CLINICIANS' PERCEPTIONS OF DEGREE OF DIFFICULTY IN TREATING DIFFERENT TYPES OF SEX OFFENDERS AND THEIR ATTITUDES TOWARD THE TREATMENT OF SEX OFFENDERS -- A COMPARATIVE RESEARCH BETWEEN TAIWAN AND MICHIGAN

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ABSTRACT

CLINICIANS' PERCEPTIONS OF DEGREE OF DIFFICULTY IN TREATING DIFFERENT TYPES OF SEX OFFENDERS AND THEIR ATTITUDES TOWARD THE TREATMENT OF SEX OFFENDERS
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This study compares the clinicians of sex offender treatment programs in Taiwan and Michigan treatment programs in terms of their perceptions of treating sex offenders, and their attitudes toward the current treatment programs as well as how their attitudes affect the clinicians' supportiveness of the program.

The objectives of this research are to: (1) understand the differences in clinicians' perceptions of the degree of difficulty in treating different types of sex offenders in Taiwan and Michigan; (2) understand the relationship between the treating experiences and the attitudes toward the treatment of sex offenders; (3) understand the relationship between the clinicians' attitudes toward the treatment of sex offenders and their supportiveness of the program; (4) understand clinicians' opinions on the three current controversial policies-- indefinite confinement, chemical castration, and Megan's Law; (5) understand clinicians' treating philosophy, theoretical approaches, and perceptions of successful treatment factors in Taiwan and Michigan.

In Memory of My dead father and mother

ACKNOWLEDGMENTS

Being an international student, I have a lot of things that need to adjust. This process is frustrated sometimes, but exciting sometimes. Having the mission to bring back to Taiwan a brand new knowledge, sex offender treatment program. I have a lot of work to do, in addition to the study. This process to me is the same as above.

I could not make it without the following people's help, and here I would like to express my appreciation to all of them sincerely. Professor Dr. Sheila Maxwell, chairperson of my thesis committee, gave me many instructions and help which helped this thesis go smoothly. Professor Dr. Vincent Hoffman and Professor Dr. Charles Corley always helped me with kindness. Clinical Psychology Professor Dr. Andrew Barclay instructed me the clinical knowledge from the very beginning of my study at MSU.

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In Taiwan, Psychology Professor Dr. Joe-chang Roda Chen, Criminology Professor

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Finally I need to thank all of the above people again, and say I will miss all of you all the time!

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INTERDUCTION

Introduction

In early 1994, the Legislative Yuan in Taiwan amended the Criminal Code and required sex offenders not get paroled unless they accept psychotherapy. This researcher was a psychiatric social worker in Taiwan and participated in the treatment program then. I have always wanted to study the sex offender treatment programs. Recently some newspapers in Taiwan reported that the program is mostly useless by citing several participating psychiatrists' comments (Wan, 1995). Therefore, the researcher decided to do research by comparing the clinicians in Taiwan and Michigan treatment program in terms of their perceptions of treating sex offenders, and their attitudes toward current treatment program as well as how they affect the clinicians' degree of supportiveness of the program.

Objectives of the Research

1. Understand the differences in clinicians' perceptions of the degree of difficulty in treating different types of sex offenders in Taiwan and in Michigan
2. Understand the relationship between the treating experience and the attitude toward the

treatment of sex offenders

3. Understand the relationship between the clinicians' attitude toward the treatment of sex offenders and their supportiveness of the program
4. Understand clinicians' opinions on the three current controversial policies-- indefinite confinement, chemical castration, and Megan's Law
5. Understand clinicians' treating philosophy, theoretical approach, and perception of successful treatment factors in the two areas

Chapter 2

LITERATURE REVIEW

Typological Research of Sex Offenders

Several typological researches about sex offenders were developed in the last two decades. Following are the main ones.

Typologies of rapists.

(1) Groth: Groth is a clinical psychologist who provided psychotherapy for sex offenders in Connecticut and Massachusetts. Groth's most famous comment on sex offenders is that " rape is a pseudosexual act, complex and multidetermined, but addressing issues of hostility (anger) and control (power) more than passion (sexuality)."(1981, pp2) He gave two types of classifications in 1977 and 1979.

I. 1977: He and A. W. Burgess submitted that sex offenders could be divided into two main types and four subtypes. The two main types are power type (power reassurance type and power assertive type) and anger type (anger retaliation type and anger excitation type).

(A) Power Type: In this type of assault, the offender seeks power and control over his victim through intimidation by means of a weapon, physical force, threat of bodily harm. Physical aggression is used to overpower and subdue

the victim. The aim of the assault usually is to effect sexual intercourse as evidence of conquest. This type of sex offender often shows little skill in negotiating interpersonal relationships and feels inadequate in both sexual and nonsexual areas of his life. So rape is the means by which he reassures himself of sexual adequacy and identity, and of his strength and potency.

(a) power-assertive rapist: They mentioned as the followings:

> The power-assertive rapist regards rape as an expression of his virility and master and dominance. He feels entitled to " take it " or see sexual domination as a way of keeping "his" woman in line. The rape is a reflection of inadequacy he experiences in terms of his sense of identity and effectiveness. (Groth, Burgess, & Holmstrom, 1977)

(b) power-reassurance rapist: They mentioned as the following:

> The power-reassurance rapist commits the offense in an effort to resolve disturbing doubts about his sexual adequacy and masculinity. He wants to place a woman in a helpless, controlled position in which she can not refuse or reject him, thereby shoring up his failing sense of worth and adequacy. (Groth et al.)

(B) Anger Type: This type of sex offender often expresses anger, rage, contempt, and hatred for his victim by beating her, sexually assaulting her, and forcing her to perform or submit to additional degrading acts. He often uses more force than would be necessary simply to subdue his victim, and uses profane and abusive language. The victims often get more serious hurts and trauma such as physical and psychological hurts.

(a) anger-retaliation rapist:

> The anger-retaliation rapist commits rape as an expression of his hostility and rage towards women. His motive is revenge and his aim is degradation and humiliation. (Groth et al.)

(b) anger-excitement rapist:

> The anger-excitation rapist finds pleasure, thrills, and excitation in suffering of his victim. He is sadistic and his aim is to punish, hurt, and torture his victim. His aggression is eroticized. (Groth et al.)

II. 1979: Two years latter in 1979, Groth and Birnbaum submitted another similar typology of sex offenders. It includes the anger type (40%), the power type (55%), and the sadistic type (5%). He combined the two power subtypes into "power type" in the newer typology, changed the anger-retaliation type to a new name- "anger type", and changed anger-excitement type to a new name- "sadistic type" (Groth & Birnbaum, 1979)

(2) Cohen & Seghorn(1980): They have clinically inspected twenty-seven rapists in the Massachusetts Treatment Center, and found that based on the offensive motivation, rapists' characteristics fall several dimensions as serial dispersion. They tried to classify rapists according to the homogeneous and heterogeneous crime behavior and life history. The typology of their research seems to focus on the issue of sexual and assaultive motivation, and different from Groth's focusing on the issue of power and anger. The following four types of rapists were classified by them (Hsiu & Ma, 1994).

(a) Compensatory rapists: This type of rapist is pretty close to the Groth's power assurance type, for the offender wants to get some confirmation of his competency. The offender often seems not to have sufficient social ability, and lower social status, but the offense always is not so serious.

(b) Displaced aggressive rapists: This type of rapists is very close to the Groth's anger-retaliation rapists. They always had bad experience with their girlfriends, wives, or

mothers, and this induced the intention to hurt females by transferring their hostility.

(c) Sex-aggression-fusion rapists: Similar to Groth's anger-excitement rapists, they seem to have some assaultive and social-path personality. Their offenses are often serious and crude, and get gravitation from the hurting instead of the sex. Sometimes they even seriously hurt or kill the victims.

(d) Impulsive rapists: Groth did not have this type in his typology. Cohen et al. mentioned that this rapist's offense always is based on the psychological impulse and dose not seem to be related to sex and assault. The sex offense behavior often follows the other crime behaviors, such as burglary and robbery. The nature is opportunity, and impulse. This type of offenders often do not have crime records in childhood.

(3) Knight and Prentky(1992) developed a statistically based typology for rapists, which is used by Massachusetts Treatment Center for many years. After three revisions, they settled on a typology consisting of nine types derived from four basic categories--opportunistic, pervasively angry, sexual, and vindictive. The eight types are called Type 1 to Tapes 8.

Typologies of child sex offenders.

There are several important researches about child sex offenders including the following:

(1) Groth (1979): Based on the two dimensions, Groth divided pedophiles into the following types : (1) Based on the psychological needs, he divided Fixated Type and Regression Type. (2) Based on the degree to which behavior is entrenched: sex-pressure type, sex-force type, and sadistic type. According to Groth's typology, there

are six types of pedophiles were submitted. As the researcher's clinical experience, the dimension of fixated and regressed is a good to recognize the pedophiles' psychological characteristics . And the fixated offenders are always difficult to treat.

(2) FBI : This typology was developed by Lanning in 1986, and based loosely on Groth's typology. It divided the child sex offenders into two main types and seven subtypes. The two main types are :

1. Opportunistic Child Molesters: This is very close to Groth's regressed type. They often do not have a defined sexual preference for children. It contains four subtypes-- regressed, morally indiscriminate, sexually indiscriminate, and inadequate.

2. Preferential Child Molesters: This type is close to Groth's fixated offenders. They show a strong sexual preference for children, which characterizes their sexual attraction pattern throughout their lives. It contains three subtypes-- seduction, introverted, and sadistic. (Schwartz, 1996)

Researches on Degree of Treating Difficulty -- Relapse Rate and Treatment Effectiveness

The relapse rate of sex offenders is always an issue. Detroit News mentioned that 75 to 80 percent of untreated sex offenders will strike again, compared to a general recidivism rate of about 35 percent, citing the description of an officer of Safer Society Program in Vermont (Basheda & Hoffman, Jan. 29, 1995). But the more careful researches have always revealed the opposite situation, that is, the sex offenders are generally found to have relatively low rate of recidivism when compared to other types of offenders (Tracy, Donnelly, Morgenbesser, & Macdonald, 1983)

Treatment effectiveness is another attractive subject. Many researches revealed the optimistic results in this decade (Marques, Day, Nelson, & West, 1994; Whitaker & Wodarski, 1989; Smith & Wolfe, 1989). There are still pessimistic findings in addition to the optimistic ones in the researches.

Pessimistic aspect.

As regard to the pessimisitic aspect, as early as 1989, Furby, Weinrott, and Blackshaw reviewed existing studies of sex offender recidivism and concluded that "there is as yet no evidence that clinical treatment reduces rates of sex reoffenses in general and no appropriate data for assessing whether it may be differentially effective for different types of offenders"(p.27). Subsequently, numerous reviewers refuted these findings, pointing out serious methodological flaws in this study. Some reviewers noted that most of the programs surveyed by Furby, et al., did not employ currently accepted treatment methods. Most of the programs in the study have not survived.(Steele, 1995). But some researchers in institutional settings are skeptical of the ability of treatment to reduce recidivism (Quinsey, Harris, Rice, & Lalumiere, 1993)

Optimistic aspects.

With regard to the optimistic aspect, G. Hall (1995) identified 12 studies of sex offender treatment since Furby et al.(1989) reported the recidivism rates of treatment and comparison groups of sex offenders could be included in a meta-analysis. In contrast to Furby et al. (1989), G. Hall (1995) concluded that treatment was more effective than no treatment or comparison treatments.

In Hall's meta-analysis review, three behavioral treatment programs reduced deviant

sexual arousal among sexually aggressive men. But none of these programs was significantly more effective in reducing sexually aggressive behavior than the no treatment or comparison treatment groups. In fact, these behavioral programs were slightly less effective (i.e. , resulted in slightly higher rates of recidivism) (Hall, 1995). G. Hall also found that antiandrogen hormonal treatment programs were more effective in reducing sexually aggressive behavior than behavior treatment programs or no treatment. (Hall, 1995). In addition to the above, cognitive-behavioral treatments were found effective in reducing sexually aggressive behavior than behavioral treatment programs or no treatment, but are not significantly more effective than hormonal treatment programs in the findings of Hall's meta-analysis review. However, cognitive-behavioral treatment programs may be more effective than hormonal treatments for a wider range of sexual aggressors, while compared the comprehensive nature of cognitive behavioral programs and the compliant problems with hormonal treatment.(Hall, 1996).

Continuously, two important researches of sex offender treatment programs are revealed as the following:

1. California's Atascadero Research Project: The project, Sex Offender Treatment and Evaluation Project (SOTEP), has a series of outcome studies since 1988 (Marques, Day, Nelson, & West, 1994). The project combined inpatient and outpatient services for their clients. It started in 1985 for imprisoned sex offenders who volunteered to receive treatment two years before their release from prison.

   The evaluation was based on the comparison of three groups: (1) Treatment group: sex offenders who volunteered and were randomly selected for the treatment program.

(2) Volunteer control group: sex offenders volunteered to be in control group, and were matched to the treatment subjects on the basis of age, type of offense, and criminal history. (3) Nonvolunteer control group: sex offenders who qualified for the program but chose not to participate in both groups. They were also matched as above.

The procedure for this research were: (1) Treatment group was transferred to Atascadero State Hospital, where they remain about 2 years (14-30 months). (2) Treatment group participated in 1-year aftercare program in community after their parole. (3) All 3 groups were traced on official record data within 5 years after their release. Treatment program here provided a cognitive-behavioral approach. In the hospital, participants attended group therapy and individual therapy per week. The therapies contain relaxation training, sex education, human sexuality, social skill training, stress and anger management, and preparation for release. In community, participants attend aftercare program by clinicians trained by this research group. All the treatments were conducted according to the manuals. The results are shown in Table 1 (Steele, 1995).

Table 1 California's Atascadero Research Program (1993)

	Treatment (N=116)	Voluntary control group 1 (N=126)	Nonvoluntary control group 2 (N=121)
Time at risk	38 months	38 months	38 months
Rapists (N=78)	23.0%	48.0%	28.5%
Child molesters (N=285)	7.8%	11.0%	13.8%
Total (N=363)	11.2%	19.0%	14.9%

According to the explanation of the researchers, there are some important findings in

the research: (1)the estimated risk for new sex offenses was lower for treatment subjects than for the control groups, but the difference was not statistically significant; (2) Rapists have no significant difference in the survival analyses between treated and untreated groups, though the apparently large difference on their sexual or their violent reoffense; (3) Treated child molesters were found to be at significantly lower risk for other violent offenses than was the volunteer control group ($p<0.5$) (Marques et al., 1994). On the other hand, the attrition were also highlighted, 21% of their clients failed to complete the program: 15% dropped out and 6% were removed for disciplinary reasons and all of them committed new sex offenses(Steele, 1995).

2. Vermont's Sex Offender Program: It was another continuous institution-based program like the former one, but the follow-up term is 1-8 years. The result was revealed as the following table:

Table 2 Vermont's Sex Offender Program, Prison and Community Involvement (1992)

Type of Offender	Number of Offenders	% New Sex Offense
Pedophiles	195	7%
Incest Offenders	190	3%
Rapists	53	19%
Untreated	--	38%

There are some problems to determine what percentage of the sex offenders failed the institutional or in community phase and what their recidivism was. But the result of this program are consistent with other studies in that the incest offenders have a low recidivism rate (Steele, 1995).

Current Sex Offender Treatment Programs in Taiwan and Michigan

Taiwan.

(1)Background

In November of 1993, a female university student was sexually murdered. It raised a heated discussion about having sex offenders receive more rigid punishment. A female legislator held a hearing in the morning of January 18,1994 , and then she submitted the script of Criminal Law revision in the latest conference of the Legislative Yuan. The script was passed on the same day (Wan, 1995).

(2)Legislative Origin

The original Criminal Law in Taiwan does not specifically rule how to treat sex offenders in prisons, but only rules that people with mental disorder could be put in appropriate institutes for security care (like the civil commitment in the U.S.). In the above discussion, everyone thought that it is the rapist who should receive more rigid treatment, but the revised code was changed to "Persons who violate 'the violating moral custom chapter' of Criminal Law should not be paroled unless they have passed the obligatory diagnosis and treatment."

What the researcher should explain further here is that criminals contained in the violating moral custom chapter are not only sex offenders, but also persons who dealt with prostitution or erotic publishing. S. Wan mentioned that only about half of moral custom offenders are sex offenders (Wan, 1995).

(3)Program of Sex offender Treatment

After passing the revision of the Criminal Law, the Ministry of Law Affair submitted

" Executive Order of Obligatory Diagnosis and Treatment for Inmate Breach 'Violating Moral Custom Chapter' "

In that order, there are several steps below (see figure 1) :

- Move such inmates to the instructed prisons(inmates in northern Taiwan go to Taipei Prison; those in the south go to Kaohsiung Prison)
- Instructed prisons should contract with hospitals, and request psychiatrists and clinic psychologists provide sex offenders diagnosis and treatment.(In contract, it also contains psychiatric social workers and clinical nurses.)
- Intake team in prison should screen all of such inmates and decide on who might have mental disorders and refer these to mental health professionals. Inmates without mental problems should continuously receive the prison mentors' counseling.
- Instructed prisons should hold the evaluative conference of diagnosis and treatment, and evaluative conference of counseling. (In contract, the conference should be held very three months.)
- Such inmates' evaluation for parole should firstly pass through one of these two conferences and then the parole committee.
- In budget, the payment for practitioners under the contract are (based on each time their treatment in prison's clinic): psychiatrist NT $5000 (US $180),and the others NT $1000 (US $36).

(4)Practical Situations

- Real numbers of sex offenders in prison who received psychiatric treatment:

United News in Taiwan (Wan, 1995) reported that from March 1994 to October

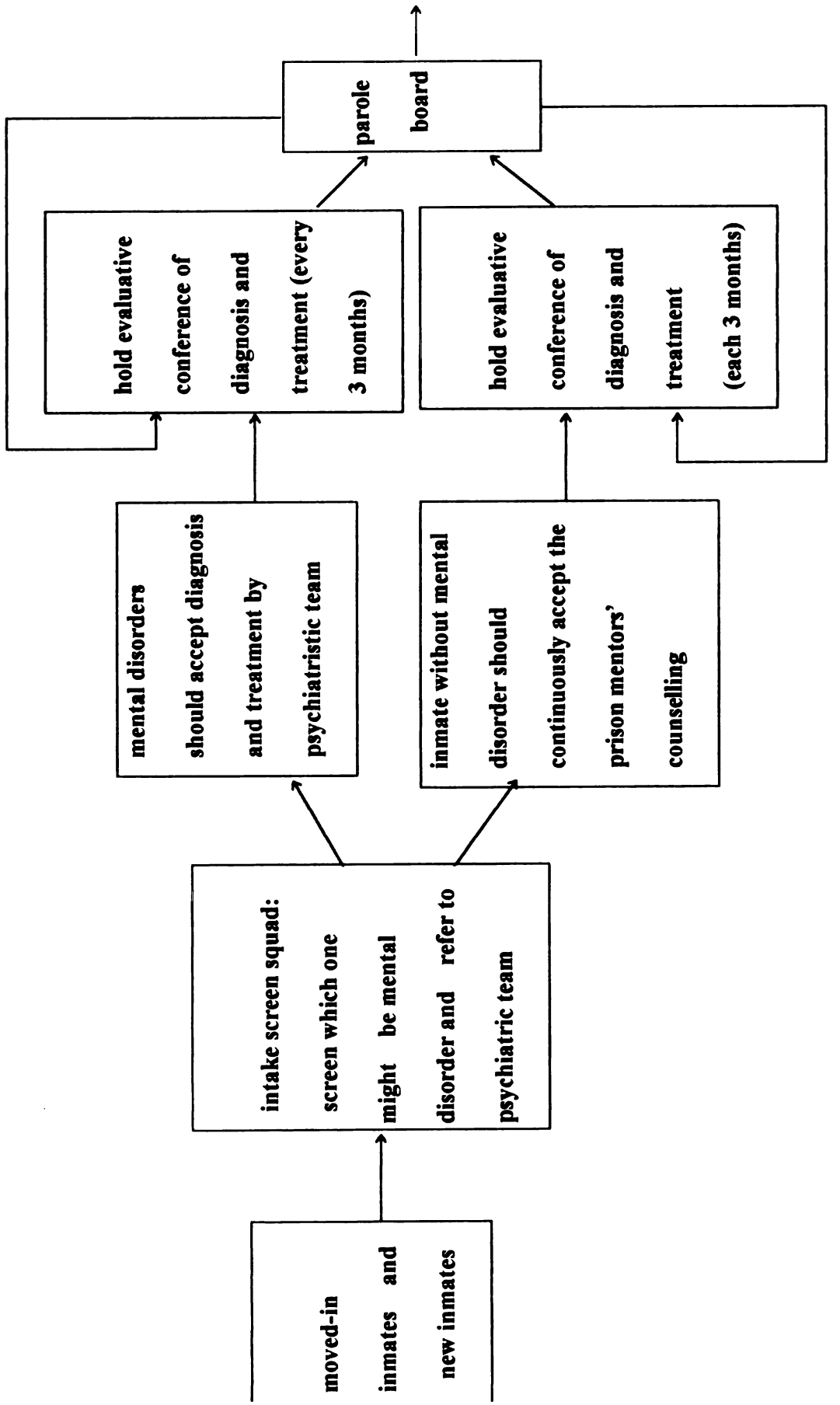


Figure 1 :Sex Offender Treatment Model in Taiwan Prisons

1995, altogether 1191 moral custom offenders were moved to Taipei Prison. After screening, generally the nonsexual offenders would be excluded, 542 moral custom offenders of the 1191 were suspected of mental disorders and were transferred to psychiatric diagnosis and treatment. After the psychiatrists' diagnosis, only 56 moral custom offenders really needed psychiatric treatment-- that is, 4.9 percent of all moral custom offenders.

- Real screening and process

Taiwan Ministry of Law Affair held a conference discussing whether it is necessary to have all moral custom offenders receive psychiatric treatment, and they finally decided that some types of these offenders need to be directly excluded, such as dealers of prostitution and erotic publishing. A prison officer said that would exclude half of such inmates. A psychiatrist said that according to his experience, 90 percent of moral custom offenders do not have psychiatric problem. Besides he said it should not say there is no one should accept the psychiatric therapy, and pedophilia, for example, should receive therapy , but it is very rare (Wan, 1995).

(5)Important Issues from Different Sections of Society

There were several important criticisms of the new law from the society: (1) Rushed law making: It took only half a day to submit the legislative script and for it to pass at the whole conference of Legislative Yuan. All the procedures were not careful enough. It ignored the more serious sex offenses-- rape combined with robbery or rape in the Military Criminal Law. (2) Goal of the law was not clear: What was the real goal, and

how to achieve it were not clear by stated. (3) Suddenly delaying parole resulted in unstable moods of inmates who offended moral customs.(A little collective roaring was happened in Taipei Prison while the law began to be effective.) (4) Low quality of treatment: There are too many sex offenders in prison, but the willing psychiatrists are very rare. (5) High expense and ambiguous outcome: C. Chiu, the chief of Health Division in Kaohsiung Prison, said that the officials of Ministry of Law Affair want to reconsider the contract system because it is too expensive, and he agreed with this (personal communication, May 14, 1996).

Michigan.

(1) Origin and Sex Offense Rate

According to a Memorandum submitted by the Michigan Department of Corrections in July 6, 1994 (see in Appendix A), the following are the origins of sex offender treatment in Michigan:

- 1971-72 Implementation of residential sex offender treatment program in Top 6 of SPSM (a reception and guidance center in Jackson Prison Complex, noted by author) reception center (under auspices of Psychiatric Services)
- 1975 Reception and Guidance Center(R&GC) Psychological Service Unit staff begin operating sex offender program therapy groups at SPSM
- 1979 ...as prison facilities opened across the state and Psychological Services staff were allocated, sex offender program therapy groups were implemented at those sites housing sex offenders

- 2/25/1993 Recommendations of Psychological Services Advisory Committee (PSAC) regarding standardization and revision of sex offender program(the product of a series of meeting in 1992)
- 11/19/1993 Proposed implementation plan and program statement for standardized sex offender program (two-year program) submitted
- 5/17/1994 Deputy Director Jabe approves 11/19/93 sex offender program proposal and addendum(which outlines the accelerated sex offender program designed to accommodate the waiting list sex offenders within 24 months of ERD) (ERD is acronym of earliest release date. Author noted.)

So sex offender treatment program in Michigan began in some prison and gradually was developed to most prisons in Michigan. Within the last four years, the Michigan Department of Corrections was devoted to standardize and accommodate the sex offender treatment program.

Sex offense rate in Michigan, United States, and Taiwan and sex offender proportion in Michigan and Taiwan prisons are organized as the succeeding tables in order to know the differences between the two areas further. From 1996, the sex offense rate in Michigan (57/100,000) is 8.38 times of that in Taiwan (6.8/100,000). But we should note the "hidden" numbers (dark figure) of sex offenses. Generally speaking, sex offense has very serious dark figure problem, as the victims of sex offense may be unwilling to report to the police. This also happens in the both areas. In Taiwan, several non-offical researches revealed that sex offense rates are much higher than those of official statistics are. The range of sex offense rates in these non-offical researches is between 0.6% to 4.2%, both of

the researches were done in 1993 (Taiwan Ministry of Justice, 1995). The latter research conducted by Joe-chang Roda Chen (1993). Using female university students in Taiwan

Table 3 Sex offense Rate in United State, Michigan, and Taiwan.

	United States	Michigan	Taiwan
1996	36.1	57.0	6.5
1995	37.1	62.0	4.3
1990	41.2	78.0	2.9
1985	36.6	67.6	4.0

Note. All the rates are based on 1/10,000,000. The rates in the United State and Michigan are from Uniform Crime Report. The rates in Taiwan are from Taiwan Crime Statistics.

Table 4 Sex Offender Proportion in Michigan and Taiwan Prisons

	Michigan(sex offender/ prison population)	Taiwan(sex offender/ prison population)
1995	18.71% (7271/ 38854)	NA
1994	14.48% (5633/ 38896)	1.06% (380/ 36043)

Note. The data in Michigan are from Sourcebook of Criminal Justice Statistics, edited by U.S. Department of Corrections. Because the data in Taiwan are from Crime Situation and Its Analysis and it provides the proportion of moral custom offenders instead of sex offender. In 1994,it reports 2.11% of inmates, totally 36043, are moral custom offenders. S. Wan mentioned the about half of moral custom offenders are sex offenders (Wan, 1995). Therefore, the research used half of the proportion (2.11%), 1.06%, as the proportion of sex offenders in Taiwan prisons.

as the sample, she found 4.2% (4200/100,000) of them had the experience of being sexually abused on the third degree (namely rape) behavior. Finkelhor and his colleagues (1990) conducted the comparable research in the U.S.. They used the female and male population as the sample in nationwide survey, and found 14.6% (14600/100,000) female

population had the experience of sexual intercourse by offenders (namely rape).

(2)Program

A program process data is attached in the Sex Offender Program Implementation Plan , which contains the Sex Offender Program-- Program Statement.(Bureau of Health Care Services [BHCS]in Michigan Department of Corrections, Nov. 1, 1993) It details the whole process as below (see figure 2) :

Step 1. At reception center, incoming sex offenders receive routine intake psychological screening.

Step 2. Reception center psychologist employs revised screening criteria to identify sex offenders who (a) are recommended for subsequent sex offender assessment or (b) do not receive such recommendations.

Step 3. The results of this initial screening are recorded on "transcase forms" modified to reflect changes in screening criteria and process.

Step 4. Prisoners with recommendations for subsequent sex offender assessment are maintained on an automated tracking list by earliest release date (ERD).

Step 5. When ERD for prisoner brings him/her to top of tracking list (ideally 2 to 2.5 years prior to actual ERD).

Step 6 Prisoner completes Multiphasic Sex Inventory (MSI) in group test administration (approximately 2 hours in duration) .

Step 7 Prisoner completes standardized sex offender program questionnaire prior to assessment interview.

Step 8 A two-person team of psychologists reviews the prisoner's sex offender program

questionnaire and MSI results, interviews the prisoner and makes decision for (a) sex offender program continuation or (b) termination.

Step 9 Prisoners continuing on in the sex offender program begin a standardized 6-month psychoeducational intervention delivered to classes of 16 sex offenders and employing reusable workbooks / participant manuals, videotapes, etc.

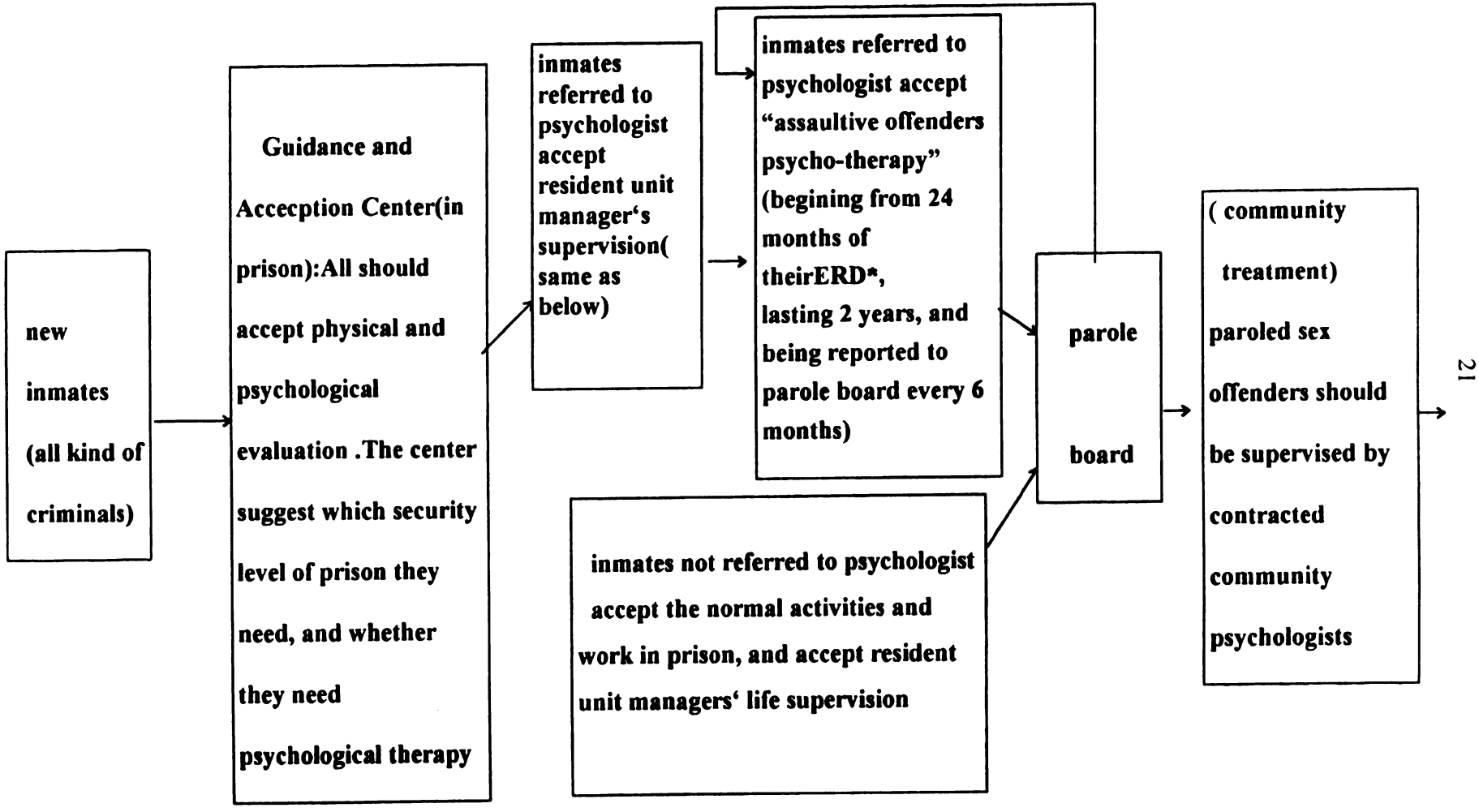
Step 10 Upon completion of the psychoeducational phase, sex offenders are recommended for (a) specialized group psychotherapy or (b) termination from the sex offender program. Sex offender group psychotherapy entails one group therapy session per week with 10 sex offenders per group for 6 to 18 months.

Step 11 Post-program assessment of sex offenders by Psychological Services to measure degree of program progress.

Step 12 Sex offender program progress report is completed for prisoner using standardized format and including recommendations for any required community-based supervision or program involvement.

However, according to the section of correctional psychological service in Michigan Statewide Annual Report-1996 , there are almost two thirds (68.09%) of joining treatment sex offenders (totally 1006 people) in above two-year program, but the rest ones (31.91%) in the accelerated treatment program. J. Rushbrook, the psychological service director of Michigan Department of Corrections, mentioned the accelerated program is a one-year program was developed in 1994 to reduce the more and more inmates in waiting list. The program has the same frequency and treatment context as the 2-year program (personal communication, Feb. 23, 1998).

Figure 2 : Sex Offender Treatment Model in Michigan Prisons (note * : ERD means earliest release date)



(3)some important traits of this program:

- The treatment is voluntary for sex offenders in Michigan prison, but every volunteer should firstly meet the program screening criteria. The criteria below was effective in June, 1993 (Bureau of Health Care Service in Michigan Department of Corrections, 1993) :

  1. The prisoner is currently serving a sentence for one or more of the following offenses Rape, Criminal Sexual Conduct (1st, 2nd, 3rd, 4th Degree, and 2nd offense), and assault with Criminal Sexual Conduct, 1st or 2nd Degree. (includes attempts)
  2. The prisoner has no more than two (included two) documented prior adult felony convictions, not counting the instant offense(s).
  3. The prisoner has an Earliest Release Date (ERD) other than life.

  On the other hand, the program is not applicable to all sex offenders. It is selectively directed at offenders with identified characteristics which enable them to effectively participate in and benefit from the program. Poor program candidates unlikely to and benefit from the program involvement will be screened out.

- It has uniform assessment methods. The Program Statement mentions that the required assessment tests contain MMPI-2, MSI (Multiphasic Sex Inventory), and a composite sex offender program questionnaire.
- It has uniform treatment methods. The program also contains psychoeducational interventions (it briefly mentioned how to do and can use the useful materials or videotapes etc.) and group psychotherapy (it briefly mentioned group should be

organized by different gender and typology, and needs to be supplemented peer counseling , support group, behavioral techniques, individual psychotherapy, and family counseling, etc.)

- It has community-based treatment after release. Community psychologists were contracted to provide supervision for parole sex offender, and encourage them participate in community- based treatment.
- It mainly provides the prisoners within 24 months of Earliest Release Date, so as to the highest priority in terms of program access will be sex offenders housing at Level I, II, and III.

(4)Practical Issues

Some practical situations are worthy mentioning as below:

- In addition to treating sex offenders, Michigan psychologists also provide the one-year grouptherapy to assaultive offenders, interpret the psychological testing, and once a week emergency spell.
- All of the psychological treatment providers are psychologists and few clinical social workers. However, if a sex offender diagnosed with serious mental disorder should be transferred to prison hospital being as an outpatient or inpatient, and receive the treatment provided by the psychiatrists or psychiatric social workers.
- Considering the high expense of health care professionals, Michigan Department of Corrections have been planing to replace the original personnel by the health care professionals employed by outside hospitals contracting with the Department in the last three years in order to save the budget. Currently the Department has been doing the

system in few prisons under the experimental stage and evaluating it.

Three Controversial Policies about Treating Sex Offenders in America

Indefinite confinement.

Six states in America have the laws to allow state officials the right to indefinitely confine sex offenders: Arizona, California, Minnesota, Washington, Wisconsin, and Kansas (Mishra, 1997). All of these states consider the potential objects as sexual violent predators or sex offenders as having psychopathic personalities, because they are considered to pose a severe danger to the community. Whatever they are called, the definition of the objects have raised controversies in legal and clinical fields from the beginning, especially on the substantial due process issue, civil commitment process issue, and an issue that "sex offenders-- even diagnosed pedophiles-- had never been classified as mental illness; they are thought to have mental abnormalities." (Cohen, 1997; Mishra, 1997).

Chemical castration.

In medical technique, antiandrogens, main ingredient in female hormone, can be used to reduce the sexual drive in male. The most famous drug of antiandrogens is medroxyprogesterone acetate (MPA or Depo-Provera). MPA was first used with sex offenders in 1966 by John Money, then it was followed by a series of related researches. It was found to be effective on the subjects such as XXY sexual deviant males, homosexual pedophiles, heterosexual pedophiles, and rapists in reducing sexual drive and sexual violence, but there are still some controversies as to whether it reduces the sexual fantasy or not (Bradford, 1990; Land, 1995; Pallone, 1993). The other main

reason MPA raises legal controversies is that Depo-Provera at times are referred to as chemical castration, which is thought similar to surgical castration-- an inhumane punishment especially for sex offenders in the past or in some countries (Cohen, 1995).

Megan's Law.

Megan's Law is named after Megan Kanka, a New Jersey seven-year old girl who was sexually killed by a paroled sex offender in July 1994. It made the public angry and a law was quickly passed to require paroled sex offenders to register to the community in New Jersey. Before this murder, only five states had similar laws. Shortly after that, more states and even the federal government have enacted this law. The federal law even pushed the other states to enact a registration of sex offender or risk the loss of 10% of federal funding for local and state law enforcement. After Massachusetts passed the law in August 1996, all of the states in America have passed the registration laws, although there are several differences among the states, such as differences of registration places, and whether notifying the community is further required or not (Walsh, 1997). In Michigan, the law requires sex offenders be registered to local police without notifying the community, but encourages the community people to check about the information to protect their safety. This Law also causes the controversies among the offenders, jurists, clinicians, and the public on legal, clinical , and public safety issues. The critiques generally include that there is no proof that this law actually reduces recidivism and that the law might inhibit offenders from seeking treatment after parole or even make them feel more frustrated and reoffend (Walsh, 1997).

Chapter 3

METHODOLOGY

Hypotheses of the Research

1. There are no differences in perceptions of the degrees of difficulty in treating different types of sex offenders between clinicians in Taiwan and Michigan.
2. There is no significant relationship between clinicians' treating experience (such as years of experience, numbers of clients, and length of the treatment) and the attitudes on the treatment of sex offenders (such as attitudes toward the sex offenders' deserving to be treated, the effectiveness of treatment, and familiarity of treating techniques).
3. There is no significant relationship between the clinicians' attitudes toward the treatment of sex offenders and their supportiveness of sex offender treatment program.

Design of the Research

1. Questionnaire design

   (1) In addition to the demographic questions, the questionnaire contains five main parts: the treating experience (including three items-- Item 1(2): the length of participating in treating sex offenders; Item 2(1): the number of treating sex offenders; Item 3: the average length of treating every sex offenders), the perceptions of the degree of

difficulty in treating different types of sex offenders (Item 5), the perceptions of the degree of difficulty in treating sex offenders in general (Item 6) , the clinicians' attitudes toward the treatment of sex offenders (including three items-- Item 7: the degree of agreement on sex offenders deserving to be treated; Item8: the degree of agreement on treating sex offenders being effective; Item9: the degree of familiarity on the techniques of treating sex offenders), the clinicians' supportiveness of the program (Item 10), and the clinicians' suggestions in improving the program (Item 11).

(2) The items about the perceptions and attitudes are based on the 7-level Likert Scale.

(3) A brief introduction of Groth's Typology for Sex Offenders was provided on a separate page attached on the questionnaire.

(4) There were three open-ended questions pertaining to the following treatment issues: treatment philosophy (Item 12), specific theoretical approach (Item 13), and successful treatment factors (Item 14).

(5) There were three open-ended questions pertaining to the three controversial policies in the America. They are indefinite confinement (Item 15), chemical castration (Item 16), and Megan's Law (Item 17). Respondents were asked their degree of support on the policies, the reason of their degree of support, and what their suggestions are if the policies passed as law.

2. Sampling process

(1) Clinicians in Taiwan: There are about 40 clinicians participating in the sex offender treatment program in Taiwan. They include psychiatrists, clinical psychologists,

psychiatric social workers, and clinical nurses. The researcher requested all of them to complete the questionnaires.

(2) Clinicians in Michigan: There are about 90 clinicians participating in the sex offender treatment program in Michigan. All of them are psychologists except few clinical social workers. The researchers handed out the questionnaires at an annual training conference by the permission of the Authority where all of the psychologists were present, and requested all of them to complete it.

3. Methods of the Analysis

(1) The researcher used two-sample t-test to test the significance of difference between the two areas' different perceptions on the degree of difficulty in treating different types of sex offenders (Because the sample sizes in the two areas are different, the researcher would use "pooled t-test" mainly).

(2) The researcher tested the significance of the relationship between clinicians' treating experience (such as years of experience, numbers of clients, and length of the treatment Item 1(2), 2(1), and 3) and their attitudes toward the treatment of sex offenders-- Item 7, 8, and 9)

If Items 7, 8, and 9 are tested to be related to each other, using MANOVA to test the significance of correlation on Hypothesis 2 would be tried.

If Items 7, 8, and 9 are tested to be not related to each other, the Multiple Regression Analysis for every one of them would be used.

(3) The researcher tested the significance of relationship between the three clinicians' attitudes toward the treatment of sex offenders (Items 7, 8, and 9) and clinicians'

supportiveness of the program (Item 10) by the method of multiple correlation.

(4) The suggestions toward current treatment program (Item 11) would be analyzed by the number of approved items as priority of clinicians' suggestions.

(5) The open-ended questions would be analyzed by the numbers of similar responses, and tried to keep their original meaning.

4. Tools of Analysis

All the above close-ended questions in this research were analyzed by the software of SPSS 6.0-- Statistical Package for Social Science 6th edition.

Chapter 4

ANALYSIS

Description of the Samples in Michigan and Taiwan

General description on response rate.

In Michigan, the researcher obtained 33 responses, all of which are useful. The response rate is 34.74% (33/ 95= .3474). In Taiwan, the researcher obtained 34 responses. One of them is useless, because of insufficient amount of information provided. The response rate is 91.66% (33/ 36 = .9166). The followings are tables of the response rates (response/ population) in Michigan and Taiwan.

Table 5 Numbers of Response and Population in Michigan

	(types of clinicians)	response/ population (rate)
Michigan	psychologist	30 / 87 (.34)
	clinical social worker	3 / 4 (.75)
	(total)	33 / 91 (.36)

Table 6 Numbers of Respondent and Population in Northern and Southern Taiwan

	(types of clinicians)	818 Military Hospital	Taoyuan psychiatric Center	Taipei Psychiatric Center	response/ population(rate)
Northern Taiwan	psychiatrist	7 / 8	1 / 1	1 / 1	9/ 10 (.90)
	psychologist	5 / 5	0 / 1	0 / 1	5/ 7 (.71)
	clinical social worker	0 / 0	0 / 0	0 / 0	0/ 0
	(total)	12 / 13 (.92)	1 / 2 (.50)	1 / 2 (.50)	14 / 17 (.82)

	(types of clinicians)	802 Military Hospital	Kai-suan Psychiatric Hospital	Kaohsiung Hospital	response/ population(rate)
Southern Taiwan	psychiatrist	5 / 5	1 / 3	1 / 1	7/ 9 (.78)
	psychologist	5 / 6	6 / 7	1 / 1	12/14(.86)
	clinical social worker	0 / 1	0 / 0	1 / 1	1/ 2 (.50)
	(total)	10 / 12 (.83)	7 / 10 (.70)	3 / 3 (1.00)	20/ 25 (.80)

Types of clinicians.

In Michigan, most clinicians are psychologists. Of the valid responses, 30 (90.9%) are psychologists. The other three are clinical social workers (9.1 %).

But the situation is quite different in Taiwan. Of the sample, 16 clinicians are psychiatrists (45.5%) , 16 are psychologists (48.5%), and 1 is a clinical social worker (3%). As mentioned before, all of the participating clinicians work in community hospitals and provide treatments to sex offenders once a week in prisons by contract with the prisons. Therefore, all of them are in the psychiatric teams, and psychiatrists are the leaders of the teams. The difference in the proportions of clinician types between the two areas is significant (Chi-square= 21.26, significance= .00***).

Gender.

The proportion of male clinicians to female clinicians in Michigan is 72.7%: 27.3%, and 66.7%: 33.3% in Taiwan. The difference is not significant (chi-square= .29, sig.= .59). In this study, male clinicians constitute around 70% of the sample both in Taiwan and in Michigan.

Table 7 Clinical Position, Gender, and Educational Background of Samples in Both Areas

	Michigan	Taiwan	Total
Clinical position			
psychiatrist	0	16 (48.5%)	16
psychologist	30 (90.9%)	16 (48.5%)	46
clinical social worker	3 (9.1%)	1 (3%)	4
(chi-square= 21.26, significance= .00***)			
Gender of clinicians			
Male	24 (72.7%)	22 (66.7%)	46 (69.7%)
female	9 (27.3%)	11 (33.3%)	20 (30.3%)
(chi-square= .29, significance= .59)			
Educational background			
medical degree	0 (0%)	15 (45%)	15
doctoral degree	11 (34.4%)	1 (3%)	12
master degree	21 (65.6%)	7 (21.2%)	28
bachelor degree	0 (0%)	11 (30.3%)	11
associate degree	0 (0%)	0 (0%)	0
missing	1	0	1
(chi-square= 40.33, significance= .00***)			

Note. The chi-square tests conducted here may not be reliable, because numbers in several cells are less than 5. For more information, please see McNemar (1962, p218).

Educational background.

In Michigan, all of clinicians for treating sex offenders are psychologists and social workers. 63.6% of them have master's degree, and 33.3 of them have doctoral degree (one missed this item).

The qualifications for being a clinician are also very different between the two areas. In Taiwan, social works and nurses with a bachelor's or associate degree are allowed to involve in mental health practice. However, only a bachelor's degree or higher is offered for psychologist. 11 (33.3%) clinicians have bachelor's degrees, and 7 (21%) have master's degrees (all of them are psychologists). The other 16 are psychiatrists (They are considered

to have medical degrees, but one of them getting a doctor degree are considered as doctor degree). The difference between the two areas is significant (chi-square= 40.33, sig.= .00***).

Age.

The average age of clinicians in Michigan is 44.67, and 35.66 in Taiwan. The difference between them reaches significance (significance of t-test is .00***). This might be because most Taiwan clinicians are at military hospitals, the places psychiatrists might apply retirement earlier than other hospitals' and psychologists might be more younger than other hospitals'. On the other hand, Michigan has been running the correctional psychological service for decades, which might be the reason why the correctional psychologists in Michigan are generally older than those in Taiwan have.

Comparing four Clinical Experiences in Both Areas

Four items concern about "generalized clinical experience" in this research. They are attending length, numbers of clients, treating term, and main treating from of clinicians. They are analyzed as the following.

Attending length.

The average of attending length of clinicians in Michigan is 89.52 months and that in Taiwan is 17.04 months. Furthermore, there are 7 missing values in Taiwan, and three of them responded they just provide assessment or diagnosis instead of treatment in the questionnaires. After the researcher consulted Northern Taiwan clinicians, they mentioned all of them just provided assessment or diagnosis for sex offenders, that is very different

from Southern Taiwan (It will be explained latter in this study). Moreover, the difference reaches significance (sig.= .00***).

Numbers of clients.

The average of client numbers in Michigan's clinicians is 194.18 , and that in Taiwan is 30.85. The two averages are significantly different (significance of t-test = .00***).

Treating term.

The average of clinicians' treating term (or treatment length) for sex offenders in Michigan is 19.81 months, and 1.30 in Taiwan. Again, the difference is significant (significance of t-test=.00***). The treating terms between northern and southern Taiwan also differ as shown in the following table. The average treating terms in Northern Taiwan is .71 month, and 1.85 months in Southern Taiwan. The difference between the two is significant based on 90% level of confidence (significance of t-test = .09 *). The researcher reviewed the response of clinicians in Northern Taiwan and consulted some of them. It turns out that all Northern Taiwan clinicians have been doing is just interviewing sex offender in prison for one time and then giving them diagnosis. They do not provide any treatment at all. This is very different from Southern Taiwan. In southern Taiwan, although most of the psychologists mentioned they only provided psychological assessment, most clinicians gave psychotherapy for sex offenders in prison.

After a discussion with Director of Adult Psychiatry Department in 818 Military Psychiatric Center and Psychological Service Department in Kai-suan Psychiatric Hospital, it was agreed .25 month would be the treating term for those who only provided assessment or only gave diagnosis for sex offenders in prisons, because the researcher

using the "treating term" in the questionnaire seemingly confused them and some of them left it blank.

Table 8 Average Treating Terms in Different Clinicians of Northern and Southern Taiwan

		means of treating term (month)	means of treating term(month)	response/ population
Northern Taiwan	Psychiatrist	.97 mo.	.71 mo.	9 / 10
	Psychologist	.25 mo.		5 / 7
Southern Taiwan	Psychiatrist	3.05 mo.	1.85 mo.	7 / 9
	Psychologist	1.05 mo.		12 / 14
	clinical social worker	3 mo.		1 / 2
total Taiwan			1.30 mo.	34 / 42

(sig. T of difference between Northern and Southern Taiwan= .075*)

Main treatment modality.

The treatment modalities in Michigan and Taiwan are also very different. As mentioned before, there is a regulation in Michigan that the clinicians provided group psychotherapy for 2 years. But there is no such rule in Taiwan. The difference reaches significance (chi-square= 38.34, significance= .00***) (see Table 9).

The main treatment modalities in Northern and Southern Taiwan are also significantly different-- more grouptherapy been used in the South, and more individual interventions been used in the North (All of the interventions in the North are assessment by psychologists or diagnosis by psychiatrists, as mentioned before), as the following table reveals (significance of chi-square= .02**).

Table 9 Main Treatment Modalities of Clinicians in Both Areas

	Michigan	Taiwan	Northern Taiwan	Southern Taiwan
Missing	0 (0%)	5(15.2%)	3 (21%)	2 (10.5%)
only group	22(66.7%)	1(4.3%)	0 (0%)	1 (5.3%)
most group & some individual	11(33.3%)	13(39.4%)	2 (14.3%)	11 (57.9%)
only individual	0 (0%)	4(12.1%)	1 (7.1%)	3 (15.8%)
most individual & some group	0 (0%)	10(30%)	8 (57.1%)	2 (10.5%)
(column total)	33(100%)	33(100%)	14 (100%)	19 (100%)
	(sig. of chi-square= .00***)		(sig. of chi-square=.02.11**)	

Comparing Means of Percentage of Different Types of Sex Offenders Perceived by Clinicians in both areas.

The proportions of different types of sex offenders perceived by clinicians in the two areas are very different. The average of perceived percentage of rapists is 28.09% in Michigan and 70.92% in Taiwan. On the other hand, that of child molesters is 71.91% in Michigan and 25.84% in Taiwan. The phenomenon in Michigan was also detected by the researcher while doing an internship in Michigan state prison at the summer of 1997. However, the ranks of proportions of the subtypes in rapists and child molesters in the two areas are the same, though the proportions of them are somewhat different (table 11). Groth and his colleagues estimated that in the rapist population, the proportion of power type rapists is 55%, anger type rapists 40%, and sadistic type rapists 5% (Groth, 1979) ; in the child molester population, the proportion of regressed type child molesters is 49% and

fixated type child molesters 51% (Groth, 1978). The reasons why the perceived proportions of rapists and child molesters in the two areas are very different might result from the following reasons: (1) difference in treatment programs: Every sex offender in Taiwan is required by law to receive mandatory diagnosis and treatment before they parole, but in Michigan sex offenders will be recommended by prison psychologists two years before the offenders' early release date and they have the right to decide whether they will be treated or not. S. Bolt, the director of psychological service unit in Cotton Correctional Facility at Jackson, Michigan, said that generally fewer rapists want to join the therapy sessions than child molesters, and that the former also more likely to withdraw from the group even when they joined the group, because of their higher tendency to denial (personal communication, June 12, 1997). (2) difference of child abuse report system: E. Bojdos, a psychologist in Cotton Correctional Facility, said that the better child abuse report systems would always get more reports than the worse ones (personal communication, July 20, 1997). As the researcher know, the child abuse report system in Taiwan is worse than the U.S.. (3) different compositions of sex offense rates: The composition of sex offenses in the United States and Taiwan are very different as the researcher found in official statistics reports. The proportion of child sex abuse cases in sex offense cases in Taiwan generally is generally in the range between 10% to 20%, but about 46% in the United States (table 10).

Table 10 Proportion of Child and Adult Sex Offense in Sex Offense in U.S. and Taiwan

	United States (child sex abuse: adult sex offense)	Taiwan (child sex abuse: adult sex offense)
1996	NA	10% : 90%
1995	46.86% : 53.14%	NA
1990	NA	20% : 80%

Note. Of the U.S. data, the proportions of victims above 12 and victims below 12 are calculated from Sourcebook of Criminal Justice Statistics -- 1996 (edited by U.S. Department of Justice). The Taiwan proportions are from Taiwan Crime Statistics (edited by Taiwan Criminal Investigation Bureau). The cutpoints of child and adult in both areas here are 12 years old.

Table 11 Proportions of Different Types of Sex Offenders perceived by clinicians in the Two Areas

		Michigan	Taiwan	(sig. T of difference)
Rapist		28.09%	70.92%	.00***
	power type	51.15%	64.25%	.06*
	anger type	42.56%	23.80%	.00***
	sadistic type	8.15%	15.70%	.11
Child Molester		71.91%	25.84%	.00***
	regressed type	72.11%	65.06%	.44
	fixated type	27.89%	30.78%	.75

Note. *p<.1; ***p<.01

Comparing Means on Degree of Difficulty of Treating Different Types of Sex Offenders Perceived by clinicians in both areas.

The ranks of clinicians' perception of degree of difficulty on treating different types of

sex offenders in Michigan and Taiwan are totally the same. From the most difficult to the easiest, they are sadistic type rapists, fixated type child molesters, power type rapists, anger type rapists, and regressed type child molesters. None of the degrees of difficulty in treating every type of sex offenders reach the significant difference between the two areas (Table 12). Therefore, the first hypothesis of this research, there are no differences in perceptions of the degrees of difficulty in treating different types of sex offenders between clinicians in Taiwan and Michigan, was met. The reason of this result might be the clinical intuition of two areas' clinicians is very close. Moreover, because the majority of Taiwan clinicians did not know the Groth's typology, there was an appendix explaining every types of sex offender in Groth's typology attached to every copy of questionnaire in order to help Taiwan clinicians understand this typology and respond the questions by their clinical experience or clinical intuition. Groth did not specify the degree of difficulty on treating different types of sex offenders, but he submitted some of important assessment guides such as family background, childhood history, medical history, military history, interpersonal development, occupational history, criminal history, means of the offense etc (Groth & Birnbaum, 1979). However, some researches revealed that if juvenile sex offenders were not effectively treated, they might develop into fixated pedophiles, incestuous fathers (Thomas & Rogers, 1983) or perpetrators of other increasingly deviant and dangerous behaviors (Freeman-Longo & McFadin,1981). Generally if the sex offenders with tortured childhood, early developed deviant sexual fantasy, or antisocial personality disorder (namely psychopathic personality), they should be very difficult to be effectively treated (S. Bolt, personal communication, July 10, 1997; R. Walter, personal

communication, Feb. 21, 1998).

Table 12 Clinicians' Perception of Degree of Difficulty on Treating Different Types of Sex Offenders in the Two Areas (based on 7-level Likert Scale)

		Michigan	Taiwan	(sig. T of difference)
Rapist	power type	4.74	4.85	sig=.77
	anger type	4.63	4.64	sig=.33
	sadistic type	6.48	6.08	sig=.16
Child Molester	regressive type	4.09	4.41	sig=.30
	fixated type	6.06	5.88	sig=.46
general sex offenders		5.00	5.33	sig=.14

Checking the Relationship between 3 Independent Variables and 3 Dependent Variables

Comparing means for the dependent variables should be done before checking the relationship between independent variables and dependent variables.

Comparing means of the 3 dependent variables.

The following three dependent variables are obtained from a 7-point Likert Scale with higher score representing higher degree of agreement with the statements or higher familiarity with the techniques (thus midpoint 4 means "so so" on the items, and scores below 4 would mean disagree and unfamiliar).

1. Deserving to be treated (labeled "deserve" in the statistics)

It means the degree of agreement on the statement "all sex offenders deserve to be treated". Michigan clinicians responses have a mean of 4.30 point on the item, close to the midpoint, "so so", on the scale. Taiwan clinicians responses' mean is 3.47, a little bit

close the side of disagreement. The difference of the two areas is not yet significant (sig. T of difference= .10).

Table 13 Comparing Means of 3 Dependent Variables in the two areas (based on 7-level Likert Scale)

	Michigan	Taiwan	(sig. T of difference)
deserve	4.30	3.47	sig=.10
effective	4.94	4.21	sig=.03**
technique familiarity	5.30	3.32	sig=.00***

2. Treating sex offender is effective (labeled "effective" in the statistics)

It means the degree of agreement on the statement "treating sex offender is effective". Average Michigan clinicians response is 4.94, more than that of Taiwan clinicians' response 4.21. Both areas are on the positive side. The difference of the two areas is significant(sig. T of difference= .03**).

3. Degree of familiarity with the techniques of treating sex offender (labeled "technique familiarity" in the statistics)

It means the degree of agreement on the statement "the degree of familiarity on the techniques of treating sex offender". Average Michigan clinicians response is 5.30 (on the familiar side), higher than that of Taiwan clinicians' response 3.23-- on the unfamiliar side. The difference of the two areas is significant (sig. T of difference= .00***).

Checking bivariate relationship within the 3 dependent variables.

If there is significant relationship within the three dependent variables, it is better to use Multiple Analysis of Variance (MANOVA). But if not, then Multiple Regression

should be used instead. After checking the bivariate relationship (see the following table), only one significant relationship exists-- between "effective" and "technique familiarity". Therefore, using Multiple Regression is necessary.

Table 14 Bivariate Relationship within the Three Dependent Variables

	deserve	feel effective	technique familiarity
deserve	1	.20 p=.13	-.01 p=.99
feel effective		1	.39 p=.00***
technique familiarity			1

Multiple regression.

1. Predicting "deserve" by 3 independent variables in both areas

The following table is the result of multiple regression. Only "treating term" can significantly predict "deserve", and the slope is .06, a mild positive slope-- which means the longer the treating term is, the more likely the clinician is to agree that "sex offender deserve to be treated".

Table 15 Predicting "deserve" by "attending length", "numbers of clients", and "treating term"

Multiple R	.36		
R Square	.13		
Variable	B	SE B	Sig. T
"attending length"	-.011	.01	.13
"numbers of clients"	-.00	.00	.98
"treating term"	.062	.03	.04**
(Constant)	4.07	.45	.00

After making two scatter plots of predicting "deserve" by "attending length" and predicting "deserve" by "treating term" in both Michigan and Taiwan for a try (Figure 3

and 4), the researcher found that the spread of the data points in the two areas are very different, so analyzing the two areas separately is inevitable in this research.

2. Predict "feel effective" by 3 independent variables

The following table is the result of multiple regression. There is no significant slope in it, that means none of the three independent variables can predict "feel effective".

Table 16 Predict "Feel Effective" by "Attending Length", "Numbers of Clients", and "Treating Term"

Multiple R	.22		
R Square	.05		
Variable	B	SE B	Sig. T
"attending length"	.00	.00	.97
"numbers of clients"	.00	.00	.44
"treating term"	.01	.02	.67
(Constant)	4.38	.32	.00

3. Predict technique familiarity by 3 independent variables

The following table is the result of multiple regression. Only "treating term" can significantly predict technique familiarity. The slope is .05, a mild positive slope. That means the longer the treating term, the more familiar to the techniques of treating sex offenders.

Table 17 Predicting "Technique Familiarity" by "Attending Length", "Numbers of Clients", and "Treating Term"

Multiple R	.59		
R Square	.35		
Variable	B	SE B	Sig. T
"attending length"	.00	.00	.51
"numbers of clients"	.00	.00	.15
"treating term"	.05	.02	.03**
(Constant)	3.33	.32	.00

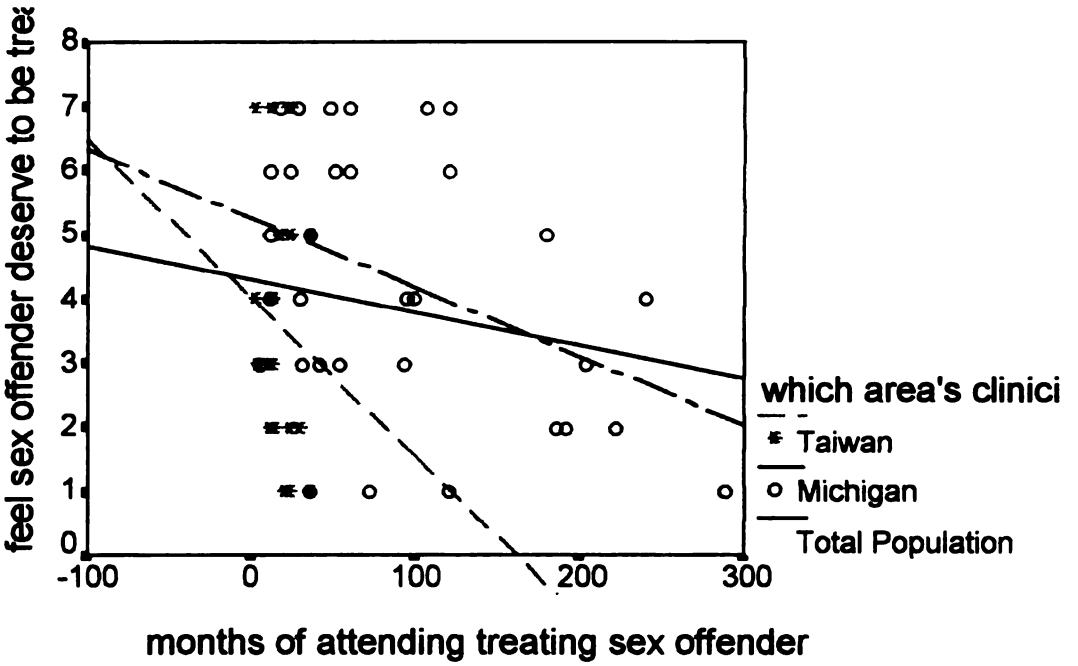


Figure 3 Scatter Plot and Regression Lines of Predicting "deserve" by "attending length" in Michigan and Taiwan

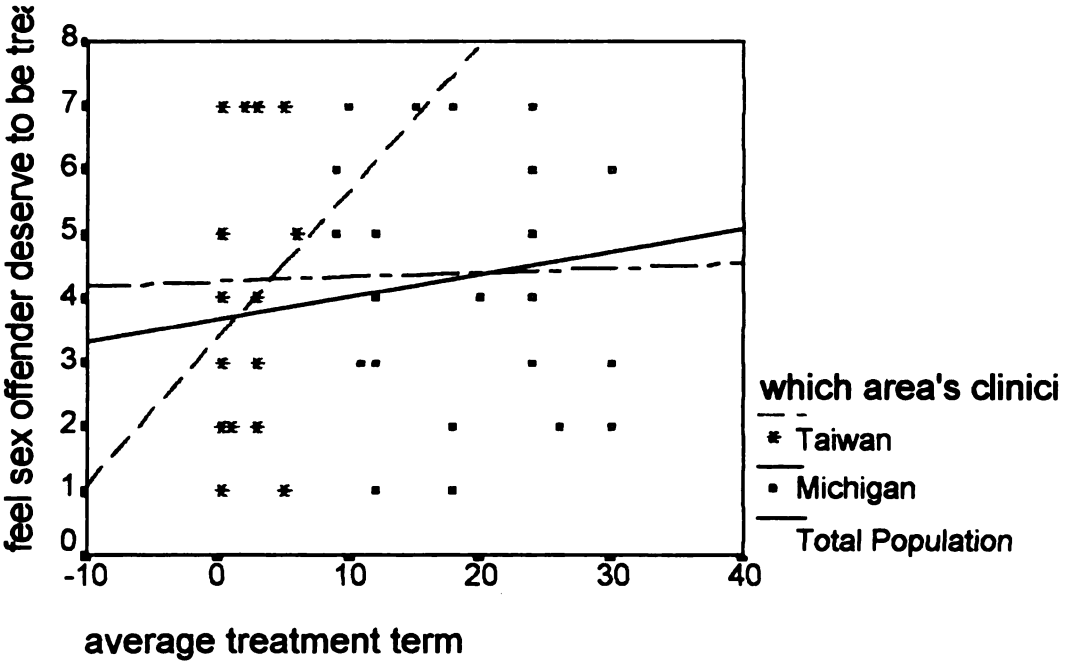


Figure 4 Scatter Plot and Regression Lines of Predicting "deserve" by "treating term" in Michigan and Taiwan

4. Running factor analysis on 3 independent variables, and running multiple regression

Because there are few significant predictions in the above multiple regressions and the three multiple Rs (multiple correlation coefficient) are still high (.36, .22, and .59), it is a reasonable doubt that there might be high correlation within the three independent variables. The following table (Table 18) reveals all of the three bivariate correlations are significant. It is worthy to check whether there is a factor within them.

Table 18 Bivariate Correlation within 3 Independent Variables

	"attending length"	"numbers of clients"	"treating term"
"attending length"	1.00 (59) P= .	.79 (57) P= .00***	.48 (54) P= .00***
"numbers of clients"	.79 (57) P= .00***	1.00 (59) P= .	.34 (55) P= .01**
"treating term"	.48 (54) P= .00***	.34 (55) P= .01**	1.00 (61) P= .

After factor analysis on 3 independent variables being done, one factor (named FACTOR a1) is revealed. Obviously, "attending length" and "numbers of clients" have heavier loading than "treating term" on FACTOR a1, so it can be presumed to contain the meaning of "extensive clinical experience" (see Table 19). On the other hand, treating term can be meant as "deep clinical experience. After doing factor analysis within "attending length" and "numbers of clients" further, the loading is obviously heavier on a factor, named FACTOR a2 (see Table 20).

Table 19 Factor Analysis within "Attending Length" and "Numbers of Clients"

Variable	Communality	*	Factor	Eigenvalue	Pct of Var.	Cum Pct
"attending length"	.87	*	1	2.09	69.6	69.6
"numbers of clients"	.77	*				
"treating term"	.45	*				

Factor Matrix:/	Factor 1
"attending length"	.93
"numbers of clients"	.88
"treating term"	.67

Table 20 Factor Analysis within "Attending Length" and "Numbers of Clients"

Variable	Communality	*	Factor	Eigenvalue	Pct of Var.	Cum Pct
"attending length"	1.00	*	1	1.79	89.6	89.6
"numbers of clients"	1.00	*	2	.21	10.4	100.0

Factor Matrix /	Factor 1
"attending length"	.95
"numbers of clients"	.95

(1) predicting "deserve" by FACTOR a2 and "treating term"

Both FACTOR a2 and "treating term" can significantly predict "deserve" (see Table 21). The interesting finding here is the slope of the former is negative (slope = -.68), that means the more "extensive clinical experience" the clinician has, the less he/she would agree that "sex offenders deserve to be treated".

Table 21 Predicting "Deserve", "Feel Effective", and "Technique Familiarity" by FACTOR a2 and "Treating Term"

	deserve		feel effective		Technique familiarity	
	B	sig. T	B	sig. T	B	sig. T
FACTOR a2	-.68	.03**	.25	.23	.66	.00***
treating term	.06	.06*	.01	.72	.05	.03**
(Multiple R)	.34		.22		.59	
(R square)	.12		.05		.34	

Note. B means regression coefficient; sig. T means significance of t-test.

(2) predicting "feel effective" by FACTOR a2 and "treating term"

Either FACTOR a2 or "treating term" can not significantly predict "feel effective" (see Table 21).

(3) predicting "technique familiarity" by FACTOR a2 and "treating term"

Both FACTOR a2 and "treating term" can significantly predict "technique familiarity". Especially, the slope of former is very high (.66), that means the more "extensive clinical experience" the clinician has, the more he/she would be familiar with the techniques of treating sex offenders.

5. Running factor analysis on 3 independent variables, and running multiple regression in Michigan and Taiwan separately

Because the three independent variables are significantly different in both areas as found before, the researcher ran the above again in Michigan and Taiwan separately to check whether there is further difference.

(1) Michigan

None of the three independent variables can significantly predict the three dependent variables in Michigan (see Table 22). But FACTOR m1 (abstracted from factor analysis on "attending length" and "numbers of clients" in Michigan, and meaning "extensive clinical experience) can significantly predict "deserve" and "technique familiarity". The slope of the former is severely negative (-.8508), that means the more "extensive clinical experience" the clinician has, the far less he/she would agree that "sex offender deserve to be treated" (see Table 23). The reasonable explanations might be the burn-out effect of clinicians (A. M. Barclay; personal communication, Jan. 27, 1998) or considerable

proportion of sex offenders might be impossible to be treated well (R. Walter; personal communication, Feb. 21,1998). J. Rushbrook, the psychological service director of Michigan Department of Corrections, interpreted that it might result from the burn-out effect and feeling not good on the political issue, the State and politicians always want to cut down the money on the expense of health care and prison (personal communication, Feb. 23, 1998).

Table 22 Predicting 3 Dependent Variables by 3 Independent Variables in Michigan

dep. var. \ indep. var.	deserve		feel effective		Technique familiarity	
	B	sig. T	B	sig. T	B	sig. T
Attending length	-.01	.20	.00	.80	.00	.46
Numbers of clients	-.00	.64	.00	.74	.00	.49
treating term	.01	.88	-.03	.51	-.02	.67
(Multiple R)	.44		.21		.37	
(R square)	.19		.04		.14	

Table 23 Predicting 3 Dependent Variables by FACTOR m1 and "Treating Term" in Michigan

dep. var. \ indep. var.	deserve		feel effective		Technique familiarity	
	B	sig. T	B	sig. T	B	Sig. T
FACTOR m1	-.85	.02**	.22	.40	.56	.04**
treating term	.00	.98	-.03	-.51	-.02	.66
(Multiple R)	.43		.21		.37	
(R square)	.18		.04		.14	

(2) Taiwan

None of the three independent variables can significantly predict the three dependent variables in Taiwan (see Table 24). Also FACTOR t1 (abstracted from factor analysis on "attending length" and "numbers of clients" in Taiwan) and "treating term" cannot significantly predict the three dependent variables (see Table 25). It might be caused by the

Table 24 Predicting 3 Dependent Variables by 3 Independent Variables in Taiwan

dep. var. \ indep. var.	deserve		feel effective		Supportiveness	
	B	sig. T	B	sig. T	B	sig. T
attending length	-.07	.21	-.03	.38	.02	.51
numbers of clients	.01	.41	.01	.36	.01	.35
treating term	.27	.29	.21	.16	.20	.15
(Multiple R)	.39		.42		.50	
(R square)	.15		.18		.25	

Table 25 Predicting 3 Dependent Variables by FACTOR t1 and "Treating Term" in Taiwan

dep. var. \ indep. var.	"deserve"		"feel effective"		"technique familiarity"	
	B	sig. T	B	sig. T	B	sig. T
FACTOR t1	-.22	.63	.01	.96	.44	.11
treating term	.26	.30	.21	.16	.20	.14
(Multiple R)	.27		.35		.50	
(R square)	.08		.12		.25	

attending length, numbers of clients, and treating term of Taiwan clinicians is too small in quantitative to significantly predict the three dependent variables; that is the spread of the three independent variables is too narrow for the slopes to significantly predict the three dependent variables. Both Figure 1 and Figure 2 can prove this situation.

Checking the Relationship between 3 Dependent Variables and "supportiveness"

1. Comparing means of "supportiveness" (in Michigan and Taiwan)

"Supportiveness", the degree of support on the current sex offender treatment program, was obtained from a 5-level Likert Scale with higher score representing higher degree of supportiveness (thus midpoint 3 means "so so" on the item, and scores below 3 would mean unsupportiveness on the program).

The average Michigan clinicians' response is higher than that of Taiwan. Both areas are in the positive side, though Taiwan clinicians' response is closer to the midpoint 3, "so so". The difference of the two areas is significant (see Table 26). Crosstabulation and open-ended answers would be analyzed later.

Table 26 Comparing Means of "Supportiveness" in the Two Areas

	Michigan	Taiwan
means of "supportiveness"	3.64	3.03
	sig. T of difference= .03**	

2. Predicting "supportiveness" by 3 independent variables (Combined, Michigan, and Taiwan)

The researcher wanted to understand which variable might affect the degree of

supportiveness on the current sex offender treatment program. Therefore, predicting "supportiveness" by three independent variables and three dependent variables through multiple regression was done as in the following two tables. In the former multiple regression in the Combined, Michigan, and Taiwan, none can significantly predict "supportiveness", except "treating term" in Taiwan (sig. T=.08*)(see Table 27).

Table 27 Predicting "Supportiveness" by 2 Independent Variables in the Combined, Michigan, and Taiwan

	Combined		Michigan		Taiwan	
	B	sig. T	B	Sig. T	B	sig. T
factor(extensive clinical experience)	.05	.87	-.07	.70	-.16	.53
treating term	.04	.15	-.01	.78	.25	.08*
(Multiple R)	.24		.09		.45	
(R square)	.06		.01		.20	

3. Predicting "supportiveness" by 3 dependent variables (Combined, Michigan, and Taiwan)

In predicting "supportiveness" by three dependent variables in the Combined, Michigan, and Taiwan, only "feel effective" can significantly predict "supportiveness" in the Combined and Taiwan. Overviewing these two tables, the researcher found the 3 independent variables and the 3 dependent variables can explain .21 and .30 percent of variation of "supportiveness" in Taiwan, and they are far higher than Michigan.

Table 28 Predicting "Supportiveness" by 3 Independent Variables in the Combined, Michigan, and Taiwan

	Combined		Michigan		Taiwan	
	B	sig. T	B	sig. T	B	sig. T
Deserve	.10	.13	.08	.40	.09	.38
feel effective	.20	.07*	.11	.43	.37	.05**
Technique familiarity	.14	.11	.05	.68	.27	.18
(Multiple R)	.45		.25		.55	
(R square)	.20		.07		.30	

Table 29 Predicting "Supportiveness" by Factor (abstracted from "attending length" and "numbers of clients") and "Treating Term" in the Combined, Michigan, and Taiwan

	Combined		Michigan		Taiwan	
	B	sig. T	B	sig. T	B	sig. T
Factor	.43	.00**	.20	.28		
Deserve	.10	.13	.08	.35		
(Multiple R)	.45		.25			
(R square)	.20		.06			

Note. In Taiwan, there is no significant relationship between "feel effective" and "technique familiarity", but the Combined and Michigan have. Also, a factor could be abstracted from the Combined and Michigan, and it might contain the meaning of feeling treatment effective and familiar to treating technique.

Crosstabulation and Open-ended Answers of "supportiveness"

Analysis of the "supportiveness".

1. Comparison of Michigan and Taiwan

The clinicians' degrees of supportiveness on current treatment program in Michigan

and Taiwan are significantly different in the comparing means (sig. T of difference = . 025**), though they do not reach significantly difference in crosstabulation as the following table shows. The clinicians in Michigan generally tend to be more supportive on the current treatment program than the ones in Taiwan do.

Table 30 Crosstabulation and Comparing Means of Clinicians' Degree of Support on the Current Program in Michigan and Taiwan

	Michigan	Taiwan
not supportive at all	0 (0%)	2 (6.5%)
not supportive	6 (18.2%)	9 (29.0%)
so so	7 (21.2%)	8 (25.8%)
Supportive	13 (39.4%)	10 (32.3%)
very supportive	7 (21.2%)	2 (6.5%)
(total)	33 (100%)	31 (100%)
	Chi-square= 5.78, sig.= .22	
means of "supportiveness"	3.64	3.03
	sig. T of difference = .03**	

Note. 2 missing values, both in Taiwan.

2. Comparison of Northern Taiwan and Southern Taiwan

The clinicians' degrees of supportiveness on the current program in Northern and Southern Taiwan are significantly different as the following comparing means table shows (sig. T of difference = .03**). The clinicians in Southern Taiwan generally tend to be more supportive the current treatment program than the clinicians in Northern Taiwan do.

Open-ended answer analysis of "supportiveness".

The question in this item is " If you answered the above question as 'not satisfied' and 'not satisfied at all', would you explain why?" The followings are the responses:

1. Michigan: Of the negative reposes, including "not supportive" or "not supportive

Table 31 Crosstabulation and Comparing Means of Clinicians' Degree of Support on the Current Program in Northern and Southern Taiwan

	Northern Taiwan	Southern Taiwan
not supportive at all	2 (16.7%)	0 (0%)
not supportive	5 (41.7%)	4 (21.1%)
so so	2 (16.7%)	6 (31.6%)
supportive	3 (25.0%)	7 (36.8%)
very supportive	0 (0%)	2 (10.5%)
(total)	12 (100%)	19 (100%)
	chi-square= 6.46, sig.= .17	
means of "supportiveness"	2.50	3.37
	sig. T of difference = .03**	

Note. 2 missing values, both in Northern Taiwan.

at all", 6 clinicians responded "not supportive" in this question, and all of them wrote down the reasons of their responses, totally ten reasons, been classified as the following.

(1) four (40%) relating to treating term: Three (30% of negative responses) are not satisfied with short time, and one (10%) is not satisfied with infrequency. They are " I am not satisfied with accelerated program" (m1), " program is overly structural and too short" (m18), " too restrictive in time" (m24), and "infrequency of therapy" (m27).

(2) two (20%) relating to treating format: Two (20%) of the negative responses relate to treating format, one (10%) for cognitive behavioral approach and the another one (10%) for too structure.

(3) the others (each for 7.69%): Because they might provide some clues for the policy makers, the researcher prefer to leave them. They are " parole review

process allowed to impair therapy alliance" (m25), " time limits beginning at time incarcerated" (m27), "lack of training and expertise of most clinicians" (m27), and "people who are not clinicians tend to develop programming" (m27).

2. Taiwan: Of the negative responses, 9 clinicians responded " not supportive" and 2 clinicians responded " not supportive at all". There are 13 reasons of their responses been classified as the following.

(1) Four (30.77% of negative responses) are "We just do the diagnosis instead of treatment currently." (t2,3,6,12)

(2) two (15.38%) relating to treating objects. They are "the one lost control after drunk should be excluded" (t2), and "It is wrong that every sex offender should get the mandatory treatment." (t23).

(3) the others (each for 7.69%): They are as the followings: "Screening high risk factors needs to be established." (t5), "That every sex offender needs to see medical doctor limits other clinicians' professional intervention." (t7), "I do not feel there is any sex offender treatment program." (t10), "Eligible professionals and manpower are not enough." (t12), "The program with only outside clinicians and without professionals in prisons might get half the result with twice the effort." (t16), "Sex offenders should be intervened according to the individual situation. Not only psychiatric treatment, but also psychotherapy and family therapy should be included." (t28), and "It is mere formalism, because the program can not be really fulfilled." (t29)

Clinicians' Response on Suggestions for the Current Treatment Program

In order to understand what are the clinicians' suggestions on the current program in the two areas, the researcher asked the following question in the questionnaire. The choice items were from the suggestions of clinicians in Cotton Correctional Facility and Southern Michigan Correctional Psychology Director, in addition to my clinical experience in Taiwan. The seven items, including the two blank items, are named as suggestion #1 to suggestion #7 in the table and latter descriptions. This question was asked as the following:

> What would be your suggestions to improve the efficiency of treating sex offenders in the current system? (Please choose **at least two items** from the followings. If the choices are not so suitable for you, please write it/them down.)

suggest #1 □ continuing the community treatment program after being paroled
suggest #2 □ providing meetings or seminars to improve the professional techniques
suggest #3 □ clarifying which kind(s) of sex offenders deserve to be treated
suggest #4 □ making the length of the treatment at least one or two years
suggest #5 □ concentrating the sex offenders to exclusive prisons in order to provide more treatments
suggest #6 □ _____
suggest #7 □ _____

Because this question is multiple choice, the testee can choose as many as they want, but at least two items. Including the responding on the blank items, there are 111 responses in Michigan, and 104 in Taiwan. From the total responses of the following table (table 32), it reveals the priority in the two areas seems somewhat different. Suggestion #1 is the highest priority in the two areas. 96.97% of Michigan clinicians chose Suggestion #1 and 86.21% of Taiwan clinicians. This reveals the clinicians in both areas mostly agree that "continuing the treatment program after being paroled" is extremely important. Suggestion #2 is the other highest priority in Taiwan (86.21%),

and the third priority in Michigan (51.52%). It indicates that the on-work training is also very important. Suggestion #3, clarifying which kind(s) of sex offenders deserve to be treated, is the third priority in Taiwan (79.31%) but not in Michigan (24.24%). Suggestion #4, making the length of treatment at least one or two years, is the second priority in Michigan (54.55%), and the fourth priority in Taiwan (48.28). Suggestion #5, concentrating the sex offenders to exclusive prisons in order to provide more treatments, are the third priority in Michigan (51.52%), and the fourth priority in Taiwan (41.38%).

Table 32 Clinicians' Response on Suggestions for the Current Treatment Program in Michigan and Taiwan

	Michigan (33 people responded)		Taiwan (29 people responded)		(column total) (62 people responded)	
	no. of approve	proportion of approve	no. of approve	proportion of approve	no. of approve	proportion of approve
suggestion #1	32	96.97%	25	86.21%	57	91.94%
suggestion #2	17	51.52%	25	86.21%	42	67.74%
suggestion #3	8	24.24%	23	79.31%	31	50.00%
suggestion #4	18	54.55%	14	48.28%	32	51.61%
suggestion #5	17	51.52%	12	41.38%	29	46.77%
suggestion #6(blank)	15	45.45%	5	17.24%	20	32.26%
suggestion #7(blank)	4	12.12%	0	0.00%	4	6.45%
(row total)	111		104		215	

Relating to the open-ended suggestions (suggestion #6 and #7), there are totally 24 responses in the two items, 19 in Michigan and 5 in Taiwan. They are sorted as the

following:

(1) three relating to the treating term: They are "having termination related to criteria rather than arbitrary i.e. 1 year and you are out" (m2), "increasing the quality, substance, and length of involvement with arbitrary time limits" (m3), and "three years of treatment prior to parole" (m21).

(2) three relating to the training for the clinicians: It is similar to Suggestion #2, but it is still been emphasized in the two blank items. They are "more training" (m20, 18), and "training of the therapists should be professional" (t2).

(3) two relating to the qualification of the clinicians: They are "credentialing sex offender therapists" (m9), and "The qualification of the therapists should be limited and their professional standard should be identified" (t3).

(4) three relating to the beginning time of the treatment: All suggest the treatment should be provided as soon as possible. They are "beginning treatment soon after prosecution" (m9), "address the issue when inmates are first imprisonment" (m10), and "Therapy and assessment should be done as soon as the client is sentenced..." (t6).

(5) others: The following suggestions are provided as their original sentences in order to keep the meaning of them.

A. Michigan: They are as the followings: "(1) clarify risk assessment issues; (2) develop a standard procedure for dealing with denials. (m1); " (1) better data kept on who fails on parole and conjoin it to the specific of their treatment; (2) also examine who is successful to treatment and what factor account for it (m16); "...

(2) fitting the treatment to the offenders instead of the offenders to the treatment- - behaviorally, culturally, intellectually etc. (m18); "distance the parole board" (m25); "(1) hiring clinicians who are the most skilled rather than the least; (2) support by the Department for clinicians to provide most effective treatment" (m27); "offer mandatory substance abuse treatment for dual diagnosis" (m29); "personally no treatment can be completed without a spiritual dimension involved" (m31); "divide rapists and child molesters into separate groups" (m32).

B. Taiwan: They are as the following: "...besides it is necessary to evaluate the effect of treatment periodically" (t2); " Ministry of Legal Affair needs to provide the budget for the related researches, such as the research of reoffense criteria, so the research outcome can direct the clinical approaches." (t8); "The prisons should have the full time psychologists and clinical social workers in order to do the individual, psychological, familial, and environmental assessment and treatment and do the appropriate transference if necessary." (t16).

Clinicians' Response on 3 Controversial Policies

Indefinite confinement.

1. Crosstabualtion in the two areas

It can be found that the responses concentrate on both sides in both areas, although the disagree sides are lower. 69.7% (23) of Michigan clinicians agree or totally agree indefinite confinement, but 51.7% (15) of Taiwan clinicians do. On the other hand, there are 21.2% (7) of Michigan clinicians disagree or totally disagree indefinite confinement, but

31.0% (9) of Taiwan clinicians do (Table 33).

Table 33 Crosstabulation and Comparing Means of Clinicians' Response on Indefinite Confinement in Michigan and Taiwan

	Michigan	Taiwan	(row total)
Total disagree	3	1	4
	9.1%	3.4%	6.5%
Disagree	4	8	12
	12.1%	27.6%	19.4%
so so	3	5	8
	9.1%	17.2%	12.9%
Agree	6	14	20
	18.2%	48.3%	32.3%
Total agree	17	1	18
	51.5%	3.4%	29.0%
(column total)	33(100%)	29(100%)	62(100%)
chi-square=20.08, sig. of chi-square=.00***, contingency coefficienct=.49			
Means of indefinite confinement	3.91	3.21	
	sig. T= .03**		

Note. There are 4 missing values, all in Taiwan.

2. Comparing means in the two areas

The averages of degree of agreement in the two areas are significantly different. The mean in Taiwan is 3.21, and Michigan 3.91 (Table 33). Clinicians in Michigan tend to agree with indefinite confinement than those in Taiwan.

3. Analysis of open-ended questions

(1) The reasons of the above responses:

a. negative comments on indefinite confinement: They can be sorted to three categories as the following: it is against the law-- citizens can only be confined for the criminal acts (m16, 17, 24; t15, 16, 21, 24); this can not solve the original problems (t2, 3); finishing serving the sentence means completing the punishment (m16, 21).

b. positive comments on indefinite confinement: They can be sorted as the following: some offenders are unable or unwilling to change their behavior, such as psychopathic or fixated offenders (m2, 3, 4, 5, 7, 8, 9, 10, 13, 20, 21, 22, 23, 25, 26, 27, 29, 30, 31, 33; t8, 14, 15, 18, 27, 33); concerning public safety, the system is necessary (m2, 12; t4, 6); if the treatment is not successful in prison, continuing the treatment is necessary (t25, 26).

(2) "If indefinite confinement for sex offenders is passed as law, what is/are your suggestion(s) to enforce it?": The answers can be sorted as the three followings: criteria for qualified indefinite confinement should be established (m4, 13, 17; t2, 13, 18, 19, 21); it better to change the imprisonment of sex offenders longer instead of indefinite confinement (m1, 14, 18; t21); indefinite confinement should also combine with treatment (m12, 14, 17).

Chemical castration.

1. Crosstabulation in both areas

The following crosstabulation reveals less clinicians in Michigan agree or totally agree with chemical castration than in Taiwan, but the difference is not significant. 42.5% (14) of Michigan clinicians agree or total agree with it, and 72.4% (21) in Taiwan (Table 34).

2. Comparing means in both areas

The averages of degree of agreement in the two areas are significantly different. The mean in Taiwan is 3.76, and Michigan 3.15 (Table 34). It reveals Michigan clinicians tend

to be neutral toward the chemical castration while Taiwan clinicians are a little more supportive.

Table 34 Crosstabulation and Comparing Means of Clinicians' Response on Chemical Castration in Michigan and Taiwan

	Michigan	Taiwan	(row total)
total disagree	6	1	7
	18.2%	3.4%	11.3%
Disagree	2	2	4
	6.1%	6.9%	6.5%
so so	11	5	16
	33.3%	17.2%	25.8%
agree	9	16	25
	27.3%	55.2%	40.3%
total agree	5	5	10
	15.2%	17.2%	16.1%
(column total)	33 (100%)	29(100%)	62(100%)
	chi-square=7.56, sig. of chi-square=.11		
means of chemical castration	3.15	3.76	
	sig. T=. 04**		

Note. There are 4 missing values, all in Taiwan.

3. Analysis of open-ended questions

(1) The reasons of the above responses:

a. negative comments on chemical castration: They can be sorted as the three followings: chemical castration is not addressing the behavioral problem (m2, 10, 17, 26, 27, 28, 30); this treatment can not reduce the offenders' assault by other methods or tools. (m2; t1, 3, 21, 23); there would be massive abuse of civil rights. (m15)

b. positive comments on chemical castration: They can be sorted as the five followings: chemical castration may work small minority of sex offenders (m1, 8, 12, 18; t19); only if we had provide series of positive treatment and the prognosis is still bad, we might consider this kind of treatment. (t6, 8, 16); this treatment would increase the

possibility of behavioral control (t12, 27); some sex offender are happy about it (m18, 31); biological factor is one of the clients' problem, so the treatment could work (t25, 33).

(2) "If chemical castration is passed as law, what is/are your suggestion(s) to enforce it?": The suggestions can be sorted as the four followings: this treatment should be voluntary (m7, 14, 19, 31; t4, 23, 25, 26, 27); accurate diagnosis of those who require chemical castration, and classifying sex offenders (m1; t4, 5, 17, 19, 20, 21, 22, 26, 27, 33); this treatment should be ruled the receivable clients should have commit at least three time of reoffense and have received at two years of professional treatment. (t16, 25); use in conjunction with lie detector and penile plethymography (m26).

Megan's Law.

1. Crosstabulation in both areas

It can be found more clinicians in Taiwan agree with the Megan's Law than in Michigan, but the difference is not significant. 72.4% (21) of Taiwan clinicians agree or totally agree with the law, and 57.6% (19) in Michigan. On the other hand, 3.4% (1) Taiwan clinicians disagree or totally disagree with the law, but 21.2% (7) in Michigan (Table 35).

2. Comparing means in both areas

The averages of degree of agreement in the two areas are not significantly different. The averages in Taiwan is 3.90, and Michigan 3.64 (Table 35). It reveals that more Taiwan clinicians tend to agree with Megan's Law than Michigan clinicians do.

Table 35 Crosstabulation and Comparing Means of Clinicians' Response on Megan's Law in Michigan and Taiwan

	Michigan	Taiwan	(row total)
total disagree	1	0	1
	3.0%	0.0%	1.6%
disagree	6	1	7
	18.2%	3.4%	11.3%
so so	7	7	14
	21.2%	24.1%	22.6%
agree	9	15	24
	27.3%	51.7%	38.7%
total agree	10	6	16
	30.3%	20.7%	25.8%
(column total)	33 (100%)	29(100%)	62 (100%)
	chi-square=6.84, sig. of chi-square=.14, p>.10		
means of Megan's Law	3.64	3.90	
	sig. T= .32, p>.10 (not significant enough)		

Note. There are 4 missing values, all in Taiwan.

3. Analysis of open-ended questions

(1) The reasons of the above responses:

a. negative comments on Megan's Law: They can be sorted as the following six comments: this system will isolate the offenders, and leads their committing reoffense cycle (m10; t27); it can be a good way of implementing supervision if it is not the only thing being done (m1); the courts need to recognize their responsibility to define the term of incarceration. (m6); encourages a "witch hunt" mentally (m14); we need to have effective deterrents that before the crime not after. I am not convinced that public safety if enhanced as a resort. (m29); it's not being enforced secretly-- implicated wrong people (by address) and misses appreciate ends sometimes (m32).

b. positive comments on Megan's Law: They can be sorted as the following:

community people have the right to know whether a sex offender lives nearby, and protect themselves (m7, 15, 16, 22, 28, 33; t17, 23); the protection of the community people is more important than the right of offenders (m24, 33; t3, 21, 22); to save children and women from predators (m24; t1).

(2) "What is/are your suggestion(s) to enforce the Megan's Law?"

The responses can be sorted as the followings: agree with registration, but disagree with notification (m17, 18, 27; t14, 20, 24, 25, 26, 27); continuing treatment after release (t5, 12, 14, 17).

Analysis of Clinicians' Philosophy, Theoretical Approaches, and Perception of Successful Treatment Factors in the Two Areas

Clinicians' philosophy of therapy.

Personal philosophy always affect a person's work attitude and interpersonal interaction. This surely includes the clinicians. Clinicians' philosophy of therapy might come from what they learned, their clinical experience, or even their personal experience. The question asking clinicians' philosophy in the questionnaire is " what philosophy underlies your treatment of sex offenders such as ' Do you think they can be cured?' and 'Why treat them?' " . The following are the analyses of the two sub-questions. (2 Michigan clinicians and 7 Taiwanese missed this question)

1. "Do you think they can be cured?"

There is no consensus in the sub-question as the following reveal. The reason of non-consensus might mainly come from the very different treating experience of two areas'

clinicians, surely including the intensive and extensive clinical experience. They are as the followings: 51.6% (16) of Michigan clinicians and no Taiwan clinician responded "Sex offender can not be cured". The reasons for the above response further provided by five respondents can be sorted into three types-- sex offense is a behavior not an illness (9.68% (3) of Michigan respondents), sex offender can only be managed (3.22%(1)), and sex offender may be taught to control his behavior (3.22%(1)); 30.7% (10) of Taiwan clinicians and none Michigan clinicians responded "It depends". The reasons they described further can be sorted into two types-- 30.77% (8) said it depends on the typology, and 7.69% (2) believed it depends on the motivation to be treated.

2. "Why treat them?"

The reasons of treating sex offenders can be mainly sorted into the following categories: 5 8.06% (18) of Michigan clinicians and 11.54% (3) of Taiwanese wanted to provide sex offenders opportunity to change behavior and learn coping skills. 19.35% (6) of Michigan clinicians and 11.54% (3) of Taiwanese responded "no more victim", "protecting society", or "reducing recidivism". 11.54% (3) Taiwan clinicians responded "If we understand the offenders' motivation of crime, we might know the ways to take prevention.". 11.54% (3) Taiwan clinicians responded "Therapy is necessary for the sex offenders with mental illness"

Theoretical approaches.

The question asking the clinicians' theoretical approach in the questionnaire is "Do you

have a particular theoretical position that underlies your treatment? What is it? How successful is it in providing the particular treatment you use?". The following are the analysis of the responses (3 Michigan clinicians and 7 Taiwanese missed this question).

(1) cognitive behavioral approach: 56.67% (17) of Michigan clinicians and 23.08% (6) of Taiwan clinicians chose cognitive behavioral approach as their theoretic base. The comments given by clinicians are: (a)Primarily cognition-behavioral. However, I'm a believer in offering as many resources and techniques to treat sex offenders. They don't respond to just one form of therapy (m1). (b) Cognitive behavioral techniques to avoid relapse (m13). (c) I combine the dynamics of cognitive- behavioral treatment (via Safer Society) with 12-step dynamics with emphasis on development of a strong spiritual base (m29). (d) It has been successful on recidivism rate of 4 to 10 % (m30). (e) After some discussion, I give them chance to correct some wrong cognition, discuss some risky situations with them, and how to positively coping with these situations. That might help them keep away from reoffense (t8). (f) I do not want to deal with their sexual impulse, but I guide their expression of sexual impulse to an acceptable way, and help them produce the newly replacing behavior. That can satisfy the sexual desire and keep them from doing harm to the society (t11). (g) That can help inmate restructure the cognition, and train social skill and anger control (t26).

(2) relapse prevention approach: 16.67% (4) of Michigan clinicians and none of Taiwanese chose relapse prevention approach as their theoretical base. Two of them combined it with cognitive behavioral approach. The given are: Utilize model from Safer Society Press, and I believe it to be effective (m28); relapse prevention plan with many cases the

inculcation of strong sense of a religious conviction which inmate has before but weak in some degree (m31).

(3) psychodynamic or psychoanalysis approach: 13.33% (4) of Michigan clinicians and 7.69% (2) of Taiwanese chose psychodynamic approach. The reasons to submitted it as the following: It is very helpful to in understanding, and helps most people with an average IQ or above (m18, 27); It is positive in emphasizing the elements of trust and love (m25); It helps clinicians understand clients' history and dynamic of criminal behavior, then it can also help clients induce the insight (t13).

(4) cognitive approach: 11.54% (3) of Taiwan clinicians and none of Michigan clinician chose cognitive approach. One described that he used the cognitive therapy (or rational emotion therapy) to deal with the offenders' interpersonal relationship problems and impulse control problems through grouptherapy (t21).

(5) rational emotional therapy (RET) approach: 3.33% (1) of Michigan clinicians and 3.85% (1) of Taiwan clinicians chose RET developed by Ellis.

(6) reality therapy approach: 3.33% (1) of Michigan clinicians and 3.85% (1) Taiwanese submitted reality therapy approach. Neither of them explained further.

(7) fits clients' need: 10% (3) of Michigan clinicians and 3.85% (1) of Taiwanese said it is better to fit the clients' need. The reasons being explained further are the following: (a) Being skilled enough and flexible enough to a number of relevant, multiple model approaches dependent on clients' personality, specific pathology, and behavioral needs, and history (m3). (b) Each offender is different and requires a treatment plan and therapy goals and objectives to his/her needs (m12). (c) If the underlying causes of offenses is

personality disorder, impulse control problem or any kind of psychotic disease, it is a good way to provide therapy according to these underlying causes. But if sexual impulse is the main cause, punishment should be enforced. The justification of law is more important than criminals' right (t3).

(8) spiritual refining (12-step) approach: 3.33% (1) of Michigan clinicians and 3.85% (1) of Taiwan clinicians mention about the spirit. The former said he combines cognitive behavioral treatment with 12-step dynamics, with emphasis on development of a strong spiritual base (m29). The latter mentioned it is a way to let sex offenders' molded spirit be exposed to sun, and bask in the sunshine, then the molded part of their spirit will be gone gradually and naturally (t25).

(9) no specific therapeutic approach: 34.62% (9) of Taiwan clinicians and none Michigan clinicians said they have no specific therapeutic approach.

(10) inducing empathy to victim impact: 3.33% (1) of Michigan clinicians and none Taiwanese emphasized the empathy to victim impact is very important, and said when the offenders began to know victim impact, they see the change sometimes (m10).

(11) others: Each of the following four approaches were mentioned by 3.85% (1) of Taiwan clinicians-- behavioral approach, supportive psychotherapy, biological therapy, and interpersonal approach. The one submitted supportive psychotherapy mentioned he only did diagnosis in one session, but sometimes he provides supportive psychotherapy to sex offender at the same session (t6). The one submitted biological therapy mentioned biological treatment can be used if clients' motivation is not strong enough (t14).

Perception of successful treatment factors.

The question asking the perception of successful treatment factors in the questionnaire is "What do you think constitutes a successful course of treatment? How do you know when a sex offender is done being treated?". The following are the analyses of the two sub-questions. (2 Michigan clinicians and 10 Taiwanese missed this question)

1. What do you think constitutes a successful course of treatment?

The response were summerized as the following table: It can be easily found that most of the items submitted by the clinicians in the two areas are strongly oppisite. That might reveal that the clinical experiences of clinicians in both areas are very different. From the researcher's point of view, the main reason of this outcome might come from Taiwan clinicians' clinical experience far less than Michigan clinicians'.

Table 36 Clinicians' Perception of Seccessful Treatment Factors in Michigan and Taiwan

	Michigan	Taiwan	Total
1. having developed skills to prevent relapse	8 (25.81%)	3 (13.04%)	11 (20.37%)
2. understanding cognitive distortion of oneself	5 (16.13%)	4 (17.39%)	9 (16.67%)
3. taking responsibility on offense	7 (22.58%)	2 (8.70%)	9 (16.67%)
4. developing empathy for others/ victims	7 (22.58%)	1 (4.35%)	8 (14.81%)
5. willingness to change	1 (3.23%)	7 (30.43%)	8 (14.81%)
6. never ending ongoing tenure of treatment	4 (12.90%)	1 (4.35%)	5 (9.26%)
7. no more sex assault	3 (9.68%)	2 (8.70%)	5 (9.25%)
8. understanding relapse cycle	3 (9.68%)	1 (3.23%)	4 (7.41%)
9. depending on clinicians' data collection, evaluation, and classifying their problem	0 (0%)	4 (17.39%)	4 (7.41%)

2. How do you know when a sex offender is done being treated?

The answers can be sorted into the following: (1) "They are never done.": Totally 8 clinicians answered and all of them (25.81%) are Michigan clinicians. (2) "I am not sure.": Totally 5 clinicians answered, and all of them (21.74%) are in Taiwan. (3) "It is hard to say they will never relapse after release.": Totally 4 clinicians answered. All of them (17.39%) are in Taiwan.

From the response of the subquestion, a total disparity phenomenon between Taiwan and Michigan was revealed, such as many Michigan clinicians said they are never done, but no Taiwan clinicians said it. This might result from the very different treating experience between areas.

Chapter 5

SUMMARY AND CONCLUSIONS

Summary of This Research

The summary of this research is as the following:

1. finding about demography in the two areas: Educational background, types, and ages of clinicians between Michigan and Taiwan are significantly different but gender of the clinicians not. Most Michigan clnicians are psychologists. Two third of them have master degrees, and one third have doctoral degrees. But Taiwan clincians include psychiatrists, psychologists, and social workers. Psychiatrists have medical degrees, and the other clinicians have either master degrees or bachelor degrees. The ages of Michigan clinicians are generally older than Taiwan clinicians.
2. finding about clinical experience in the two areas: Four factors are considered as factors of clinical experience-- attending length, numbers of clients, treating term, and treating form. All of them reach significant difference between Michigan and Taiwan. Even treating term and treating form are also significantly different between northern and southern Taiwan.
3. finding about the proportions of different types of sex offenders in the two areas: The proportions of different types of sex offenders are very different. The percentage of rapists is 28.09% in Michigan and 70.92% in Taiwan. On the other hand, the percentage

of child molesters is 71.91% in Michigan and 25.84% in Taiwan. The ranks of proportions of the subtypes in rapists and child molesters in the two areas are the same, though the proportions of them are somewhat different.

4. finding about clinicians' perception of degree of difficulty on treating different types of sex offenders in the two areas: The ranks of clinicians' perception of degree of difficulty on treating different types of sex offenders in Michigan and Taiwan are totally the same. From the most difficult to the easiest, they are sadistic type rapists, fixated type child molesters, power type rapists, anger type rapists, and regressed type child molesters. The reason of this result might be the clinical intuition of two areas' clinicians is very close.
5. finding about relationship between three kinds of clinical experience and three kinds of perception of treating sex offenders: In Taiwan, there is not any one significant relationship between them. But in Michigan, the extensive clinical experience (including the length of attending treatment and the number of clients) have a significant relationship with sex offender deserving to be treated (slope is sever negative) and with the familiarity of treatment technique (the slope is positive). The former means the longer the Michigan clinicians provide treatment to sex offenders, the less they think sex offenders deserve to be treated. The reasonable interpretations might be the burn-out effect of clinicians or considerable proportion of sex offenders might be impossible to be treated well.
6. finding about clinicians' degree of support to the current treatment program and its reasons: The average degree of support to the current treatment program in Michigan is

significantly stronger than that of Taiwan. But only the degree of support in Taiwan can be significantly predicted by treating term and confidence on treating effect, and both slopes are positive.

7. finding reasons why some of clinicians do not support the current treatment program: In Michigan, the main reasons are treatment is too short and too structural; In Taiwan, the main reasons are only doing the diagnosis instead of treatment and not every sex offender needs to be treated.
8. finding about the clinicians' suggestions for the current treatment program: Though the priority is somewhat different, the three most favorite suggestions in both areas are continuing community treatment program after being paroled, providing training to clinicians, and clarifying which kind(s) of sex offenders deserve to be treated.
9. finding about the clinicians' attitudes on three controversial policies: The three controversial policies are indefinite confinement, chemical castration, and Megan's Law. In addition to the society, all of the three also have bipolar comments in the clinicians in Michigan or even in Taiwan. There are significant differences in indefinite confinement and chemical castration between the responses of Michigan and Taiwan, but not in Megan's Law. (1) indifinite confinement: 69.7% of Michigan clinicians agree or totally agree indefinite confinement, but 51.7% of Taiwan clinicians do. On the other hand, there are 21.2% of Michigan clinicians disagree or totally disagree indefinite confinement, but 31.0% of Taiwan clinicians do. (2) chemical castration: 42.5% of Michigan clinicians agree or totally agree with it, and 72.4% in Taiwan, but the difference is not significant. However, the comparing means in both areas reaches

significant difference. (3) Megan's Law: 72.4% of Taiwan clinicians agree or totally agree with the law, and 57.6% in Michigan. On the other hand, 3.4% Taiwan clinicians disagree or totally disagree with the law, but 21.2% in Michigan. The difference above is not significant and the comparing means is the same.

10. finding about clinicians' philosophy, theoretical approaches, and personal perception of successful treatment factors in the two areas: The most favorites will be provided as the following. (1) clinicians' philosophy: About half (51.61%) of Michigan clinicians said sex offenders can not be cured. On the other hand, about one third (30.77%) of Taiwan clinicians said whether or not the sex offenders can be cured depends on the typology. (2) theoretical approach: Over half (56.67%) of Michigan clinicians chose cognitive behavioral approach as their favorite, but over one third (34.62%) of Taiwan clinicians mentioned they have no specific theoretical approach. (3) personal perception of successful treatment factors: The first three factors chose by Michigan clinicians are having developed skills to prevent relapse, taking responsibility on the offense, and developing empathy for victims, but by Taiwan clinicians are willingness to change, understanding self cognition distortion, depending on the data collection, evaluation, and classifying their problems.

Conclusions of This Research

Sex offenses are often scaring and even horrible in the society, especially to female population. Dealing with sex offenders is always very complicated in most countries in the world, because community people, human right groups, politicians, or even offenders

always try to intervene the related policy-making, in addition to the suggestions of criminal justice professionals and mental health professionals. Sex offenders in criminal justice system, no matter in correctional facilities or in communities, are also likely to cause the administrative problems, such as the followings: they are more likely to be harassed by other inmates in prisons should the treatment be mandatory? how effective is the treatment? what are the criteria to get parole? will the paroled sex offenders never reoffend in the community? are the registration or notification hurt the offenders' privacy? etc.

All of the above problems need to be dealt with. This research tries to understand what are the clinicians' perspectives in dealing with sex offenders. The information revealed in this research might be helpful for the criminal justice practitioners, mental health clinicians, policy-makers, legislators or anyone who is concerned about sex offender treatment. However, there are several strengths and limitations in this research.

Strengths of this research.

This research have the following advantages:

1. Comparative research between two different countries: It is very rare in this field to do comparative research between two countries, especially comparing America to an Asia country. Taiwan is the first and the only one country to provide psychological treatment to sex offenders by law in Asia, though North America have been doing it for decades.
2. Research about clinicians' perceptions: The researches dealing with clinicians' perceptions on treating different types of sex offenders, current treatment program, successful treatment, treatment philosophy, or even the three controversial policies are still very few in this field. Even though Safer Society Foundation has been doing the

consecutive nationwide survey for treatment providers every two years since 1986 (Freeman-Longo, Bird, Stevenson, & Fiske, 1995), it only focuses on treatment program context and treatment Modalities currently used by the treatment providers.

3. Understanding the degree of difficulty in treating different types of sex offenders: After Groth developed the sound typology of sex offenders in 1979, little research has been done on understanding the degree of difficulty in treating different types of sex offenders, as the researcher knows.
4. Providing comments and suggestions to current treatment program based on clinicians' opinions: Clinicians participating treatment programs are in the first line to treat incarcerated sex offenders. They should understand the psychological characteristics of sex offenders better than others, including community people and legislators. Therefore no matter in which countries or states the policy-makers should not disregard clinicians' related opinions, in addition to community people's perception. After this treatment programs been run for years in the two areas, it is time to evaluate them, especially in Taiwan, a country just began this treatment program for four years. This research can be an important part, surely not an only one part, in evaluating current treatment program, because the respondents are the main actors to fulfill the treatment programs.

Limitations of this research.

There are several disadvantages:

1. Having limitation to generalize to all states in America: Because the researcher only chose Michigan clinicians as the sample in the America, this research results cannot generalize to every state of America, besides there are several differences in the

treatment program and policies within every American state such as treatment processes and modalities in correctional facilities or communities, tracking systems, and even public perceptions.

2. Not enough understanding about the practical situation in northern Taiwan: Originally the researcher thought the treatment situation in northern Taiwan should be the same as in southern Taiwan, providing psychotherapy followed by doing psychosocial diagnosis by the psychiatric team. But while the researcher administrated the questionnaires in northern Taiwan, all northern Taiwan clinicians said they did not do any treatment except diagnosis for one time, besides the psychologists in northern Taiwan only did the psychological testing for one time then provided to psychiatrists to do the diagnosis. This caused low response rate in these some questions.
3. Not clear in one question: There is one ambiguous question in the English edition of the questionnaire. Five Michigan respondents noted or hinted that they get confused on the "What is/are your suggestion(s) to 'enforce' it?" in the later open-ended questions which are about the three controversial policies. This might cause relatively low responses compared to other questions in Michigan respondents.

Implications of Future Research

After writing this research, the researcher felt that several implications of research in the future need to be addressed as the following:

(1) It is worthy doing the researches about the relapse rate in different types of sex offenders by Groth's typology. Until now, most of the evaluation researches are only

based on rougher classification such as dividing sex offenders into rapists, incestuous offenders, and child molesters, but even rapists can be further divided into several subtypes.

(2) The survey of clinicians' opinions on treating offenders or current program is very important to the policy-making, but it is few that their opinions to be taken into serious account. It is necessary that more related researches to be done. The related researches might include how to improve the treatment efficiency, what are their suggestions on the community registration and treatment, and what are the criteria to screen whether the sex offenders get parole or not etc.

(3) According to some suggestions of the respondents, it is necessary to establish a standardized screening scale to screen a high risk reoffensive group before parole. To protect the society, this kind of screening scale deserves to be researched, developed, and established.

(4) Evaluation of sex offender treatment program had been done in several other states except Michigan. Evaluation could be a good way to understand whether the current program work or not, though it is a very sensitive issue. Facing the same circumstances-- budget constrains, expectation of public safety, and overcrowded prisons etc., hopefully Taiwan and Michigan have their own program evaluation done by interested clinicians or scholars in the near future to show the way improving the treatment effectiveness and protecting the public safety in the two areas.

Questionnaire for Clinicians of Sex Offenders' Treatment-- English edition

* The following questions will ask about your attitudes toward treatment of sex offenders. Please answer honestly. Your answer will be kept **strictly confidential.**

0. Demographic Data:**(place "x" in front of items that apply; <u>All are single choice,except 11.</u>)**

(1) Gender: __ male; __female

(2) Highest Educational Level: __Bachelor; __Master; __Doctor; __Medical Degree

(3) How old are you? _____ years old

1. Clinical Background

(1) Which kind of clinician are you: __ psychiatrist; __ psychologist; __ clinical social worker; __clinical nurse

(2) How long have you been treating sex offenders?
_____ year(s) _____ month(s)

2. The population and percents of the sex offenders you have treated:

(1) Approximately, how many sex offenders you have treated ?

About _____ persons.

(2) I. What percent are rapists? About_____% (** <u>The sum of I and II should be 100%</u>)
(a. The sum of following subtypes is 100%: power type_____%, anger type_____%, sadistic type_____%.)

II.What percent percent are child molesters (including incestuous offenders)? About_____%
(a. The sum of following subtypes is 100%: regressed type_____%, fixated type_____%)

3. Generally, how long do you take to treat sex offenders, on the average?

_____ year(s) _____month(s) (*If there is any special course, please note: _____
_____)

4. Which form is your main treatment for sex offenders ? (Choose **one** of the followings)

___ group therapy only; ___ mostly group therapy with some individual therapy;

___ mostly individual therapy with some group therapy; ___ individual therapy only

5. Scales of your perceptions on the degree of difficulty for treating different types of sex offenders

	extremely easy			average			extremely difficult
(***based on <u>Groth's Typology</u>***)							
(1) about **rapists**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
A. **Power type**	☐	☐	☐	☐	☐	☐	☐
B. **Anger type**	☐	☐	☐	☐	☐	☐	☐
C. **Sadistic type**	☐	☐	☐	☐	☐	☐	☐

(2) about **child molesters** 1 2 3 4 5 6 7

A. **Regressed type** □-------□-------□-------□-------□-------□-------□

B. **Fixated type** □-------□-------□-------□-------□-------□-------□

6. What do you believe the degree of difficulty is in treating sex offenders **in general**?

extremely easy — average — extremely difficult

1 2 3 4 5 6 7

□-------□-------□-------□-------□-------□-------□

7. Do you agree the all sex offenders deserve to be treated?

totally agree — average — totally disagree

1 2 3 4 5 6 7

□-------□-------□-------□-------□-------□-------□

8. Do you agree that treating sex offenders is effective?

totally agree — average — totally disagree

1 2 3 4 5 6 7

□-------□-------□-------□-------□-------□-------□

9. How familiar do you think you are with techniques of of treating sex offenders?

pretty familiar — average — pretty unfamiliar

1 2 3 4 5 6 7

□-------□-------□-------□-------□-------□-------□

10. How supportive are you with the current sex offender treatment program?

__pretty supportive; __supportive; __so so; __not supportive; __ not supportive at all

10.1 If you answered the above question as "not satisfied" and "not satisfied at all", would you explain why? _____

_____

11. What would be your suggestions to improve the efficiency of treating sex offenders in the current system? (Please choose **at least two items** from the followings. If the choices are not so suitable for you, please write it/them down.)

□ continuing the community treatment program after being paroled

□ providing meetings or seminars to improve the professional techniques

- ☐ clarifing which kind(s) of sex offenders deserve to be treated
- ☐ making the length of the treatment at least one or two years
- ☐ concentrating the sex offenders to exclusive prisons in order to provide more treatments
- ☐ _____
- ☐ _____

(Please feel free to write the following items as much as you want !)**

12. What **philosophy** underlies your treatment of sex offenders such as " Do you think they can be cured?" and "Why treat them? " _____

_____

_____

_____

_____

13. Do you have a particular **theoretical position** that underlies your treatment? What is it? How successful is it in providing the particular treatment you use? _____

_____

_____

_____

14. What do you think **constitutes a successful course of treatment**? How do you know when a sex offender is done being treated? _____

_____

_____

_____

15. Do you agree that some sex offenders could be **indefinitely confined**, even when their terms are up, because they pose a danger to society?

___ totally agree; ___ agree; ___ so so; ___ disagree; ___ totally disagree

15.1 Why do you have the above answer? _____

_____

_____

15.2 If indefinite confinement for sex offenders is passed as law, what is/are your suggestion(s) to enforce it? _____

_____

_____

16. Do you agree that **chemical castration** could be used on some sex offenders in order to make relapse prevention more effective?

___ totally agree; ___ agree; ___ so so; ___ disagree; ___ totally disagree

16.1 Why do you have the above answer? _____

_____

_____

16.2 If chemical castration is passed as law, what is/are your suggestion(s) to enforce it?

_____

_____

_____

17. Do you agree with the **Magan's Law** (The paroled sex offenders should be registered or the police should nortify the community if paroled sex offeneders move in.) ?

___ totally agree; ___ agree; ___ so so; ___ disagree; ___ totally disagree

17.1 Why do you have the above answer? _____

_____

_____

17.2 What is/are your suggestion(s) to enforce the Magan's Law?

_____

_____

_____ (Thank you for your help!! I appreciate it by heart!!)

Appendix: Introduction for Groth's Typology of Sex Offenders

Groth (1979) mainly divided the sex offenders into two types, **rapists** and **child molesters**, and also divided them into the following subtypes:

1. **Rapists** (The victims are usually those at the age after puberty.):

(1) power type: They think that rape serves a means of exercising dominance, mastery, strength, authority, and control over the victim. There is little to use the excessively offensive violence, but more about the compulsively sexual fantasies or reaffirming their sexual potency.

(2) anger type: They *more intend to hurt, debase, and contempt for the victim* and is marked by suddenly gratuitous violence. They might think rape is a good way to punish and disgrace the women, and is a outlet to discharge their frustration either associated with the victim or utilizing the victim as a scapegoat.

(3) sadistic type: They might usually cause most seriously physical hurt to the victim or even death. The ritual of torturing the victim and perceptions of suffering and degradation become erotized, and as the assailant's arousal builds, so may the violence of his acts , progressing in some cases to lust murder. The pattern of the assault and the characteristics of the victim are repetitious and symbolic of something he wants to humiliate and destroy.

2. **Child molesters** or **Pedophiles** (The victims are always at the age of puberty or before.) (**Incestuous offenders also could be fallen into the below subtypes.)

(1) regressed type: They have related sexually to appropriate peers at some time in their lives. However, a variety of situation stressors (such as long unemployment, physically impair, or disputed by female adult especially on sex) may undermine their confidence in them as a man. Then they transfer their sex gratification to the underage individual who are less threatening.

(2) fixated type: They have been attracted to children throughout their lives and been unable to attain degree of psychosexual maturity. Groth found that this type of molesters might relate to physical abuse or even sex abuse in their childhood, and that causes them can not develop the trust relationship with adult. Therefore they transfer to getting close with children, and even regard the sex offense as an expression for the child.

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Appendix B

Michigan Department of Corrections

Memorandum

DATE: July 6, 1994

TO: Franklyn Giampa, Ph.D./BHCS

FROM: John C. Rushbrook, Ph.D., Chief of Psychology
Bureau of Health Care Services

SUBJECT: Sex Offender Program Chronology

As requested, here is a chronology of the most significant dates related to the implementation and development of the sex offender program within the Department of Corrections.

1971-72 Implementation of residential sex offender treatment program in Top 6 of SPSM reception center (under auspices of Psychiatric Services)

1975 Reception and Guidance Center (R&GC) Psychological Services Unit staff begin operating sex offender program therapy groups at SPSM

1979 Riverside Reception Center opens at Riverside Correctional Facility in Ionia; Psychological Services Unit staff begin operating sex offender program therapy groups. first at Michigan Reformatory and then other Ionia correctional facilities as Psychological Services staff are hired, as prison facilities opened across the state and Psychological Services staff were allocated, sex offender program therapy groups were implemented at those sites housing sex offenders

5/17/87 DOC staff, including current BHCS Chief of Psychology, attend National Academy of Corrections training: The Sex Offender: Strategies for Treatment (Thirty-six hours)

11/87 BHCS Chief of Psychology position filled, among other tasks, assuming overall programmatic direction for department's sex offender program; program primarily consisted of group psychotherapy interventions delivered by staff psychologist and social workers employed by DOC Psychological Services Units at those sites housing sex offenders; program was relatively unstructured and non-specialized with therapy groups conducted at the professional discretion of the involved psychologist/social worker

9/9/91 More selective criteria for reception center sex offender program recommendations

and general sex offender program eligibility were implemented (an attempt to "manage" program waiting list size by culling out "low risk" sex offenders with less apparent need for the program)

12/8/92 Meeting of sex offender program review committee: Richard McKeon, William Burghardt, Dan Bolden, Franklyn Giampa, Tom Patten and Lynn Green

3/23/92 BHCS Chief of Psychology and other staff attend National Academy of Corrections training: Developing and Administering Sex Offender Programs (Thirty-six hours)

3/27/92 Approval to begin implementation of pilot sex offender program at Muskegon Temporary Correctional Facility

1/28/93 Meeting of sex offender program review committee: Director McGinnis, Richard McKeon, William Burghardt, Robert Steinman, Gary Gabry, Lynn Green, Richard Russell and Greg Owen

2/93 Implementation of residential sex offender program in one housing unit at MTF

2/8/93 Informational meeting with Parole Board chair regarding psychological report terminology, program waiting lists and reception center recommendations

2/25/93 Recommendations of Psychological Services Advisory Committee (PSAC) regarding standardization and revision of sex offender program (the product of a series of meetings in 1992)

3/15/93 Sex offender program proposal submitted to sex offender program review committee review and comments; proposal outlined history of proposed options/strategies for reducing sex offender program waiting list numbers (e.g., more restrictive program screening criteria, redeployment/reassignment of existing staff, use of staff overtime and transfers of program-eligible prisoners) and related problems (growth in prisoner/sex offender populations, staff vacancies and work force reduction)

4/21/93 Meeting of same committee to discuss 3/15/93 sex offender program proposal

6/22/93 Implementation of revised sex offender program screening criteria for determining which sex offenders are recommended for further assessment and continued program involvement; CHJ-251 form, Notice of Sex Offender Program Screening used to document screening

10/6/93 Recommendation to incorporate proposed penile plethysmography on a pilot test basis into the Muskegon Temporary Correctional Facility pilot sex offender program

11/19/93	Proposed implementation plan and program statement for standardized sex offender program (two-year program) submitted
1/5/94	11/19/93 sex offender program proposal submitted to Deputy Directors Steinman and Bolden and M. Van Ochten for review and comment
3/29/94	BHCS allocated an additional 4.6 psychologist and 2.0 secretarial positions dedicated to sex offender program activities at specific sites; stage is set for transfer of sex offenders to these sites for program participation as needed
4/26/94	Directive from Gayle Lafferty to proceed with implementation of proposed accelerated sex offender program
5/3/94	Proposed addendum to 11/19/93 sex offender program proposal to Deputy Director Jabe for approval; addendum modifies the sex offender program into an accelerated program (six- to nine-month program) designed to accommodate sex offenders on the waiting list within 24 months of earliest possible release date (ERD)
5/4/94	Lafferty directive to medical directors/clinical administrators regarding denial of medical clearances for transfer for prisoners involved in sex offender program
5/9/94	Demarse Academy training of staff related to assessment instruments to be used in accelerated sex offender program; assessment materials for the accelerated sex offender program distributed to regional psychologists
5/16/94	BHCS central office decision to forestall trial implementation of penile plethysmography at Muskegon Temporary Correctional Facility until review of related liability and legal issues is completed
5/17/94	Deputy Director Jabe approves 11/19/93 sex offender program proposal and addendum (which outlines the accelerated sex offender program designed to accommodate the waiting list sex offenders within 24 months of ERD)
6/6/94	Psychoeducational materials (Safer Society workbooks) for the accelerated sex offender program distributed to regional psychologists
6/21/94	Following suggestions from M. Van Ochten and with input from Lafferty and Giampa, work groups recommended to (a) draft a sex offender program policy directive, (b) collect documentation supporting the reliability/validity/efficacy of penile plethysmograpny, (c) explore other state prison systems' experience with the use of penile plethysmographs and (d) gather materials for central office review of proposed plethysmograph stimulus materials

cc: File

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