

# Supervision of Sex Offenders

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## Supervision of Sex Offenders – Training Agenda

- Overview of Psychological Assessment and Risk Assessment
- Individual Risk Factors in Supervision
- Ongoing Risk Assessment throughout Supervision
- Offense Cycle Dynamics
- Containment Model



## Rules

- Ask questions throughout
- All slides are in handouts
- Feel free to call or email me after the presentation with any questions
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## About your presenter

- Working with sex offenders since 1983
- Johnson, Leavenworth & Miami Counties
- State of Kansas Sexual Predator Transition Program
- Federal Bureau of Prisons & Federal Probation and Parole
- Clinical Associates, P.A.
  - Multi-disciplinary group
  - About 15 practitioners
- ATSA Clinical member
- Evaluation and Forensic Experience

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### How a pre-sentence sex offender evaluation figures into subsequent supervision issues

- Intellectual
- Educational
- Overall Function
- Personality and Mental Health
- Social
- Developmental
- Family
- Current Status
- Sexual Issues
- Delinquency and Conduct
- Risk Assessment
- Risk and Protective Factors in the Community
- Awareness of Victim Impact
- Relapse Prevention Resources
- Amenability to Treatment

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### Juvenile Risk Assessment Measures

- ERASOR II- Estimate of Risk of Adolescent Sexual Offense Recidivism
- J-SOAP II – Juvenile Sex Offender Assessment Procedure
- J-RAT – Juvenile Risk Assessment Tool
- Older Adolescents – SORAG Sex Offense Risk Assessment Guide
- Older Adolescents – VRAG Violence Risk Assessment Guide
- Psychopathy Check List - Youth Version – PCL-YV (special training needed)

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### **Adult Risk Assessment Measures**

- SORAG Sex Offense Risk Assessment Guide
- VRAG Violence Risk Assessment Guide
- Psychopathy Check List II - PCL-II (special training needed)
- STATIC 99
- RRASOR – Rapid Risk Assessment for Sex Offense Recidivism
- MnSORT-R – Minnesota Sex Offender Screening Tool – Revised
- SONAR – Sex Offender Needs Assessment Rating
- Relevant Research and Other Resources

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### **6 types of methodologies**

- Unguided clinical judgment
- Guided clinical judgment
- Clinical judgment based on anamnestic (medical history) approach
- Research guided clinical judgment
- Clinically adjusted actuarial approach
- Purely actuarial approach

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## Unguided clinical judgment

- Review case materials
- No significant theory  
prioritizing importance of the  
data obtained
- Each judgment unique

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## Guided clinical judgment

- Start with ideas about  
importance
- Clinician's own ideas
- Without research support
- More consistent than unguided  
in theory

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Clinical judgment based on  
anamnestic approach

- Based on medical history
- *a priori* list of factors for consideration and weighting
- Research supported

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Research guided clinical judgment

- Analyze life history to find factors of importance relative to historically documented risk
- Examine degree to which those conditions still exist
- Uses individual's own history as guide to recidivism

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### Clinically adjusted actuarial approach

- Actuarial instruments
- Potential adjustment to actuarial results based on clinically derived considerations
- Hopefully research based

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### Purely actuarial approach

- Most mechanical approach
- Actuarial instruments with no adjustments
- Consistent results
- Can be utilized by non-professionals or para-professionals with training
- This is what we are here for today
- You will be able to employ these methods based on your training today

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## Clinical vs Actuarial

- Studies of sex offenders and recidivism risk
- Two Meta-Analyses
- Same conclusion
- “Mechanical predictions of human behavior are equal or superior to clinical prediction for a wide range of circumstances” Grove 2000

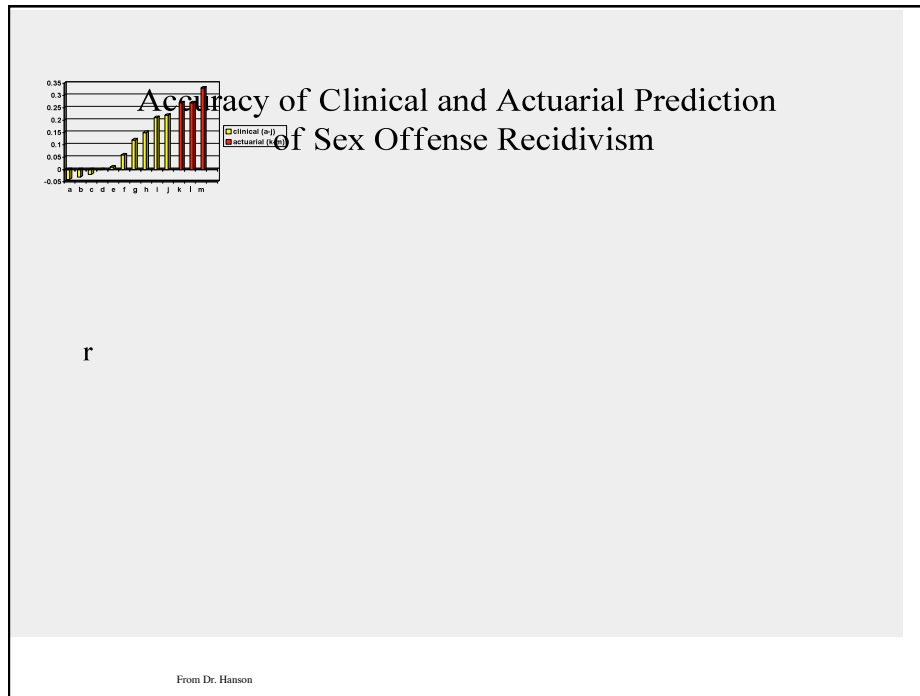
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## Combination of Factors

from Dr. Hanson

	<u>type of recidivism</u>		
	sex	violent	any
Clinical	.09	.06	.13
Statistical	.46	.46	.42
General Scales			
SIR	.09	.34	.41
VRAG	.20	.47	
Sex Risk Scales			
Minnesota	.27		
RRASOR (Hanson)	.27	.22	
STATIC-99	.33	.32	

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## Clinical Judgment is Inadequate

- Empirical tools significantly and consistently surpassed clinical judgment – Grove and Meehl 1996
- Despite seven decades of findings about the superiority of actuarial methods over clinical opinion, clinicians remain reluctant to replace their judgment with scientific tools
- The tools we have are not perfect but they are getting better all the time and they surpass clinical opinion

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## Bottom Line

- “There seem, then, to be no barriers to a general preference for mechanical prediction where an appropriate mechanical algorithm is available.”
- Grove et al., 2000, page 19

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## Psychologists not obsolete yet...

- 6-16% clinical predictions superior
- Mechanical 10% more accurate than clinical overall
- In some individual cases clinical was better
- Actuarial is only as good as the research behind it
- ...and that research is done by -  
Psychologists

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## Group Statistics Versus the Individual

- Potential problems and errors

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## Ecological Fallacy

- Inferences about the nature of individuals are based solely upon aggregate statistics collected for the group to which those individuals belong.
- This fallacy assumes that all members of a group exhibit characteristics of the group at large. Stereotypes are one form of ecological fallacy.

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## Example

- A study is done that shows people from Springfield score higher on the SAT on average than people from Shelbyville. Assuming that a randomly selected individual from Springfield scored higher on the SATs than a randomly selected individual from Shelbyville is an ecological fallacy. Since the SAT scores given in the study were an average, it is indeed possible that the individual from Springfield scored in the bottom ten percent on the SATs and the individual from Shelbyville just happened to score in the top 10%.

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## Pre-Sentence Evaluation and Supervision Issues

- A good report addresses all of the following issues on the upcoming slides
- Supervision is impacted, limited and facilitated as a result of where the offender falls in these areas
- Understanding of the relationship between such information and the subsequent requirements directly impacts compliance

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## Intellectual and Educational

- Capacity of the offender = intelligence
- Formal academic completion = educational achievement
- There may be a great disparity between the two
- A bright offender is likely to be even more devious and create situations allowing for benefit of the doubt
- This may be unrelated to his formal education level
- In general, higher risk comes from either end of the spectrum
- Persons at the lower and upper extremities are considered higher risk than those in the middle

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## Overall Function - Personality and mental health

- The higher functioning the better in terms of compliance issues
- Having a high degree of function allows one to drive over the bumps in the road without ending up in the ditch
- Dealing with other factors of stable living increase risk that they will offend as a coping response
- When coping responses are stretched thin, they are most vulnerable
- A personality disorder diagnosis or diagnosis of a severe and persistent mental illness increases risk of re-offending

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## Social, Developmental, Family

- These factors relate to one's resiliency
- They also address issues of support which may decrease risk
- A socially adept or facile offender may present greater risk in terms of opportunity and success
- Treatment focus may need to address particular developmental issues such as adultification at a young age or developmental stagnation
- Family may be a hindrance or a help

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## Current Status

- What are the static versus dynamic variables
- Is risk likely to increase or decrease over time
- Does the supervising officer influence or control variables that impact this?
  - Where or with whom he lives - yes
  - Stability of present job - probably not
  - Health issue in offender or relative - no
- Supervising officer should watch for variables / changes that are identified as impacting status
  - Current relationship

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## Sexual Issues

- Has offender been married or in appropriate relationships - if so this decreases risk
- What is his current status
- Monitoring relationships with access to children
- Focusing therapy on relevant topics specific to the offender

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## Delinquency and Conduct

- Risk of continued non-sexual legal involvement
- Risk as a function of decision making and other life consequences
- Even though there is a sexual offense - general rules of supervision still hold

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Risk Assessment,  
Risk and Protective Factors in the Community

- Current risk level
- Static and dynamic factors
- Watch for changes in identified protective factors
  - Parent, spouse or mentor change such as illness or relocation

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Awareness of Victim Impact

- Significant variable
- Ongoing recognition vs able to say the right thing
- Role as a deterrent for future behavior

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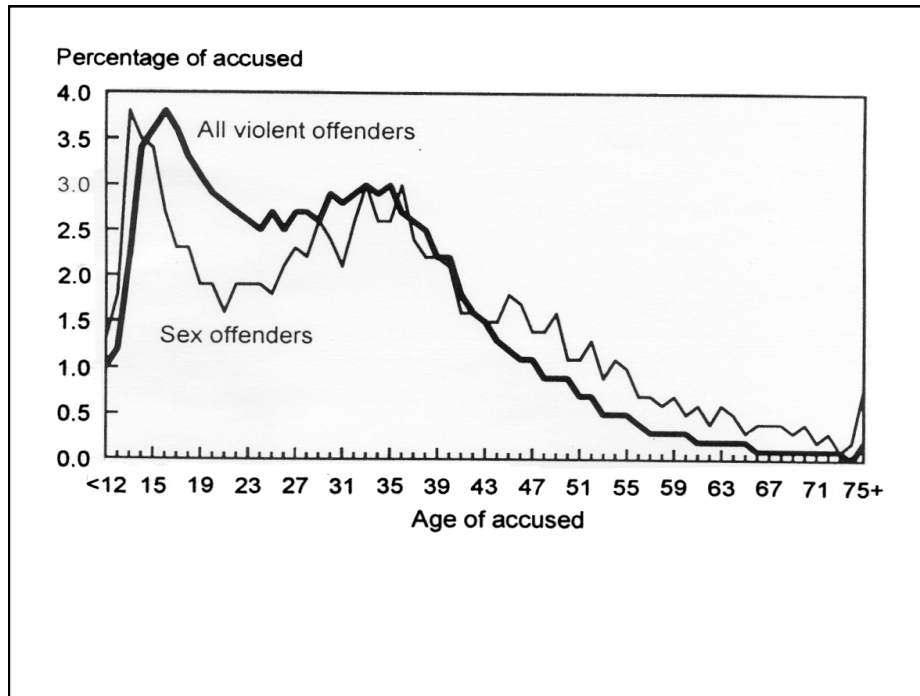
### Relapse Prevention Resources & Amenability to Treatment

- Resources available in the community
- Willingness to access resources
- Commitment to treatment
- Ability to benefit from treatment
  - IQ, predator status
- Acceptance of problem and treatment

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### Sex Offender Risk Assessment

- Static (unchangeable)
  - Prior sexual offenses
  - Age
  - Any extrafamilial victims
- Dynamic (changeable)
  - Stable
    - Marital status
    - Deviant sexual preferences
    - Personality disorders
  - Acute
    - negative mood
    - drunkenness



### VRAG - Violence Risk Assessment Guide

- Probably best measure for classifying reoffense risk of violent offenders
- Only a few items different between VRAG and SORAG - 12 items
- Requires a thorough and reliable social history, knowledge of the offender's DSM diagnosis and a PCL-R score

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### SORAG - Sex Offense Risk Assessment Guide

- A variation of the "Violence Risk Appraisal Guide" (VRAG)
- Effective though relatively complicated 14-item scale
- Requires a thorough and reliable social history, knowledge of the offender's DSM diagnosis and a PCL-R score

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### SORAG

- SORAG may be the best currently available instrument for classifying reoffense risk among violent sexual offenders but appears inferior to other instruments (RRASOR, Static-99) for classifying risk of non-violent offenses often more typical among child molesters

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### Hare Psychopathy Check List - Revised PCL-R

- Special training needed through Darkstone - Dr. Hare's educational company
- Measure of psychopathy - a construct
- NOT a measure of antisocial personality disorder from DSM IV
- Scored as part of SORAG and VRAG
- Percentile rankings and T-scores available for both institutionalized and parole populations
- Britain dictates that incarcerated inmates who score above a cutoff will not be given treatment as they will not benefit - upheld by their courts

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### Factors Associated with a New Sex Crime

- Sees self as no risk
- Access to victims
- Attitudes tolerant of child molesting
- Uses general excuses / justifications
- Low victim empathy
- Attitude of sexual entitlement

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### Sex Offenders who Failed on Supervision

- View themselves as not being a risk
- Had diverse victim types
- Spent fewer months in the community
- Had access to victims
- Higher sense of sexual entitlement
- Poor social influences

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### Using Assessment in Supervision

- PCL-R
  - Predicted general and serious recidivism
- McSOST-r
  - Predicted general recidivism

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## Recidivism

- Barbaree, Seto, Langton & Peacock Criminal Justice and Behavior, 2001
- All received SO treatment
- 215 offenders followed for an average of 4.5 years
- 38% recidivate for any offense
- 24% recidivate for serious offense
- 9% recidivate for sexual offense

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## Treatment progress and predicting recidivism

- Positive treatment behavior was associated with greater risk of reoffending for those with high PCL-r scores

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## Oregon Sex Offender Assessment Scale

- Series of positive and negative items scored either -10, -5, +5, or +10.
  - High = -210 to -50
  - Medium = -45 to 0
  - Low = 5 to 85
  - 39% of high risk re-arrested for any crime
  - 19% of medium risk
  - 7% of low risk
- (2 year follow-up)

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## Scored -10

- History of sex crime
- History of sex offense conviction \*
- Stranger to victim \*
- Multiple victims in current crime \*
- Use of weapons or threats \*
- Vulnerable victim (< age 12, disabled, drunk)
- Predatory behavior\*
- Not in treatment
- No empathy for victims(s)
- Not progressing in treatment

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## Scored -10

- New crime during supervision
- Technical violation related to assault cycle
- Multiple paraphilia
- Impulsive or compulsive behavior
- Primary sexual preference is children
- Community instability
- Prior non-sexual history\*
- Substance abuse involved in offending behavior

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## Scored -5

- Substance abuse problems
- Anger problems
- Technical violation during supervision
- Use of sexually arousing materials
- Mental status inhibits responsible functioning
- No support system or support system tolerates denial

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## Scored +10

- Takes full responsibility for offending behavior
- Clear identification and understanding of assault cycle
- Passes disclosure polygraph
- Clarification of victims completed
- Successful completion of approved treatment program
- Passed maintenance polygraph
- Completed substance abuse tx and maintains abstinence

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## Scored +5

- Demonstrated understanding of thinking errors
- Support system reinforces compliance and treatment
- Special conditions compliance
- Automatic override characteristics \*
  - Forcible rape
  - Use of weapon during offense
  - Males who molest boys

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## Risk assessment is ongoing

- Risk is not stable over time
- Denial occurs on a continuum
  - Denial of the act
  - Denial of the fantasy
  - Denial of the responsibility
  - Denial of the seriousness
  - Denial of the impact
  - Denial of true risk level

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## Low vs High Risk

- Accuracy of prediction increases as rate of occurrence increases
- High frequency events are easier to predict than low frequency events
- Low risk may not be in actuality low risk
  - Specific factors may be useful here
- Polygraphs aid in treatment and in ongoing assessment of risk

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## Specificity and Recidivism

- Kim English – paraphrased – If Coke is not available then they will drink Pepsi
- Crossing over is natural and expected
- When pictures are inadequate then they progress to touching
- Data is controversial
- Certainly some will and do cross over
- However, some persons will drink nothing if Coke is not available
- Not everyone engages in homosexual acts in prisons despite a lack of preferred gender partners

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## Specificity and Recidivism

- You must know what is prioritized and what is restricted for that individual
- If dying of thirst then might drink alcohol in the desert
- If there are no boundaries or weak boundaries then cross over might be easier
- Some will never cross over
- Some have no boundaries and there is nothing to cross
- Management of offenders needs to take into account such differences in terms of risk
- Can an offender have contact with daughter now that she has reached puberty and is not in his target? It Depends.

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## Does Treatment Work?

- Depends on who you ask, how you ask and how they slice the data ...but it can reduce recidivism
- Recidivism rates over 5 years in Colorado n=1585
- No Treatment – 47% recidivism rate
- Phase 1 Treatment – 30% recidivism rate
- Phase 1 & 2 Treatment – 15.7% recidivism rate
- Differences are statistically significant
  
- Phase 2 is therapeutic community

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## Offense Cycle

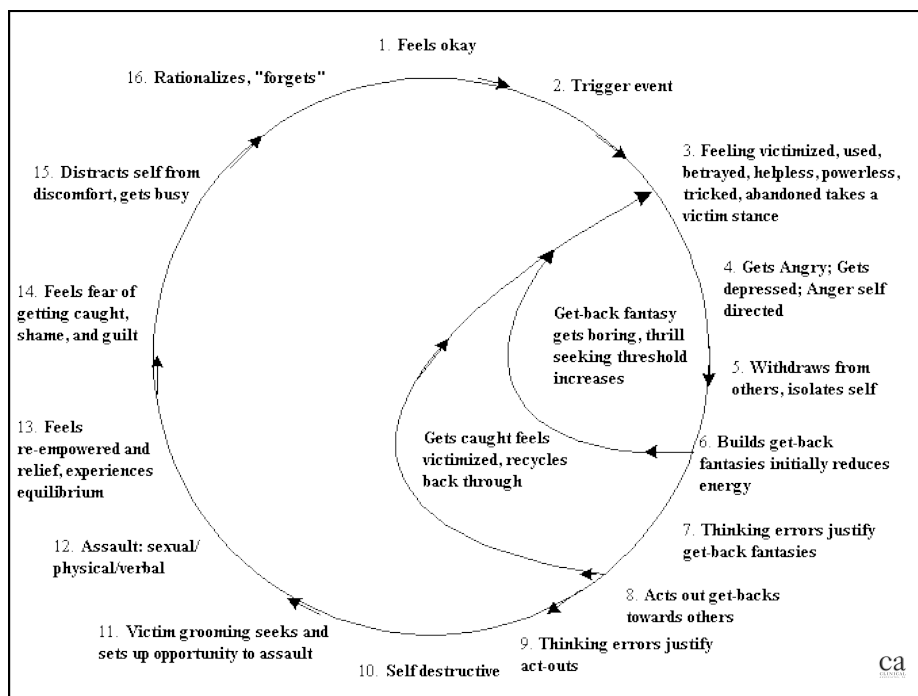
- The specific details of events, thinking errors, feelings, goals, and behavior which precede, occur during, and follow a sexual offense
- Sexual offense behavior is viewed as a middle step in predictable sequence of repeating maladaptive behaviors.
- Feeling victimized by a sense of betrayal, helplessness or powerlessness appears to be the first step in this cycle, followed by a predictable pattern of maladaptive and acting-out behaviors which precede the sexual offense.

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## Offense Cycle

- There are also post-assault behaviors, thinking errors, goals and feelings which are predictable and repetitive, and which conclude the final step of the cycle - that of the offender feeling "okay" in his/her world.
- Generic versus specific for each offender
- They must learn their own cycle as part of the treatment process
- Journals are tied back to offense cycle events

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## Dynamics of Offense Cycle

- Within the repeated sequence of predictable maladaptive feelings and behaviors exists a potent dynamic for change called recycling.
- It is a predictable departure from a series of predictable behaviors, and a re-entry to the beginning point of cycle prior to an assault.
- It is a dynamic of self-perpetuating stress. The offender is dysfunctionally failing to meet personal needs in mid-cycle and before the assault.

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## Dynamics of Offense Cycle

- The offender experiences feeling re-victimized by non-victimizing events and starts back through cycle another time.
- Each repetition through an incomplete assault cycle, through return to a repeated sequence of thinking errors, feelings and behaviors serves to decrease esteem and to increase the offender's practices to self-protect in ways which exclude and increasingly exploit the rights and needs of others.
- The process appears to escalate objectifying others, viewing others as objects.

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## Dynamics of Offense Cycle

- Recycling functions as a build up of increasing internal frustration and pressure.
- This pressure may be vented by acting-out behaviors or by fantasy of getting back at others.
- Initially get-back fantasies serve as a pressure reducer.
- Recycling desensitizes the individual to the initially high degree of pressure release achieved by fantasy or acting-out behaviors.

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## Dynamics of Offense Cycle

- Repeating get-back fantasy as a maladaptive form of problem resolution, pressure release, or discharge of anger or hurt may subsequently decrease in desired effect.
- Effectiveness is lowered over time – like tolerance for addicts – they need more to reach same levels
- Fantasy may need to become increasingly sensational, intrusive or exploitive in order for the individual to continue to derive the same rush or relief.
- Fantasy translates to action.

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## Logistics

- Awareness of Cycle – Offense Patterns – Early Signs
- Familiarity with offender's schedule and whereabouts
- Encourage application of treatment tools outside therapy
- Working closely with treatment provider
- Acknowledge seriousness of offending behaviors
- Hold offender accountable early in the onset of risky behaviors
- Report non-compliance to treatment providers

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## Containment Approach

- Victim orientation
- Multidisciplinary collaboration
- Containment strategy
- Informed policy
- Quality control

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## Victim Orientation

- From pre-trial to post-conviction through supervision
- What's best for the victim
  - Children need protection
  - Adults need empowerment

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## Collaboration

- Law enforcement
- Child protection
- Rape crisis centers
- Prosecuting attorney
- Probation and parole
- Treatment providers
- Polygraph services
- Prison staff
- Judges
- School staff, medical staff, victim advocates

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## Containment Strategies

- Criminal Justice
- Treatment Staff
- Polygraph

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## Supervising officer

- Intensive supervision with small caseloads
- Seek and respond to information
- Provide the 'hammer'
- Provide corroborative information
- Response is linked to risk

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## Treatment Providers

- Sexual history
- Specific issue polygraphs
- Maintenance polygraphs (every 6 months)
- Accountability focus
- Consequences for not following directives
- Emphasize that everything is a choice
- Verify behavior change externally
- Confidentiality limits
- transparency

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## Polygrapher

- Develop working relationship as member of the team
- Timely reports – fast feedback if action needed
- Input in developing specific issue questions

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## Informed Policies

- Research based
- DA policies of agreements and pleas in sex cases
- Acceptance of sex offenders in denial for both community supervision and treatment
- Limited immunity to offenders who reveal additional sex crimes during treatment / polygraph process
  - Antelope 9<sup>th</sup> circuit decision – polys cannot be used to circumvent 5<sup>th</sup> amendment right to not self-incriminate
- Selection criteria for treatment providers

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## Quality Control

- Frequent training
- Understanding of job impact on community
- Adequate supervision
- Standards for practice
- Risk assessment
- Regular meetings
- Individual treatment approach
- Measures of progress

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# Time For Your Questions

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