


SECTION 4: SEX OFFENDER-SPECIFIC TREATMENT IN THE CONTEXT OF SUPERVISION

2 hours

Presentation Content	Teaching Notes
<p>TOPIC: INTRODUCTION (2 minutes)</p> <p> LEARNING OBJECTIVES At the conclusion of this section, you will be able to –</p> <ul style="list-style-type: none"> ▪ Summarize the research findings about the effectiveness of sex offender treatment; ▪ Outline the components of sex offender treatment currently in use around the country; ▪ Outline the expectations a probation/parole officer may reasonably hold for a sex offender treatment provider; ▪ Identify the characteristics of a sex offender treatment provider associated with effective practice; and ▪ Identify at least three ways in which a probation/parole officer might collaborate with a sex offender treatment provider in order to enhance the effectiveness of supervision. 	<p>Note: If a treatment provider is part of the training team, it is recommended that s/he conduct this session.</p> <p>Note: A full training module on sex offender treatment is forthcoming.</p> <p>➤ Use slide 1: Learning Objectives</p> <p>Note on Learning Activities for Section 4: This section contains six discussion questions. If fewer than 25 participants are present, the trainer may want to stop after each topic and use the questions to process the information just presented. (The section is written in this way.) If the group is larger, the trainer may want to break the group into smaller groups once or twice to discuss and process the material.</p>

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<p>individuals. She also found that recidivism rates seemed to decline in studies conducted after 1980, suggesting an improvement in treatment methods in recent years, or more effective evaluation methods, or both.⁸ Other findings from Alexander’s review suggested that treatment over a long period of time may be needed in order to be effective, that completing treatment (rather than dropping out) seems to be important in sustaining treatment effects, and that mandatory treatment may be even more effective than voluntary treatment. Recently, Alexander (1999) conducted an analysis of a large group of treatment outcome studies, encompassing nearly 11,000 sex offenders. In this study, data from 79 sex offender treatment studies were combined and reviewed. Results indicated that sex offenders who participated in relapse prevention treatment programs had a combined rearrest rate of 7.2 percent, compared to 17.6 percent for untreated offenders.⁹</p> <p>A number of researchers have also observed that the research is inconclusive – that there are so many problems in how studies are designed, that it is difficult to know whether or not treatment is effective. Some of the most common studies that are cited on these points include Furby et al., (1989) and the GAO Report (1996) and they reach similar conclusions:</p> <ul style="list-style-type: none"> ▪ There are serious methodological problems with the studies that have been conducted; ▪ There is no evidence or it’s inconclusive that treatment reduces recidivism; and ▪ Current programs may be more effective than those that were studied in the past.¹⁰ <p>David D’Amora, in reviewing literature, cites a 1991 U.S. Department of Justice study that found the recidivism rate of untreated sex offenders to be about 60 percent within 3 years of release from prison. Recidivism rates of those sex offenders who have completed a specialized treatment program are between 15 and 20 percent. In other</p>	<p>➤ Use slide 4: Review of the Research</p>

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<p>associated with increasingly effective treatment and/or evaluation techniques;</p> <ul style="list-style-type: none"> ▪ Analytic or insight oriented therapies are not effective¹⁶; ▪ Cognitive-behavioral approaches appear most promising, and a combination of educational, cognitive-behavioral, and family system interventions can be effective;¹⁷ and ▪ When all studies are reviewed, we can conclude generally that sex offender treatment reduces sexual recidivism about 10 percent. The generally accepted recidivism rate for all untreated sex offenders is about 30 percent compared with a recidivism rate of about 20 percent for treated sex offenders.¹⁸ <p>A few studies support the effectiveness of a combination of specialized supervision and sex offender-specific treatment (with or without the polygraph).¹⁹ Agencies that have moved to a containment approach are hopeful that the combination of these three resources will prove significantly effective in reducing re-offense rates. An evaluation currently underway of the program in Maricopa County, Arizona, which incorporates all three elements of the containment approach, is showing promising results with single-digit rates of re-offense (although this does not include some offenders who were returned to prison as a result of technical violations).²⁰</p>	<p>➤Use slide 9: Effectiveness of Treatment Plus Supervision</p>



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<p data-bbox="186 325 945 367">TOPIC: SEX OFFENDER TREATMENT</p> <p data-bbox="186 373 699 405">(60-70 minutes, including Learning Activity)</p> <p data-bbox="186 436 860 468">DISTINCTIONS FROM OTHER TYPES OF TREATMENT</p> <p data-bbox="186 480 946 674">One of the most helpful things for probation/parole officers to be aware of is that the cognitive-behavioral therapy proving to be successful with sex offenders is distinctively different from traditional counseling or psychotherapy.</p> <ul data-bbox="186 720 1019 1896" style="list-style-type: none"><li data-bbox="186 720 1019 1108">▪ Traditional therapy focuses on the offender as the “client” or “patient” primarily, whereas sex offender treatment has a goal of preventing future victimization and striving to ameliorate the harm done by the offender to the victim of the crime. Some therapists say that the community and potential future victims are their real clients. Indeed, as states begin to develop standards for treatment, at least one has adopted the “victim/community as client” perspective officially in its standards.²¹<li data-bbox="186 1155 1019 1308">▪ Traditional psychotherapy seeks to reduce feelings of anxiety and inadequacy, while sex offender therapy seeks to confront the offender with his thinking errors and to bring him to accept accountability for his actions.<li data-bbox="186 1354 1019 1623">▪ Where traditional treatment may take place in the context of individual psychotherapy/counseling <i>or</i> in a group setting, most sex offender therapists find that the group therapy setting is essential to treatment. The group setting including offenders with similar backgrounds helps to undermine the secrecy and denial typical in a sex offender’s view of himself.<li data-bbox="186 1669 1019 1780">▪ Traditional therapy is undertaken voluntarily by the client, while sex offender treatment is often ordered by the court and may not be considered entirely voluntary.<li data-bbox="186 1827 1019 1896">▪ Therapists traditionally operate in a context where the patient-client privilege shields both parties from	<p data-bbox="1047 730 1422 835">➤ Use slide 10: Traditional vs. Sex Offender Treatment</p>



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<p data-bbox="186 296 829 327">WHAT COMPRISES SEX OFFENDER TREATMENT?</p> <p data-bbox="186 373 440 405"><i>Goals of Treatment</i></p> <p data-bbox="186 422 1015 646">In order to begin to understand specialized sex offender treatment, it is perhaps most important to review its goals. First of all, the primary, overall goal is to reduce recidivism. According to Georgia Cumming and Maureen Buell, some of the typical steps toward reaching that goal in sex offender treatment include:²²</p> <ul data-bbox="186 657 1015 1873" style="list-style-type: none"><li data-bbox="186 657 1015 846">▪ <i>Accepting responsibility and modifying cognitive distortions.</i> Offenders are masters of deceit—even of themselves. The treatment process will confront thinking errors and attempt to correct them so that the offender will accept responsibility for his actions.<li data-bbox="186 856 1015 1087">▪ <i>Developing victim empathy.</i> Part of the denial and deceit that sex offenders employ is that the victim is somehow complicit in the activity, did not really mind, and—at least—was not really harmed. Being able to understand the fear and trauma experienced by the victim is an important goal of therapy.<li data-bbox="186 1098 1015 1245">▪ <i>Controlling sexual arousal.</i> Treatment will focus on sexual arousal as a part of the offense cycle, along with methods of controlling or rechanneling arousal toward acceptable partners and activities.<li data-bbox="186 1255 1015 1402">▪ <i>Improving social competence.</i> Difficult social situations may generate the type of anxiety that is a precursor to re-offending. Treatment will help offenders identify those situations and develop skills to address them.<li data-bbox="186 1413 1015 1602">▪ <i>Developing relapse prevention skills.</i> Treatment will help offenders understand the sequence of events that leads to their offense behavior. Offenders will then be helped to interrupt that cycle or chain of events in order to prevent future victimization.<li data-bbox="186 1612 1015 1873">▪ <i>Establishing supervision conditions and networks.</i> Working with probation or parole officers, treatment providers will help identify high-risk situations, behaviors, and locations to help the officers customize supervision conditions that will assist in managing risk. They may also identify other individuals in the community who might become part of a supervision network.	<p data-bbox="1047 667 1404 772">➤Use slide 12: Means of Reducing Recidivism Through Treatment</p>

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<p data-bbox="186 268 1023 976"> <ul style="list-style-type: none"> ▪ <i>Clarification.</i> Many treatment providers have as a goal that their offender clients will complete a process of clarification regarding their sexual offending. The purpose of the clarification process is to have offenders express full responsibility for their offense to victims in order to relieve victims of any responsibility for the sexual abuse and to clarify what occurred in language victims can understand. Victims may or may not play a role in this process, through their choice. Clarification involving victims is permitted only after offenders and victims have adequately completed the majority of their respective treatment programs. It is often done through a letter. However, such a letter is never presented to a victim without the approval of the therapist and probation/parole officer, the approval of the victim’s treatment provider, and custodial parent or guardian.²³ Ideally, clarification should always occur before any victim recontact or reunification. </p> <p data-bbox="186 1008 787 1081"> LEARNING ACTIVITY: DISCUSSION QUESTIONS (10-15 minutes) </p> <p data-bbox="186 1087 1015 1197"> One suggested approach to supervision includes close collaboration between treatment and supervision. Refer to your discussion questions: </p> <ol data-bbox="186 1239 1006 1512" style="list-style-type: none"> 3. Please consider the goals of treatment listed above. To what extent do those goals match the goals you may have for an offender under supervision? What are the ways in which these goals – if achieved – might be of benefit to the offender’s supervision? 4. Are there any goals in this list that create a conflict or tension between supervision and treatment? <p data-bbox="186 1543 527 1585"> METHODS OF TREATMENT </p> <p data-bbox="186 1591 1023 1900"> Research and current practice point strongly to the need for sex offender-specific treatment to emphasize cognitive-behavioral and relapse prevention modalities, along with whatever adjunctive treatments are included. A comprehensive treatment approach for sex offenders addresses a variety of issues that reflect the variety of causes or sources (or etiology) of sex offending. Denial is often confronted prior to the formal start of treatment with </p>	



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<p>the use of a deniers’ group or the polygraph to confront the offender with objective facts. Although some treatment programs are hesitant to accept sex offenders who are in denial, most will accept these offenders on the condition that they work through their denial either in individual therapy before joining a group or within a set timeframe after beginning treatment. Specialized treatment can take the form of psychoeducational groups, cognitive-behavioral groups, administration of medication for deviant arousal reduction or mental health, individual therapy, and such psychological and physiological testing as the polygraph. Therapists may also refer offenders for other specialized treatment if necessary for issues like substance abuse. Some forms of educational groups are recommended for the family and extended supervision network as well.</p> <p>The overall goal of treatment is to reduce recidivism. Each factor named above that contributes to recidivism requires various techniques to address them.</p> <p>To modify cognitive distortions and cause an offender to accept responsibility, treatment might include –</p> <ul style="list-style-type: none"> ▪ Education about denial; ▪ Support for incremental steps toward accountability; ▪ Making the acceptance of some responsibility a prerequisite for admission into treatment, and full acceptance a prerequisite for successful completion; ▪ Confronting denial and other cognitive distortions by challenging discrepancies between different versions of the events, educating the offender about the relationship of cognitive distortions to sex offense behavior, and modeling accountability. <p>To develop victim empathy, treatment might include –</p> <ul style="list-style-type: none"> ▪ Psychoeducation on the effects of abuse on victims; ▪ Opportunities for an offender to develop an emotional understanding of the impact of sexual abuse, such as role playing or writing exercises; ▪ Teaching empathy skills, such as recognizing emotional distress and communicating empathy; 	<p>➤Use slide 13: Methods of Treatment</p> <p>➤Use slide 14: Components of Treatment</p> <p>➤Use slide 15: Components of Treatment</p>

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<ul style="list-style-type: none"> ▪ Referral to specialized treatment, such as marriage and family therapy, substance abuse treatment, or anger management; and ▪ Involvement of significant others in treatment, if appropriate. <p>To develop relapse prevention skills, which extend the effects of treatment over time, treatment may include—</p> <ul style="list-style-type: none"> ▪ Education about relapse prevention as a model for identifying and interrupting the offense cycle; ▪ Requiring offenders to analyze the behavior, emotions, thoughts, and settings that lead to their own sexual offense behavior and assisting them to develop strategies to interrupt their cycles (offenders learn to recognize the “seemingly unimportant decisions” that can lead them into high risk situations); ▪ Teaching strategies to avoid lapses, which might include stimulus control (making changes to the immediate environment to avoid contact with stimuli that provoke lapses), avoidance strategies (similar to stimulus control – avoiding altogether circumstances that may provoke lapses), programmed coping responses (using a strategy that has been selected, evaluated, and practiced in advance), and escape strategies; ▪ Teaching strategies to minimize the extent of lapses and to prevent lapses from becoming relapses. These might include cognitive restructuring (learning to think of lapses as opportunities for the offender to practice new skills and learn more about their relapse process), reminder cards (an aid to cognitive restructuring which summarizes the points the offender should remember), and therapeutic contracts (signed by the offender and which define the extent to which a “lapse” is allowed to go forward safely). <p>To establish supervision conditions and networks, the treatment provider works in close collaboration with the supervising agency. This is essentially the “external supervisory dimension” of relapse prevention.</p>	<p>➤Use slide 18: Components of Treatment</p> <p> Refer to handout: It might be useful here to refer to the handout on relapse prevention from Section 3 to indicate the points at which these strategies are used.</p> <p>➤Use slide 19:</p>

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<p>increase in recent years, it is by no means a universally used tool. The plethysmograph is even less widely used, but is considered by many to be an extremely helpful tool in treatment, particularly in assessing deviant sexual arousal.</p> <p><i>The Polygraph</i></p> <p>Many jurisdictions have found the postconviction polygraph to be a particularly useful tool to help monitor treatment progress and to evaluate the nature and severity of treatment-related problems and issues. Information that is obtained from polygraph examinations is used to inform and update the treatment plan and as a supervision tool. Many treatment providers feel that they are much more able to design a meaningful treatment plan and then make appropriate adjustments to it with the additional insights provided them by the use of the polygraph.</p> <p><i>The Plethysmograph</i></p> <p>One method of evaluating an offender’s progress in treatment and determining his level of dangerousness is the use of the penile plethysmograph. The plethysmograph is a physiological tool that measures an offender’s arousal pattern or erectile response to certain stimuli. It is typically used in two ways: to measure the offender’s sexually deviant interests and ascertain if he has any nondeviant sexual interests, which serves as an aid in developing a behavioral program to decrease the deviant arousal and increase the positive, if necessary; and as an evaluation tool to measure the success or failure of the behavioral interventions.</p> <p>The penile plethysmograph is considered by some to be one of the more intrusive techniques used in the field of sex offender management. However, deviant sexual arousal is a significant contributing factor in sex offending (research indicates that deviant sexual arousal is positively correlated with re-offense²⁵), and the self-report of offenders regarding their sexual arousal is not always reliable. The Association for the Treatment of Sexual Abusers (ATSA) has also developed guidelines for the use of the plethysmograph with sex offenders.²⁶</p>	<p>Note: The polygraph is not covered here in depth. Additional materials on polygraph are available through CSOM and a separate curriculum on polygraph is in development.</p> <p>Note: Participants may voice concern over the intrusiveness of the plethysmograph. Trainers should acknowledge that this aspect of the plethysmograph has given rise to controversy and may be one reason that it is not more widely used.</p>



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<p>TOPIC: WHAT TO EXPECT IN A SEX OFFENDER TREATMENT PROVIDER (15 minutes)</p> <p>COMMON PHILOSOPHY OF SEX OFFENDER TREATMENT What can a probation agency or officer reasonably expect from a sex offender treatment provider? Practice around the country suggests that, increasingly, sex offender treatment providers have philosophies that support –</p> <ul style="list-style-type: none"> ▪ Teamwork: They are willing to collaborate with others, especially probation/parole officers, victim representatives, polygraph examiners, prosecutors and defense attorneys; ▪ Community safety: They are willing to view the community (especially victims and potential victims) as the client; ▪ Limited confidentiality: They are willing to share information openly with the supervising officer and other stakeholders who are responsible for sex offender supervision; and ▪ Evaluation: They are interested in having their work evaluated and in making an evaluation component part of their practice <p>Supervising officers are often in the best position to choose the most appropriate treatment provider for a given client. It’s important that the officer and treatment provider have similar philosophical views on sex offender management, such as sharing all information, prioritizing community safety above all else, participating in a “team” management approach, and being willing to accept feedback from other team members regarding treatment progress and efficacy.</p> <p>EVALUATING TREATMENT PROVIDERS Keep in mind that most graduate schools do not teach students how to evaluate or treat sex offenders. Therefore it’s important that officers look for treatment providers who have experience and/or recent specialized training in the areas of sex offender evaluation, treatment, and victim</p>	<p>➤Use slide 21: What to Expect From a Sex Offender Treatment Provider</p> <p>Note: You may want to refer participants to the materials distributed during Section 3 of this curriculum – statewide standards from Colorado and Arizona that speak to qualifications and expectations for treatment providers as one indicator of practice.</p>



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<p>issues and who update their training frequently as this is a rapidly changing field.</p> <p>In assessing the quality of a given treatment provider's services, officers should take into account the quality of the written reports received from the provider. The provider should be willing to meet regularly with the officer to discuss new cases, issues arising regarding a particular offender, and work on solving systemic problems.</p> <p>One of the best ways for an officer to assess the quality of a provider's work is to watch him or her in action, in group. The officer can then view the <i>content</i> of the group:</p> <ul style="list-style-type: none"> ▪ Are they on task? ▪ Is there an agenda? ▪ Does the treatment provider allow offenders to spend too much time on non-offense-related issues? <p>Of equal importance is the <i>process</i> of the group:</p> <ul style="list-style-type: none"> ▪ Does everyone participate or are some members allowed to remain silent? ▪ Are group members confronted but still treated with respect? <p>The provider should notify the officer anytime there is cause for concern and be willing to meet immediately when there are emergency situations. The provider should also be willing to listen to and incorporate community concerns regarding the program. Providers should also be willing to communicate and collaborate with the victim's and nonoffending partner's therapist(s), particularly in cases of family offenses.</p> <p>Officers should also consider the differences between programs that have stated graduation criteria and fixed timeframe programs. If offenders don't have specific criteria to achieve for treatment completion and just have to "put in time," how much work will they really put in to long-term change?</p>	<p>➤Use slide 22: Monitoring Treatment and Providers</p> <p>➤Use slide 23: Monitoring Treatment And Providers</p>

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<ul style="list-style-type: none"> ▪ Willing to work with limited confidentiality; ▪ Willing to monitor client’s behavior outside treatment; ▪ Knowledgeable of criminal justice system and victims; ▪ Able to cope with stress; ▪ Able to attend to details; ▪ Able to maintain objectivity; and ▪ Possesses the ethics and integrity to work in a court system-- <ul style="list-style-type: none"> ▪ Knowledge/adherence to ATSA* standards; ▪ Knowledge/adherence to ethics of discipline; and ▪ Open, honest relationship with treatment team. <p>? Discussion Question: Are there any others you’d like to add?</p>	<p>*ATSA is the Association for the Treatment of Sexual Abusers, a nonprofit membership organization founded in 1984. More information can be found at its Web site: www.atsa.org.</p>





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<p data-bbox="186 268 925 403">TOPIC: COLLABORATION BETWEEN PROBATION/PAROLE SUPERVISION AND TREATMENT</p> <p data-bbox="186 409 698 441">(20-25 minutes, including Learning Activity)</p> <p data-bbox="186 478 560 510">COLLABORATION ACTIVITIES</p> <p data-bbox="186 516 1015 630">Given the goals and content of treatment discussed above, there are many opportunities for probation or parole agents to collaborate with treatment providers.</p> <ul data-bbox="186 636 1023 1774" style="list-style-type: none"><li data-bbox="186 636 1023 903">▪ Some probation/parole agencies offer classes on sexuality and sexual deviance, where offenders learn concepts that are new to them and where they can begin to develop a sense of what will be expected when they do begin cognitive-behavioral treatment. Family members or other members of the offender’s network should also be encouraged to attend these classes.<li data-bbox="186 909 1023 1102">▪ Probation/parole officers and treatment providers can exchange information drawn from the pre-sentence investigation and from a sex offender-specific evaluation in order to develop complementary treatment and supervision plans.<li data-bbox="186 1108 1023 1375">▪ Probation/parole officers sometimes sit in on individual or group therapy sessions with the offender in order to understand the treatment process more clearly and to assess offender progress. This can reduce “splitting” by the offender because he sees the treatment provider and officer working closely together.<li data-bbox="186 1381 1023 1533">▪ The probation/parole officer should obtain a copy of the written treatment plan from the treatment provider and use it as a guide for monitoring conditions and progress.<li data-bbox="186 1539 1023 1774">▪ Both probation/parole officers and treatment providers should develop a clear understanding of the offender’s offense cycle so that supervision conditions can be tailored to monitor and address the specific flags and triggers related to the particular needs of different offenders. <p data-bbox="186 1816 990 1890">In jurisdictions that include the polygraph as one component of a larger, more comprehensive approach to</p>	<p data-bbox="1047 483 1372 630">➤ Use slide 25: Collaboration Between Treatment and Supervision</p> <p data-bbox="1047 661 1437 1176">Alternative presentation: Since some of these have already been mentioned in the section, the trainer can invite the participants to suggest areas for collaboration and write them on newsprint, filling in if necessary from the given list. Invite participants to explain the value or rationale for each collaborative activity.</p>



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<p>sex offender management, the polygraph examiner is also a partner in the collaboration and the exchange of information that occurs (regarding information drawn from the pre-sentence investigation, the sex offender-specific evaluation, treatment sessions, the treatment plan or contract, and the offender’s sexual abuse cycle).</p> <p>LEARNING ACTIVITY – DISCUSSION QUESTIONS (10 minutes)</p> <p>Participants are asked to consider the following questions:</p> <ol style="list-style-type: none">5. Some probation/parole officers work closely enough with treatment providers that they may actually sit in on group therapy sessions. Is that the practice in your agency? If so, what are the benefits and possible danger? If not, would you consider doing so?6. What are the ways in which you now collaborate with sex offender treatment providers? What are your questions or concerns about this? If you do not currently have close relationships with treatment providers, what are some first steps you might take to initiate such a relationship, if you would want to pursue it?	



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<p>TOPIC: SUMMARY (3 minutes)</p> <p>The most important things to take away from this section are —</p> <ul style="list-style-type: none">▪ The primary goal of treatment is to reduce future victimization.▪ The goals of treatment, including reducing cognitive distortions and accepting responsibility, developing victim empathy, controlling sexual arousal, improving social competence, developing relapse prevention skills, and establishing supervision conditions and networks are all <i>means to the end</i> of reducing future victimization. <p>Treatment providers must be willing to —</p> <ul style="list-style-type: none">▪ Work with you as part of a team;▪ Share all information;▪ Protect the community as their primary responsibility; and▪ Evaluate their work by these standards.	<p>➤ Use slide 26: Primary Goal of Treatment — Reduce Future Victimization</p> <p>➤ Use slide 27: Treatment Providers Must be Willing to...</p>

¹ Marshall, W.L., and Pithers, W. (1994). A reconsideration of treatment outcome with sexual offenders, *Criminal Justice and Behavior* 21 (1).

² English, K. (1996). "Does Sex Offender Treatment Work? Why Answering This Question Is So Difficult" in *Managing Adult Sex Offenders: A Containment Approach*. Edited by English, K., Pullen, S., and Jones, L. APPA.

³ Marshall, W.L., and Barbaree, H.E. (1988). The long-term evaluation of a behavioral treatment program for child molesters, *Behavioral Research and Therapy* 26: 499-511.

⁴ Ibid, 499-511.

⁵ Marshall, W.L., Barbaree, H.E., and Eccles, A. (1991). Early onset and deviant sexuality in child molesters. *Journal of Interpersonal Violence* 6: 323-335.

⁶ Marques, J.K., Day, D.M., Nelson, C., and West, M.A. (1993). Findings and recommendations from California's experimental treatment program. In Hall, G.C.N., Hirschman, R., Graham, J.R., and Zaragoza, M.S. (eds.), *Sexual Aggression: Issues in Etiology, Assessment and Treatment*, Taylor and Francis Publishers, Washington, D.C.

⁷ Marshall et al., 1991; Maletzky, B.M. (1991). *Treating the Sexual Offender*, Sage Publications, Newbury Park, CA.; Pithers, W., Martin, G. and Cumming, G. (1989). Vermont treatment program for sexual aggressors. In Laws, D.R. (ed.), *Relapse Prevention with Sex Offenders*, Guilford Press, New York, NY.

⁸ Alexander, M.A. (1994). *Sex Offender Treatment: A Response to the Furby, et al., 1989 Quasi Meta-analysis II*, paper presented at the annual meeting of the Association for the Treatment of Sexual Abusers, San Francisco, CA.

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- ⁹ Alexander, M.A. (1999). Sex offender treatment efficacy revisited. *Sexual Abuse: A Journal of Research and Treatment* 11, 101-116.
- ¹⁰ Furby, L., Weinrott, M.R., & Blackshaw, L. (1989). Sex offender recidivism: A review. *Psychological Bulletin* 105, 3-30. United States General Accounting Office. (1996). *Sex offender treatment: Research inconclusive about what works to reduce recidivism*. Report to the Chairman, Subcommittee on Crime, Committee on the Judiciary, House of Representatives (GAO/GGD-96-137). Washington, DC: Author.
- ¹¹ D'Amora, D. Presentation at CSOM Training at the American Probation and Parole Association Institute. New York, NY.
- ¹² Grossman, L.S., Martis, B., & Fichtner, C.G. Are sex offenders treatable? A research overview. *Psychiatric Services* 50, 349-361.
- ¹³ Gallagher, C.A., Wilson, D.B., Hirschfield, P., Coggeshall, M.B., & MacKenzie, D.L. (1999). A quantitative review of the effects of sex offender treatment on sexual re-offending. *Corrections Management Quarterly* 3(4), 19-29.
- ¹⁴ Polizzi, D.M., MacKenzie, D.L., & Hickman, L.J. (1999) What works in adult sex offender treatment? A review of prison- and non-prison-based treatment programs. *International Journal of Offender Therapy and Comparative Criminology* 43, 357-374.
- ¹⁵ Hall, G.C.N. (1995). Sex offender recidivism revisited: A meta-analysis of recent treatment studies. *Journal of Consulting and Clinical Psychology* 63 (5), 802-809.
- ¹⁶ Quinsey, V.L.; Harris, G.T.; Rice, M.E.; Lalumiere, M.L. (1993) Assessing the treatment efficacy in outcome studies of sex offenders. *Journal of Interpersonal Violence*. Vol 8(4), 512-523; Salter, A. C. (1988) Newbury Park, CA: Sage Publications, Inc.; Lanyon, R. I. (1986) Theory and treatment in child molestation. *Journal of Consulting & Clinical Psychology* 54(2), Apr 1986, 176-182.
- ¹⁷ Knopp, F.H. (1995). Building bridges: Working together to understand and prevent sexual abuse. *Sexual Abuse: Journal of Research & Treatment* 7(3), 231-238; Freeman-Longo, R.E.; Knopp, F.H. (1992). State-of-the-art sex offender treatment: Outcome and issues. *Annals of Sex Research* 5(3), 141-160.
- ¹⁸ Sinclair, L. *Treatment of Sex Offenders*. Center for Sex Offender Management (in press).
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- ²¹ Colorado Sex Offender Management Board. (1999). *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders*. Colorado Department of Public Safety, Denver, CO. "The provider shall employ treatment methods that give priority to the safety of an offender's victim(s) and the safety of potential victims and the community," 28.
- ²² McGrath, R.J. (ed). (1995). *Vermont Clinical Practices Guide for the Assessment and Treatment of Adult Sex Offenders*. Vermont Center for Prevention and Treatment of Sex Offenders, Burlington, VT.
- ²³ Maricopa County Adult Probation, *Sex Offender Supervision Operations Manual*, Appendix D, 5.
- ²⁴ Ibid. and Colorado Sex Offender Management Board, 14.
- ²⁵ Ibid.
- ²⁶ *Ethical Standards and Principles for the Management of Sexual Abusers*. (1997). The Association for the Treatment of Sexual Abusers, 52-57.