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Assessment, management, and treatment of sex offenders: what is known, what is controversial, what needs further investigation

Valutazione e trattamento degli autori di reati sessuali

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Abstract
Sex offending is considered one of the most offensive crimes in Western societies. This article presents a description of the advances in scientific and clinical studies in the understanding of sexual offending, with particular attention to risk and criminogenic needs, sexual recidivism and its assessment. It offers an overview of the treatment programmes that work most efficiently, of those that are promising, and of those that do not seem to work, and why. Much can be learnt about sex offenders from using criminal career information, and from assessing the risk dimensionally, in order to identify accurately the level of risk and the criminogenic needs that require intervention.

Keywords: sexual violence, sex offenders, criminal careers, risk assessment, treatment

Riassunto
La violenza sessuale è considerata uno dei reati maggiormente offensivi nella società occidentale. Questo articolo presenta una descrizione degli avanzamenti negli studi scientifici e clinici in tema di violenza sessuale, con particolare attenzione al rischio e ai bisogni criminogenici, al recidivismo sessuale e alla sua valutazione. Viene offerta sia una panoramica dei programmi di trattamento riconosciuti tra i più validi ed efficaci, di quelli risultati i più promettenti, e di quelli che, invece, non sembrano funzionare, sia una riflessione critica sul perché di questi risultati. Si può comprendere molto sugli autori di reato sessuale a partire da un'analisi della carriera criminale e dalla valutazione dimensionale del rischio.

Parole chiave: violenza sessuale, autori di reato sessuale, carriere criminali, valutazione del rischio, trattamento

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1. Introduction

Sex offending is considered one of the most offensive crimes in Western societies. Its consequences are damaging for the victims and their families, and, in many cases, the traumatic impact is likely to be long lasting. However, views on sexual violence are often influenced by uninformed media, and by biased information, which do not contribute to deepening the understanding of the problem, and to how to deal with its causes, but rather tend to raise social preoccupation and moral panic (Cohen, 1972).

The assumption underlying all this is, according to Janus and Prentky (2008), the notion of *exceptionalism*: sex crimes constitute a different type of offence (Lussier, 2005), and sex offenders are seen unlike other offenders (Lieb, Quinsey, & Berliner, 1998). Sex offenders are in fact seen as always dangerous (La Fond, 2005), frequently committing crimes (Miethe, Olson, & Mitchell, 2006), at risk of re-offending, more likely than other offenders to recidivate (Harris, Smallbone, Dennison, & Knight, 2009), and especially to recidivate sexually (Lieb, Quinsey, & Berliner, 1998). The general opinion is that sex offenders deserve more severe sentencing (Tewksbury, Mustaine, & Payne, 2011), should be forced into community registration and notification (Zgoba & Levenson, 2012), should be coerced to undergo treatment (Burdon & Gallagher, 2002), should face post-conviction polygraph testing (Rosky, 2012), and should be surgically sterilised or chemically castrated (Farkas & Stichman, 2002; Miller, 1998).

While it is suggested that sex offenders benefit from treatment, interventions to prevent sexual recidivism are often contrasted with social discredit (DiBennardo, 2018). As McAlinden has advocated (2007, 2012), there are dangers attached to the deployment of such pejorative views. The dangers reside in the promotion of stereotypical images of predatory sex offenders that strengthen the effects of labelling, especially when the sexual abuse is against children, by contributing to 'an enduring and privileged site of anxiety' (Ashenden, 2002, p. 199) and to professional preoccupation and fear (Munk, Larsen, Buch Leander, & Soerensen, 2013).

More severe laws (e.g. Sexual Predatory Laws) (Prenkty, Barbaree, & Janus, 2015; Prentky, Janus, Barbaree, Schwartz, & Kafka, 2006) and tougher control measures (e.g. sex offender registration and notification systems – SORN; geographical restriction, monitoring movement across international borders, civil commitment, etc.) (Thomas, 2013, 2016) have been the immediate responses to the societal outcry, often neglecting what scientific research suggests about the life course prevalence and prevention of sex offending, and the treatment of sex offenders.

It would be naïve to assume that this social climate has not had any influence on the legal, social, and policy-making responses to sex offending. This is why it becomes essential that 'emotional topics' such as sexual abuse are addressed in relation to scientific evidence (Lösel & Schmucker, 2017; Zara & Farrington, 2016) and to the ethics of responsibility (Jung, 2017).

Evidence-based interventions and policies are successful, when they offer a more complete and sound scientific perspective to a very complex and often misunderstood area of criminal careers that is 'when offending goes sexually' (Zara & Farrington, 2016, p. 308). It is not just a matter of repairing the broken things in life or fixing the damage, but also of building positive perspectives, amplifying and nurturing them, and making change possible and conceivable. Being a sex offender does not make one an eternal offender, just as being at high-risk does not mean being at high-risk forever (Hanson, Harris, Helmus, & Thornton, 2014).

The aim of this article is twofold. First, we present a description of the advances in scientific and clinical evidence in the understanding of sexual offending, with particular attention to risk and criminogenic needs, sexual recidivism and its assessment. Second, treatment findings are explained, along with an introduction about which treatment programmes work more efficiently, which are promising, and which do not seem to work, and why.

The theoretical background of this work is rooted in the paradigm of criminal careers (Blumstein, Cohen, & Farrington, 1988a,b; Piquero, Farrington, & Blumstein, 2003, 2007). The clinical and professional assessment of the intervention and treatment of sex offenders is based on the Risk-Need-Responsivity (R-N-R) Model (Bonta & Andrews, 2017).

2. Assessing the risk of sexual (re-)offending

Criminal statistics show that the rates of sexual recidivism are overall lower than for other crimes (Hanson & Morton-Bourgon, 2009; Hanson, Morton, & Harris, 2003; Harris, Knight, Smallbone, & Dennison, 2011; Harris, et al., 2009; Piquero, Farrington, Jennings, Diamond, & Craig, 2012). As Zara and Farrington (2016) claimed, this finding is counterintuitive for two reasons.

The first is explained by the *cooling-off mechanism* between criminal events, borrowed from serial homicide studies (Douglas, Burgess, Burgess, & Ressler, 2006; Osborne & Salfati, 2015), and which, in this instance, is used to denote the *time interval* between sex offences. The likelihood of relapsing into another sex crime in the short or medium term is rather low, suggesting that a mechanism of antisocial latency usually takes place before another serious and violent offence is

committed (Zara, 2005). Hanson and Bussière (1998) suggest that the risk of sexual recidivism is typically around 14% after 5 years. More recent research even suggest sexual recidivism rates at about 10% or less (e.g. Jennings, 2015).

The second explanation focuses on the *aging process* (Farrington, 1997, 2005). A sort of criminal *burnout process* (Coid, 2003) seems to influence the trend of the most active and prolific criminal career offenders. The likelihood of persisting into a sex offending career diminishes with time and, after reaching its peak between ages 18 and 30 (Hanson & Morton-Bourgon, 2005), it starts decreasing, waning substantially after age 60. Although cumulative recidivism rates increase with time, the chances that an offender will re-offend decrease the longer the offender remains offence-free in the community (Hanson, Harris, Helmus, & Thornton, 2014). Hanson and colleagues (Hanson & Bussière, 1998; Harris & Hanson, 2004; Helmus, Hanson, Thornton, Babchishin, & Harris, 2012) carried out major meta-analyses on sexual recidivism risk assessment and showed that recidivism base rates for sex offenders decline with time, as happens with many other types of violent crimes. Overall, the observed sexual recidivism rates in the studies meta-analysed increased with the length of follow-ups (e.g. 10% and 15% after 5 years; 20% after 10 years; and between 25% and 40% after 20). These average rates of sexual recidivism should be considered cautiously because they are based on old studies, diverse methods, and variable follow-up times (ranging from 5 to 20 + years) (Hanson, Harris, Letourneau, & Helmus, 2018).

Interpreting these results is also difficult, nevertheless these rates do not support the common belief that sexual offenders show high rates of sexual recidivism. Whereas sex offenders are proportionately more likely than other criminals to commit another sex crime, the vast majority of new sex crimes were not committed by registered sex offenders (Bureau of Justice Statistics, 2003). Many sexual offences remain undetected (Bonta & Hanson, 1994), many others are unidentified (Zara, 2018c), with many sexual offences not appearing in official records (Zara & Farrington, 2016). Furthermore, Hanson and colleagues (2018) reviewing some long-term (10 + years) studies of sexual recidivism, have observed that the highest rates seemed to occur during the first few years after release, and gradually decline thereafter (Blokland & van der Geest, 2015; Cann, Falshaw, & Friendship, 2004; Hanson, et al., 2014). As Hanson and colleagues (2018) demonstrated, after 10 to 15 years most individuals with a sexual criminal career were no more likely to commit a new sexual offence than individuals with a criminal history that did not include sexual offences.

In the US the sex recidivism rate, measured by arrests for a new sex crime, was 5.3% over a 3-year period (Bureau of Justice Statistics, 2003). In England and Wales, the proportion reconvicted for another sex offence was less than 10%, even amongst those who could be followed for up to six years (Hood, Shute, Feilzer, & Wilcox, 2002). Similar figures are found in Italy, where the proportion of offenders being reconvicted of another sex crime, over the whole convicted population, over a period of 10 years was 3.3% (Istat National Crime Statistics, 2000-2011). These Italian figures are, however, based on cumulative re-offending data. Thus it is not possible to specifically extract from the national databank which individuals, with previous convictions for sex crime, generally reoffended, which ones reoffended sexually, which ones were first-time sex offenders, and which ones were recidivists. In order to build up a clearer picture of sexual recidivism trends in Italy, it would be necessary to have a nationalised system to gather data on recidivism, recidivism percentages and the time since the last offence committed.

In the Cambridge Study in Delinquent Development (CSDD)[1], a prospective longitudinal study of the development of offending and antisocial behaviour in 411 London males (called generation G2) mostly born in 1953 (Farrington, Coid, & West, 2009; West & Farrington, 1973, 1977), sex offending was rare. To the best of our knowledge, such an investigation still represents the longest longitudinal analysis of sex offending and sex offenders in the world using a community-based sample.

While there were 808 total convictions in the CSDD by age 50, only 1.6% (n = 13) were for sex offences, committed by 10 offenders (Piquero, et al., 2012). Less than 3% of the CSDD males were convicted for sex offences through age 50. The median age for sex offences was 33, which was high compared to other offences (where the median age was 28). Seven of these men committed a single sex offence, while three men committed two sex offences each. Regarding their criminal careers, six sex offenders had non-sex offences as well. While there were very few recidivist sex offenders, the probability of any recidivism for sex offenders (30%) was similar to other offenders. Sex offending varied depending on the age-ranges: offences under age 20 were mainly indecent assault on females and indecent exposure, while offences over age 30 were mainly indecent exposure or sexual assault on male victims.

After 50 years of investigation (the CSDD men have been followed from age 8 to age 61) (Farrington, 2019), no continuity in sex offending from the juvenile to adult years was found, and very few recidivists were sex offenders.

Desistance in sex offenders is hard to assess, as in any other offenders (Farrington, 2007a; Kazemian, 2007), because any residual risk that still remains provokeS considerable professional and juridical preoccupations. However, it is paramount that the assessment of risk is led by scientific clarity, and not by social panic.

Hanson and colleagues (2018) designed a 25-year risk model of sexual recidivism in a large sample of over 7,000 individuals. The sample included sexual offenders from diverse settings and from the full range of risk levels, as measured by the Static-99R (Helmus, Thornton, Hanson, & Babchishin, 2012). It was found that the likelihood of new sexual offences declined the longer individuals, with a history of sexual offending, remained free from sexual offences

1 The Cambridge Study in Delinquent Development (CSDD) is one of the most important longitudinal studies in the world, which has gathered data from three generations of individuals: G2 (411 men in the original sample) + G3 (the children of G2) + G1 (the parents of G2) and the parallel generation (the female partners of G2) (Farrington, 2003, 2019).

in the community. This effect was found for all age groups and all initial risk levels. Nonsexual offending during the follow-up period increased the risk of subsequent sexual recidivism independently of the time free effect. After 10 to 15 years, the risk of a new sexual crime was similar to the risk of spontaneous new sexual offences among offenders with no history of sexual crime.

These research findings provide a few important messages to consider as relevant in risk assessment and in intervention, which can be summarised as follows:

A sex offender is not always a high-risk offender; the risk level can change (Hanson, et al., 2014).

The natural, but slow, process of aging contributes to a decline in sex offending (as in other offender groups) (Booth, 2016; Rice & Harrins, 2007, 2014).

The risk of sexual recidivism decreases the longer the offender stays away from offending while free in the community, and despite the offending opportunities around (Hanson, et al., 2018).

With time the risk of a new sex offence by offenders with a history of sex offending is likely to be equal to the risk of offenders with no previous sexual offences (Hanson, et al., 2018).

Assessing the risk of sexual recidivism needs to include mechanisms to adjust initial risk classifications to the actual risk of the individual currently reassessed (Hanson, Bourgon, McGrath, Kroner, D'Amora, Thomas, et al., 2017).

It is necessary to establish a tolerable risk level that will balance the duty to protect victims and the public, with a warrant exempting an individual, with a history of sexual offences, from carrying the label of sexual offender (Kahn, Ambroziak, Hanson, & Thornton, 2017).

The effect of interventions depends on both the quality of treatment (*external responsivity*) (Hanson, Bourgon, Helmus, & Hodgson, 2009) and the individual's responses to treatment and motivation to change (*internal responsivity*) (Hanson & Yates, 2013; Jung, 2017).

As in any other context and with other samples, changes in the psycho-social reality of sex offenders do not occur in a vacuum. Any change is likely to be linked to deliberate interventions (e.g. rehabilitation programmes). Nevertheless further consideration of this aspect requires acknowledging how many sex offenders are actually involved in treatment *versus* how many are, instead, not involved (e.g. refusers, lack of adequate programmes) or excluded from treatment (e.g. sex offenders in absolute denial) (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010); how many sex offenders complete treatment successfully *versus* how many drop out and why (i.e. an evaluation of responsivity) (Jung, 2017),

Communication of risk should be informative to help the criminal justice system in its decision-making by also disentangling the seriousness of the crime (i.e. harm) from the risk of recidivism (Monahan, Steadman, Silver, Appelbaum, Robbins, Mulvey, et al., 2001; Slovic, Monahan, & MacGregor, 2000; Zara, 2016). These two issues should be differently assessed because they are likely to be inversely correlated as research shows (Turner, Boccaccini, Murrie, & Harris, 2015; Krauss, McCabe, & Lieberman, 2012; Scurich & Krauss, 2014; Zara & Farrington, 2016).

Professionals have the responsibility for finding an adequate balance between a necessary diagnosis of risk and the inadequate and counter-productive stigmatisation of the sex offender that often follows after a conviction (Duwe, 2014; Lasher & McGrath, 2017; Scurich & Krauss, 2014; Soothill & Francis, 2009).

In light of the summary of these research findings, one crucial issue to address is which plausible threshold to establish for recognising sexual offending desistance. Hanson and colleagues (2018) suggest that a plausible threshold is when the risk for a new sexual offence among sex offenders is not different from the risk of a sexual offence among individuals with a history of only nonsexual crime. We believe that a more plausible threshold would perhaps be the base rate of sexual offending in the general population, and not only among offenders. However further research is necessary to test this assumption.

Studies show that the rate of sexual offences among general offenders is within the 1% to 2% range after 5 years (Kahn, et al., 2017), which is lower than the sexual recidivism rate of adults who have a conviction for a sexual offence. Despite this risk being not zero, as Hanson and colleagues (2018) pointed out, these researchers believe that a sexual recidivism rate of less than 2%, after 5 years, is a defensible threshold below which individuals, with a history of sex crime, should be released from some of the restrictions imposed by the sexual offender label. This may also involve the release from the *invisible punishment* (Hargreaves & Francis, 2014, p. 164) that follows any sexual conviction (e.g. from September 1997, in countries like England and Wales, individuals convicted, cautioned or released from prison, for a sexual offence against a child or an adult, must register on the sex offenders register under the Sex Offenders Act 1997, later amended by the Sexual Offences Act 2003).

It is at this point that a higher beneficial effect for society as a whole, and specifically for victims of sexual violence, would be achieved if policy makers implemented scientific evidence and decided to invest resources efficiently on risk assessment and risk management. Experts have pointed out the importance of differentiating risk assessment practice and instruments on the basis of types of offenders and on risk levels. From a risk management perspective, resources should be spent on higher risk sex offenders rather than on very low risk offenders, so that the prevention of sexual re-offending would gain in efficiency and efficacy, as along with the sex offenders' rehabilitation programmes.

3. Risk assessment instruments for sexual (re-)offending

The scope of risk assessment is germane to the conception of translating scientific knowledge into services for humanity and public security (Zara & Farrington, 2016). Risk assessment is not only about specifying the risk and the level of it (e.g. low, medium or high). Risk assessment is about giving a psychological and behavioural sense to it, because it is about people and their functioning in the world that psy-

chologists, psychiatrists, criminologists, lawyers, public prosecutors, judges and juries deal with professionally. Zara and Farrington (2013, 2016) suggested that risk assessment is a method and not an end. It should inform treatment and management decisions, guide and sustain prevention, and lead to adequate communication in policy making, e.g. about investment into research and intervention (Zara, 2016).

Numerous risk assessment instruments are specifically designed for evaluating criminogenic needs of sex offenders, and for assessing their risk; they can be used in psychocriminology and forensic settings. Some are actuarial (AJ) and some are structured professional (SPJ) instruments (see tables 1 and 2 respectively). The instruments, described in tables 1 and 2, are chosen on the basis of their scientific and empirical soundness, their predictive accuracy, and their specificity for targeted groups of offenders (Farrington, Jolliffe, & Johnstone, 2008; *Risk Management Authority – RATED*[2] version 3 – 2013; Zara & Farrington, 2016, for a review).

The interest in having specialised instruments is for having an integrated approach in which clinical and risk assessment information assists decision making about criminal responsibility, social dangerousness, sentencing, alternative measures to detention, release or discharge, and specific civil orders, or remits, for probation programme admittance. Risk assessment represents the anticipatory phase before intervention, and its scope is to inform and sustain specific treatment. As for any crime, and especially for sexual violence, the identification of risk alone is a static procedure, especially when it does not lead to prevention or intervention, or does not attempt social reintegration.

Table 1 - Risk assessment instruments: AJ instruments for assessing the risk of sex violence in adults *(continues)*

Instrument	Type	Aims and Description	No. Items	Author(s)
ACUTE 2007	AJ	Assessing the risk for both sex/violent recidivism, and a total score for general recidivism. It is the acute counterpart of Stable 200, and it consists of seven acute factors: Victim access Hostility Sexual preoccupation Rejection of supervision Emotional collapse Collapse of social supports Substance abuse	7	Hanson, et al. (2007)
STABLE 2007	AJ	Focusing on stable risk factors to predict sexual recidivism or breach. It is a scale organised in two parts, with 12 (+ 1 for child molesters) stable-dynamic risks: Significant social influences Capacity for relationship stability Emotional identification with children (<13) Hostility towards women General social rejection Lack of concern for others Impulsive Poor problem solving skills Negative emotionality Sex drive/sex preoccupation Sex as coping Deviant sexual preferences Co-operation with supervision Static assessment should be used within the first month of supervision; stable assessment should be completed within three months and then every six months thereafter; the acute assessment to be assessed every session (but not more than weekly) (Hanson, Harris, Scott, & Helmus, 2007). The combination of acute and stable factors incrementally improve the predictive accuracy when added to the static factors assessed in Static-99 (see later). When properly used, these tools showed levels of predictive accuracy as high as other established methods of risk assessment with sexual offenders. Further research is needed particularly for 3 reasons: to determine the extent to which the stable and acute variables are related to changes in the recidivism risk; to reliably assessed changes of stable factors upon criminal behaviour; to identify rapidly truly acute factors associated with the timing of recidivism. In this last case also more frequent evaluations (daily rather than monthly) would be rather necessary.	13	Hanson, et al. (2007)

2 *RATED - Risk Assessment Tools Evaluation Directory* (August, 2013) is an on-line tool directory that facilitates periodic reviews and updates. It aims to provide a summary of the empirical evidence to offer a balanced approach to assessment and to contribute to effective and ethical practice. RATED is available at: http://rated.rmascotland.gov.uk/

Instrument	Type	Aims and Description	No. Items	Author(s)
Minnesota Sex Offender Screening Tool-Revised (MnSOST-R)	AJ	Screening referral tool for commitment under the state's Sexual Psychopathic Personality and Sexually Dangerous Person Laws, and as part of the state's Community Notification Act. The MnSOST-R is used to implement laws demands that dangerous or predatory sex offenders remain incarcerated to prevent sex re-offending until treatment renders them safe to re-enter society. The 16 variables retained in the MnSOST-R are categorised as either historical/static variables or institutional/dynamic variables. The latter category refers to the offender's period of incarceration for the current or most recent sex offence. *Institutional/Dynamic Variables*: Discipline history while incarcerated Status of chemical dependency treatment Status of sex offender treatment Age at time of release Historical/Static Variables: Number of sex-related convictions Length of sexual offending history Commission of sex offences while under correctional supervision Commission of sex offences in public places Force or threat of force in sex offences Multiple acts committed against a single victim Number of age groups victimised Sex offences against a 13- to 15-year old victim Sex offences against strangers Evidence of adolescent antisocial behaviour Pattern of drug or alcohol abuse Employment history The developers stated that the assessing strategy behind the MnSOST-R is to develop an actuarial tool that can firmly anchor the judgement process, and not simply to make an actuarial score the sole basis of important decisions. It has not yet been validated on a new sample (Hanson, 1998), and some shortcomings are related to its experimental procedures and its ethical standards, so that it cannot support expert testimony in a legal proceeding.	16	Epperson, Kaul, & Hesselton, (1998)
Minnesota Sex Offender Screening Tool-3 (MnSOST-3)	AJ	Assigning low, moderate, or high-risk designations to all sexual offenders who are required by law to register. It is a revision of the MnSOST-R, and was developed on a population of adult male incarcerated offenders who were convicted of either a sex or sex-related offence. It is not appropriate for offenders who have never been sentenced for a sex/sex-related offence. It is designed to be scored based upon a file review (paper, electronic, or both). Access to official criminal records including an offender's prior criminal history is necessary. It is not necessary to interview an offender, but if an offender is interviewed and he provides credible self-report information, which subsequently becomes part of the offender's file, this information may be used to score the MnSOST-3.1. It contains 11 predictors, 9 main effects and 2 interaction [x] effects. Of the nine main effects, only three were items derived from the previous version (public place, completion of chemical dependency and sex offender treatment, and age at release). The items retained are: Predatory offence sentences Sentences with male victims Public place Felony sentences VOFP Harassment/stalking Disorderly conduct sentence (last 3 years) Completion of sex offender and chemical dependency treatment Age at release Unsupervised release [VOFP x Age] [Disorderly conduct sentence x Age]	11	Duwe & Freske, (2012)

Instrument	Type	Aims and Description	No. Items	Author(s)
Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR)	AJ	Predicting sexual offender recidivism. The brief risk scale is designed to be used as a screening procedure in settings that require routine assessments of sexual offender recidivism risk. It consists of an actuarial formula and calculate the risk level on the basis of the following static factors: Prior sexual arrests Age Ever targeted male victims Whether any victims unrelated to the offender R-RASOR does not provide a comprehensive evaluation and should not be used in isolation. It cannot assist in monitoring change over time or during/following treatment; the static factors do not help identify treatment or intervention, so its utility for risk management is limited.	4	Hanson, (1997)
Sex Offender Needs Assessment Rating (SONAR)	AJ	Assessing sexual re-offending risk among adult sex offenders using a weighted scoring key by clinical staff or case managers. It contributed significantly to the understanding of dynamic risk factors and is best used as a complement to other tools that measure static factors. The items are divided into two areas. *Stable factors*: Intimacy deficits Negative social influences Attitudes tolerant of sexual offending Sexual self-regulation General self-regulation *Acute factors*: Substance abuse Negative mood Anger Victim access	9	Hanson & Harris, (2000)
Sex Offender Risk Appraisal Guide (SORAG)	AJ	Assessing the recidivism risk (sexual and violent) of previously convicted sexual offenders. The items are: Living with biological parents until age 16 Elementary school maladjustment History of alcohol problems Marital status Nonviolent offence history Violent offence history Sexual offence history Sex and age of index victim Failure on prior conditional release Age at index offence DSM-III criteria for any personality disorder DSM-III criteria for schizophrenia Phallometrically measured deviant sexual interests PCL-R score The tool is not simple to use; it requires more specific information than many of the other tools, some of which might be difficult to obtain.	14	Quinsey, Harris, Rice, & Cormier, (1998, 2006)
STATIC-99	AJ	Predicting sexual recidivism. It provides explicit probability estimates of sexual reconviction, is easily scored, and has been shown to be robustly predictive across several settings using a variety of samples. It demonstrates only moderate predictive accuracy. The items are: Prior sexual offences (same rules as in RRASOR) Prior sentencing dates (number of distinct occasions on which the offender has been sentenced for criminal offences of any kind) Any conviction for non-contact offences Index non-sexual violence Prior non-sexual violence Any unrelated victims Any stranger victims Any male victims Young Single	10	Hanson & Thornton, (2000)

Instrument	Type	Aims and Description	No. Items	Author(s)
STATIC-2002	AJ	Evaluating the risk of sexual and violent recidivism among adult male sexual offenders. It improves the consistency of scoring criteria of Static-99. It can be used by a wide range of evaluators (e.g. psychologists, probation officers, psychiatrists, therapists) using commonly available criminal history information. Static-2002 predicts sexual, violent, and any recidivism as well as other actuarial risk tools commonly used with sexual offenders. It is intended to assess some theoretically meaningful characteristics presumed to be the cause of recidivism risk (persistence of sexual offending, deviant sexual interests, general criminality). The items are organized into five subscales: *Age*: Age at release *Persistence of sexual offending*: Prior sentencing occasions for sexual offences Any juvenile arrest for a sexual offence Rate of sexual offending *Deviant sexual interests*: Any non-contact sex offences Any male victim Young/unrelated victims *Relationship to victims*: Any unrelated victim Any stranger victim *General criminality*: Any prior involvement with the criminal justice system Prior sentencing occasions Any community supervision violation Years free prior to index sex offence Any prior non-sexual violence	14	Hanson & Thornton (2003); Harris, Phenix, Hanson, & Thornton, (2003); Hanson, Helmus & Thornton (2010)

Notes: These tables are an adaption from Zara & Farrington, 2016a, pp. 166-220.
AJ =Actuarial Judgement or Statistical Tool.
SPJ = Structured Professional Judgement or Structured Clinical Judgement.
Hanson and Harris have developed a system with both stable and acute risk factors. Originally called SONAR (The Sex Offenders Need assessment Rating); this system has now been renamed in two parts: STABLE – and ACUTE – 2007 (SA07 = total of 20 items) and represents a collaborative long lasting effort by the Canadian Department of Corrections. The STABLE-2007 and the ACUTE-2007 are specialised tools designed to assess and track changes in risk status over time by assessing changeable "dynamic" risk factors. These assessment tools, when properly used, showed the value of combining static, stable and acute risk factors in the community supervision of sexual offenders and high levels of predictive accuracy in assessing the risk of reoffending.
VOFP: Harassment/stalking/violate order for protection/violate no contact order/violate restraining order.

Table 2 - Risk assessment instruments: SPJ instruments for assessing the risk of sex violence in adults *(continues)*

Instrument	Type	Aims and Description	No. Items	Author(s)
Risk Matrix 2000 (RM2000)	SPJ	Predicting the likelihood of reconviction for a sexual or violent offence in the long term (up to 15 years) among adult males convicted of sexual offences. It is used nationally in England and Wales by the Prison, Probation and Police Services. The RM2000 utilises a stepwise approach to risk classification. For assessing risk for sexual aggression the following factors are considered in the first subscale (RM: Sexual): Age at Commencement of Risk Sexual Appearances Criminal Appearances Four aggravating factors are examined: Sexual Offences against a Male Sexual Offences against a Stranger Single Non-contact Sex Offense A second subscale (RM: Violent) is designed to assess risk for violent recidivism and is comprised of three items: Age Violent appearances Prior convictions for burglary The strength of the instruments is based on valid risk factors and explicit rules for combining factors. Robust across settings and samples. The combination of risk categories (both RM: Sexual and RM: Violent) is tabulated to produce an overall level of risk (on a 0-to-6 scale) intended for predicting sexual or other types of violence (see Kingston et al., 2008).	3 scales RM2000/S RM2000/V RM2000/C	Thornton, et al., (2003)
	SPJ	Assessing and managing individuals considered to pose a risk of sexual violence. RSVP is an evolved form of SVR-20 (see below) and its main task is risk formulation, and not risk prediction. It can be used with adult males (aged 18 and older) who have a known or suspected history of sexual violence. A comprehensive assessment of risk of sexual violence in clinical and forensic settings needs to be conducted by experts who also must gather comprehensive case information from multiple sources. Twenty-two individual risk factors composed the instrument and these factors must be assessed along with any additional case-specific risk factors. These factors are divided into five dimensions: *Sexual Violence History* Chronicity Diversity Escalation Physical Coercion Psychological Coercion *Psychological Adjustment:* Extreme Minimisation and Denial Attitudes that Support or Condone Sexual Violence Problems with Self-Awareness Problems with stress or Coping Problems Resulting from Child abuse *Mental Disorder:* Sexual Deviance Psychopathic Personality Disorder Major Mental Illness Problems with Substance Abuse Violent or Suicidal Ideation *Social Adjustment:* Problems with Intimate Relationships Problems with Non-Intimate Relationships Problems with Employment Non-Sexual Criminality *Manageability:* Problems with Planning Problems with Treatment Problems with Supervision Each item is coded three times: for presence in the Past, Recent presence and future Relevance. Each of these ratings is on a three-point scale: no evidence, partial evidence, or definite evidence.	22 items	Hart, et al., 2003

Instrument	Type	Aims and Description	No. Items	Author(s)
Sexual Violence Risk 20 (SVR-20)	SPJ	Predicting the risk of future sexual violence of a particular sexual offender and to guide potential risk management strategies. The items fall within three domains of psychosocial adjustment, sexual offending, future plans: 1. Sexual deviation 2. Victim of child abuse 3. Psychopathy (PCL) 4. Major mental illness (DSM-IV) 5. Substance use problems 6. Suicidal/homicidal ideation 7. Relationship problems 8. Employment problems 9. Past nonsexual violent offences 10. Past nonviolent offences 11. Past supervision failures 12. High density sex offences 13. Multiple offence types 14. Physical harm to victim(s) in sex offences 15. Use of weapons or threats of death in sex offences 16. Escalation in frequency or severity of sexual offences 17. Extreme minimization/denial of sex offences 18. Attitudes that support or condone sex offences 19. Lacks realistic plans 20. Negative attitude towards intervention *Other Considerations*: acute mental disorder, recent loss of social support network, frequent contact with potential victims or poor attitude towards intervention. SVR-20 is useful in assisting the structuring of clinical assessments, and has the advantage of incorporating a 'recent change' score (Douglas, Cox, & Webster, 1999). SVR-20 is a simplified, brief version of the RSVP, and is used in forensic mental health and criminal justice settings around the world. The SVR-20 *Version 2* is an updated 20-item checklist of risk factors for sexual violence that were identified by a review of the literature on sex offenders.	20	Boer, et al., (1997)
Structured Assessment of Risk and Need (SARN)	SPJ	Assessing sexual offenders' risk, need and progress in treatment. It is like a clinical framework to assess the presence of personality characteristics, which research has shown to be significantly associated with reconviction. These can be grouped into four risk domains: *Sexual Interests*: Sexual preoccupation Sexual preference for children Sexualised violence preference Other offence related sexual interest *Distorted Attitudes*: Adversarial sexual beliefs Child Abuse supportive beliefs Sexual entitlement beliefs Rape supportive beliefs View women as deceitful *Management of Relationships*: Feelings of personal inadequacy Distorted intimacy balance Grievance thinking towards others Lack of emotional intimacy with adults *Management of Self*: Lifestyle impulsiveness Poor problem solving Poor management of emotions	16	Webster, et al. (2006)
Violence Risk Scale: Sex Offender Version (VRS:SO)*	'atypical' SPJ*	Predicting sexual recidivism and linking treatment changes to sexual recidivism. This scale is believed to fall into the category of dynamic-actuarial risk assessment. The dynamic items yielded three factors that represent sexual deviance, criminality, treatment responsivity. It comprises 26 items, of which 7 are static, 17 dynamic, and 2 responsivity factors.	26	Wong, et al. (2003)

Note

* Despite the fact that it does not exist in literature a clear position for how to categorise these types of instruments, whether actuarially or clinically structured, in this analysis they are considered SPJ by looking at their structure and considering the presence of both dynamic and responsivity factors, which will also require clinical evaluation.

For instance, in various risk assessment instruments (e.g., SARN, SVR-20, STABLE, etc.), the total risk score is relevant in so far as it depends on specific risk factors or specific combinations among them. The summary risk rating cannot be interpreted strictly numerically, so that high scores definitely equal high dangerousness; the summary risk rating acts as a guideline to indicate which areas are more problematic, which are most criminogenic, and which ones need specialised attention.

What is crucial is that offenders' risk should be translated into plans for treatment and care. It follows that risk instruments should be part of a more comprehensive evaluation of the person and of their psychological functioning, and their social adjustment, so that the passage from classifying sex offenders at the group level into the individual level becomes more precise for aiding treatment and management. Risk assessment instruments are, therefore, valid to the extent that they can accurately identify the risk differently, depending also on the populations to be assessed (e.g., adults vs. adolescents; ethnic minorities; mental disordered sex offenders; developmentally disabled sex offenders; internet sex offenders; clerical sex offenders; paraphilic sex offenders; male vs. female sex offenders, etc.). The closer the demographic characteristics of the tested sample is to those of the original one used for constructing the instrument, the higher the predictive validity (Singh, Grann, & Fazel, 2011).

This synthesis leads inevitably to the importance of looking at the criminal careers of sex offenders.

4. Criminal careers of sex offenders

Under the criminal career paradigm, a criminal career is defined as the longitudinal sequence of crimes committed by an individual offender (Blumstein, Cohen, Roth, & Visher, 1986, p. 12). The criminal career paradigm offers a valuable perspective on the study of sex offenders as it is able to describe both between- and within-individual differences and changes in offending across time (Piquero, et al., 2003). Farrington (1999, 2003a, 2007b) demonstrated that a criminal career includes a time ordered sequence of events that helps researchers to focus on the time before and/or after an offence is committed: an *onset* (i.e., the first time an individual begins to offend), a *duration* (i.e., the length of offending), and an *end* (i.e., when an offender desists). The duration of the criminal career includes some important characteristics[3] namely *antisocial escalation* (i.e. the orderly switching from petty crimes to more serious offences with the increasing time spent in engaging in criminal activities; its opposite is defined as de-escalation) and *heterogeneity* or *versatility* (i.e. the tendency to engage in a variety of different crimes as opposed to specialisation). The concepts of relative stability and absolute change (Farrington, 1990, 1991, 1992) are applicable to sex offending in so far as they help to explain the development of criminal careers in sex offenders by making them serve as their own control. Differences, changes or continuity in their adjustment to life, and in the impact of risk factors and criminogenic factors upon their behaviour, can be better identified by employing within-individual analyses.

In the absence of specific criminogenic needs related to sexual deviance (Laws & O'Donohue, 2008), such as paraphilias (i.e. intense and pathological anomalous sexual interests) (American Psychiatric Association, 2013), paedophilic interests (Seto & Lalumière, 2001), emotional congruence or identification with children (Wilson, 1999), intimacy deficits (Bumby & Hansen, 1997; Hanson & Harris, 2000; Mann, Hanson, & Thornton, 2010), and deviant sexual fantasies (Carabellese, Maniglio, Greco, & Catanesi, 2011), offenders are likely to be heterogeneous and involved in a versatile criminal career in which sex offending is one of the many types of crime they end up committing.

This differentiation is essential not only for theoretical and classification reasons (Blokland & Lussier, 2015), but especially for clinical, assessment and treatment purposes (Freilone, 2011; Hanson, 2014; Hanson & Bourgon, 2017). In those cases in which sex offenders are specialised (i.e. they have committed sex-only offences), the risk of re-offending should be assessed differently because clinical and psychopathological aspects might be more strongly involved. In fact, sexual offending is a heterogeneous category *per se* that contains various types of *hands on* (e.g., child abuse, rape) and *hands off* (e.g., exhibitionism, distribution and consumption of child pornography, internet recruiting of victims) offences. When they abuse multiple victims, the victims could be of a specific age (e.g., some preferences are for children or teenagers, or adult victims, or special needs victims, or elderly people). Some sex offenders manifest cross-age preferences (the so called *polymorphic sex offenders* who switch from children or teenager victims to adult victims, and vice versa) (Stephens, Reale, Goodwill, & Beauregard, 2017) and others show some gender crossover interests (i.e. victimising both males and females) (Heil & Simons, 2008). Some offenders commit more than one kind of only sex offences, while some offenders commit other types of offences. The former can be considered *specialised sex offenders*, whereas the latter are called *versatile sex offenders*.

Prior research found that a history of indiscriminate and diverse victim types (Hanson & Harris, 1998) and diverse sex crimes (Hanson & Bussière, 1998) is predictive of sexual recidivism risk. However, heterogeneous offending is more predictive of general recidivism (Lussier & Cale, 2013), and an overall higher frequency of offending (Piquero, et al., 2007).

This differentiation is necessary for three reasons: (1) to be able to assess the criminogenic factors that are likely to influence criminal careers; (2) to be able to assess the risk of recidivism (general, violent and sexual); (3) to be able to plan intervention and differential treatment.

3 Because of the restraint of space in this article we introduce only those features that are directly related to the main focus of the paper (e.g. sex offending); we invite interested readers to see the specialised bibliography (Farrington, 1997, 2003b; Piquero, et al., 2003; West & Farrington, 1973, 1977).

The model that seems most likely to indicate how to assess the risk and plan intervention is the Risk-Need-Responsivity (R-N-R) Model.

5. The Risk-Need-Responsivity (R-N-R) Model

The *risk principle* states that offender recidivism can be reduced if the level of treatment provided for the offender is proportional to the offender's level of risk. It endorses "who to treat". The *need principle* calls for the focus of treatment to be on criminogenic needs or dynamic psychological risk factors. It highlights the importance of identifying and targeting the specific criminogenic needs (or dynamic risk factors) of the individual in treatment. It targets "what to treat". The *responsivity principle* requires that treatment should be delivered responsively i.e. matching the type of treatment to the ability, cognitive and emotional resources, and learning style of the offenders. The respective intervention strategies often follow behavioural and social learning approaches and the style and mode of intervention should match an offender's personality, learning style, and motivation. It endorses "how to treat". This means that both the design and delivery of the treatment play a crucial role in its effectiveness, along with the general structure of the programme, which should be explicit, and should be delivered in adherence to its rationale and in respect of its design.

Adherence to these principles has shown improvement in the effectiveness of treatment rehabilitation (Bonta & Andrews, 2017; Andrews, Bonta, & Wormith, 2011; Jung, 2017; Looman, Dickie, & Abracen, 2005). More recently, Hanson, Bourgon, Helmus, and Hodgson (2009) have found strong support for the application of the RNR principles in the treatment and management of sexual offenders. Dowden and Andrews (2000) completed a meta-analysis on human service, risk, need and responsivity[4], to explore whether programmes that addressed these principles were more effective than other programs that dealt with only clinical issues and non-criminogenic needs (e.g. personal distress, poor self-esteem, hallucination, anxiety and depression, feelings of alienation and exclusion, victimization, disorganised community, lack of ambition; see also Bonta & Andrews, 2017)[5]. The findings were interesting: programmes that addressed criminogenic needs contributed to a significant reduction in recidivism, showing an effect size of .55, in comparison with other programmes. The RNR principles were also valid in a meta-analysis of treatment programs for young offenders (Koehler, Lösel, Humphreys, & Akoensi, 2013), and a meta-analysis on the treatment of female offenders (Dowden & Andrews 1999a). Similar results are found for sex and violent offenders.

Hanson and colleagues (2009) found evidence for the effectiveness of the RNR principles in the treatment of sex offenders. 23 studies were reviewed. They reported that treated, compared to untreated sex offenders, had lower general recidivism rates (31.8% vs. 48.3%), and sexual recidivism rates (10.9% vs. 19.2%). Those studies, which did not adhere to any of the principles, had the weakest effects, while the effectiveness of treatments increased with adherence to RNR, as recidivism decreased significantly when all three principles were tackled (Zara, 2019).

According to Bonta and Andrews (2017), and Bonta (2002), programmes that adhere to all three principles can anticipate a 26% reduction in the recidivism rate. The recidivism reduction reached an average of 17% if delivered in residential and custodial settings and 35% if delivered in community settings. Programmes that followed two principles achieved an 18% reduction, and those that included only one principle showed a 2% reduction. When no RNR principle has been considered, the mean effect even seems to be slightly negative, i.e. in spite of best intention an inappropriate program can sometimes even harm.

Lösel and Schmucker (2017) stated that the treatment of sex offenders embraces a variety of interventions and a diversity of treatment cores, ranging from behavioural, cognitive-behavioural and relapse prevention programs to psychodynamic approaches, therapeutic communities and multi-systemic therapy, and to pharmacological interventions and surgical castration (Marshall & Marshall, 2010; McGrath, et al., 2010).

Taking in mind Lösel's and Schmucker's conclusion, we advocate that treating sex offenders is a complicated clinical matter *per se*, but especially because of the differential risks and the heterogeneity of sex offenders that need to be assessed before any treatment takes place, so that such a variety of intervention programmes are necessary. For instance, it is not unusual that sex violence is combined with other forms of violence, especially when the victim is intimately known, as in intimate partner violence (IPV) (Zara & Gino, 2018). In this case, multiple risks seem to be in place, and require differential risk assessment (Zara & Farrington, 2013, 2016).

Risk assessment, as the anticipatory phase of any treatment, might require some adjustment according to the sex offender's specific needs, responsivity and readiness. The validity of treatment needs to be assessed too, along with the efficacy of interventions. All tasks require scientific coordination, methodological competence and governmental investment (Zara, 2018c). This process describes an ideal scenario that, in countries like Italy, where very few programmes for sex offenders are currently available, seems to

4 *Criminogenic needs* or *dynamic* (psychological) *risk factors* are factors that, when present, enhance the likelihood of reoffending, while when they are directly addressed via treatment reoffending is significantly reduced. Criminogenic needs (e.g. antisocial personality patterns, procriminal attitudes, social supports for crime, substance abuse, family/marital relationships, school/work, prosocial recreational activities) are dynamic and changeable, unlike static risk factors (e.g. criminal career features) that can only change in one direction. Higher risk offenders are likely to have a broader range of criminogenic needs and problems than lower risk offenders, and generally they respond better to treatment if the treatment matches the risk. (For a review see also Bonta & Andrews, 2017).

5 Treatments focusing on non-criminogenic needs appear to slightly increase offending rates (Andrews & Dowden, 2006), even though they might increase the sense of self-efficacy, self-esteem or reduce the anxiety level of the offenders. More studies are certainly necessary to disentangle these mechanisms that, though encouraging, do not reduce the reoffending pattern (Zara & Farrington, 2016).

be only futuristic, especially in comparison with what already happens in North America, Great Britain, and other European countries. In Italy, the Ministry of Justice does not require that offender risk assessments be conducted. Consequently, there are caveats for conducting large-scale studies on sexual offenders in countries such as Italy, with all the negative consequences related to limited research funds available, with no research on the generalisability of findings[6].

Well replicated evidence is necessary for successful treatment. For example, a large recent study in England and Wales that evaluated the widely used core Sex Offender Treatment Program in prisons showed desiderable effects, but a slightly negative result in sexual recidivism (Mews, Di Bella, & Purver, 2017). This study used the currently widely used method of Propensity Score Matching (PSM) to achieve equivalence between treatment and control groups when a randomised experiment was not possible. In contrast to Mews and colleagues (2017) a recent evaluation of sex offender treatment in Germany that also applied PSM found at least a (non-significant) tendency in favour of the treatment group (Lösel, Link, Schmucker, Bender, Breuer, Endres, et al., 2020). These and other findings underline the importance of replication of single studies to achieve a solid basis for policy and practice (Farrington et al., 2018; Lösel, 2018).

The remainder of this paper focuses on the scientific treatment of sex offenders, and summarises some of the main findings available, along with the sound methodology required to carry out such programmes.

6. Work with sex offenders, what is promising and what is controversial

In light of the pivotal studies on sex offending, the essential question is to what extent sex offenders can be treated, and the extent to which the effectiveness of treatment contributes to a reduction in the risk of general or sexual recidivism, or to a reduction in both types of recidivism. Welsh and Farrington (2012) emphasise that the prime requirement of an evidence-based approach to treatment and crime intervention is one that requires a commitment to the use of the most scientific, validated, and evaluated assessment methods and programmes. When examining the general effect sizes of sex offending treatment it is notable that they are not particularly large, but not necessarily smaller than the treatment effect, effect sizes obtained with other types of intervention with other types of offenders (Hood, Shute, Feilzer, & Wilcox, 2002; Ireland, Ireland, & Birch, 2009).

A meta-analysis conducted by Hanson and colleagues (2002) included few true randomized studies, involved a vast range of treatment programmes and a total of over 9,000 sex offenders. The findings indicated that the rate of sex offending was lower for treated offenders (12.3%) in comparison with untreated groups (16.8%). Significantly, those studies that employed a cognitive-behavioural or systemic treatment approach had a reduction in recidivism ranging from 9.9% to 17.4%. This approach consists mostly of teaching sex offenders to re-organise their attitudes towards their sexual behaviour, to develop an ability to empathise with the victims, to appreciate the consequences of their sexually abusive behaviour, even when not explicitly aggressive or violent, and to learn how to control their sexual obsessiveness and their sexual needs in order to avoid further offending.

A meta-analysis by Schmucker and Lösel (2015) showed that cognitive-behavioural approaches seem to be the most promising, in so far as they are set up to move sex offenders towards a process of changing their internal (cognitive and emotive) functioning, as well as their overt behaviour, and their social adjustment to others and to life. From their conceptual evaluations of the treatment of sex offenders, some key points on what is relevant and what needs further investigation have emerged:

The characteristics of the offenders (e.g. age; heterogeneous or specialised; persisters or first-time; high-risk or low-risk; psychopathic; mentally disordered; paraphilic, etc.) have a significant impact on treatment participation, completion and success. Specific risk assessment instruments take into consideration some of these characteristics (e.g. Static-99R, Stable-2007, etc.). Therefore some differentiation between offenders is required to take account of offenders' characteristics, needs and readiness to change.

The type of treatments (group *versus* individual) may vary in efficacy. The meta-analysis of Schmucker and Lösel (2015) suggested that including, at least partly, individualised modules seem to be more effective. This might have depended on aspects related to privacy and specific offender needs.

Sample size seems to be relevant in so far as it might relate to the extent to which the sex offenders are supported. Previous meta-analyses (Lösel & Schmucker, 2005; Schmucker & Lösel, 2015) found larger effects in very small samples. This could partially be due to a publication bias, but a better quality assurance in smaller studies may also be relevant.

The quality of programme delivery and integrity are important issues, and are widely recognised: best practice (Boer & Hart, 2009), and sound quality implementation leads to better effects (Lösel & Schmucker, 2005; Schmucker & Lösel, 2008, 2015).

The context of the treatment seems to make some differences to the effectiveness of programmes for sex offenders. Treatments delivered in prison seem less effective than those delivered in the community (Lösel & Koehler, 2014)

6 An exception to this is the project **SORAT** (*Sex Offenders Risk Assessment and Treatment*), now in its second edition, whose scientific coordinator is one of the authors (GZ). This project is the first national one that takes into consideration the necessity to set up a systematic process of risk assessment within the correctional system that anticipates treatment, and informs and promotes it. The project is funded by the Compagnia San Paolo, and involves the Department of Psychology, University of Turin, the 'Lorusso e Cutugno' Prison in Turin, the Department of Mental Health - ASL Città di Torino, the Abele Group O.N.L.U.S., and the Centre for the Study and Treatment of Violent Behaviour.

or in forensic psychiatry units (Schmucker & Lösel, 2015). This finding may be partially related to criminogenic effect that a custodial setting has on inmates. In addition, sound therapy requires coping with reality. This is, for example, not possible in custodial treatment of child abusers because there are no risk situations with children in prisons. Therefore, aftercare and relapse prevention are highly important.

The characteristics of the evaluation are not easily assessed. In their meta-analysis, Lösel and Schmucker (2017) reported that the findings on the relation between design quality and the effect of sexual offender treatment were mixed.

The transparency of the report on the evaluation is important as an expression of *descriptive validity* (Lösel & Köferl 1989) which, despite not being a characteristic of the evaluation process itself, has substantial correlations with effect sizes. There is no doubt that clear and transparent documentation of the treatment concept, implementation, outcome measurement and statistical analysis is a sound indicator of the overall good quality of a treatment program and its evaluation (Lösel, 2007, 2012). Therefore, programme evaluations should pay more attention to these issues (Farrington, 2006), and follow a sound method (e.g. the Maryland Scientific Methods Scale) (Farrington, et al., 2002).

In their work on treatment of sex offenders, Lösel and Schmucker (2017) provide a condensed overview of some general and differentiated results of meta-analyses on sex offender treatment that deserve specific attention, not least because of the clarity with which they are presented (see also their table on p. 400). There is no doubt that more high-quality primary studies and systematic integrations of the results are crucial to answer open questions, clarify ambiguities over what works and what does not, and help to turn promising findings into replicated knowledge, as Lösel and Schmucker (2017) suggest.

7. Some other issues that need to be clarified in sex offending risk and treatment

Some psychological dimensions need further investigation because their impact upon sex offending is often misunderstood (Mann, Hanson, & Thornton, 2010). They do not seem to have an impact upon risk and sexual recidivism, at least directly, but otherwise seem to be relevant to responsivity and commitment to treatment. Some of these factors are motivation, empathy and denial.

Motivation to engage in treatment is an important factor for participation and perhaps success, but it also depends upon readiness to change (Burrowes & Needs, 2009; McMurran & Ward, 2010).

Denial is a common response in sex offenders (Zara, 2018a,b). Denial is conceptualised as a dynamic process, and various layers of masking individual difficulties (Barbaree, 1991) are included in the *dance of denial* (Happel & Auffrey, 1995). This involves maintaining a stance of innocence (O'Donoghue & Letourneau, 1993) or of defensiveness (Rogers, 2008), deflecting attention from what was done (*absolute denial*) or recounting differently 'known knowledge' (*interpretative denial*) or minimising the consequences of what happened (*implicatory denial*) (Schneider & Wright, 2004). Research findings have shown that the relationship of denial with recidivism risk is at best indirect (Harkins, Beech, & Goodwill, 2010). Denial is an important factor in treating sex offenders (Jung & Zara, 2018; Zara, Farrington, & Jung, 2020). As such, denial should be seen as a challenge for programme improvement, rather than as an asset or a flaw of the offender *per se* (Bekyo & Wong, 2005).

Though empathy is an important dimension in human relationships, it is a non-criminogenic need and is not directly related to sex offending, and victim empathy is not a significant predictor of recidivism (Hanson & Morton-Bourgon, 2005). More important seem to be general aspects of perspective taking and specific components of empathy. In a meta-analysis carried out by Jolliffe and Farrington (2004), a common measure of effect size (the standardised mean difference) in 35 studies, 21 of cognitive empathy and 14 of affective empathy, was calculated. It was found that cognitive empathy had a stronger negative relationship with offending than had affective empathy. The relationship between low empathy and offending was relatively strong for violent offenders, but relatively weak for sex offenders. Empathy differences between offenders and non-offenders disappeared when intelligence and SES was controlled for in the non-offending and offending populations.

Jolliffe and Farrington (2004) specifically identified studies that used sex offenders exclusively as the offending group, or where sex offenders were separable from other offenders. A subset of 18 studies covering 1,752 participants, with a mean number of 52 offenders and 45 non-offenders per study, was gathered. Contrary to expectations, low empathy was more strongly related to mixed offending than to sex offending. When the mean effect size of these 18 studies was compared to that of the remaining 19, a significant between-groups difference was found (Q between groups = 4.33, $p < .04$). However, it was the mixed offender group that demonstrated the higher mean effect size at - 0.31 ($p < .0001$), compared to - 0.18 ($p < .0005$) for sex offenders. This result shows that the disparity in empathy between mixed offenders and controls was greater than between sex offenders and controls. The suggestion that sex offenders may have particular deficits in concordant emotional responses (affective empathy) compared to other types of offenders was not supported.

Empathy in sex offenders needs further investigation, and interventions that target it require a different focus depending on which specific dimensions of empathy are addressed (e.g. perspective taking or emotional recognition or compassion) and, also, on what types of offenders and offending are investigated. It is plausible to assume that sex offenders have some impairments, more of the affective facet of empathy that also includes the relational dimension of emotional sharing, than of cognitive empathy, that includes perspective taking and sympathy (empathic concern), which may summarise the *knowing without caring*

attitude described by Ciman, Tonnaer, and Hauser (2010). Some sex offenders are in fact quite 'empathic', which makes them very able to relate to potential victims and, also, to seduce and groom them. It would not be desirable to increase the empathy of these offenders, as they may then become more successful sex offenders.

Clinical findings suggest that there are some individuals who are difficult to treat (Freilone, 2011) or, in extreme cases, untreatable (Stone, 2006). For instance, highly deviant sexual preferences are viewed as particularly difficult (if not impossible) to treat (Lösel & Schmucker, 2017). Psychopathic sex offenders are also an extremely difficult clinical and criminological population, almost impossible to treat (Abracen, Looman, & Langton, 2008).

8. Conclusions

Much can be learnt about sex offenders from using criminal career information, and by assessing the risk, considering not simply the nature of the crime (e.g. sexual), but the heterogeneity of the criminal career. The risk of recidivism is higher when the criminal career is more versatile, not least because criminal opportunities are more common, and therefore are more frequently taken advantage of.

Longitudinal studies have shown that many changes occur in the criminal career of a sex offender. For instance most juvenile sex offenders do not become adult sex offenders; most offenders who commit sex crime, commit other crimes as well; and those sex offenders who are specialised need differential assessment and personalised treatment so as to deal first with their sexual deviance and psychopathology. The risk of recidivism for sex offenders is not significantly higher than for other offenders. Their risk declines the longer they stay out of crime while in the community. Intervention seems to work in reducing the risk of reoffending, and promoting a rehabilitated life for these individuals. Its efficacy depends upon targeting the specific criminogenic factors that contribute to sexual deviance and to the acting out of their deviancy. Much of our knowledge about sex offenders relies upon known offenders, who have been convicted for a sex crime. Certainly, much less is known about those individuals who commit sexual violence but remain undetected. More research on sex offenders using self-reports is needed. Further research needs to be carried out especially in those countries in which a great deal has to be learned about assessing differential risk and evaluating the efficacy of treatment programmes.

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