

**THERAPEUTIC TECHNIQUES PROVEN TO BE EFFECTIVE IN REDUCING  
RECIDIVISM RATES IN CHILD SEXUAL OFFENDERS**

**by**

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### **Abstract**

This literature review compared various therapeutic techniques typically utilized in the treatment of child sexual offenders (CSOs). Meta-analyses, literature reviews, and studies were utilized to help determine which intervention styles could help reduce recidivism rates in CSOs. Literature was also used to determine the demographics and cognitive processes of CSOs, and to understand the onset of such deviant sexual behaviour. Implicit theories such as sexual entitlement, offence supportive attitudes, and the thought of children as sexual objects are risk factors in offenders engaging in sexual deviancy towards children. Some additional risk factors are: cognitive distortions such as empathy deficits and blame attribution. Treatments found to positively impact this demographic are: cognitive behavioural therapy (CBT), hormonal treatment, risk-need-responsivity (RNR) model, trauma therapy for the offender, offender taking responsibility for actions, and victim empathy work. Additional factors which help the success of these interventions such as therapeutic alliance, group therapy, and the length of treatment will be discussed. This paper also includes a discussion of the gaps in research, as well as the implications for social work.



**List of Acronyms**

CBT - Cognitive Behavioural Therapy

CSO - Child Sexual Offender

RNR - Risk-Need-Responsivity



## **Introduction**

There is much controversy regarding the correctional and recidivism processes of child sexual offenders (CSOs) in our society today. Grady and Strom-Gottfried (2010) discuss the lack of research in this particular field, and state that it is due to a lack of researchers' interest, a lack of funding for such research, and the difficulty of researching numerous contributing factors which impact the behaviour of CSOs. Some therapeutic intervention strategies have been found to be effective when introduced individually, while other research states that such interventions would be best offered in group settings. Some professionals believe that hormonal therapy and castration are beneficial in reducing recidivism rates; however, others believe that such methods are inhumane and unethical. Another controversy is whether or not it is essential for the offender to take responsibility for their actions, as there is conflicting evidence which presents itself on this topic. Empathy work being included in the intervention process is another controversial topic as some believe it to be beneficial, while others state that there is not enough evidence to show this strategy's benefits. Although this is a topic which is undoubtedly sensitive, one must look at the reality of the current situation with CSOs, which is that they are generally, depending on their offences, reintegrated back into community. There is typically a requirement for CSOs to obtain a form of therapeutic intervention upon release into community. However, this is a controversial issue and there are conflicting reviews as to what intervention strategies are helpful to reduce recidivism rates.

This paper introduces the research question which is: what therapeutic techniques are proven to be effective in reducing the recidivism rates in CSOs? Some personal characteristics of CSOs that have been found throughout the research of this review, is that they are typically

males, adults, and individuals who have experienced sexual abuse in their past. Another characteristic of CSOs is that it is common for these individuals to either be family members or acquaintances of the victim. It is also more common for females to be victims of child sexual assault than males, with the average age of victims being 14 years old (466 per 100,000 population), (Statistics Canada, 2015).

It is essential that the outcomes and validity of these therapeutic strategies are widely understood within the professionals who work with CSOs, so that therapeutic intervention strategies which are being utilized with them effectively help to reduce recidivism rates. This will hopefully result in a reduction in incidences and the number of victims of child sexual assault. This paper will outline factors contributing to CSOs committing child sexual assault such as cognitive distortions and implicit theories, in the attempt to understand the emotional and cognitive processes that sometimes present within CSOs. This paper will also discuss the therapeutic environment, specifically what factors benefit the therapeutic process. If there is the expectation and hope that CSOs will integrate back into community with reduced rates of recidivism, it is essential for research to demonstrate which treatment methods will best support CSOs. As noted earlier, there is a lack of research in this area due to professional interest and funding. An area of concern regarding this lack of research is that certain therapeutic techniques continue to be used with sex offenders despite a lack of evidence to prove their effectiveness (Grady & Strom-Gottfried, 2010). This leads professionals to facilitate treatment with this specific population without having proper understanding of the impacts of treatment. This means that interventions are potentially being used with CSOs that might be causing more harm than good to both the offender and potential victims, which is an unethical way of practicing (Grady & Strom-Gottfried, 2010).

Social workers working with this demographic must understand which therapeutic techniques have been proven to help reduce recidivism rates with CSOs, as this demonstrates ethical practice. This is because it is the social worker's responsibility to ensure best practice and competency in practice with the populations with whom they work (BCASW, 2005). Grady and Strom-Gottfried (2010) discuss the concerns regarding the lack of evidence that demonstrates which therapeutic intervention strategies have proven to be consistently effective in reducing recidivism rates in CSOs, and call for more research to be done in this area so that professionals can adequately support CSOs. This application of knowledge will also likely have a positive impact on society as a whole. This is because CSOs pose as a risk to the public due to the community violence which they inflict, and if professionals have a better understanding of effective therapeutic intervention strategies to utilize in treatment, it might help to reduce recidivism rates. This may, in turn, result in fewer victims experiencing child sexual assault within our society.

### **Methods**

This paper provides a thematic review of the literature on effective therapeutic interventions used with CSOs. The selected research is peer-reviewed, and was found using Ebsco Host, an accredited post-secondary institution database. Articles from around the world were used in this review, with the majority of the articles coming from North America and the United Kingdom. Articles published within the years of 1996 to 2017 were used in this review. Initial attempts were made to include only recent articles, from the last 5-10 years. However, due to the limited nature of the research, the timeframe was widened in order to include a sufficient number of articles. Articles from journals in the fields of psychology, corrections, social sciences, social

work, behavioural therapy, criminology and psychiatry were included in this review. It is important to note the reasons why there is a lack of current research outlining this topic. Grady and Strom-Gottfried (2010) note the lack of researchers who are interested in such a topic, and state that there is a lack of funding for such research to be conducted. It was therefore deemed necessary to include older references in order to appropriately discuss the topic. Combinations of key terms used in the online search were “child sexual offenders”, “child molesters”, “hormonal therapy”, “cognitive-behavioural-therapy”, “offence supportive attitudes”, “implicit theories”, “characteristics”, “risk-need-responsivity”, “recidivism rates”, “therapeutic techniques”, “treatment”, “therapeutic interventions”, “cognitive distortions”, and “empathy”. The materials used to formulate this paper are meta-analyses, literature reviews, and studies, and a total of 30 sources are utilized. The articles’ abstracts were reviewed to determine their relevancy to the characteristics of CSOs, and whether or not the material helped explain either their cognitive processes or effectiveness of treatment. It was also essential for abstracts to be reviewed to ensure the articles discussed adult CSOs, as there were numerous articles found which focused on adolescent CSOs. The studies utilized in this design include participants who are both in custody as well as in community. This is relevant to gain a better understanding of the cognitive processes of the offenders after their convictions, and to determine how therapeutic interventions impact offenders’ recidivism after their release. Studies which discuss recidivism rates will be included in this paper; however, as noted by Martínez-Catena and Redondo (2017), it is important to include more than just recidivism rates, such as the methods of treatment and how such interventions help change behaviours in CSOs. Therefore, this paper will include both statistics on recidivism rates,

as well as an overview of therapeutic techniques and how they are implemented with CSOs to help reduce recidivism rates.

## **Findings**

There were some common themes found in the articles relating to CSOs which led to formulating main themes for this literature review paper. The first main theme that will be discussed is in regard to the personal characteristics of CSOs. Implicit theories which are common amongst CSOs will be the second theme discussed, with a specific focus on offence supportive attitudes, sexual entitlement, and the viewing of children as sexual objects. Although such implicit theories do not exist within all CSOs, the theories discussed are said to be widely prevalent in this population. Lastly, cognitive distortions will be discussed, specifically noting the topics of empathy deficits and blame attribution. Again, such distorted thought processes may not be relevant to each and every CSO, however the distortions discussed are commonly found in the CSO demographic.

## **CSO Characteristics**

A characteristic which was found in the CSO population was that it is common for such individuals to have experienced sexual abuse as a child themselves. D'Orazio (2013) states that there is a 30-70% chance that CSOs have experienced childhood trauma, a rate that is substantially higher than the typical person. Another finding is that CSOs are typically male. Statistics Canada (2015) states that in 2012, 97% of individuals who sexually offended a child were male, while 3% were female. Adams (2003) suggests that men are more prone to becoming offenders because of the way in which they are socialized in our society, adding that this socialization causes males to lack the ability to cope with their own sexual abuse. This means that because men are socialized to be tough and discouraged from speaking about or showing their emotions

towards sensitive topics, they are not provided with as many opportunities to cope with their own sexual abuse in a healthy manner. When examining the population of children who experienced sexual assault, 81% of this category consisted of males offending female children (Statistics Canada, 2015). In terms of the statistics regarding the age of the victims, in 2012, the average age of sexual assault victims was 14 years old (466 per 100,000 population). In terms of the age of offenders, in 2012, one-third of sexual offences towards children were committed by another youth, specifically occurring when the offender was 13 or 14 years of age. Furthermore, 51% of all individuals who were accused of sexually offending a child were over 25 years of age, reaching 61% when the victims were between the ages of 0-3. It is important to consider the relationship which the offender typically has with the victim as it is common for offenders to be a family member or an acquaintance of the victim. For example, in cases where the victim was under 12 years of age and the offender was between the ages of 12 and 17, the accused was proven to be a family member 56% of the time, and proven to be an acquaintance 37% of the time (Statistics Canada, 2015).

### **Implicit Theories**

Implicit theories within CSOs are underlying offence supportive attitudes that sexual offenders possess, which predispose them to engage in deviant behaviour (Pemberton & Wakeling, 2009). Pemberton and Wakeling (2009) claim that these implicit theories are, in a sense, distorted ways of thinking. The following section will outline some commonly found implicit theories within CSOs. This is an important aspect to discuss because this concept can help professionals working with CSOs understand how an individual's thought process may influence their deviant

behaviour. Although these implicit theories are not consistent for all CSOs, they are found to be present in a large portion of the population.

### **Sexual Entitlement**

CSOs typically demonstrate a sense of sexual entitlement toward their sexual needs and desires, which contributes to their sexual deviancies. Pemberton and Wakeling (2009) claim that it is common for such individuals to feel entitled to sex, which correlates to CSOs engaging in sexual deviant acts. Entitlement is said to be the most common implicit theory, which also contributes to the offence supportive perspectives of CSOs. These same researchers also state that children are at increased risk when CSOs demonstrate sexual entitlement (Pemberton & Wakeling, 2009).

Pemberton and Wakeling (2009) studied CSOs who were imprisoned in an England penitentiary due to their sexual offences, in the hopes of determining how such entitled thoughts contributed to their sexual offences. The authors analyzed the thoughts of offenders during the time of their offences with the use of inductive and deductive reasoning. The study's participants were involved in a CBT program, and the thoughts of the individuals at the time of their offence were clinically documented. The study categorized the offenders into groups: rapist, sexual murderers, extra familiar child offenders (offenders not related to their victims), and interfamilial child offenders (offenders related to their victims), to determine sexual entitled thoughts within CSOs. Major themes appeared, and these included: sex being the right of the offender, women and children being the property of the offender, the belief that only the offender mattered to themselves, and sex as a man's birthright. It was found that CSOs see themselves as "superior" to others, specifically their victims, which subsequently leads them to think that their needs should be met when and where they wish (Pemberton & Wakeling, 2009, p. 290). This is specifically true for incest offenders as the common perspective taken on by these CSOs is that they believe that their

daughters or stepdaughters are their own property, or that they deserve something in return for taking on a parenting role. This subsequently means they feel entitled to inflict the sexual abuse upon their victims. The study determined that practitioners who treat CSOs must incorporate treatment that addresses implicit theories such as entitlement because such belief systems are what contribute to attitudes supportive of deviant behaviour. The hope is that through such treatment, the attitudes of CSOs will be challenged and their justifications to their criminal behaviour will be addressed. Without addressing the concept that a CSO is entitled in the treatment process, such individuals are less likely to succeed at refraining from engaging in deviant criminal activity when reintegrating back into community (Pemberton & Wakeling, 2009). This leads us to believe that addressing these feelings of entitlement with CSOs could benefit the therapeutic process as it will allow the individual to observe their own perspectives and how such thought process might impact their victims.

### **Offence Supportive Attitudes**

Helmus and colleagues (2012) conducted a meta-analysis of 46 samples of quantitative studies to determine predicting factors of recidivism within CSOs. It was determined that there was a correlation between recidivism rates of CSOs and the attitudes towards sexual offending. More specifically, it was found that there could be a prediction of recidivism in offenders who displayed “attitudes supportive of sexual offending” (Helmus et al., 2012, p. 42). This means that individuals who have attitudes that minimize or are in favour of criminal behaviour, termed offence supportive attitudes, are more likely to re-offend. The meta-analysis also found that individuals who held attitudes which were supportive of sexual offending were also found to have

additional “offence-related constructs, such as deviant sexual interests, general pro-criminal attitudes, and hostility towards women” (Helmus et al., 2012, p. 47). It is therefore suggested by Helmus and colleagues (2012) that the treatment process of CSOs should include discussions and interventions surrounding offence supportive attitudes.

There are distinct factors mentioned by the authors that underpin offence supportive attitudes, including “the belief that sex with children is harmless and the belief that some children are sexually provocative” (Hempel et al., 2015, p. 36). The authors state that these offence supportive attitudes are a predicting factor for recidivism within CSOs, specifically noting that offence supportive attitudes are more widely present within CSOs than they are within non-offenders. It is also mentioned that these offence supportive attitudes lead CSOs to justify their sexual offending behaviour. This offending behaviour will likely continue to happen if the individual does not recognize how their behaviours impact and harm their victims (Hempel et al., 2015). Adams (2003) states that these distorted views towards child sexual abuse are typically addressed in treatment with the goal of reducing the chances of re-offending.

### **Children as Sexual Objects**

Offenders have certain implicit theories about their victims regarding their wants and needs which can be wrongfully interpreted (Burn & Brown, 2006). These false impressions of the victim’s preference can be what leads offenders to follow through with their deviant behaviour (Burn & Brown, 2006). Ward and Keenan (1999) second this concept as they suggest that these implicit theories “enable individuals to make inferences about what another person is probably experiencing and to predict his or her future actions” (p. 833). For example, the authors

state that CSOs often view their victims as sexual objects. CSOs also often believe that the victims are benefiting from the sexual deviant behaviour by thinking that the victim is enjoying the sexual act. The implicit theories that children are sexual objects cause CSOs to be selective with processing information in that they disregard any other interpretations of sexual deviant behaviour. In other words, CSOs will categorize children based on their implicit theories, which contributes to how the CSO treats their victims, and how they believe their victims to be feeling (Ward & Keenan, 1999). It is suggested that deciphering these implicit theories in the treatment process can be helpful, as these underlying beliefs are what often lead CSOs to assault their victims, and justify their actions (Gannon et al., 2007; Ward & Keenan, 1999).

Another example is that CSOs often believe that their actions did not cause the child any significant harm (Gannon et al., 2007). Furthermore, Hempel and colleagues (2015) suggest that CSO's "offence supportive cognition and levels of empathy" are contributing factors to such misinterpretations (p. 355). Such implicit theories have said to "facilitate decision making in the direction of sexual offending behaviour at an unconscious level" (Kamphuis et al., 2005, p. 1352). These unconscious decisions can occur as a result of an offender developing a certain theory about the victims, as well as themselves (Kamphuis et al., 2005). Ward and Keenan (1999) explain this further by saying that a CSO who believes their actions do not cause harm to children, is more likely to offend.

### **Cognitive Distortions**

Significant research has shown that cognitive distortions are very much relevant in the perceptions held by CSOs. The following section will outline a variety of cognitive distortions

that typically present themselves within adult male CSOs, and how such interpretations contribute to sexual offences. Burn and Brown (2006) state that the cognitive distortions that are present within CSOs are formed by such theories about their victims, themselves, and their overall worldview.

## **Empathy Deficits**

Empathy is a topic that is widely controversial within the professionals working with this population. Some researchers believe that CSOs lack the ability to express empathy, while other researchers state that empathy is situational within CSOs. For example, Burn and Brown (2006) state that CSOs do not demonstrate empathy in incidences involving the individuals they have sexually offended; however they can demonstrate empathy towards an accident victim.

Another example is that CSOs have shown an ability to demonstrate sensitivity towards their victims with respect to grooming; however this is done in a way that benefits themselves, not the victim. These examples allow us to see that CSOs' ability to demonstrate empathy is situational, meaning that it is typically only applied when it favours the CSO.

Martínez-Catena and Redondo (2017) also discuss the concept of empathy and state that CSOs typically have difficulty accurately determining the perspectives of their victims, specifically their wants and feelings, which are key aspects of empathy. These kinds of perspectives can also be said to contribute to CSOs experiencing difficulty determining what other people, specifically victims, are realistically thinking and feeling, which can undoubtedly contribute to acting in ways which could potentially harm the victim (Martínez-Catena & Redondo, 2017). For example, CSOs' inability to feel empathy towards their victim's pain and trauma from the assault, contributes to them having the ability to be sexually aroused by children (Burn & Brown, 2006). This is because, the offender is not considering the negative impacts that their behaviours are having on the child, therefore allowing permission for such arousal to occur instead of resisting such thoughts and behaviours. In other words, if a CSO were to demonstrate empathy towards

their victims, the empathy would prevent the deviant behaviour from occurring, as they would have a better understanding of the pain and trauma caused by the assault (Burn & Brown, 2006).

Brown and colleagues (2013) conducted a study which aimed to determine how empathy correlates to the cognitions and sexual offending behaviours of CSOs. The study took 50 interview transcripts of male participants who were serving time in custody for committing a child sex offence which were gathered from a previous study. The study used thematic analysis to help the researchers analyze the collected data, and found a common theme to be that participants created “psychologically comfortable positions that enabled them to offend and continue with their offending” by rationalizing their offending behaviour (Brown et al., 2013, p. 279). It is suggested that offenders “shift some of the responsibility for their actions” contributing to them having this “psychologically comfortable position” and inflicting a “role reversal, creating themselves as victims” (Brown et al., 2013, p. 280). This means that offenders would victimize themselves in an attempt to justify their actions instead of taking ownership for the damage they were causing. The authors state that CSOs would not only justify and rationalize their behaviour by viewing themselves as the victim, but also by seeking external factors such as being intoxicated at the time of the event. This does not necessarily mean that offenders lack the ability to express empathy, but instead that the need to use empathy is reduced due to the perceptions that offenders have towards their own behaviour (Brown et al., 2013). Adams (2003) takes a different perspective on empathy deficits, and states that such distorted perceptions “are maintained by the inability to feel empathy, or imagine what the victim is experiencing” (p. 82). Furthermore, if CSOs demonstrate an inability to use empathic responses in their human interactions, it is considered to be a contributing factor to them engaging in deviant sexual behaviour (Covell & Scalora, 2002).

Wood and Riggs (2008) also conducted a study based on empathy, and utilized two groups to do so; one included 61 CSOs on parole, and another was comprised of 51 individuals in community who had not been convicted of any type of crime. The study confirmed that empathy deficits predisposed individuals to become a CSO. Interestingly enough, the study indicated that CSOs might be faced with more challenges in demonstrating empathy for victims regardless of the treatment they receive. This could be because offenders demonstrate empathy deficits towards victims as a form of self-protection. In other words, demonstrating low levels of victim empathy through the use of denial or guilt can be a mechanism which offenders use to protect themselves from the contradictory feelings that might come up regarding their offending behaviour. It is suggested that CSOs should not be labelled as non empathetic because any development of empathy skills that an offender makes in treatment can then be viewed as progress. Wood and Riggs (2008) state that more longitudinal studies need to be implemented in order to help us see how deficits in empathy relate to CSOs. It is also suggested that larger samples of CSOs be included for professionals to have a better understanding of how deficits in empathy are represented in this population (Marshall & Maric, 1996).

### **Blame Attribution**

Blame attribution is a process in which the offender justifies their actions by placing blame on factors which prevents them from taking responsibility for their actions (Blumenthal et al., 1999). Blame attribution factors that exist in CSOs are; external factors such as the victim, mental element attribution such as a mental illness, or guilt feeling attribution. These three factors will be discussed in the following section. Blame attribution is said to be different than simply

having offence supportive attitudes. With blame attribution, the offender is acknowledging the deviancy of the act, but they are distancing themselves from the offence (Helmus et al., 2012). However, a correlation may exist; as more CSOs justify sexually offending children, there is a higher likelihood that they will blame the victim for the offence (Blumenthal et al., 1999).

Guilt feeling attribution is when the offender reports remorse, guilt or regret that they offended (Blumenthal et al., 1999). In order to reduce feelings of guilt or anxiety, the offender instead places blame on the victim. CSOs demonstrate a higher guilt feeling attribution than adult sexual offenders, due to the fact that sexual assaults against children carries more social disapproval. This means that the more an offence is judged by society, the more guilt feeling attributions the offender will have. External attribution, the process of offenders placing blame on their victim, is also seen to occur within CSOs. For example, offenders justify their actions by stating that the sexual experience was beneficial for the child, or that the child wanted to engage in such acts (Blumenthal et al., 1999). Gannon and colleagues (2007) discuss this process further and state that CSOs often make the statement that the child played a role in instigating the sexual acts. This means offenders place themselves in a psychologically comfortable position as they have distanced themselves from the offence and the negative feelings associated with it (Brown et al., 2013). Mental element attribution occurs when an offender blames their behaviour on a mental illness, or a loss of self control (Blumenthal et al., 1999). Offenders who blame their offences on mental factors do not experience a reduction in feelings of guilt, however, when an offender blames external factors, a reduction in guilt is experienced (Blumenthal et al., 1999).

Blumenthal and colleagues (1999) suggest that there may be such a high amount of distorted thinking in CSOs, and that they are not able to recognize societal expectations regarding

appropriate sexual behaviour. Research surrounding prevention therapy for CSOs shows that treatment to reduce cognitive distortions has been proven most effective. Further, CSOs have been known to have a high level of cognitive distortions as they typically do not view sexual encounters with children to be inappropriate (Blumenthal et al., 1999). It is important for professionals to have a thorough understanding of these underlying implicit theories because the distorted perceptions that CSOs have toward what their victims are thinking or wanting may lead them to behave in ways that might be harmful to the child.

### **Interventions**

The following section will include a variety of therapeutic interventions such as victim empathy work, addressing the offender's personal trauma, techniques which focus on the offender taking responsibility for their offences, cognitive-behavioural therapy (CBT), risk-need-responsivity (RNR), surgical castration and hormonal therapy. Through the analysis of meta-analysis and studies, this section will discuss how these methods are proven to be effective in reducing recidivism rates with CSOs.

#### **Victim Empathy Work**

Empathy is described as a skill which allows an individual to understand the feelings and/or the experience of another person. It is also the ability to appropriately provide a response based on what the feelings of the other person might be. Victim empathy work for CSOs is the process of imagining the trauma that the child is experiencing as a result of the sexual assault (Mathews & Collin-Vézina, 2016). Regardless of the findings which indicate that there is not a

strong link between recidivism and deficits in victim empathy, 90% of treatment centres for CSOs incorporate victim empathy work (Martínez-Catena & Redondo, 2017). This is an interesting finding and it is worth questioning why so many programs incorporate such perspectives. Empathy could help in the therapeutic process because “it is strongly correlated with self-esteem, shame, and cognitive distortions, possibly influencing each other in treatment improvement” (Martínez-Catena & Redondo, 2017, p. 43).

Martínez-Catena and Redondo (2017) conducted a study of 153 participants who were inmates in a Spanish penitentiary as a result of committing sexual offences. The goal of the study was to determine effective therapeutic interventions within this specific population. It was found that these individuals typically had difficulty accurately determining the perspectives and feelings of their victims, and that interventions utilized in therapy act to address these perspectives in order to “restructure cognitive distortions and crime justifications” (Martínez-Catena & Redondo, 2017, p. 43). Overall, treatment which addressed empathy deficits demonstrated positive results in terms of treatment effectiveness, as the “recidivism rate of treated sex offenders ranged from 9% to 11% compared with a rate of around 17% for untreated sex offenders” (Martínez-Catena & Redondo, 2017, p. 43). Blumenthal and colleagues (1999) add that in order to expect to see a decrease in recidivism within child sex offenders, it is important to implement “distorted attitudes and beliefs” in therapy with these individuals (p. 130).

Worling and Curwen (2000) conducted a study in Canada examining treatment used with CSOs which included 58 offenders who received treatment and 90 offenders who did not. Treatment methods including CBT, as well as methods to address sexual attitudes, denial, victim empathy, and accountability, were implemented in treatment consisting of at least twelve months.

Offenders who completed treatment, demonstrated to have a 72% reduction in sexual recidivism compared to participants who did not complete treatment. Specifically, incorporating victim empathy work in the treatment of CSOs was found to help reduce recidivism rates (Worling & Curwen, 2000).

Mathews and Collin-Vézina (2016) also discuss empathy work in treatment, and specifically mention that the incorporation of empathy work is recommended in order to reduce sexual assault against children. It is also said that CSOs can learn victim empathy with appropriate supports and that it is an essential component for practitioners to use in therapeutic intervention with this population (Mathews & Collin-Vézina, 2016). Covell and Scalora (2002) state that aggression and anti-social behaviour correlate to empathy, leading to the belief that incorporating empathy work with sex offenders helps to reduce “aggressive behaviour and hostile responses, and increases the occurrence of prosocial behaviour” (p. 253). Considering the relationship that aggression has with empathy, an increase in empathy could support the reduction of CSO offending as it would lead to them “resisting the impulse to abuse a child” (Mathews & Collin-Vézina, 2016, p. 309). This is because an increase in empathy within CSOs would likely help them to recognize the trauma that the sexual offence would inflict on the child (Mathews & Collin-Vézina, 2016).

An interesting point is made by D’Orazio (2013) in regard to the perceptions that practitioners have towards CSOs. It is recommended that practitioners consider their own perceptions of these individuals to ensure that they have empathy for the offender. D’Orazio (2013) claims this approach to be necessary for a practitioner to take because; “offenders will not see themselves differently until we do” (p. 6). Thus, it is valuable for the practitioner to place importance

on the emotional processes of the client in order for the client to feel understood and for them to be able to develop their ability to express empathy (D’Orazio, 2013).

Covell and Scalora (2002) state that there are some limitations in the implementation of empathy work. One concern is that it might lead offenders to simply understand how to *portray* empathy based on new awareness of the societal expectations. Another limitation is that it is unclear if implementing empathy work will actually “increase an offender’s ability to get close to his victims and ultimately facilitate the offence process” (Covell & Scalora, 2002, p. 264). Although empathy work is clearly a large part of the therapeutic process with CSOs, it is evident that more research must be conducted in order for professionals to determine the effectiveness of such interventions.

### **Client’s Personal Trauma History**

Adams (2003) discusses the importance of empathy for not only the victim, but for the CSOs themselves, as it is common for such offenders to have also experienced childhood sexual assault. Adams (2003) highlights the relationship that exists “between a person’s capacity to experience and express their own painful emotions and the capacity to respond sympathetically to the emotional pain of another person” (p. 82). This means that, without addressing their own trauma, CSOs are unable to feel empathy for their victims as there is a barrier to understanding the emotional impacts that childhood sexual assault can have on an individual (Adams, 2003). D’Orazio (2013) states that there is a 30-70% chance that CSOs have experienced childhood trauma. Martínez-Catena and Redondo (2017) add that CSOs “have more varied and atypical sexual experiences at an early age than is the norm, including violent pornography or actual

childhood experiences of physical or sexual abuse” (p. 42). These experiences can contribute to CSOs preferring violent sex as well as having deviant sexual thoughts. There is also a correlation between empathy deficits within CSOs and their early sexual experiences such as sexual abuse or violent pornography (Martínez-Catena & Redondo, 2017).

Worling and Curwen (2000) agree that in order to see a decrease in sexual offending in CSOs, it is essential for the offenders themselves to have a reduction in their own trauma-related distress. Without addressing such trauma, treatment meant to prevent relapse in CSOs will not be effective (D’Orazio, 2013). Utilizing a trauma-informed perspective, D’Orazio (2013) states that trauma stays in the individual’s body causing “excessive self-focus and dysregulation greatly impacting the structure and function of the brain” (p. 5). The author claims that an individual who has not yet been able to deal with the abuse that they have experienced, will then turn these unmet needs and conflicting feelings into aggression, therefore making them the abuser. An effective therapeutic approach in addressing such issues within abusers is to respond in an empathic way to the individual’s trauma so as to build trust in the helping relationship and to help foster acceptance of the individual. With these techniques in mind, it is thought that the client will become less psychologically defensive and be less prone to denying or avoiding the topic at hand. D’Orazio (2013) believes that when these therapeutic techniques are used, the individual often displays more empathy for others, which then facilitates motivation to change abusive patterns.

**Taking Responsibility**

In the beginning stages of treatment, a common approach is for CSOs to take responsibility for the sexual offences they have been convicted of (McGrath et al., 2010). Offenders commonly deny their deviant sexual behaviour, and this denial is viewed at by professionals as a barrier to providing treatment. CSOs accepting responsibility for their sexually abusive behaviour is an approach used in treatment as there is the belief that an individual must admit that there is a problem before the problem can be addressed (McGrath et al., 2010). CSOs typically place themselves in psychologically comfortable positions which supports their belief that the victim is not being harmed and consents to the acts (Helmus et al., 2012). This allows the offender to separate themselves from the deviant sexual behaviour and not take responsibility for it (Helmus et al., 2012, p. 35). Treatment geared towards helping the offender take responsibility for their actions is important because individuals who minimize their offending behaviour are actually at a higher risk of reoffending (McGrath et al., 2010).

Yet, conflicting evidence presents itself within this discussion. As mentioned above, taking responsibility for sexual offences is considered by some clinicians and researchers to be helpful, or even essential, in the treatment process. However, Marshall and colleagues (2011) state otherwise, noting that individuals who take responsibility for their sexual offences actually have a higher likelihood of reoffending than individuals who make excuses for their offences. A study was conducted in Canada which included 58 offenders who received treatment and 90 offenders who did not, in order to examine the effectiveness of treatment provided to CSOs (Worling & Curwen, 2000). Treatment included CBT, as well as methods to address sexual attitudes, accountability, victim empathy, and denial. It was found that the group of offenders who completed

treatment consisting of at least 12 months, displayed a 72% reduction in sexual recidivism compared to the participants who did not (Worling & Curwen, 2000). This helps us see the positive impact that taking accountability for one's actions can have in the treatment process with CSOs. Marshall and colleagues (2011) explain that those who tend to make excuses for their offences are acknowledging that their behaviour is deviant. Thus, some researchers presume that CSOs who deny their crimes are displaying protective factors, placing individuals who admit their crimes in a higher risk category. This means that individuals may not feel compelled to make excuses for their behaviour because such deviant acts are parallel to their usual characteristics. Furthermore, research states that when determining the number of CSOs who reoffend after treatment, those who deny their crimes are said to have lower recidivism rates than individuals who admitted their offences (Marshall et al., 2011).

Interestingly enough, Brown and colleagues (2013) mention how it was a common theme for participants to admit their wrong-doings only after they had been convicted instead of during the process of offending, leaving one to see how they are only accepting responsibilities based on their convictions. Brown and colleagues (2013) question whether or not offenders state that their behaviour is inappropriate only after being labelled as a sex offender in the hopes of following through with what responses would be deemed acceptable by society. This contradictory evidence signals that there is a need for more research to be conducted in order to have a better understanding on the role of taking responsibility and whether or not this is something that should be incorporated into treatment with CSOs.

### **Cognitive Behavioural Therapy**

In discussing cognitive distortions and therapy to address such implicit theories, it is essential that we examine aspects of CBT and how such interventions might help to reduce recidivism rates in CSOs.

Yates (2013) states that the utilization of CBT in the treatment of CSOs is the most widely used therapy that has the most empirical evidence in terms of reducing recidivism rates. The author states that a CBT lens views sexual deviancy as the result of thoughts, emotions, and behaviours which have been learned through observation, implicit theories and attitudes towards sexual deviancy. The goal in utilizing CBT with CSOs is for such thoughts and behaviours to be altered and “replaced with adaptive, non-deviant, pro-social responding” (Yates, 2013, p. 90).

Polizzi and colleagues (1999) evaluated 21 CSO treatment programs, which were offered both in-prison and non-based prison settings in the United States. It was found that the programs based outside of prison that incorporated CBT interventions helped to reduce recidivism rates for CSOs, however the prison-based treatment programs did not demonstrate enough evidence to prove that such interventions are effective. It was also determined that only 50% of treatment programs demonstrated findings that were in favour of therapeutic intervention strategies such as CBT. Another finding was that 4.7% of CSOs who had received CBT while in custody reoffended once released into community, in comparison to the control group which demonstrated a 6.2% reoffending rate (Polizzi et al., 1999).

Martínez-Catena and Redondo (2017) claim that the initial goal of clinical interventions for CSOs is to facilitate “internal changes” within the individual (p. 43). The authors state the ways in which CBT works to change the offenders’ perceptions, is by improving their level of

empathy, their assertiveness and their self-esteem. This form of therapy also changes the individual's interpretation of the crimes they committed to one that is more realistic, in that it works to help the offender recognize the impact that their behaviour has on their victim (Martínez-Catena & Redondo, 2017).

Aytes and colleagues (2001) conducted a study to determine the effectiveness that CBT has on CSOs, and obtained data from individuals who had participated in group therapy for an average of two to three years at a treatment centre in the United States. The study included a group of sex offenders who did not receive treatment, and a group of nonsexual offenders. This was a mandated program operated through a community corrections department. The study's goal was to determine if CBT would help reduce recidivism rates in CSOs. The program utilized aspects of CBT with the hopes of addressing deviant sexual thoughts and behaviours and implementing elements of control which the individual could then utilize to maintain any behavioural changes that occurred through treatment. It was determined that individuals who completed the treatment had reduced rates of reoffending in comparison to the group which did not receive any treatment. More specifically, individuals who stayed in the treatment program for over one year demonstrated even lower recidivism rates. The author claims that implementing a longer treatment process, which is naturally more intense, could potentially help to increase the chances of a reduction in recidivism rates within CSOs. It is important to mention that individuals who dropped out of the group process demonstrated higher rates of recidivism than those who remained in the group (Aytes et al., 2001).

Mpofu and colleagues (2016) conducted a literature review of the effectiveness that CBT has on reducing recidivism rates within CSOs who were seen as moderate to high risk. A moder-

ate to high risk offender is an offender who has anti-social personality traits and who engages in lifestyle risks such as being exposed to criminogenic settings, having negative peer associations, or substance abuse. The review included 10 studies which implemented CBT approaches with male CSOs, and the discussion of comparative interventions in the attempt to determine CBT's effectiveness. It was found that there were lower recidivism rates within groups which utilized CBT approaches, specifically that such groups demonstrated a recidivism rate of 10.25% whereas compared groups demonstrated a sexual recidivism rate of 17.67% (Mpofu et al., 2016). The findings from this study speak to the impact that CBT can have on the treatment process of CSOs, as such interventions clearly have an impact on reducing recidivism rates in this demographic. Kamphuis and colleagues (2005) also state that addressing the cognitive process within CSOs could play a role in reducing recidivism in CSOs; however, it is noted that more research must be completed in order to prove this hypothesis. More research needs to be done with CSOs to help them recognize their own thought processes as well as how to address their cognitive processes and distortions in order to prevent the individual from re-offending.

### **Risk-Need-Responsivity**

Another intervention with CSOs is risk-need-responsivity (RNR). RNR is a model used to develop recommendations on how offenders should be assessed and treated in order to reduce recidivism rates. Risk, the first principle of the model, is when treatment programs offer intensive interventions to clients who demonstrate to be moderate to high risk (Hanson et al., 2009). Some factors that impact the behaviour of high risk offenders are anti-social personality traits, negative peer associations, unstable employment, substance use, and propensity to hostility

(Hanson et al., 2009). Yates (2013) describes the risk aspect of the model to emphasize the need for certain interventions with CSOs to be relevant to the level of risk which the offender is at. This is because offenders are at a greater risk of recidivism if the level of intensity of the treatment does not align with the level of risk of the offender. This means that if an individual is at a higher risk of offending, it is essential for treatment to be lengthier and offered at a higher intensity level than if an individual was deemed to be low risk. It is suggested that the best way to ensure there is a reduction in recidivism rates in CSOs, is for those who are at moderate risk of reoffending to receive moderate intensity intervention, and for those who are at high risk of reoffending, to receive more intensive treatment intervention. This would appropriately align the needs of the offenders with the most suitable treatment offered (Yates, 2013).

Need, the second principle, is based on criminogenic needs, meaning the characteristics of an individual that predispose them to offending and reoffending (Hanson et al., 2009). Examples of some needs are limited social skills, cognitive delay, substance use, and/or deviant sexual desires (Hanson et al., 2009). Other criminogenic needs could also be malevolence towards women, impulsivity and intimacy deficits (Martínez-Catena & Redondo, 2017). Some perspectives toward treatment focus on reducing risk factors in order to determine how to reduce recidivism risk. However, the authors suggest that the focus should instead be on the criminogenic needs of the individual as this is what is typically associated with an increased risk in offending. For example, Martínez-Catena and Redondo (2017) state that when issues such as self-esteem or loneliness get addressed in treatment, there is a correlation to decreased aggression and poor impulsivity, which are specific criminogenic needs. Houtepen and colleagues (2016) conducted a study including 15 participants who self-disclosed as pedophiles, and it was found that risk fac-

tors of offending included offenders not being able to self-regulate, as well as a lack of healthy coping strategies that help prevent them from engaging in such actions.

Yates (2013) also discusses the criminogenic needs that tend to increase risk in offending, and adds that having an “antisocial lifestyle” and presenting with “deviant sexual interests” are two of the most prevalent predictors of such reoffending (p. 90). Again, this means prioritizing criminogenic needs potentially leads to an increase in healthy behaviour which could subsequently lead to reduced risk (Martínez-Catena & Redondo, 2017). The need principle of the model can be attributed to clients who are either mandated for treatment, or who are voluntarily accessing such supports. For example, Lösel and Schmucker (2005) discuss the effectiveness of voluntary treatment and state that recidivism rates are lower amongst such groups of CSOs. Those who are mandated to seek treatment are at a higher risk of reoffending, often because the goals of the group do not fit the needs of the client (Lösel & Schmucker, 2005).

The last aspect of the RNR model is responsivity, which is when treatment programs are designed to meet the learning styles and cognitive abilities of the offender so that all program participants have an equal opportunity to understand and retain treatment materials (Hanson et al., 2009). Lösel and Schmucker (2005) state that recidivism rates have been said to increase when CSOs drop out of the treatment program, which speaks to the importance of the treatment process needing to fit the needs of the individual. Lösel and Schmucker (2005) encourage this risk of reoffending to be viewed as a result of the program not meeting the needs or motivations of the individual instead of blaming the individual for not cooperating or succeeding at not reoffending again. For example, it has been found that group therapy for CSOs is not suitable for individuals who are experiencing psychosis, have low cognitive functioning, or who are disruptive

to the group behaviour (McGrath et al., 2010). In such cases, a therapeutic process catered to the ability of individuals might be of more benefit.

Hanson and colleagues (2009) conducted a meta-analysis of 23 recidivism outcome studies to determine the usefulness of RNR in treatment programs, and found that recidivism rates were lower in individuals who received interventions which followed the RNR model, than that of comparison groups. The meta-analysis concluded that when a treatment plan follows all three principles of the RNR model, there is an increase of treatment effectiveness. Furthermore, the meta-analysis found that when treatment interventions followed some but not all principles of the RNR model, treatment effectiveness decreased. This speaks to the need for the whole model to be followed during treatment, and not just aspects on their own. It was also found that programs which focus on criminogenic needs such as substance use and criminal attitudes, have a higher likelihood of reducing recidivism rates in CSOs (Hanson et al., 2009). Furthermore, programs which implement a level of skill development such as developing insights toward prosocial behaviours and practicing certain strategies which have been modelled to them, have higher success with reducing recidivism rates (McGrath et al., 2010). More specifically, Martínez-Catena and Redondo (2017) state that programs which offer CBT methods formulated with the RNR model in mind, prove to be the most effective in treatment with CSOs.

### **Surgical Castration and Hormonal Therapy**

Surgical castration and hormonal therapy also impact an individual's sexual deviant behaviour and their likelihood to reoffend. McGrath and colleagues (2010) discuss such hormonal aspects in CSOs, and state that these individuals often struggle with sexual arousal problems

which contribute to a higher sex drive, and are often aroused by deviant sexual activities. Lösel and Schmucker (2005) mention that while it has been proven that male CSOs do not have higher than usual male sex hormones, taking specific hormonal medication such as Medroxyprogesterone Acetate or Cyproterone Acetate significantly reduces levels of sexual arousal. McGrath and colleagues (2010) add that in addition to the above listed medications, Luprolide Acetate and Selective Serotonin Reuptake Inhibitors are commonly used to treat CSOs as they help to decrease their sex drive as well as lessen the intensive sexual thoughts that they may have. Kim and colleagues (2015) add that Depo-Provera is sometimes used with CSOs as this medication has proven to help with reducing the physiological aspects which help drive individuals from involving themselves in such sexual deviant behaviour.

Lösel and Schmucker (2005) created a meta-analysis of studies comparing treated and untreated sex offenders, specifically evaluating CBT, surgical castration and hormonal treatment. It was found that when individuals received a combination of psychological and medical modes of treatment, they demonstrated 37% less reoffending rates than individuals who did not receive treatment. More specifically, the authors state that such interventions proved to help reduce recidivism rates in CSOs more so than alternative psychosocial treatments. Interestingly enough, Lösel and Schmucker (2005) found that hormonal therapy was found to have more of an impact on reducing recidivism rates than did psychosocial treatments, however when combined, these two interventions proved to be the most promising. Kim and colleagues (2015) mention that surgical castration along with hormonal treatment has proven to reduce recidivism rates in CSOs. McGrath and colleagues (2010) suggest that such medications can help to “regulate mood, reduce sex drive, and reduce sexually obsessive thoughts” (McGrath et al., 2010, p. 74).

It is important to mention however, that such medications can have negative side effects which can cause CSOs to drop out of the treatment process (Lösel & Schmucker, 2005). This can subsequently lead to increased risks of reoffending, so it is suggested that such an intervention only be used in conjunction with other therapeutic interventions such as CBT, and when there are concerns of deviant sexual arousal (Lösel & Schmucker, 2005). McGrath and colleagues (2010) second this statement, as it is mentioned that while such medication can help CSOs obtain some amount of control over their sexual urges, it is not seen to be an effective treatment plan without the help of psychosocial treatments. Kim and colleagues (2015) call for more studies to determine the effects of castration and hormonal treatment for CSOs, specifically because such interventions are viewed at by many as unethical. This is because such treatment methods can be seen to violate human rights as well as take on more of a punitive role, rather than a treatment role (Kim et al., 2015). As we can see, more research is needed in the area of hormonal treatment and surgical castration to determine the effectiveness this has on reducing recidivism rates in CSOs, and whether or not this is a suitable form of intervention for this demographic.

### **Therapeutic Environment**

#### **Group vs. Individual Therapy**

It is important to note the effectiveness of group therapy as McGrath and colleagues (2010) state that the majority of treatment programs utilize group therapy when working with CSOs. Some of the advantages of group therapy as outlined by the authors, is that offenders are more likely to be receptive to feedback from group participants than they are from therapists alone. Another advantage of group therapy is that group dynamics simply are more economically

friendly than individual therapy. A third advantage of group work with CSOs is that it gives participants a chance to practice social skills, something that has been noted to be typically lacking in CSOs. It is important to note that at times CSOs can negatively influence each other. For example, low risk offenders can at times be placed in the same group as high risk offenders, which as discussed earlier can pose as a risk due to there being a variety of criminogenic needs requiring to be met through just one method. It is therefore essential for professionals to recognize the needs of the client before introducing a treatment plan (McGrath et al., 2010). This means that although group therapy may be the form of treatment that is most widely offered, it does not necessarily mean that it is what fits everyone's needs. Mpofu and colleagues (2016) note that while group therapy is widely offered within the demographic of CSOs, some studies show that when group interventions are combined with individual interventions, the therapeutic process can actually be more effective. These same authors suggest that more research be conducted to determine the helpfulness of combining group and individual therapy in the treatment of CSOs (Mpofu et al., 2016).

### **Length of Treatment**

As discussed earlier, it is essential to ensure that the forms of treatment align with the particular needs of the offender if one hopes to have successful outcomes from treatment. This leads to discussions surrounding the length of treatment and what has been effective for such a demographic. Yates (2013) states that determining the length of treatment relies on where the individual presents in terms of risk. Individuals who are at a higher risk of reoffending typically benefit from 300 contact treatment hours (combination of psychological and medical treatments).

Those who are at a moderate risk benefit from 200 contact treatment, and CSOs who are at a low risk of reoffending have proven to benefit from 100 contact treatment hours (Yates, 2013).

Again, it is essential for practitioners to determine the level of risk that the individual presents with, and also effectively determine the criminogenic needs of the client before proceeding with treatment if there is the expectation that treatment will help to reduce recidivism rates in CSOs.

### **Therapeutic Alliance**

Yates (2013) discusses the importance of establishing a healthy therapeutic alliance, and adds that the characteristics of a therapist are extremely important in determining treatment outcomes. Characteristics that have said to be impactful are; genuineness, warmth, empathy, demonstrating interest in the therapeutic process with the client, as well as demonstrating respect to the client. Furthermore, CSOs can be more cooperative with the treatment process and motivated to participate and stay in treatment if the environment is healthy and motivating. It is important that aspects of the therapeutic environment are taken into consideration as this can influence an individual's willingness to complete the treatment program. Creating a treatment program which motivates CSOs to participate and complete is essential as individuals who complete treatment are at a lower risk of reoffending than individuals who drop out of treatment (Yates, 2013).

### **Implications for Social Work**

Understanding which therapeutic intervention strategies are effective in reducing recidivism rates with CSOs is essential for social work practice because there are professionals in the field who work directly with this population both in custody and in community. In order to en-

sure best practice, it is important that social workers utilize interventions which are evidence based with this population. Providing treatment which is not evidence based, means social workers could be inflicting more harm than good to both the offender as well as society. This is because if offenders are released into community without proper treatment, they can pose as a risk to community members. According to the BCASW (2005) Code of Ethics, it is the social worker's responsibility to ensure best practice and competency with the populations with whom they work, and ensuring that evidence based research makes up the foundation of intervention strategies aligns with this principle. As mentioned in this review, there appears to be a significant amount of conflicting research for this population in general. This allows us to see how important it is for social workers to recognize the need for more research in this particular area, as this will help determine the effectiveness of current or potential intervention strategies with CSOs. This aligns with the BCASW (2005) Code of Ethics as this demonstrates advocating for change in the best interest of the client and overall society.

### **Conclusion**

In examining the thought process of CSOs, one can see that cognitive distortions, offence supportive attitudes, empathy deficits, blame attribution, entitlement, and implicit theories contribute to deviant sexual behaviours. Treatments which have found to be helpful with such a demographic are: RNR, the client's taking responsibility for their own offences, victim empathy work, addressing the client's own trauma history, castration and hormonal therapy, and CBT. A major theme that surfaced is the perception that CSOs have towards sexual assault and how this

perception impacts their likelihood of reoffending. These cognitive distortions are said to heavily impact an individual's likelihood of reoffending, however numerous studies demonstrate the need for more research on this. Another theme was the importance for professionals to determine the needs of the individual before establishing a treatment plan in order for interventions to be of benefit to the individual.

Empathy deficits in CSOs proved to be a large contributing factor to the likelihood of sexual offences towards children, although there appears to be some discrepancies as to whether or not incorporating empathy in the treatment of CSOs is effective. It was found that more research is needed in order to determine the presence of empathy deficits in CSOs, and whether implementing empathy work helps to reduce recidivism rates in this demographic. Some researchers recommend that in order to accurately determine this, larger sample sizes are needed, along with more longitudinal studies. Strategies such as ensuring CSOs take responsibility for their crimes also has conflicting evidence as to whether such interventions are risky or beneficial. More research needs to be done to determine if this would be a helpful focus of treatment with CSOs. Combining intervention strategies such as CBT as well as empathy therapy appear to be the most common form of treatment for CSOs, however further exploration using longitudinal studies which incorporate both of these perspectives is essential in order to have more conclusive statements about the efficacy of these approaches. Surgical castration and hormonal therapy have proven to be effective in reducing recidivism rates, however there is controversy with these topics due to ethical concerns. Professionals could benefit from research which outlines the outcome and impacts of such intervention strategies.

The therapeutic environment was also something that was said to be something that impacts recidivism rates, specifically the length of treatment, the therapeutic alliance, as well as treatment being offered in a group or individual setting. More research could be done to determine the effectiveness of combining group and individual therapy with CSOs. More research is also recommended to determine the theories of sexual offending, as it is mentioned that having a better understanding of this will help with the assessment and intervention process of working with CSOs. Overall, it can be determined that more research is needed in order to see how such techniques could benefit treatment programs and help prevent CSOs from reoffending. It is essential for social workers to utilize therapeutic intervention strategies that are evidence based, as not doing so is not only unethical, it could inflict more harm to the client and society than good. This is because if offenders are released into community without proper treatment, they can pose as a risk to community members. As controversial as the topic of CSOs are, social workers must continue to advocate for more research that helps to determine which intervention strategies best help to reduce recidivism rates with this population as this is in the best interest of the client and society overall.

## 8. References

- Adams, M. J. (2003). Victim Issues Are Key to Effective Sex Offender Treatment. *Sexual Addiction & Compulsivity*, 10(1), 79–87. doi: 10.1080/10720160309046
- Aytes, K. E., Olsen, S. S., Zakrajsek, T., Murray, P., & Ireson, R. (2001). Cognitive/Behavioral Treatment for Sexual Offenders: An Examination of Recidivism. *Sexual Abuse: A Journal Of Research And Treatment*, 13(4), 223–231. Retrieved from <https://search-ebshost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=mnh&AN=11677924>
- BCASW Code of Ethics. (2005). Retrieved from [https://www.bcasw.org/wp-content/uploads/2011/09/CASW\\_Code-of-Ethics\\_e.pdf](https://www.bcasw.org/wp-content/uploads/2011/09/CASW_Code-of-Ethics_e.pdf).
- Blumenthal, S., Gudjonsson, G., & Burns, J. (1999). Cognitive distortions and blame attribution in sex offenders against adults and children. *Child Abuse & Neglect*, 23(2), 129–143. doi: 10.1016/s0145-2134(98)00117-3
- Brown, S. J., Walker, K., Gannon, T. A., & Keown, K. (2013). Creating a psychologically comfortable position: The link between empathy and cognitions in sex offenders. *Journal of Sexual Aggression*, 19(3), 275–294. doi: 10.1080/13552600.2012.747223
- Burn, M. F., & Brown, S. (2006). A review of the cognitive distortions in child sex offenders: An examination of the motivations and mechanisms that underlie the justification for abuse. *Aggression and Violent Behavior*, 11(3), 225–236. doi: 10.1016/j.avb.2005.08.002
- Covell, C. N., & Scalora, M. J. (2002). Empathic deficits in sexual offenders. *Aggression and Violent Behavior*, 7(3), 251–270. doi: 10.1016/s1359-1789(01)00046-5

- D'Orazio, D. M. (2013). Lessons learned from history and experience: Five simple ways to improve the efficacy of Sexual Offender Treatment. *International Journal of Behavioral Consultation and Therapy*, 8(3-4), 2–7. doi: 10.1037/h0100975
- Gannon, T. A., Ward, T., & Collie, R. (2007). Cognitive distortions in child molesters: Theoretical and research developments over the past two decades. *Aggression and Violent Behavior*, 12(4), 402–416. doi: 10.1016/j.avb.2006.09.005
- Grady, M. D., & Strom-Gottfried, K. (2010). No Easy Answers: Ethical Challenges Working with Sex Offenders. *Clinical Social Work Journal*, 39(1), 18–27. doi: 10.1007/s10615-010-0270-9
- Hanson, R. K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). The Principles of Effective Correctional Treatment Also Apply To Sexual Offenders. *Criminal Justice and Behavior*, 36(9), 865–891. doi: 10.1177/0093854809338545
- Helmus, L., Hanson, R. K., Babchishin, K. M., & Mann, R. E. (2012). Attitudes Supportive of Sexual Offending Predict Recidivism. *Trauma, Violence, & Abuse*, 14(1), 34–53. doi: 10.1177/1524838012462244
- Hempel, I. S., Buck, N. M. L., Vugt, E. S. V., & Marle, H. J. C. V. (2015). Interpreting Child Sexual Abuse: Empathy and Offense-Supportive Cognitions among Child Sex Offenders. *Journal of Child Sexual Abuse*, 24(4), 354–368. doi: 10.1080/10538712.2015.1014614
- Houtepen, J. A. B. M., Sijtsema, J. J., & Bogaerts, S. (2016). Being Sexually Attracted to Minors: Sexual Development, Coping With Forbidden Feelings, and Relieving Sexual

- Arousal in Self-Identified Pedophiles. *Journal of Sex & Marital Therapy*, 42(1), 48–69.  
doi: 10.1080/0092623x.2015.1061077
- Kamphuis, J. H., Ruiter, C. D., Janssen, B., & Spiering, M. (2005). Preliminary Evidence for an Automatic Link Between Sex and Power Among Men Who Molest Children. *Journal of Interpersonal Violence*, 20(11), 1351–1365. doi: 10.1177/0886260505278719
- Kim, B., Benekos, P. J., & Merlo, A. V. (2015). Sex Offender Recidivism Revisited. *Trauma, Violence, & Abuse*, 17(1), 105–117. doi: 10.1177/1524838014566719
- Lösel, F., & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology*, 1(1), 117–146. doi: 10.1007/s11292-004-6466-7
- Marshall, W. L., & Maric, A. (1996). Cognitive and Emotional Components of Generalized Empathy Deficits in Child Molesters. *Journal of Child Sexual Abuse*, 5(2), 101–110. doi: 10.1300/j070v05n02\_06
- Marshall, W., Marshall, L., & Kingston, D. A. (2011). Are the cognitive distortions of child molesters in need of treatment? *Journal of Sexual Aggression*, 17(2), 118–129. doi: 10.1080/13552600.2011.580572
- Martínez-Catena, A., & Redondo, S. (2017). Psychological treatment and therapeutic change in incarcerated rapists. *The European Journal of Psychology Applied to Legal Context*, 9(1), 41–49. doi: 10.1016/j.ejpal.2016.11.001
- Mathews, B., & Collin-Vézina, D. (2016). Child sexual abuse: Raising awareness and empathy is essential to promote new public health responses. *Journal of Public Health Policy*, 37(3), 304–314. doi: 10.1057/jphp.2016.21

McGrath, R. J., Cumming, G. F., Burchard, B. L., Zeoli, S. undefined, & Ellerby, L. undefined.

(2010). *Current practices and emerging trends in sexual abuser management: The Safer Society 2009 North American Survey*. Brandon, VT: Safer Society Press. Retrieved from <https://search-ebscohost-com.proxy.ufv.ca:2443/login.aspx?direct=true&db=psyh&AN=2013-22252-000>

Mpofu, E., Athanasou, J. A., Rafe, C., & Belshaw, S. H. (2016). Cognitive-Behavioral Therapy Efficacy for Reducing Recidivism Rates of Moderate- and High-Risk Sexual Offenders: A Scoping Systematic Literature Review. *International Journal of Offender Therapy and Comparative Criminology*, 62(1), 170–186. doi: 10.1177/0306624x16644501

Pemberton, A. E., & Wakeling, H. C. (2009). Entitled to sex: Attitudes of sexual offenders. *Journal of Sexual Aggression*, 15(3), 289–303. doi: 10.1080/13552600903097212

Polizzi, D. M., Mackenzie, D. L., & Hickman, L. J. (1999). What Works in Adult Sex Offender Treatment? A Review of Prison-and Non-Prison-Based Treatment Programs. *International Journal of Offender Therapy and Comparative Criminology*, 43(3), 357–374. doi: 10.1177/0306624x99433008

Statistics Canada. (2015). Police-reported sexual offences against children and youth in Canada, 2012. Retrieved from <https://www150.statcan.gc.ca/n1/pub/85-002-x/2014001/article/14008-eng.htm#a9>

Ward, T., & Keenan, T. (1999). Child Molesters Implicit Theories. *Journal of Interpersonal Violence*, 14(8), 821–838. doi: 10.1177/088626099014008003

Wood, E., & Riggs, S. (2008). Predictors of Child Molestation. *Journal of Interpersonal Violence*, 23(2), 259–275. doi: 10.1177/0886260507309344

Worling, J. R., & Curwen, T. (2000). Adolescent sexual offender recidivism: success of specialized treatment and implications for risk prediction. *Child Abuse & Neglect*, 24(7), 965–982. doi: 10.1016/s0145-2134(00)00147-2

Yates, P. M. (2013). Treatment of sexual offenders: Research, best practices, and emerging models. *International Journal of Behavioral Consultation and Therapy*, 8(3-4), 89–95. doi: 10.1037/h0100989