYMPATHY AND EMPATHY

Much of the debate surrounding the definition of empathy stems from what may be seen as semantic confusion specially, between the concepts of empathy and sympathy. The constructs of empathy and sympathy have different origins although the differences between them are subtle.

## THE CONCEPTUAL ORIGINS OF SYMPATHY

Both Hume (1739) and Smith (1790) wrote about the compassion of one human being toward the suffering of another. In regards to sympathy, Hume Stated that “No quality of human nature is more remarkable, both in itself and its consequences, than that propensity we have to sympathize with others, and to receive by

communication their inclinations and sentiments, however different from, or even contrary to our own.” It was similarity between two people, the greater the similarity between two people, the greater the the propensity to experience sympathy. “The stronger the relation is betwixt us and any object, the more easily does the imagination make the transition.” Hume, however, did not sufficiently clarify the concept of sympathy (Wispe 1986) but his works were influential in Adam Smith’s later work on the subject.

Smith (1790) viewed sympathy as critical in his “Theory of moral Sentiments.” Smith wrote “How selfish so ever man may be supposed, there are evidently some principles in his nature, which interest him in the fortune of others, and render their happiness necessary to him, though he derives nothing from it except the pleasure of seeing it. Of this kind is pity or compassion, the emotion which we feel for the misery of others, when we either see it, or are made to conceive it in a very lively manner.”

Both Hume (1739) and Smith (1790) perceived sympathy to be a process requiring the imagination. That is, comprehending the emotions of the other by imaginatively placing oneself in the position of the other. Smith saw this as a limitation to the intensity of sympathy, stating that “The thought of their own safety, the thought that they themselves are not really the sufferers, continually intrudes itself upon them, and though it does not hinder them from conceiving a passion somewhat analogous to what is felt by the sufferer, hinders them from conceiving anything that approaches to th same degree of violence” Therefore, th emotion in th observer was likely to be less intense than the actual emotion of the distress other.

Sympathy has been described as pre-reflexive (Switankowsky 2000) and passive (Davis 1994). In being moved by the misfortune of another, an individual experiences sympathy but that experience is fleeting.”That imaginary change of situations, upon which their sympathy is founded, is but momentary” (Smith 1790).

## THE CONCEPTUAL ORIGINS OF EMPATHY

Empathy, in comparison to sympathy is far younger concept. The origin of the concept, in the psychological domain at least, has been accredited to the work of Theodore Lipps (1903) who used the German word *Einfühlung* which referred to the act of projecting oneself into the English term Empathy using the Greek word *empathia*, meaning affection or passion. Sawicki (1997), however, argues that *Einfühlung* is

not empathy. The general construct of empathy is surprisingly difficult to define. The roots of the term empathy are said to originate in the German concept *empathy*, which translates as “feeling into” (Oxford English Dictionary 2002), and its introduction into psychology at the very end of the 19<sup>th</sup> century has been credited to Theodore Lipps (Mahrer et al. 1994). Examination of dictionary definitions immediately suggest confusion about what empathy is. One of the fullest definitions is from the Merriam-Webster’s Collegiate Dictionary (2002). Here empathy is “The action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts and experience of another of either the past or present without having the feelings, thoughts and experience fully communicated in an objectively explicit manner, also: the capacity for this.”

Evident in this definition is that process of being empathic is conflated with empathy as a disposition. Furthermore, empathy can be generated in association with both positive and negative experience. Empathy is often difficult to distinguish from sympathy. For example, sympathy can be distinguished from empathy by its selective application to negative events, in which the sympathetic person feels sorrow, compassion, or pity for the target, or to being in agreement of opinion or desire (Oxford English Dictionary 2002).

*Einfühlung* originated in the German hermeneutical tradition, and was used by Lipps (1903) cited in Sawicki (1997) in his description of human knowledge. Lipps maintained that there were three areas of knowledge: knowledge of things was achieved via sense perception; knowledge of the self was achieved via inner reflective perception; and knowledge of other human beings was achieved via *Einfühlung*. *Einfühlung* was an inner awareness of the other which could only be distinguished from the inner reflective perception of the self retrospectively. “I can then tell, reflectively, whether the I developed in the experience has been my own or someone else’s” (Sawicki 1997).

Empathy comprises multiple components and processes, which need to be understood as a preface to any work in this area. Empathy has been defined as a cognitive ability to understand and identify with another’s perspective (Cronbach 1955; Taguiri 1969), an emotional capacity to experience the same feelings as another (Clore & Jeffrey 1972) or an interplay of cognitive and affective factors (Aronfreed 1968). Briggs (1994) noted that cognitive empathy is where the offender has an intellectual understanding of the feelings of others without necessarily experiencing

any emotional change themselves, whilst emotional empathy is where they experience the emotions of others in response to their situations and feelings. Other writers have argued that it should embrace communicative and relational elements. Freeman-Longo, bays and Bear (1996) have argued that it is not about being self-centered, harsh, indifferent, resistant, discouraging, unsupportive, impatient, angry, inconsiderate, hostile, irritated, selfish, mean, abusive, cynical (p. 7).

The mechanism underlying empathy, according to Titchener (1909, cited in Davis 1994) was analogous with modern models of motor mimicry and lead to a weaker version of the original affect in the observer. Empathy involves the perception of emotion in another that leads one to feel or act them in the mind’s muscle” (Titchener 1909: 21, cited in Wispe 1986). Davs’ review of the history of empathy highlights the deliberate nature of empathizing with another, which involves effort to “step outside the self and ‘into’ the experiences of others” (p. 5). Unlike the original *Einfühlung* described by Sawicki (1997), however, Titchener’s empathy maintained a distinction between the self and the other.

#### DISTINCTIONS BETWEEN SYMPATHY AND EMPATHY

The previous, brief outline of the origins of sympathy and empathy highlights that, although originating a century apart, there are many similarities between the two concepts. Both sympathy and empathy describe and individual’s response to the emotional displays of another and both involve the use of the imagination, which results in the observer experiencing affect. The distinctions, however, are important in that they help to explain some of the confusion surrounding modern definitions of empathy.

Sympathy is viewed as passive process while empathy is viewed as active. Furthermore early descriptions of empathy, or more accurately *Einfühlung*, describe a way of knowing and suggest a cognitive role in the process, while Smith’s (1790) sympathy was primarily thought to be a affective response. This distinction may helps explain the duality apparent in later definitions of empathy. While one interpretation of the construct of empathy revolved around affective responses (e.g. Scotland, 1969), others viewed empathy as being a cognitive mechanism (e.g. Chapin 1942).

Several papers have been written on the distinction between empathy and sympathy. Wispe (1991)



conducted an extensive review of the distinction, concluding, "In empathy, the self is the vehicle for understanding, and it never loses its identity. Sympathy, on the other hand, is concerned with community rather than accuracy, and self-awareness is reduced rather than enhanced. The object of empathy is an understanding one. The object of sympathy is the other person's well-being (pp. 79-80). Despite such reviews, however, debate continues and is evident in Switankowsky's (2000) review of attempts within the literature to separate these two constructs. Switankowsky does reiterate the distinction between empathy and sympathy on the basis of activity of the observer. Empathy requires effort, sympathy occurs passively. This distinction, then, appears to be a fairly robust and consistent distinction and one which will be adopted in the current text.

## OPERATIONALISATION AND RESEARCH

Once introduced to the field of psychology by Titchener (1909), empathy became a theoretically important construct. Interpersonal affective responses and the process of understanding our social peers had potential in several fields of study, quickly "becoming a 'buzz' word" (Olinick 1984: 137). Researchers, however, needed to redefine empathy in operational terms in order to proceed with their investigations. These definitions varied and reflected interpretative differences as well as semantic confusion with the original construct or sympathy. Table 1 provide a summary of the some of the major definitions of empathy used in psychology.

TABLE 1. Progression of Empathy Definitions

Author(s)	Definition / Measure
Titchener (1909, cited in Wispe 1986)	"Not only do I see gravity and modesty and pride and courtesy and stateliness, but I feel or act them in the mind's muscle" (p. 21)
Feshbach (1964)	"vicarious emotional response of a perceiver to the emotional experience of a perceived object" (p. 102)
Stotland (1969)	"an observer's reacting emotionally because h perceives that another is experiencing or is about to experience an emotion" (p. 272)
Hogan (1969)	"empathy refers only to the act of constructing for oneself another person's mental state; the verisimilitude of the resulting construct is not a necessary part of the concept's meaning" (p. 308)
Miller & Eisenbergh (1988)	"empathy is defined as an emotional response evoked by the affective state or situation of the other person. This emotion may be either identical or similar to the state of the other and involves at least a minimal degree of self-other differentiation" (p. 325)
Davis (1994)	"empathy is broadly defined as a set of construct having to do with the response of one individual to the experiences of another" (p. 12)
Preston & de Wall (2002)	"any process where the attended perception of the object's state generates a state in the subject that is more applicable to the object's state or situation than to the subject's own prior state or situation" (p. 4)

As can be seen from the above table, definitions have varied in their reliance on the passive or active nature of empathy, as well as their acceptance of empathy as either a cognitive or an affective construct. Only Davis' (1994) definition appears congruent with Titchener's original description of empathy, in that it includes both effective and cognitive aspects, however Davis has broadened the definition to include passive response while Titchener's definitions required an active response "in the mind's muscle" (Wispe 1986). It could be argued that by broadening the definition in this way, Davis has simply contributed toward the blurring of the distinction between empathy and sympathy. Davis, on the other hand, takes the position that defining empathy in strict terms has resulted in

constructs, which are excluded by the definition, being "in some sense seen as peripheral" (p. 12). For example if empathy is defined in strictly affective terms, cognitive processes will not be included in subsequent research.

Therefore, by broadening the definitions of empathy, Davis has alleviated Wispe's concerns that sympathy has become ignored by experimental psychology. Even though it may has as much to offer as the more popular empathy.

It should also be noted that only Stotland's (1969) and Davis' (1994) definitions of empathy include non-congruent affective responses and therefore do not exclude aberrant emotional responses from the study of empathic responding. This is particularly useful

for researchers investigating antisocial behaviour as it allows for a broader set of hypotheses to be studied instead of a simple inhibitory empathy – aggression hypothesis.

### MEASURES OF EMPATHY

Empathy assessment in children has developed quite differently from that used to assess adults. As the purpose of this document it to address the issue of aggression and violence and its relationship with empathy will be reviewed.

Measurement of individual differences in empathic responses has followed one of two fairly distinct paths. Several researchers have adopted a physiological approach to the study of empathy (e.g., Stotland 1969). Others have approached empathy measurement from a personality or dispositional trait using self-report measures (e.g., Hogan 1969). This section will begin with a review of physiological indicators of empathy followed by a review of self-report measures of individual differences in empathic responding.

### PHYSIOLOGICAL INDICATORS

Typically, studies employing physiological indicators of empathy have involved participants observing a confederate undergoing either a positive or a negative experience while physiological measures are taken. The type of measures employed has varied greatly, and changed overtime as new methods have become available. Early measures included palmar sweating and vasoconstriction measures (Stotland 1969), but now include measures such as galvanic skin response, heart rate change (Eisenberg & Lennon 1981), skin conductance, general somatic activity and finger pulse amplitude (Levenson & Ruef 1992).

Early work involved instructional conditions such as ‘imagine-self,’ ‘imagine-other’ and ‘watch.’ It was assumed that, since the basis of empathy is presumed to be an imaginatory process, the ‘imagine-self’ would evoke greater physiological arousal than the other two conditions and that the ‘imagine-other’ condition would evoke a greater than response than simply watching the other. There does appear to be some evidence to support this suggest, but not for all physiological indicators (Stotland 1969).

Other early description of empathy also indicated that non verbal motor mimicry (facial muscles movement in response to observing emotional displays) was responsible for shared affect would

be used by the observer to understand the other’s emotional experience (Lipps 1907, cited in Blairy, Herrera & Hess 1999). Blairy et al. provided evidence for the assumption that motor mimicry occurs using measures of *corrugator supercilli* (draws the brow in and down). *Orbicularis oculi* (widens the eyes) and *levator labii alesque nasi* (lifts upper lip) muscle movement. Furthermore, using self report measures they found that affect arousal occurred in observes, however no increase in participants accuracy in rating the other’s emotional state was observed. Levenson and Ruef (1992) used a combination five physiological measures to assess emotional contagion and subsequent rating accuracy of the other’s motional state. These authors did find a significant relationship between affect sharing and accuracy, however, unlike Blairy et. al., Levenson and Ruef used general categories of affect such as negative and positive. Participants were asked to indicate the type of affect (positive versus negative) and the strength of the other’s emotional reaction. Blairy et al. asked participants to rate specific emotions, such as happy, sad or angry. It may be that empathic responses only increase accuracy ratings of general emotional states.

Physiological indicators of empathic reactions have provided some indication as to the underlying mechanisms of empathy, in that motor mimicry appears to lead to shared affect, and that shared affect appears to increase rating accuracy of another’s emotional state at a superficial level. Several problems exist, however, with these findings and with physiological indicators in general.

Although most studies have employed self-report measures in order to clarify the meaning of physiological arousal (e.g., Stotland 1969), it is still difficult to determine exactly what physiological responses really indicate. Eisenberg and Lennon (1981) discuss the problem of differentiating between empathy and distress for example. These authors also highlight the problem of cognitive load, in that it also appears to have an impact on physiological measures and may explain why empathic reactions are evident in some physiological indicators but not others. Furthermore, although self-report measures of empathy may be used to help clarify physiological arousal, Levenson and Ruef (1992) found no relationship between such measures.

### EMPATHY RESEARCH WITH SEX OFFENDERS

Overall, on general empathy measures, child sexual abusers rarely have been found to differ from

TABLE 2. General Empathy Studies

Study and Sample	Scale	Results
Fisher et al. (1999) 81 CM prisoners, 59 community treatment CMs, 81 new recruit prison officer Cs	IRI	CMs scored higher on PD and EC than controls. No differences on PT and F. Extrafamilial CMs did not differ from Cs on EC, but had lower PT.
Hayashino et al. (1995) 22 pretreatment incest CM prisoners, 21 pretreatment extrafamilial CM prisoners, 33 R prisoners, 27 non-SO prisoners, 26 community Cs.	IRI (PT, EC only)	No significant differences.
Langevin, Wright, & Handy (1988) 32 Incest CMs, 38 nonfamilial CMs, 21 Rs and 7 exhibitionists (all pretrial)	M-E	No differences between sex offender types. Only nonfamilial CMs scored lower than original non-offender validation sample, Deniers more empathic than admitts.
Marshall, Jones, Hudson, & McDonald (1993) (1) 92 pretreatment CM prisoners (2) 20 community CMs, 20 matched Cs	IRI IRI	No differences cf. Salter's (1988) norms for factory workers and students. No statistical testing
Marshall & Maric (1996) 29 pretreatment CM prisoners 29 community Cs	Hogan M-E	CMs found to be significantly less empathic than controls on both measures
McGrath et al. (1998) 30 SO prisoners (anonymous), 30 non-SO in community (anonymous), 30 SO prisoners (anonymous, fake good) 44 non-anonymous SO prisoners assessed for parole hearing	Empat-G	No differences found between groups
Pithers (1994) 10 CM prisoners, 10 R prisoners, in CBT program, prior to empathy module	IRI	CMs obtained higher total score, and higher PT and subscales than rapist. CM scores similar to Salter (1988) norms
Pithers (1999) (Expt 1) 15 CMs, 15 Rs partway through CBT program, prior to empathy module	IRI	IRI administered twice to all offenders in (a) typical mood, (b) offense-percussive mood. CMs scored significantly higher than Rs on IRI total an on PT and EC subscales in (a). (b) scores were significantly related to (a) scores. Rs' IRI total scores and EC scores decreased more than CMs' from typical to percussive mood. CM scores fro percussive mood similar to typical mood. CM scores for percussive mood similar to typical mood.
Rice, Chaplin, Harris, & Coutts (1994) 14 Rs, 14 non-SO patients in max, security hospital, 11 community Cs	M-E Hogan	Rs lower on Hogancf, other two groups. Otherwise no differences.
Tierner & McCabe (2001) 36 CM prisoners, 31 R prisoners, 30 non-SO prisoners, 40 community	M-E Empat-G	Rs scored significantly lower than CM and community Cs on M-E.

No significantly differences on Empat-G

Notes: \* also used other, nonempathy scales, CM = child sexual offender; SO = sex offender, R= rapist, C = control; IRI = Davis's Interpersonal Reactivity Index. Subscales: PT = perspective taking, F = fantasy, PD = personal distress, EC = empathic concern, M-E = Mehrabian-Epstein scale (1972); Empat-G (cited in McGrath et al. 1998).

TABLE 3. Victim Empathy Studies

Study and Sample	Scale	Results
Fernandez et al. (1999) Expt 2: 29 CM prisoners, 29 Community Cs	CMEM	Controls and CM scores not different for CAV, Cs scored higher for CSAV, CMs Scored lower on OV than other two vignettes.
Fernandez & Marshall (in Press) 27 R prisoners, 27 non-SO prisoners	REM	Rs scored higher than non-SOs on WAV scale. No differences for WRV. Rs were less empathic toward their own victims than WRV.
Fisher et al. (1999) see table 2 for sample	VEDS	CMs scored higher on victim empathy distortions than Cs
Hanson & Scott (1995) 21 Rs, 66 CMs, 39 CM +R, 23 deniers (all in prison or treatment), 26 Rs, 14 CMs, 9 CM +R (all in community, admitting offences, never convicted), 84 non-SO prisoners, 84 community Cs, 76 students Cs (EFWT only)	CET EFWT	No differences between groups on CET scores, SOs currently in treatment made fewer errors on the CET than those not in treatment. Rs (prison and community unconvicted) made more errors than non-offenders combined. Community Rs made more errors than community non-offender Cs on EFWT. No differences between Rs and CMs, or between offenders in and not in treatment
Marshall, Champagne, Brown & Miller (1997) 32 CM prisoners, 32 community Cs	CMEM	As for Fernandez et al. (1999)
Marshall et al. (2001) 34 CM prisoners, 24 non-SO prisoners, 28 community Cs	CMEM	No differences between groups for CAV (Parts A or B). CMs lower than other two groups on part A for CSAV. CMs lower on Part A for OV than for other two vignettes. No differences between groups on Part B
Marshall & Moulden (2001) 32 pretreatment R prisoners, 28 violent non-SO prisoners, 31 community	REM	No differences on WAV between groups. Rapist scored lower for WRV than other two groups. Rapist scored lower on OV than both WRV and WAV
McGrath et al. (1998) see Table 2	Empat-A	SOs scored lower than university Cs or non SO group. There were no differences between the SO groups
Tierney & McCabe (20001) see table 2	Empat-A	CMs scored lower than other 3 groups on Empat-A. no other intergroup differences

*Notes:* also used other, nonempathy scales, CM = child sexual offender; SO = sex offender, R = rapist, C = control; CMEM = child molester empathy measure (Fernandez et al. 1999); Part A = child victim's experiences, part b = how the perpetrator feels about the child's experience, 3 vignettes: CAV = child accident victim; REM = Rapist Empathy (Fernandez & Marshall, in Press).3 vignettes; WAV = own car accident victim, WRV = woman victim or rape (other perpetrator), OV = own victim; CET = child empathy test, EFWT = empathy for women test (Hanson & Scott, 1995); VEDS = victim empathy distortions scale, cited in Fisher et al. (1999); Empat-A (child sexual abuse -specific' cited in McGrath et al. 1998).

controls or normative non-offenders samples. Rapist sometimes score lower than both child molesters and controls (Table 1). On victim-specific measures (Table 2) the findings are more complex. On the Child Molester Empathy Measures (CMEM), child molesters and controls generally do not differ on the accident victim scenario, and molesters endorse less empathy for their own victims than for other victims. On other measures, there is no consistent pattern of findings. The two REM studies contradict each other, perhaps because one sample of rapist was waitlisted for treatment and the other was not. In both, however, rapist was less empathic toward their own victim than other victim types.

#### EMPATHY AND ANTISOCIAL BEHAVIOUR RESEARCH: FESHBACH'S EMPATHIC AROUSAL MODEL

Feshbach (1962) theorised that empathy represented one possible inhibitor of aggressive behaviour, but that the relationship would be dependent upon the type of empathic deficit and the type of aggression on being displayed. In a series of studies, Feshbach and colleges investigated the impact that empathy and fantasy training would have on children's aggressive behaviour (Feshbach & Feshbach 1982).

Utilising a three component model of empathy, these authors presented a complex theory to account for



the inverse relationship often found between empathy and aggression. Feshbach and Feshbach proposal that empathy was a shared affective experience between two individuals and that it was dependent upon three components. Firstly, the observer needed to be able to identify and discriminate the feelings being experienced by the other. Additionally, the observe needed to be able to be perceive the situation from the perspective of the other, and this perspective taking needed to lead to affective arousal in the observe. This model attempted to explain, not so much the resulting empathic experience, but the system responsible for that experience. By focusing upon the necessary factors for the production of empathy, Feshbach's team effective provided a means of designing and implementing treatment programs, for example with aggressive children. Furthermore, Feshbach and Feshbach provided an analysis of three types of aggression and theorised the effects that this three component system of empathy would have upon each type.

Emotional aggression, according to Feshbach and Feshbach's (1982) examination, is associated with feelings such as frustration and anger. They argue that, although anger can occur without physical attack, it frequently leads to aggressive behaviour. Empathy should impact upon displays of emotional aggression, not by impacting on the aggressive behaviour itself, but by influencing the antecedents of anger. Individuals who are able to accurately take the perspective of the other would be less likely to misinterpret and more likely to understand the actions of others. Therefore, perspective taking (the cognitive component of empathy) would facilitate more effective communication and result in less frequent manifestation of anger.

When aggression is instrumental, that is the aggression is directed toward the attainment of goals such as money or power, then empathy would lead the aggressor to experience negative affective responses in reaction to observing the victim in distress and pain. The result would be the aggressor desisting due to the unpleasant experience associated with the affective component of empathy.

The mechanism that underlies then relationship between empathy and hostile aggression, where the goal is to think to be the similar to that for instrumental aggression (Feshbach & Feshbach 1982), although these authors want that hostile aggression is complicated to treat. They further suggest that hostile aggression can be sadistic in nature and may be the due to perspective taking occurring in the absence of an appropriate affective response. That is, rather than

feeling concern or distress, the offender may interpret their emotional arousal as pleasurable resulting in the experience of contrast affect.

#### EVIDENCE FOR A RELATIONSHIP BETWEEN EMPATHY AND AGGRESSION

If the link between empathic responding and prosocial action is tenuous, the link between a lack of empathic responding and aggressive or violent behaviour is feeble. After conducting a meta-analysis on studies that investigated the relationship between empathy and aggression, Miller and Eisenberg (1988) concluded that "analyses provide modest but not entirely consistent support for the notion that empathic responsiveness may be an inhibitor of aggression" (p. 339). Furthermore, the results were influenced by a number of factors including age of participants, method of assessing empathy, and the method of assessing antisocial behaviours.

One of the earliest proponents of an inhibitory effect of empathic responding on aggression was Feshbach and his colleagues (e.g., Feshbach & Feshbach 1969). Although the se authors conducted several studies, the findings failed to indicate a consistent and reliable relationship between empathy and aggression in children. For example, Feshbach and Feshbach (1969) conducted an investigation into the impact of empathy training on children's aggression, finding significantly lower levels of aggression in both boys girls who were in the empathy training group. Unfortunately, however, this finding was only relevant for the younger group of children and the effect was not demonstrated in the older age group.

Other investigations into the link between empathy and aggression using young children have been equally inconsistent. Gill and Calkins (2003) investigated the presence or absence of empathy in aggressive and non-aggressive toddlers also demonstrated greater physiological arousal than the non-aggressive children, leading these authors to conclude that affect regulation may be an important factor, but developmental patterns in empathy development were likely to explain their counter-intuitive results. These points will be examined in more depth in the following section (1.5.3). Some research with children, however, has found a consistent and significant negative association between peer evaluated empathy and both physical and verbal aggression in 10.12, and 14 year old children. These authors concluded that the "perpetrator of aggression must have a certain

amount of impudence and insolence,” highlighting the judgemental bias underlying empathy research in this area.

Antisocial youth have been the target group of several investigations into the relationship between empathy and antisocial behaviour, with mixed findings. Sam and Truscott (2004) failed to find an association between self-reported empathy and use of violence in adolescent males. Nor did they find any association between empathy and exposure to community violence, as would be expected if a desensitization effect was occurring. Likewise, Bush, Mullis, and Mullis (200) found no significant difference between offender and – non-offender youth on any of the IRI subscales. LeSure-Lester (2000) did find a significant negative relationship between empathy and aggression in abused youth using the Balanced Emotional Empathy Scale (BEES). However, the BEES assesses several variants of empathic responding including affective empathy, personal distress and perspective taking. It is unclear, therefore, what the total score on the BEES actually represents. Like the Questionnaire Measure of Emotional Empathy (Mehrabian & Epstein 1972), the BEES appears to be a measuring general emotionality rather than specifying the exact nature of the resultant empathic experience, which makes interpretation of LeSure-Lester’s findings difficult.

Much of the research conducted to examine the link between empathy and aggression in adults has been accomplished using non-offender samples, primarily convenience samples such as students. Ohbuchi, Ohno and Mukai (1993) investigated the effect of self-disclosure and fearful appeal on the level of electric shock chosen by Japanese university student participants. Both self-disclosure and fearful appeal resulted in lower shock levels, leading the authors to conclude that both conditions had evoked empathy in participants. However, no direct measure of empathy was used in the study so this conclusion was only tentative. Richardson, Hammock, Smith, Garner and Signo (1994), on the other hand, used the IRI to directly assess American university students’ empathy levels. There was a significant negative correlation between Empathic Concern and direct aggression (i.e., assault), while Perspective Taking was negatively correlated with indirect aggression, irritability, and verbal aggression. Interestingly, direct aggression was positively associated with Perspective Taking. In a later study, Richardson, Green and Largo (1998) again used the IRI to assess empathy in university students, although only focusing the

Perspective taking subscale. The results of this study indicated that Perspective Taking was related to the inhibition of aggression, unlike the previous study.

Several investigations into the influence of empathic responding in sex offenders have been conducted; however, few have been conducted using non-sexual violent offenders. A discussion of sex offending per se is beyond the scope of the current work, as well as the conceptualisation of sex victim of sex victim empathy (distinguished from individual empathic dispositions).

Ireland (1999) conducted research to examine the relationship between bullying behaviour and empathy in both male and female adult prisoners. Using the IRI, Ireland found that prisoners who engaged in bullying behaviour scored significantly lower on both Perspective Taking and Empathic Concern than prisoners who were the victims of bullying. Mothers who were at high risk of physically abusing their children, however, reported equivalent levels of both Perspective Taking and Empathic Concern as mothers who were not at risk of abusing their children (Milner et al. 1995).

Lifestyle characteristic can be analyzed several different ways, for example an offender’s behavior or specific personality characteristics involved in the offending. Individuality always needs to be taken into consideration. For example, regressed or situational offenders do not have lifestyles of offending. Some offenders have fewer of the characteristics described below than other offenders, and the degree to which a sexual offender exhibits the six characteristics fluctuate.

1. Antisocial or psychopathic behaviors of the sexual offender center around exploitation (i.e., criminal mentality), lack of empathy, remorse, deception, and the like. Most sexual offenders use deception and do not advertise their offending. They also tend to lack empathy, especially for their victims, and to exploit others. Some offenders meet Hare’s (1993) and Meloy’s (1992) criteria for being psychopathic in their orientations, while others appear able to compartmentalize their antisocial behaviors and characteristics to a limited range of psychopathy and said that most everyone has some antisocial features of behavior. Adler’s view was more flexible, and this flexibility allows clinicians to take into account individual differences via a holistic view.
2. Narcissistic behavior is a self-centered orientation with features of acting grandiose and superior to others. Offenders have self-worth or self-esteem

- problems and issues (Adler 1934, 1933/1941; Blanchard 1995; Marshall et al. 1996) and attempt to show their power through sexual aggression. Their doing so is an extreme form of the masculine protest: They overcompensate by acting superior. Through sexual aggression, the offender who feels inadequate can demonstrate an illusion of power, which, for a short time, reduces the intense feelings of inferiority.
3. Characteristics of schizoid behavior center around interpersonal relationships and social skills. Some offenders lack social skills, feel alienated and isolated, and have flat affect and problems with emotional recognition. They tend to be lonely and withdrawn from adult relationships (Marshall et al. 1995; Marshall & Mazucco 1995).
  4. Borderline features center around personal and interpersonal instability, and the dynamics reflect issues of jealousy, enmeshment, possessiveness, dependency, and intense moodiness (Carich & Adkerson 1995). The borderline offender uses antithetical thinking styles and tends to devalue or overvalue self and others.
  5. Passive-aggressive characteristics include feeling inadequate and inferior to others in ways that lead offender to be passive in his or her style of relating to others, especially in terms of anger expression. Rather than express feelings directly, the offender tends to respond by creating obstacles for others or by expressing feelings indirectly.
  6. Finally, dissociation behaviors center around detachment at both conscious and unconscious levels of awareness. Dissociation in this context is defined as self-detaching from the current context or stream of consciousness. With sexual offenders, dissociative behaviors include the process of deviant fantasies (thoughts and connected feelings following a particular theme), a fantasy world, higher level of inner focusing, disinhibiting mechanisms, detachment, and the hidden observer effect (i.e., observing oneself in any given situation).

TABLE 4. Descriptions of Basic Cognitive Distortions

Distortion	Description
Denial	Any form of non-admitting to (or not taking responsibility for) one's offenses or issues. Denial appears to range from conscious to non-conscious processes
Justification	Any form of making the behavior okay. Examples: "I was not rough." "She wanted it." "I was educating her. Well somebody had to." "She deserved it." "I'm not hurting anyone." "Life is arbitrary, and shit happens." "It was pleasurable." "No one will find out, so it's okay." "We love each other." "I didn't force them; they volunteered."
Minimization	To make less significant or important. Examples; "I only did this, I would never do that..." "I'm not as bad as this guy, because I only did..." "She enjoyed it." "I apologized."
Blame	Placing the responsibility of one's own behaviors onto another. Examples: "She was in the bar." "I bought her dinner, and she owes me."
Lying	Deliberately distorting or twisting information by making false statements.
Power Games	Being superior, dominant, or controlling
Depersonalizing	Making the victim an unreal person and/or treating the victim as an object
Entitlement	Unwarranted / unrealistic request, expectations, etc. and the belief/ feeling that one can do whatever one wants to do
Self-pity	Feeling sorry for self and sympathy for self in a way that elicits sympathy from others and preserves self-esteem and a sense of entitlement
Polarizing	Thinking and behaving in extremes (i.e. either-or; black-white).

One study using data from 10 follow up studies of adult male sex offenders (a combined sample of 4,673 offenders) divided sex offenders into three separate groups that are believed to be distinctly different from each other and, thus, require different treatments

(Hanson 2001). These three groups consisted of incest child molesters who victimize related children, rapists who victimize adult women and non-incest child molesters who victimize unrelated children.

## INCEST CHILD MOLESTERS

Child molesters were the latest likely to sexually recidivate, at a rate of 8.4% (Hanson 2001). This finding carries with it many important implications for treatment. Since the rate is relatively low, it has traditionally been believed that the best form of treatment for incest child molesters is a minimally intrusive form of therapy that reduces sexual recidivism.

One program currently offered by Correctional Service of Canada does exactly that. The Violence Interdite Sur Autrui (VISA) program is meant to treat incestuous fathers who are at low risk for sexual reoffending. VISA emphasizes developing empathy for the victim and preventing recidivism by encouraging participants to complete six initiatives that have been proven to reduce recidivism for this type of offender:

1. Offenders work to overcome fear and shame so that they can acknowledge what they have done.
2. Offenders take full responsibility for the abuse, both in front of the people involved in the offence and the therapy group in which the offender is treated.
3. Offenders come to terms with the damage done to their victims, their families and themselves.
4. Offenders take steps to amend and establish healthy relationship with their victims and those close to them.
5. Offenders learn about incestuous sexual offending so that they can look critically at their sexual conduct and eventually lead sexually responsible lives.
6. Offenders learn about incestuous sexual offending so that they can look critically at their sexual conduct and eventually lead sexually responsible lives.
7. Offenders recognize the factors that contributed to the abuse and take steps to reduce the influence of these factors in their lives. (Bernie, Mailloux, David & Cote 1996).

The 14 week program consist 28 psychotherapy group meetings, 13 sex education workshops and 10 individual interviews that encourage participants to support each other, to seek out community support and to incorporate their victims and families back into their lives. The success of the VISA program has been exceptionally promising. As of 1996, 130 offenders participated in the VISA program notes, "the VISA Program has, therefore, demonstrated not only that

it is possible to treat incest in a context of respect for abusers, their victims and their families, but also suggest that it may be more effective to treat the man/father than the deviant" (Bernie et al. 1996).

However, one recent study challenges traditional thinking about incest child molester treatment, and questions the validity of the distinction made between incest child molesters and non-incest child recidivism rates among incest child molesters are actually higher than most statistic report. This is because during treatment, several offenders admitted to having committed sexual offences on additional incestuous victims that did not result in a sexual offence conviction. Of the total sample of 150 incest child molesters, 7.3% had a previous sexual incestuous conviction, and an additional 15.3% had admitted to committing sexual offences on additional incestuous victims that did not result in a conviction (p. 18). in sum, 22% of incest child molesters in the sample sexually recidivated, a rate of almost three times higher than Hanson (2001) found (8.4%).

Second, the study reveals another issue that has often been ignored by previous research. Because most research studies separate sex offenders based on their first convictions, past sexual offences that did not result in a conviction have often not been taken into consideration. Studer et al. (2000) reported that 58.7% of the sex offenders based on their first convictions, past sexual offences that did not result in a conviction have often not been taken into consideration. Studer et al. (2000) reported that 58.7% of the sex offenders classified as incest child molesters had reported other non-incestuous victims; in fact, only 33% of the incest child molesters and 18.5% of the non incest child molesters reported that they had only victimized the individuals that lead to the current conviction and had not victimized any other individuals. Therefore, the notion that sex offenders can be classified into distinctly different group based on their first convictions is open to scrutiny. The distinction drawn between incest and non-incest child molesters is brought further into disrepute when erotic preferences of child molesters are examined. In one research study, first offences conviction were used to separate 103 incest child molesters from 114 non-incest child molesters, so that their erotic preferences of child molesters are examined. In one research study, first offences conviction can used to separate 103 incest child molesters from 114 non-incest child molesters, so that their erotic preferences could be compared (Studer, Aylwin, Clelland, Reddon & Frenzel, in press). Erotic preferences were then examined by having offenders undergo phallometric



testing while being exposed to visual stimuli (mostly slides) of people who differed in age, gender and body type. The test results were used to determine the two groups' erotic preferences for four categories of people, namely: 1) pubescent partners; 3) adult partners; and 4) women of all ages.

### RAPIST

According to Hanson's study (2001), rapists were the second most likely group of sex offenders to sexually recidivate, at a rate of 17.1%. Most research done on rapists indicates that they are a distinct group of offenders who are distinguishable from child molesters. For instance, rapists tend to be younger than child molesters, each having average ages of 32.1 and 38, respectively (Hanson 2001). More importantly, a meta-analysis of sex offender treatment programs found that rapists were more likely to recidivate non-sexually than were child molesters (Hanson & Bussiere 1996). In fact, it has been noted that "rapists share more characteristics with the general criminal population than do child molesters." Characteristics that identify general criminals, such as prior criminal records and antisocial personality, are similar to characteristics that identify rapists. Furthermore, research has found that rapists are more likely than are child molesters to breach their conditional release. In one sample of 132 subjects who were conditionally released, 40.7% of rapists breached, while only 25% of child molesters did so (Barbaree et al. 1996).

Since rapists engage in a variety of criminal behaviours and have high recidivism rates, they are difficult to rehabilitate effectively. However, there is hope for treating rapists. In a research study examining treatment effects on 74 rapists, treatment completers were compared to treatment non-completing rapists. It was found that treated rapists recidivated sexually at a substantially lower rate than did their non-completing counterparts. Although the difference was not statistically significant, only 16.6% of treatment completers sexually recidivated, while 28.9% of treatment non-completers did so (Clelland et al. 1998). The 14.3% decrease in sexual recidivism for treated rapists suggests that treating rapists successfully is possible, and difficulties in treatment can be overcome. To successfully treat rapists, research suggests that adequate treatment must address general crime issues, as well as sexual crime issues, to ensure that the offenders do not

reoffend. Promising sex offender treatment research suggests that effective treatment for rapists focuses on changing deviant sexual behaviour, and incorporates Cognitive Skills Training in treatment programs (Robinson 1995; Quinsey et al. 1995).

It must be remembered that only factors that can be changed should be the focus of treatment, not only for rapists, but for all offenders who require treatment. Factors such as prior criminal record or family background are related to sexual offending, but are not changeable and, therefore, should not be the focus of treatment. However, sexually deviant behaviours are changeable. One study on sex offender recidivism found that laboratory assessed deviant sexual behaviours were the only changeable factor related to recidivism for sex offenders (Quinsey et al. 1995).

Deviant sexual behaviour was defined as use of prostitutes, deviant sexual preference (for example, a preference for young boys), frequent masturbation, and so on. When such behaviours are performed by sex offenders, chances of their reoffending increase. Therefore, treatment that reduces these deviant behaviours of sex offenders may help to reduce recidivism. Current effective methods used to decrease deviant behaviours come from a cognitive/behavioural conditioning approach, and include shaming, covert sensitization, masturbatory conditioning, and many other forms of behavioural conditioning. Also, Cognitive Skills Training programs have been known to reduce reconvictions among sex offenders. In a research study conducted by the Correctional Service of Canada, sex offenders were the most successful type of offender in reducing recidivism rates by completing Cognitive Skills Training.

The Correctional Service of Canada study examined 3,531 offenders from the correctional population who participated in Cognitive Skills Training, and 541 offenders who met the criteria to be included in the program were placed on a waiting list to be used as a control group. There was a 57.8% reduction in any form of reconviction, and a 39.1% reduction in readmission to a correctional facility for sex offenders who completed the Cognitive Skills Training program when compared to the control group. Although the study expresses doubt about such impressive results being observed in further studies, the data do suggest that sex offenders would greatly benefit from Cognitive Skills Training (Robinson 1995).

## NON-INCEST CHILD MOLESTERS

Of the three groups of sex offenders classified by Hanson (2001), the highest rate of sexual recidivism (19.5%) was recorded for non-incest child molesters. These offenders are at significant risk of re offending throughout their lives (Hanson et al. 1992). A research study that illustrates this point examined the long term recidivism of child molesters. In the study, these offenders were classified into three groups: a treated group; control group one; and control group two. Both control groups were used to control for cohort effects. A total of 197 child molesters, a majority of them being non-incest child molesters, released from Canadian correctional facilities between 1958 and 1974 were tracked over an extensive period of time (31 years for control group one offenders). Results showed that 42% of the total sample was reconvicted for a sexual and/or violent offence. The long term risk of recidivism for non-incest child molesters is based on the fact that 10% of the total sample was reconvicted between 10 and 31 years after release.

The study divided child molesters into three separate types of offenders, based on the type of individual who was victimized. Child molesters were classified as either incest child molesters, heterosexual pedophiles (non-incest child molesters) or homosexual pedophiles (non-incest child molesters). Concurrent with most research, the incest child molesters were reconvicted at the lowest rate. Homosexual pedophiles were reconvicted at the highest rate, and heterosexual pedophiles were reconvicted at an intermediate rate between the other two groups. Again, these results suggest that special attention should be paid to non-incest child molesters. In particular, non-incest child molesters who victimize boys must be given extensive treatment and require long term supervision, since much of the research has found that offenders (whether male offenders or female offenders) with boy victims are the most likely to recidivate (Hanson et al. 1992; Hanson & Bussiere 1996).

In fact, one research study has revealed that one of the highest recidivism rates among sex offenders was for those with previous sexual offences, who victimized boys from outside the family, and were never married. These sex offenders recidivated at a rate of 77% (Hanson 1996). Fortunately, sex offender treatment for non-incest child molesters does suggest promising results, if a long term commitment to treating them is maintained. It is important for child molesters to have support throughout their lives, and view their condition not as a curable disease, but rather as an undesirable outcome that can be

prevented. As a long term recidivism study on child molesters states:

Sexual offender recidivism is most likely to be prevented when interventions attempt to address the life long potential for re offences and do not expect child molesters to be permanently “cured” following a single set of treatment sessions (Hanson et al. 1993: 651).

Thus, most research suggests that intensive, long term treatment programs are essential to the rehabilitation of non-incest child molesters. Again, Cognitive Skills Training and behavioural reconditioning of deviant sexual behaviours must be part of the program, because of their proven success in treating all types of sex offenders.

Finally, most research further suggests that one essential component of sex offender treatment that should be part of any program aimed at sex offenders is relapse prevention. Since relapse prevention is inherently a part of any cognitive/ behavioural intervention, it is a part of most Canadian sexual treatment programs. Relapse prevention teaches offenders to recognize risky situations where they may be more likely to re offend. Then, coping, avoidance and escape strategies that deal with the situation appropriately are formulated for each individual offender (Blanchette 1996). This technique is highly individualized and tailored to an offender’s specific circumstances, and it further promotes self management skills.

To properly examine sex offender treatment programs, not only should the academic research be considered, but the practical application of sex offender treatment programs must also be taken into account. Sex offender treatment programs do not only employ empirically tested treatment methods that have been proven to reduce recidivism, but also incorporate many other rehabilitative components, such as life skills training, recreation, anger management, Alcoholics Anonymous meetings, psychotherapy and many more. This comprehensive approach to dealing with sex offenders focusses on treating the whole person, rather than just the criminal offender. Offenders are treated having regard to their own individual situations, and clinicians believe that it is a combination of several therapies in a treatment environment that produce the most desirable results. The Phoenix Program, a treatment program located in Edmonton run by the Alberta Mental Health Board, is a perfect example of such a comprehensive treatment philosophy. It is a 19 bed minimum to medium security unit that features private bedrooms, visiting areas, laundry facilities, kitchenettes, a dining area,

chapel, canteen, barbershop, open aired courtyard, swimming pool and a gymnasium. The Treatment Program mainly treats convicted sex offenders who volunteer for treatment from the federal and provincial correctional systems; very few of the program participants are referred to the program directly from the community (for other admission requirements, see Studer & Reddon 1998). Offenders are required to stay for a minimum of six months, but they progress through treatment at varying rates, with the average stay being 10 months. Although the program has numerous amenities, intensive treatment and a strict schedule are the main elements of the program. Offenders are required to attend 32-35 hours of therapy per week. The therapy is delivered in many forms, including: psychotherapy, victim empathy, cognitive restructuring, anger management, human sexuality, recreation, substance abuse, relapse prevention, life planning, goal attainment and more (for more information, see Studer et al. 1996). Psychotropic medication used to decrease the sex drive of offenders is rarely used in the program, and anti-androgens have only been used with a small proportion of program participants. Treatment is delivered throughout three phases of the program.

The first phase is an intensive, six to 12 month treatment schedule, focusing on treatment forms discussed above that is delivered entirely within the program facility. The second phase spans a period of four to eight months of daily, four hours per evening treatments delivered while the offender is in the community.

Finally, the third phase consists of a weekly follow up group that can be accessed over the long term (Studer & Reddon 1998). Offenders have somewhat of a life time membership in the program, and are offered continuing support from Treatment Program staff after release. Since the program is voluntary and offenders are not required to fully attend all three phases, a continuum of supervision is offered that provides individualized supervision programs tailored to the individual needs of participants. This Program has been recognized as one of the most effective sex offender treatment programs in much of the academic research (Aylwin et al. 2000; Alwin et al. in press; Clelland et al. 1998; Studer et al. 1996; Studer & Reddon 1998; Studer et al. 2000; Studer et al. in press). It has gained international recognition as a reputable sex offender treatment program, having presented research findings in many European countries. The Treatment Program is at the forefront of sex offender treatment, and has reported sexual recidivism rates as low as 3.3% for

120 treatment completing offenders, over an average follow up period of 38.8 months (Studer et al. 1996). This remarkably low sexual recidivism rate has afforded the program a great deal of respect in the treatment arena. Furthermore, more recent research produced by the Treatment Program has demonstrated that successful treatment changes the risk that sex offenders pose in a community setting, if released from a correctional institution. It is a common belief in the criminal justice system that the best predictor of future offences is the number of the offender's past offences. However, after successful treatment at the Treatment Program, even for offenders with several past offences, prior sexual offences were not significantly related to sexual recidivism. On the other hand, unsuccessful completion of treatment did produce a significant correlation between prior sexual offence convictions and sexual recidivism (Studer & Reddon 1998).

Thus, the predictive value of prior sexual offence convictions for future reconvictions seems to change at some point during treatment completion; specifically, its predictive value declines. Results suggest that a re-evaluation of the release criteria for treated sex offenders is necessary, and that current criteria are not suitable for treatment completers. More importantly, this research, as is much of the research done by the Phoenix Program, is supportive of treatment interventions for sex offenders. From personal communications with staff at the Phoenix Program, it is apparent that the staffs are committed to a comprehensive treatment philosophy. They make a point of not highlighting any specific treatment that could be singled out as being superior to another type of treatment offered at the facility. Instead, emphasis is placed on the interaction of all of the treatments, in combination with a suitable environment and capable staff. Also, it has been mentioned that offenders are, to some degree, handled on an individual basis that is in accordance with the specific needs and situations of the offender. Furthermore, staff strongly caution against attempting to pin point specific sex offender treatment therapies that will act as the solution to the sex offender recidivism problem. Staff believe that an evaluation in isolation of the program environment, staff, and individual offender issues does not take into account the whole picture of all relevant factors that must be addressed.

Another local program that shares the same comprehensive philosophy as the Phoenix Program is Counterpoint House, a treatment program that focuses on adolescent sex offenders. Although Counterpoint House is run independently from the



Phoenix Program, it is also operated by the Alberta Mental Health Board. Counterpoint House is an eight bed community based residential facility, similar to a group home. Having served over 100 adolescent sex offenders between the ages of 13 and 18 since its inception in 1986, Counterpoint House has been constantly evolving to become one of the most effective adolescent sex offender treatment programs available. The program's main goals include: reducing adolescent sex offender recidivism, promoting mental health and facilitating reintegration of offenders back into the community. While residing at Counterpoint House, offenders are expected to participate in a day program, usually school, part time or full time work, and attend four community recreation outings per week (for more information on Counterpoint House, see Aylwin et al. 2000, and Aylwin et al. in press).

The intensive therapy schedule that has been observed in the examination of the Phoenix Program is also a major element of the Counterpoint House Program. Again, a minimum stay of six months is required for offenders. The focus of therapy provided at Counterpoint House can be categorized into three main forms: cognitive/behavioural therapy, psychotherapy and skills therapy. Although the majority of the adolescents' day is occupied by school, work, chores and other activities, Counterpoint House does manage to provide a multitude of therapy programs for adolescent sex offenders.

Finally, the psychoeducational component provides offenders with the opportunity to learn about sexual offending issues. For instance, offenders learn about the effects of victimization, sex offender treatment, the law, offender and victim characteristics, and statistics of abuse and victimization. Again, cognitive distortions are identified, and offenders learn to recognize and discuss their own general sexual offending issues knowledgeably. Along with the various forms of treatment should be offered at Kajang Jail, a psychiatrist visits each offender weekly to assess mental health and therapeutic progress. Psychotropic medications are rarely prescribed by the psychiatrist, and anti-androgens are even less likely to be used at Kajang Jail. Additionally, the psychiatrist does advise staff on treatment issues, and is available on a 24 hour on call basis. Kajang Jail offers an intensive therapy program within the time constraints of adolescent offenders' schedules. There is preliminary research available that shows that Kajang Jail Sexual Offender Treatment is successful at reducing recidivism. Recently, Kajang Jail staff have presented research on the recidivism rates of offenders who completed the Counterpoint House

Program and of those who did not (Ledi 2002b). In the study, an offender was considered to have recidivated if they received any further convictions or charges.

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