

Long Version

Section 1: An Overview of Sex Offender Treatment for a Non–Clinical Audience

The Basics of Sex Offender–Specific Treatment

2 Hours



TOPIC: CURRICULUM GOALS AND CONTENT (35 minutes)

Refer to Handouts: Refer participants to two papers developed by CSOM—“Community Supervision of the Sex Offender: An Overview of Current and Promising Practices” and “The Collaborative Approach to Sex Offender Management.” These documents are included among the participant materials.

The management of sex offenders in the community is gaining more and more attention among supervision and community corrections staff. Despite longer sentences and a greater likelihood of incarceration, many sex offenders are supervised in the community—either as a direct sentence of probation or after some period of incarceration. Emerging practice around the nation reflects the importance of a collaborative and multidisciplinary approach to this work.¹ The significant trauma experienced by victims, the consequences of potential future victimization, and the inherent difficulties in managing this population have encouraged communities to develop collaborations at both the policy and case management level to better manage such offenders. Emerging practice embraces the importance of having these offenders involved in sex offender–specific treatment as a condition of their supervision. Two aspects of sex offender treatment are of particular interest to supervision staff.

- First, it is significantly different from the traditional mental health treatment used with other offenders. Most importantly, sex offender–specific treatment has as its primary goal the protection of the community, and as a secondary goal the wellness of the offender. This is in contrast to traditional mental health treatment that is geared primarily toward the needs of the client. It is important for supervision staff to understand and appreciate the differences between these approaches.
- Second, because emerging practice reflects a “team” approach to sex offender management (that includes criminal justice supervision agencies, treatment providers, and others) is the most promising approach to assure the effective supervision of sex offenders in the community, it is important for supervision staff to understand sex offender–specific treatment and how they can collaborate most effectively with treatment providers.²

Use Slide #1 and Slide #2: Goals of This Training

Therefore, the goals of this day–long training on the treatment of sex offenders are to:

- Provide an overview of sex offender–specific treatment, and outline its characteristics, particularly the ways in which it differs from traditional mental health treatment;
- Emphasize its primary goal of community protection;
- Summarize what we know of practice patterns nationwide;
- Summarize the research on the outcomes of treatment (i.e., what we know of its effectiveness); and
- Identify ways in which supervision officers can successfully work together with treatment providers in managing sex offenders in the community.

The day will be divided into five sections:

Use Slide #3: Overview of the Training

Section 1: The Basics of Sex Offender–Specific Treatment. This first section—which we’re covering now—identifies the rationale for a specialized approach to the treatment of sex offenders in the community; articulates the goals of the training curriculum as a whole; outlines the content of the curriculum; identifies the core elements of sex offender–specific treatment; and highlights the ways in which it differs from traditional mental health treatment. (2 hours)

Section 2: Sex Offender–Specific Treatment Outcome Research. This section summarizes the evidence emerging from empirical research on sex offender treatment, outlining what we know about its effectiveness, what we know about what works for what types of sex offenders, and the implications of this research for treatment and for collaboration between treatment providers and supervision agencies. (30 minutes)

Section 3: Elements of Sex Offender–Specific Treatment. This section details the elements of sex offender treatment, covering a number of challenging issues, including handling denial. It goes into a good bit of detail regarding the techniques that treatment providers may use to address the four domains of treatment—sexual interests, distorted attitudes, interpersonal skills, and behavior management. It discusses the ways in which supervision officers also are involved in supporting behavior management. (4 hours, 30 minutes)

Section 4: A National Perspective on the Current State of Practice. This section summarizes the results of a periodic national survey conducted for the Safer Society that gathers information from treatment providers regarding their practices and clients. (We use the term “client” here as not all of those receiving such treatment are involved in the criminal justice system.) It is the most comprehensive picture of actual practice that is currently available. (30 minutes)

Section 5: What to Look for in a Treatment Provider. One of the most difficult issues facing the criminal justice system—the courts, supervision agencies, prosecutors, etc.—is how to know which treatment providers will make effective partners in the management of sex offenders in the community. This brief section outlines the factors that should be considered in selecting appropriate treatment providers. (30 minutes)

Introductions of Faculty and Participants

Note: Providing the trainer and the participants with an overview of their colleagues' backgrounds and interests will encourage interaction and discussion. If the group is small, introductions can take place in the context of the entire group. Where numbers are too large for that, you could gather smaller groups around tables and have those within each group introduce themselves. A variation on this—if time permits—is to have one person from each of the smaller groups give a brief summary of the makeup of each smaller group to all the participants.

Before we begin, we would like to have participants and faculty introduce themselves. We hope to make this an interactive session and to share the considerable experience that is represented here among the participants and faculty, so we should begin by learning a bit about one another. I would like to ask each of you to please introduce yourself—tell us your name, the nature of your job, the nature of your interest in sex offender–specific treatment, and some of the issues you hope to learn about during the course of the training.



TOPIC: INTRODUCTION TO SECTION 1: THE BASICS OF SEX OFFENDER–SPECIFIC TREATMENT (10 minutes)

Use Slide #4 and Slide #5: Learning Objectives for Section 1

Refer participants to the handout: “Terms and Concepts Related to Sex Offender–Specific Treatment” for definitions of terms used in this curriculum. This document is included among the participant materials.

By the end of this section of the curriculum, participants will be able to:

- Recognize that the overarching goal of sex offender treatment is community protection. This is accomplished by effectively treating sex offenders to reduce their recidivism risk (rather than providing treatment to reduce offenders’ subjective distress);
- Contrast sex offender–specific treatment with other forms of mental health treatment;
- Identify several sex offender treatment methods and adjunctive interventions that typically comprise sex offender–specific treatment;
- Describe what specialized sex offender assessment is and why it is important in the sex offender–specific treatment process; and
- Describe the general utility of several assessment tools in the sex offender treatment process, including the polygraph, the plethysmograph, and the Abel Assessment of Sexual Interest.



TOPIC: THE GOAL OF SEX OFFENDER–SPECIFIC TREATMENT (30 minutes)

Note: This training focuses on treatment of adult male sex offenders. The majority of sex offenders are male adults; hence we are talking about the largest single group of sex offenders. It should be pointed out that because adolescent sexual offenders, abuse–reactive children (pre–adolescents who have sexually violated other children), and female sexual offenders constitute sufficiently unique groups, with unique problems and treatment needs, they will be the subject of separate training curricula.

This section of the curriculum provides an introduction to adult male sex offender–specific treatment by presenting the goal, its differences from other forms of mental health treatment, and brief descriptions of common characteristics of sex offender treatment. This section also includes a brief description of how ongoing sex offender assessment can inform the treatment process and an overview of several assessment tools that are not widely used in other kinds of mental health treatments. These tools include the polygraph, the penile plethysmograph, and the Abel Assessment of Sexual Interest. This material is intended to introduce you to several key principles and basic information that will serve as a foundation for much of the subsequent material that will be covered in this training.

Use Slide #6: The Goal of Sex Offender–Specific Treatment:

Reducing Future Victimization

The thought of providing treatment to sex offenders elicits varying reactions from different people. Some people believe that sex offenders don't deserve anything but punishment and that they should not be provided treatment because of the terrible acts they have committed. Although this attitude may satisfy understandable urges to punish sex offenders, punishment alone is unlikely to lessen the risk that they will recidivate. Unlike other forms of mental health treatment where the goal is to reduce clients' distress and improve their well–being, the goal of sex offender treatment is to reduce offenders' likelihood of committing another sex offense. In other words, we provide treatment not to make the sex offender feel better or function better in general, but rather to protect the community. As we will see, sex offender treatment has been shown to reduce the likelihood that sex offenders will reoffend.³ Thus, if we embrace the concept that our ultimate goal in managing sex offenders is fewer victims, then sex offender treatment is not only consistent with, but is an important part of, achieving that goal. In fact, since sex offender treatment reduces reoffense risk, you can make the argument that failure to provide treatment makes communities less safe.

You'll notice the term on the slide "criminogenic needs." What does this mean? It means that in order for sex offender treatment to be effective, it must address the characteristics in the offender that contribute to his committing sex crimes.⁴ In other words, if depression significantly contributes to the commission of a sex offense, then we must treat that offender's depression. However, if depression is

unrelated to sexual offending, then it should not be a part of the offense-specific treatment plan for that offender.

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The term “criminogenic need” also relates to the fact that since sex offenders are not all alike, the risk-related characteristics of any particular offender need to be assessed and addressed in treatment. For example, if a sex offender is erotically attracted to children, treatment for him should include attempts to reduce that sexual attraction. It is surprising to some people that not all child molesters have a sexual interest in children, but for those who do, this aspect of their sex offending must be addressed. Although this may seem obvious, not all sex offender treatment is oriented around the principle of targeting criminogenic needs. Many sex offender treatment programs treat a wide variety of aspects of offenders’ lives that may have no direct bearing on the offenders’ recidivism risk.

Note: Invite participants to identify—from their own experiences—what some of the characteristics of sex offender treatment programs are. (Record these on a flip chart.) Group these into categories and use these categories as a starting place for the next section of the presentation.

Of greater concern is that many sex offender treatment programs fail to treat some of the criminogenic needs of sex offenders. As a result, significant aspects of what contributes to future sex offending might be missed. We’ll be talking more specifically about criminogenic needs and treatment targets, but for now, understand that we treat sex offenders to make our communities safer, and we do contribute to their likelihood of committing future sex offenses.



In addition to the goals of treatment, what are some of the other characteristics of sex offender treatment that differentiate it from other forms of mental health treatment?



TOPIC: DIFFERENCES BETWEEN SEX OFFENDER–SPECIFIC TREATMENT AND OTHER FORMS OF MENTAL HEALTH TREATMENT (15 minutes)

Use Slide #7: Differences from Other Forms of Metal Health Treatment

Let's look in more detail at some of the differences between sex offender–specific treatment and other kinds of mental health treatment.⁵

Involuntary Clients

First, sex offender treatment almost always involves working with involuntary clients. A limited number of sex offenders seek treatment on their own before they are criminally apprehended, and they initially enter treatment either because they know they will be ordered by the criminal justice system to participate, or they do so to make themselves look good for the court. This raises the question of whether treatment can be effective if you compel someone to participate in it. Voluntary sex offender clients often enter treatment because they had a close call with apprehension and they are frightened of being caught. When that acute fear abates, they often drop out of treatment prematurely, against the advice of their treatment providers. This failure to complete treatment might make them more likely to reoffend.⁶ Another reason why voluntary sex offender treatment is not as effective may be because, as we will see later, sex offender treatment may be more effective when combined with community supervision and other interventions.⁷ In other words, sex offender treatment providers can't work alone as effectively as they can in collaboration with supervision officers and other professionals. In practice, offenders often demonstrate signs of resistance at the beginning of treatment. However, as treatment progresses and they begin to experience it as helpful, their resistance usually begins to dissipate.

Victim and Community Focus

We've already talked about how the goal of sex offender–specific treatment is to make victims and communities safer from sexual assault. But how does this play out in ways that are different from other forms of mental health treatment?

Use Slide #8: Differences from Other Forms of Metal Health Treatment (cont.)

Limited Confidentiality

Sex offenders thrive in the shadows of secrecy. Secrets are the power base of these offenders. Without the ability to hide their behaviors, it is more difficult for sex offenders to continue to commit crimes. Sex offenses almost always occur after the offender has isolated his victim and his behavior from others, and many offenders generalize this strategy to many aspects of their lives to avoid detection or responsibility for their behaviors. To counteract these manipulative tendencies in sex offenders, it is essential that treatment providers and other

professionals maintain open and frequent communication with each other about those offenders who are in treatment and under supervision.⁸ This doesn't mean sex offenders who are in treatment have no privacy; rather, it means that the professionals working with them will communicate with each other to assure that each is operating with the same information and, in particular, that their collective strategies for working with these offenders are completely consistent. Failing to do so can allow offenders the opportunity to more easily manipulate the people who are working with him.

Provider Sets Treatment Goals

With traditional mental health treatment, the client often plays a significant role in steering the course of treatment into those areas he or she feels are most problematic or promising in terms of improving his or her own distress. In contrast, sex offender-specific treatment is more clearly guided by the treatment provider toward those areas in treatment that are most directly related to a sex offender's risk to recidivate. This directly supports the primary treatment goal as a way of protecting the community.

Collaboration Among Professions

A central theme of sex offender-specific treatment is collaboration. As previously indicated, unlike other forms of mental health treatment, sex offenders are typically not granted confidentiality. For treatment and other interventions to be most effective, the regular exchange of information—among treatment providers, supervision officers, and others—is critical.⁹

Note: Ask participants to brainstorm a list of professionals who should be openly and consistently communicating about their work with individual sex offenders.

In many jurisdictions across the nation, case management teams serve as an essential first level of collaboration, with the primary purpose of sharing information about specific sex offenders and cases. Information is shared in a structured and consistent fashion among those most closely involved with the monitoring of offenders in the community, including—first and foremost—treatment providers and supervision officers. In some communities, the case management team also includes polygraph examiners, victim advocates, police officers, and prosecutors.

Local collaborative policy teams also play key roles in addressing policies and practices that guide how sex offenders are managed.¹⁰ These teams benefit from involving officials representing every aspect of the system, including treatment providers, supervision representatives, prosecutors, defense attorneys, judges, corrections officials, victim advocates, and others.

Statewide policy teams are generally formed to address policies and procedures at a state level, including the establishment of standards for sex offender management, treatment, and supervision that apply to all localities.¹¹ The composition of these teams mirrors local policy teams.

The important point here is that sex offender treatment providers should not—and cannot—effectively work alone on any level, because the achievement of community safety requires a variety of professionals, each performing their essential tasks, to share information about their work.



TOPIC: CHARACTERISTICS OF CURRENT SEX OFFENDER–SPECIFIC TREATMENT METHODS (30 minutes)

Use Slide #9: Characteristics of Current Sex Offender–Specific Treatment Methods

What are some characteristics of current sex offender–specific treatment methods? What might you expect to see in a sex offender treatment program that incorporates those practices that have been demonstrated to be effective in reducing sexual recidivism?

Group Treatment

First, most sex offender treatment takes place in a group treatment setting.¹² Although individual treatment sometimes accompanies group treatment (and, under certain limited circumstances, might replace group treatment altogether), there are a number of advantages to group treatment.

One is economic—treating offenders in groups consumes fewer resources than treating them individually.

A second reason to treat sex offenders in groups is that they learn and benefit significantly from teaching one another. As long as the treatment provider ensures a pro–social milieu, group treatment can provide a rich therapeutic environment in which offenders learn from hearing about the experiences of others. Such an environment provides offenders with opportunities to challenge and confront one another—in a constructive and helpful fashion—about the inappropriate and distorted thinking that is associated with the abuse they have perpetrated. Well–functioning treatment groups also serve as a support to individual offenders who are having problems with the treatment process.

Additionally, attending group treatment represents another level of acknowledgement by the offender of his behavior—it provides an opportunity for sex offenders to begin to practice talking openly about their issues. The group treatment setting helps address denial and confront distorted thinking far more effectively than the individual, one–on–one treatment provider–offender setting.

In a little while, we will talk about the specific criminogenic needs that are addressed in group treatment. Because sex offenders often share many of the same needs, an issue that is relevant to one offender is very often relevant to others in his group.

Later in this training, I will provide several practical examples that illustrate how—with the guidance and facilitation of trained treatment providers—individual sex offenders contribute to the treatment process in the group setting.

In addition, we will also talk in detail about what is known about the efficacy of sex offender treatment. That is, does it work? Does it reduce sexual recidivism in

sex offenders and, thereby, help us to protect past and potential victims, and our communities? Many of the studies that have been undertaken on sex offender treatment have included group treatment approaches.¹³ As some of you probably know already, the data we have to date on these approaches are promising.

Cognitive–Behavioral Therapy

The most widely accepted mode of treatment in use today with sex offenders is cognitive–behavioral (applied in a group setting).¹⁴ Cognitive–behavioral treatment addresses both the cognitions—that is, the thoughts—and the behaviors of offenders.

People commit sex offenses for a variety of reasons. What they have in common, however, are thought patterns that are conducive to sex offending. For example, if an offender believes that children are not harmed by having sexual contact with adults, then this cognitive distortion (distorted thought) justifies, and indeed encourages, his sexual offending behavior. Of course our concern is not so much with thoughts as it is with behaviors, which are the ultimate targets of our treatment and the relevant measure of treatment effectiveness, but the fact that thoughts can both promote and discourage sex offending behavior requires that offenders' cognitions (thoughts) be addressed in the therapeutic environment.¹⁵

The behavioral component in cognitive–behavioral treatment refers, of course, to offenders' behaviors. But more than that, it speaks to particular treatment methods that are effective in changing behavior.

As I just mentioned, it's often not enough to simply change people's thinking to get them to change their behaviors. Let's use an everyday example to think about it for a moment: Those of us who love ice cream or chocolate know that eating it in large quantities is not particularly good for us, especially if we are trying to be fit. Our thinking is not distorted in any way about this—we know for a fact that ice cream and chocolate are not healthy foods and that we should limit our intake of them.

However, how often do we all ignore our appropriate, non–distorted thinking and consume large quantities of ice cream or chocolate anyway? How often do our actions overpower our thinking? How often do we take the route home from work that just happens to go by an ice cream or candy store? It's pretty easy to stop for a snack when you drive right by the place, isn't it? And then after we indulge ourselves, we promise that we will never do it again.

In a sense, the same analogy can be applied to sex offenders. Just because offenders have assimilated non–distorted or appropriate thoughts doesn't necessarily mean that their behavior will always reflect their thinking. In a later section of this training, we will spend significant time talking about relapse prevention, an intervention strategy that is designed to assist offenders to

implement new behaviors and to recognize—and take specific actions—to avoid high-risk situations that increase the likelihood that they will reoffend.

Let's go back to the ice cream and chocolate analogy for a moment. What is a new behavior that one might use to reduce the risk of eating ice cream or chocolate? If you always stop at that ice cream or candy store on your way home from work, taking a new route home from work that does not go past such a store might reduce your risk of stopping for ice cream. In a similar fashion, relapse prevention helps sex offenders to identify specific behaviors, actions, and strategies that they can use in their own lives to reduce their risk of abusing again.

To sum up, then, when both cognitions (thoughts) and behaviors are addressed, offenders are able to make greater and more long-lasting changes. The research—which we will review shortly—reflects that it is this combination that is most impactful in lessening the likelihood of reoffense.

Psychopharmacology: Treating Sex Offenders with Medication

As was already mentioned, people commit sex offenses for a wide variety of reasons. These might include expressions of anger or power, inadequate skills in initiating or maintaining social and sexual relationships, having erotic attraction to persons or activities that, if acted on, constitute criminal sexual behavior, and so on. Treatment must be geared to addressing those specific issues.

The individual whose sexual arousal involves, for example, children or forcing sex on adults, has a problem that is deeper than simply poor judgment or poor impulse control. In part, what motivates him to commit sexual assaults is that to do so is sexually arousing. For some of these individuals, the only way they can become aroused is to fantasize about or act on these deviant interests. Not all sex offenders have deviant interests, but many do. This is especially true of sex offenders who sexually assault pre-pubescent children; that is, kids under the age of 13, as well as some sex offenders who use extreme violence in the commission of their offenses. For these individuals, medications can be helpful in reducing the intensity of their sexual urges and can serve as an effective adjunct to standard cognitive-behavioral treatments.¹⁶

These medications tend to fall into two categories. The first, and perhaps most well-known, are the class of medications that reduce sex drive and sometimes are referred to in the popular media as “chemical castration.” They are properly referred to as anti-androgen medications, and they are effective because they reduce the male sex hormone testosterone, which contributes to sex drive and aggression.¹⁷ Trade names for these medications include Provera and Lupron. The other class of medications that can be effective as an adjunct to other forms of sex offender treatment and supervision are anti-depressants. The class of anti-depressants most often used is Selective Serotonin Reuptake Inhibitors (SSRIs).¹⁸ These very common medications include such drugs as Prozac and Zoloft. The reason they are effective with sex offenders is that they typically

reduce sex drive as well as reducing the compulsive aspect of sex offending that exists for some sex offenders.

Because not all sex offenders have deviant sexual arousal, nor are they all compulsive, these medications aren't useful for all sex offenders. However, for those who do have these characteristics, medication can be a very important tool in the "tool bag" of treatment options. It is important to know, however, that pharmacological treatment alone—without other interventions such as cognitive-behavioral treatment and community supervision—is not sufficient.¹⁹ In other words, although medication can be an appropriate adjunct to treatment for some sex offenders, it is not a stand-alone remedy to the problem of sexual offending.

Note: Section 3 contains additional information about the use of medication in the treatment process.

We will talk in great detail later in this training about the use of medication in the sex offender-specific treatment process.

Specialized Sex Offender Assessment

Because of the complex and varying nature of sexual abuse and the offenders who perpetrate it, treatment providers, supervision officers, and others must assess sex offenders and their behavior effectively and in an ongoing, collaborative fashion. This enables them to respond appropriately to offender risks and needs as they change over time.

Note: Inform participants that CSOM is developing a training curriculum and a policy and practice brief on specialized sex offender assessment.

We'll begin our discussion of sex offender assessment with an overview of empirically validated, actuarial-based risk assessment instruments. (These are often referred to simply as actuarial tools.) It is likely that many of you have heard of—or are already using—one or more of them in your work with sex offenders. Examples include the RRASOR and the Static-9920

These instruments are noteworthy because they enhance our ability to identify sub-groups of sex offenders who pose a higher risk to reoffend than others (and who, therefore, require more intensive treatment and supervision responses than others). The tools are developed using historical or static (unchangeable) risk factors (such as the number of sex offense convictions) that are statistically correlated with sexual recidivism risk and they play a prominent role in the ongoing risk assessment process in which treatment providers and supervision officers are involved. Let's talk briefly about this process.

Risk assessments that inform our sex offender management decisions (including those related to treatment and supervision) occur in both the clinical (or treatment) and criminal justice settings. We will quickly cover both, and highlight the importance of collaboration between treatment providers and supervision officers in the assessment process.

Criminal Justice Assessments

Criminal justice assessments are undertaken and used by supervision officers to inform their sentencing, case planning, and case management decisions; and are shared with treatment providers to inform their work with sex offenders.

The different types of criminal justice assessments include pre-sentence investigation assessments, assessments for supervision case planning, and assessments for ongoing case management.

Pre-Sentence Investigation Assessments

Those (usually supervision officers or staff) responsible for conducting pre-sentence investigations (PSIs) rely on many different kinds of information about sex offenders from a variety of sources to assess the risk that offenders pose. This information is critical to making sound disposition recommendations based on risk.²¹ The information considered in a PSI assessment includes an instant offense summary, the offender's prior criminal record, offender statements, a victim impact statement, the offender's social history, the offender's substance/drug history, the offender's level of admission of the instant sex offense, the offender's willingness to enter sex offender-specific treatment, the risk posed by the offender as determined by one or more empirically validated risk assessment instruments (which we just discussed), and the results of a sex offender-specific (psychosexual) evaluation (which we will discuss in a moment).

Assessments for Supervision Case Planning

Assessments for supervision case planning are conducted by supervision officers and—like pre-sentence investigation assessments—rely on information from many different sources, including treatment providers. A primary purpose of these assessments is to identify the unique dynamic risk factors that are related to the risk that each offender poses to the community so that individualized case management plans can be designed that respond appropriately to these factors.²²

Assessments for Ongoing Case Management

Supervision officers continually monitor and assess short-term (hourly, daily, or weekly) changes in sex offender-risk to inform their ongoing case management activities and decisions. They seek input from treatment providers and others involved in the case management process to assure that their case management plans are responsive to offenders' current risk levels and specific needs.

Clinical (or Treatment) Assessments

Clinical assessments are undertaken by sex offender-specific treatment providers and are used to help guide the treatment process. Their results are also shared with supervision officers to inform their work with sex offenders. There are two types of clinical assessments: sex offender-specific

(psychosexual) evaluations, and ongoing assessments of risk and criminogenic needs.

Sex Offender–Specific (Psychosexual) Evaluations

Ideally, sex offender–specific evaluations are conducted prior to community supervision and entrance into treatment. Their purposes are to:²³

- Assess the risk that sex offenders pose to the community;
- Identify specific criminogenic needs that are related to the risk that each offender poses and that must be addressed in treatment—these become specific targets of treatment;
- Determine the most appropriate method of treatment delivery (based upon each offender’s learning style); and
- Determine the most appropriate treatment setting (i.e., institutional or community) and level of treatment intensity for each offender.

Ongoing Assessment of Risk and Criminogenic Needs

Like supervision officers, treatment providers continually monitor and assess short–term (hourly, daily, or weekly) changes in sex offenders’ risk and criminogenic needs to inform their treatment decisions and to update offender treatment plans. During this ongoing process, treatment providers seek input from supervision officers and other professionals to assure that treatment plans are responsive to current offender–risk levels and needs.

Because the information from the different types of assessments informs the responses of treatment providers and supervision officers to sex offenders, it is critically important that treatment providers and supervision officers communicate clearly and consistently about the assessment process.

Psycho–Physiological Assessments

Before we proceed, let’s spend a few minutes discussing three adjunct assessment tools that are very helpful in informing the sex offender–specific treatment process and that are not typically used in the treatment of other kinds of offender populations. They include the polygraph, the penile plethysmograph, and the Abel Assessment of Sexual Interest. These are known as psycho–physiological assessments.

Let’s talk briefly about the polygraph first.

The polygraph is used to assess whether sex offenders are being deceptive. Polygraph examinations are increasingly regarded as a valuable tool in sex offender management.²⁴ Determining whether an offender is being deceptive can be critically important in the treatment process.

Here’s an example of why: if an individual is convicted of a sex offense but claims that he did not commit the crime, a deceptive result on a polygraph

examination can be very helpful in confronting and breaking down his denial and promoting an admission. We will discuss in a later section why offender denial—and confronting and breaking it down—is a critical target of the treatment process. Here's another example: as many of you may know, sex offenders are often required to complete sexual history questionnaires in which they include their entire sexual histories, both criminal and non-criminal. The ability to verify the full extent and variety of sex offenders' sexual histories enables treatment providers to: assess more effectively the kinds and levels of risk that offenders pose to past and potential victims and the community; identify the specific issues and needs that are related to their sexual abuse; and develop treatment plans that address those issues and needs.

The polygraph is often used to assess whether or not sex offenders have knowingly withheld any information from their sexual history questionnaires. This can result in significantly increased disclosures of sexual misconduct, even prior to the actual administration of the polygraph examination.²⁵ That is, prior to the polygraph exam, the polygraph examiner shares the questions with the offender that will be asked during the polygraph exam and gives him an opportunity to divulge more information about those questions.

Now let's spend a few minutes on two other psycho-physiological assessment tools: the penile plethysmograph and the Abel Assessment of Sexual Interests. The purpose of these assessment instruments is to ascertain offenders' sexual interest and arousal patterns without having to rely on their self-report, which might be inaccurate.

The penile plethysmograph is a laboratory device that measures increments of erection of the penis. The evaluation involves the offender sitting alone in a small room. He places a small device on his penis, either an elastic band or a C-shaped metal device. Neither of these is in any way painful. The device is attached to a computer operated by the evaluator in the next room. The offender listens to audiotope descriptions of various kinds of sexual behavior, or views slides that depict males and females of various ages, typically photographs of individual nudes. The plethysmograph detects blood flow to his penis, a measure of his erotic arousal to these various stimuli.

The plethysmograph is an intrusive procedure that requires cooperation from the offender. It is also an expensive test, typically costing \$300 to \$750 per administration. Furthermore, it is not completely accurate because some offenders can distract themselves sufficiently so that they do not exhibit arousal in the laboratory when, in fact, they do have arousal in ordinary circumstances.²⁶ For these reasons, the penile plethysmograph is not widely used in sex offender treatment. Nonetheless, it is noteworthy that of all of the characteristics that are associated with child molesters' risk for sexual recidivism, Hanson and Bussiere (1998) found that having a deviant sexual interest in children as measured by the penile plethysmograph is the most powerful. (It should be noted that none of the characteristics in the research are extremely strong predictors of sexual recidivism, although the plethysmograph is accurately described as the strongest among only moderately predictive factors.) We will

talk more about the treatment approaches used to address deviant sexual interest later.

The Abel Assessment of sexual interest is a less intrusive test because it evaluates erotic interest without requiring penile measures, and it avoids the problems associated with nude photographs of children.²⁷ The Abel Assessment involves offenders' viewing slides of clothed males and females (adults and children) and measuring offenders' level of attraction to each. The device measures small differences in the visual reaction time of the person being evaluated; that is, how long they look at each slide, with longer reaction time being associated with increased sexual interest.

Although these assessments each have disadvantages, they can offer treatment providers and others important information about sex offenders that they otherwise might not have.



TOPIC: SUMMARY

Use Slide #10: Summary

Over the course of the day we will be exploring some of these topics covered in more depth. For now, however, the material presented so far provides an introduction to some of the key themes of this training:

- Sex offender–specific treatment can be an effective tool in preventing future victimization.
- Sex offender treatment varies significantly from other forms of mental health treatment and employs specialized intervention and assessment methods. Its primary goal is the protection of the community, rather than the wellness of the offender; treatment is often mandated by the court or parole board, rather than voluntary; and the treatment provider, not the offender, is more clearly in charge of the direction and plan of treatment.
- For sex offender treatment to be as effective as possible, sex offender treatment providers must work in close collaboration with other professionals involved in the management of these offenders.

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