TOPIC: Distorted Attitudes—The Second Domain of Treatment **40 min.**

- Cognitive Restructuring
  - Learning Activity
  - Processing of Learning Activity

TOPIC: Interpersonal Functioning—The Third Domain of Treatment 30 min.

- Rationale
- Targets for Change
- Appropriate Interactions in Social Situations
- Assertiveness as a Tool to Avoid Frustration and Poor Anger Management
- Adult Sex Education to Increase Knowledge about Healthy Sexuality and Responsible Behavior

TOPIC: Behavior Management—The Fourth Domain of Treatment **60 min.**

- Rationale
- Covert Sensitization: Visualizing the Consequences of Sexual Assault
- Relapse Prevention
  - Relapse Prevention Methods
  - Learning Activity
  - Processing of Learning Activity
  - Adjunctive Therapies

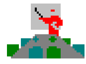
TOPIC: Ethical Practice Standards 10 min.

TOPIC: Treatment Provider Characteristics 10 min.

TOPIC: Summary

References and Resources

Long Version
Section 3: An Overview of Sex Offender Treatment for a Non–Clinical Audience
Elements of Sex Offender–Specific Treatment
4 hours, 30 minutes



TOPIC: INTRODUCTION
(5 minutes)

Use Slide #1 and Slide #2: **Elements of Sex Offender–Specific Treatment: Learning Objectives**

Learning Objectives

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

- Describe the components of sex offender–specific treatment;
- Explain why treating sex offenders who deny their offenses is important, and describe one method for encouraging sex offenders to admit their abuse;
- Identify the four domains of sex offender–specific treatment;
- Describe a number of sex offender–specific treatment methods;
- Summarize research findings related to the length of sex offender treatment and treatment provider style variables; and
- Identify several ethical issues in the treatment of sex offenders.

In this section of the training—to which we will devote more than half the day—we will be addressing sex offender treatment in some detail. We will cover program content, treatment intensity and duration issues, ethical considerations, and the most effective treatment provider styles. We'll be focusing on the most common population of sex offenders, namely adult males who are neither profoundly developmentally disabled nor acutely mentally ill. While treatment of mentally ill and developmentally disabled sex offenders is important, there are fewer of these types of offenders and much less research has been done to guide us in our work with these populations. Our purpose is not to train you to become sex offender treatment providers; rather, it is to provide you with specific information about what sex offender treatment involves—and to better equip you to work collaboratively with treatment providers and other professionals who are involved in sex offender management.

Knowing the particulars of sex offender treatment can assist community supervision officers in supporting their probationers and parolees in their treatment. For example, supervision officers can ask what the offender is experiencing from week to week in his group, encourage him to fully participate, intervene if he fails to attend, report to the treatment provider concerns related to high–risk thoughts and behaviors, and so forth. Likewise, treatment providers should apprise probation and parole officers regularly about offender progress, absence from treatment, and other concerns. This knowledge can also help you

differentiate between treatment that is likely to be effective with sex offenders and that which has been found to be ineffective.

Before we begin discussing sex offender treatment in detail, let's talk for a moment about the interrelatedness of sex offender treatment and other strategies we use to manage sex offenders.[1] Sex offender management is comprised of two different yet equally important strategies: those that place external controls on the offender as a means to manage his behavior, and those strategies that address building the offender's own internal controls.

Use Slide #3: **Two Facets of Sex Offender Management: Addressing both External and Internal Controls**

I said that external controls are used as a means to manage an offender's behavior. Probation and parole supervision, polygraph testing, sex offender registration, drug and alcohol testing, the use of community support networks, and so on, are all examples of external controls. The management strategy that addresses the development of internal controls—treatment—complements and works in tandem with these external control efforts. This training curriculum addresses the four domains of sex offender treatment: sexual interests, distorted attitudes, interpersonal functioning and behavior management. It is through these domains of treatment that we hope to assist sex offenders in the development of effective and lifelong internal controls. As you can see from this diagram, addressing internal controls is a central part of sex offender management; and one that is facilitated and enhanced by the use of external controls.

TOPIC: A FRAMEWORK FOR THINKING ABOUT SEX OFFENDER–SPECIFIC TREATMENT (25 minutes)

Use Slide #4: **Characteristics of Sex Offender–Specific Treatment**

Introduction

First let's look generally at the essential elements of effective sex offender treatment programs. What is done in treatment is not random or haphazard. Instead, treatment is based on an explicit, empirically–based model of change. What does this mean? It means that there is a philosophy that underlies the overall treatment program that can be described and is based on what has been learned through research. This treatment philosophy outlines how the sex offender's behavior will change following treatment and how the treatment methods used will facilitate the changes in behavior. The primary methods used in sex offender treatment are based on a combination of a number of theories.[2] This allows for a less narrow focus to treatment and ensures that we are considering behavioral, biological, behavioral, cognitive, socio–cultural, and other issues. Sex offender–specific treatment involves pro–social and life skills learning as a replacement for dysfunctional, anti–social learning.

Treatment Addresses Criminogenic Needs

As we discussed in the first section of this training, it is essential that sex offender treatment focus on criminogenic needs. That is, since our purpose in sex offender treatment is not to enhance the well–being of the offender but rather to make our communities safer, treatment must address the factors that lead people to commit sex offenses. This isn't always as easy or straightforward as it sounds, as we will see when we get into the specific cognitive–behavioral sex offender treatment components. But wherever possible, sex offenders' criminogenic needs should be the beacon that guides treatment.

Use Slide #5: **What Methods are Effective?**

Treatment Strategies

What sex offender treatment methods have been found to be most effective? As we've discussed already, a variety of therapeutic methods have been used with sex offenders over the years, and the one type that has emerged as the most consistently effective in reducing recidivism is a group of interventions described as cognitive–behavioral.[3]

Cognitive–behavioral treatment for sex offenders is mental health treatment that focuses on changing both how offenders think and how they behave. With respect to its cognitive dimension, cognitive–behavioral treatment identifies and challenges thinking errors and assists offenders to replace those errors with correct thinking.

With respect to behavior, this treatment is skills oriented. It provides opportunities for offenders to practice and develop skills and pro–social behaviors that are in line with correct (or pro–social, non–abusive) thinking. In the case of sex offenders, cognitive–behavioral treatment focuses on correcting the thinking errors that help convince them that their sexual offending is acceptable and assists them to integrate behaviors into their daily lives that are pro–social and non–abusive.

But what about treatment strategies? Since we're treating adults, principles of adult learning theory are utilized in sex offender treatment to enhance its effectiveness. Adult learning theory, which has a strong basis in research, is the most effective method for adults to learn new information and skills.[4] Although adult learning theory is a complex specialty unto itself, the basic assumptions related to sex offender treatment are that adults learn best when the material being presented is relevant to them in their daily lives, allows them to come to their own conclusions rather than being told what to think, provides opportunities to practice new skills, and reinforces content with material presented through multiple methods (oral, visual, etc.).[5]

We also know from a good deal of educational psychology research that people learn better when they are rewarded for things they do well rather than being punished for things they do poorly.[6] Although rewarding bright young students in the classroom comes easily to most of us, our inclination with sex offenders can be just the opposite, namely to look for opportunities to punish them because their offenses are so harmful. Additional research supports the use of positive reinforcement. I'm sure many of you are familiar with the work of Paul Gendreau and his colleagues in Canada in the mid–1990s. Gendreau's (1996) research quantified the importance of positive reinforcement with the general offender population. He found that programs that provided four positive reinforcements to every one negative reinforcement were far more successful in their work with offenders. This benchmark of 4:1 has important implications for our work with sex offenders as well. Although being punitive might satisfy our desire for revenge or our feelings of helplessness against sexual assault, the most effective sex offender treatment interventions put aside these understandable but dysfunctional intervention styles and instead emphasize positive reinforcement with sex offenders and avoid being punitive.[7]

In a similar vein, it can be satisfying to the treatment provider who is in an undisputed position of power to confront sex offenders in an aggressive fashion when they rationalize their offending behavior or blame their sex offending on their victims (see, e.g., Beech and Fordham, 1997; Beech and Hamilton-Giachritsis, 2005; Bumby, Marshall, and Langton, 1999; Marshall, 1996, 2005; Marshall, et al., 1999, 2002, 2003). But research has taught us that people learn more effectively and are more likely to change their behavior when their beliefs are questioned in a non–confrontational way. That is, when offenders are afforded respect, not attacked or made to look stupid, and questioned in a thoughtful way, they are more likely to come to their own conclusions about the errors in their thinking. Such a process is much more likely to result in long–term, authentic change in offenders' thoughts and behaviors (rather than

teaching offenders to parrot back what they know the treatment provider wants them to say).

Thus, sex offender treatment emphasizes selective reflection of responsible remarks from offenders and praise for positive comments and behavior. Effective treatment providers avoid telling sex offenders what they should think—which typically does not result in changing people's minds. Instead, treatment providers engage offenders in Socratic questioning that guides them through their own reasoning processes to pro–social conclusions. A Socratic question is one which is open–ended, cannot be answered by a yes or no, and requires the person answering the question to think to formulate an answer. Such a question is, for example, "Knowing what you know from having been sexually assaulted yourself as a child, what might your victim be experiencing now?"

Use Slide #6: **Treatment is Skills Oriented**

Treatment is Skills Oriented

Effective sex offender treatment is skills oriented. That is, it helps offenders learn specific skills to avoid sex offending and to engage in activities that don't harm others. This may seem so self–evident that stating it is unnecessary. But some sex offender treatment programs primarily teach offenders information, such as why they commit sexual assaults, but they don't adequately teach specific skills and strategies for avoiding recidivism. Skills oriented treatment includes:

- Defining the skill;
- Identifying the usefulness of the skill;
- Modeling the skill;
- Practicing the skill;
- Giving feedback; and
- Practicing the skill again.

Although sex offenders benefit from knowing why they do what they do, the most important learning is how to avoid committing sexual assaults again (see, e.g., Becker and Murphy, 1998; Laws, 1989; Laws, Hudson, and Ward, 2000; Marshall, et al., 1999; Pithers, et al., 1983; Salter, 1988; Ward, Laws, and Hudson, 2005). These "how to's" are an essential part of sex offender treatment. For example, offenders need to know how to avoid putting themselves in situations that might place them at risk for committing another sexual assault, or how to solve their problems in ways that reduce, not escalate, their anger.

Use Slide #7: **How Long Should Sex Offender Treatment Last?**

Note: Ask participants to call out what they believe to be an appropriate duration of sex offender treatment.

Optimal Length of Treatment

How long should sex offender treatment last? There has been much discussion about the length of time sex offenders should be required to participate in treatment. As we've seen, even among this audience, there is disparity of opinion on this question. At one extreme are those who believe that sex offenders should remain in treatment for the remainder of their lives; at the other, there are those who think a year or two of weekly treatment should suffice.

Until recently, this has been an opinion–based argument, but now we have some research that provides us with evidence to inform our decisions. We have one study completed by Dr. Anthony Beech and his colleagues in England.[8]

The study seems to support the general proposition that sex offenders with higher levels of sexual deviancy and denial require longer and more intense treatment to generate reductions in recidivism. However, the specific findings on length of treatment from this study are preliminary and have not yet been replicated by other studies, so caution should be used in applying the findings. What is important to recognize, however, is that the length of treatment is best determined by the specific needs of each offender and the risk that they present to the community (see, e.g., Association for the Treatment of Sexual Abusers, 2005; Becker and Murphy, 1998; Marshall, et al., 1999; Marshall, Fernandez, Hudson, and Ward 1998; McGrath, Cumming, and Burchard, 2003; Ward, Laws, and Hudson, 2003). That is, rather than assigning the same treatment requirements to all sex offenders, a better approach considers sex offenders' reoffense risk, degree of sexual deviancy and denial, and other factors particular to each individual, and uses this information to develop a specific treatment plan.

Note: Elicit answers to questions, promote audience discussion.

What implications do you think this should have for sentencing? For community supervision? For prioritizing which offenders should be assigned to treatment groups if there are not enough treatment openings for all sex offenders? For community notification? For home visits, electronic monitoring, and polygraph testing for rules compliance?

Use Slide #8: **Monitoring and Quality Control of Treatment are a Must**

Monitoring and Quality Control of Treatment Programs are a Must

An excellent treatment program has provisions for ongoing monitoring of its activities, both of its programs and its clients.[9] This means that while the treatment program might be well constituted and designed, it should be scrutinized by informed evaluators from time to time to ensure, for example, that the treatment methods and styles utilized are truly consistent with the agency's treatment philosophies. It is all too easy for treatment methods to "drift" away from the best intentions of the program design because treatment providers each have their own idiosyncratic methods. Regular monitoring of programs also helps to ensure that programs are in accordance with best practices.

Of course just as programs need to be monitored, so do the sex offenders in them. This should take many forms. An example is that sex offenders' progress should be measured from time to time throughout treatment, not simply at the close of treatment in a "final exam" fashion. Variables in the offender's environment can increase or reduce his risk, such as changes in his access to potential victims.[10] Compliance with probation supervision, return to drug abuse, new relationships, job changes, and so forth, can and do affect an offender's risk.[11] The risks and needs of many sex offenders change over time, and ongoing monitoring is necessary to recognize and respond appropriately to these changes.[12]

TOPIC: ADDRESSING SEX OFFENDER DENIAL (30 minutes)

Use Slide #9: **Treatment of the Denying Sex Offender**

Introduction

Before we move into our discussion of what constitutes good sex offender treatment, I'd like to address a question that inevitably arises in a discussion of sex offender treatment. Can you effectively treat a sex offender who is in denial? Denial is a pervasive issue when working with sex offenders, and the presence of denial does not, in and of itself, preclude effective treatment.

Note: Elicit ideas from audience, capturing them on a flip chart or white board.

Why is denial such a concern?

Denial is a major concern because most sex offender treatment is predicated on the offender's admission that he committed sexual assaults and that these behaviors are a problem for him.[13] If a convicted sex offender assumes the position in treatment that he did not commit any sex crimes, then whenever issues are discussed in treatment group meetings, such as cognitive distortions, deviant arousal, and offense cycles, the denying offender simply states that these concepts don't apply to him. This precludes his addressing his problems, and often interrupts the therapeutic process for the other sex offenders in the group who are admitting their sex offense histories. A corollary concept related to the importance of sex offenders' taking responsibility for committing sexual assaults is that by implicitly acknowledging that they chose to commit sexual assaults, they can make other choices, namely not to commit future sexual assaults. Sex offender treatment emphasizes that people can change; failure to admit problems provides no impetus to change.

Therefore, before sex offender treatment can be effective, the offender must admit his offense history, at least in part.[14] We view treatment of denial essentially as pre–treatment; not all sex offenders need it. However, those who do must substantially abandon their denial in order to benefit fully from sex offender treatment.[15]

Interestingly, the largest study of factors that predict risk for sex offender reoffense, the Hanson and Bussiere (1998) meta–analysis mentioned earlier, found that sex offenders who denied their offenses were not any more likely to commit additional sexual assaults than those who admitted their offense histories. This suggests that denial, per se, does not render a sex offender more dangerous. However, since treatment reduces recidivism risk in most offenders, and overcoming denial is the gateway to treatment, effective denial reduction is

important not because denial predicts recidivism but because coming out of denial allows sex offenders' access to treatment that, in turn, reduces recidivism risk.

Today we will discuss two approaches for addressing denial—the polygraph and group treatment.

Use Slide #10: **Tools for Addressing Denial**

Addressing Denial—The Polygraph

Denial in sex offenders can be addressed in a number of ways, including the use of polygraph examinations.[16] If he denies the crime and the polygraph examiner determines that he is being deceptive, compelling evidence of his culpability is available to challenge his denial. Many offenders abandon their denial when challenged with these test results.

Addressing Denial—Group Treatment

In situations where treatment providers do not have ready access to the polygraph, there are other methods for addressing denial in sex offenders. Usually such methods utilize a group setting.[17] In some instances, treatment providers opt to include one or two deniers in an advanced treatment group composed of individuals who have broken through their denial. Others favor working with a treatment group composed entirely of individuals still in denial.

In this curriculum, we will examine this latter approach—the use of a "deniers group" to reduce denial in sex offenders, thus enabling them to be candidates for conventional sex offender treatment. Treatment providers who employ this method report that the great majority of offenders are able to come out of their denial. This approach targets two major issues:[18]

- Eliminating cognitive distortions—which, left intact, allow offenders to continue denying or minimizing; and
- Developing victimization awareness—which can allow offenders to understand the physical and psychological harm they inflict and, thus, render them more reluctant to commit future assaults.

This approach involves a number of techniques geared toward reaching these major issues.[19] They may include:

- Forming a treatment group composed exclusively of individuals who have been convicted of a sex offense and who are in substantial denial (either of committing the offense at all or of having actually harmed the victim as a result of the offense). Another entry requirement for the group is that offenders may not have their cases on appeal, as such offenders are usually advised by counsel to admit nothing.

- Facilitation of the group by the treatment provider to introduce ideas, suggest discussion topics and activities, praise progress, and ensure that the group remains positive.
- A time–limited intervention—typically these groups meet for a period of 12–16 weekly sessions of about 90 minutes duration each.
- Articulating the assumption that denial is a normal reaction for those involved in sexual offending behavior and the reasons for that denial.
- Focusing on both the benefits and the costs of denial—and of disclosure.
- Not allowing offenders—initially—to discuss their own offenses (so they do not become solidified in stated denial).
- Allowing the group itself to identify the cognitive distortions often employed by sex offenders in order to access and assault their victims through role–plays and discussions of what "other" offenders tell themselves in order to convince themselves that their behavior is okay.
- Utilizing videotaped or live statements of sexual assault victims to communicate to offenders the nature and extent of the trauma suffered by victims.
- Inviting sex offenders who were formerly deniers to visit the group. They describe the reasons for their initial denial, the reasons they decided to admit, and a description of their sexual offenses.
- Allowing group members—as the culmination of this 12–16 week process—to describe their offense history.

A major concern of the group members is often about what other group members will say about their discussions when they are not in the group. One way to address this concern is to ask the group participants to come to an agreement about their own confidentiality, and in virtually every instance, the agreement they make among themselves is that what is discussed in group does not get discussed outside of group, as it pertains to anyone besides the person talking. Typically, it is best to have the group members come to this agreement among themselves rather than imposing such rules on them for three reasons. First, it is a simple way to begin their involvement in a discussion they are likely to understand and be interested in, without discussing any threatening content such as sex offending. This provides practice for what will be occurring in the group. Second, it requires that the group build cohesiveness and trust among its members, at least about this issue. Building trust among themselves can be a useful exercise because it leads to group members sensing that they can be helpful to each other. Finally, compliance with confidentiality agreements is more likely to occur among people who devise the agreement themselves than those for whom such rules were imposed.

Most of what occurs during group sessions is discussion among the participants. The facilitators' (or treatment providers') primary function is to introduce ideas, suggest discussion topics and activities, praise progress, and most importantly, ensure that the therapeutic milieu remains pro–social.[20] By this we mean that it is essential that as the group progresses, group members feel they will be rewarded—principally by other group members—for admitting their sexual assaults, which often is different from most of their previous experiences.

Note: Ask audience; note answers on board.

Facilitators begin the "denier group" treatment by talking about definitions of and the continuum of denial, asking group members to define what is meant by denial, followed by a discussion of the degrees of denial that range from complete denial, such as "I wasn't even in the house at that time," to minimization. How would you define denial? What about minimization? What might be examples of sex offender minimization? Examples of substantial minimization include offenders who say they can't remember anything about their offenses, but don't deny that they might have occurred.

Next the facilitators turn the discussion to how denial is commonplace and normal in human experience. Examples of denial and minimization, unrelated to sex offending, are elicited from the group. Common examples are people who know smoking is harmful but continue to smoke, people who say they want to lose weight but continue to overeat, traffic law violations such as speeding, and so forth. The purpose of such normalization of denial is to acknowledge to the offenders that their having denied isn't unusual or difficult to understand. Offenders find this supportive, which in turn promotes their being more willing to risk acknowledging their offense histories.

***Use Slide #11:* Treating Denial Focuses on its Complexity**

Facilitators then guide the discussion to the purposes of denial, that is, the advantages and disadvantages of it. The group is asked to list the advantages of denying having committed sexual assaults, which are written on a board by the facilitator, followed by a list of disadvantages. Typically the offender–generated list of advantages of abandoning denial is much lengthier than the list of advantages to maintaining denial. The purpose of this exercise is for group members to begin to consider what they might have to gain by admitting their offenses, although this is not overtly discussed at the time. Consistent with adult learning theory, group members participate in experiences that help them draw their own conclusions, rather than being told what to think.

Next the discussion is directed to the varying pressure to deny that people feel according to the magnitude of the matter in question (whether people are less likely to deny having done something wrong if it is a fairly trivial thing, such as driving a few miles over the speed limit, versus a very major thing, such as speeding resulting in hitting and killing a child with one's car, for example). Of course the group members quickly observe that the latter would be much more difficult for the responsible party to admit. They are asked by group facilitators to account for the difference since both involved the same action by the driver—speeding—and the typical answer relates to the consequences of the action. When asked to compare this to the pressure to admit or deny having committed sex offenses, group members readily agree that because society views sex offending as such a serious violation, the pressure to deny is great. The purpose of this exercise is to acknowledge that denying having committed sexual assaults is not surprising; its dysfunctional aspects will be addressed in subsequent group discussions. As in previous interventions, offenders find this supportive, which in turn encourages them to be willing to relinquish stubborn adherence to denial.

Next, group facilitators initiate a more comprehensive discussion of denial by asking the group to consider and suggest examples of denial in three phases of sex offending: before the offense, during the offense, and after the offense.

Note: Capture examples on flip chart or white board. Ask participants for reactions.

What are some examples of denial that sex offenders might employ before the offense? During the offense? After the offense?

Group members often volunteer examples of before–offense denial such as "I'm not really going to be sexual with him; I'm only taking him camping," or "I'm just driving around because I like to drive," denying that the offender's real purpose is to isolate a victim to rape. Examples of during–sex offense denial include "I'm not physically hurting her so I'm not really harming her" and "She didn't really say no, so she must be liking it." Examples of after–offense denial are "This is the last time I'll do that—never again," and "He hasn't reported the assaults, so he must have liked it." Often group members offer as examples of denial the very denial they have engaged in themselves, although they don't typically identify their examples as such, nor do facilitators (or group members) observe when this appears to be the case. Facilitators typically notice these examples and consider them as additional information about this individual. The overall purpose of this discussion is to broaden offenders' recognition of denial as not simply a matter of whether one admits having committed sex offenses but also that denial can be used in many aspects of sex offending.

A Technique to Address Cognitive Distortions Regarding Informed Consent

A major component of many sex offenders' denial is not simply that they say they did not have sexual contact with their victims, but that their victims were in fact "partners" because they gave consent. This is a common facet of denial for many offenders, both those who commit acquaintance rape and those who sexually assault minors. Therefore, the concept of informed consent is discussed at length both in sex offender denial treatment as well as in conventional sex offender treatment.

Although there are many ways for the concept of informed consent to be explored, we'll illustrate one such method. In this intervention, a facilitator turns to a randomly chosen group member and asks him to sign a piece of paper that purportedly will grant the facilitator permission to perform a pre–frontal lobotomy on him. Of course the group member refuses. Feigning surprise, the facilitator asks the group why this group member would not sign the consent. Answers given typically include that the group member couldn't possibly give such consent because he doesn't even know what a pre–frontal lobotomy is. In reply, the facilitator says, "Oh, it's brain surgery," then leans over toward the group member who refused to sign the imaginary form and asks, "Now will you give me permission?" Of course, the group member refuses again. The facilitator then turns again to the group and asks them why they think this group member still refuses to give his consent. This typically generates many replies, including that the group member doesn't know why he should allow this surgery, why the

facilitator thinks he needs it, what qualifications the facilitator has to perform such surgery if he needed it, what the likely benefits and costs might be, and so forth. After these comments are made, the facilitator observes that it appears the group believes that in order for someone to give consent, that person needs a great deal of information. The group readily agrees, because in fact they demonstrated this with their comments.

The facilitator then observes that when people engage in sexual behavior with each other, a similar dynamic exists, namely that in order to give consent, both persons need to know what they are consenting to. Indeed, largely because adults have a lot of information about sex that children typically don't, laws exist to prohibit adults from having sex with children.

Use Slide #12: **Methods to Address Cognitive Distortions**

The facilitator then performs a role–play demonstration to illustrate this point. This role–play avoids the hazards of lecturing on the topic that often is ineffective and can be sidetracked by challenges to the merits of laws prohibiting sex with minors, arguments that many adolescents are sexually experienced and, therefore, can give consent. As the role–play begins, the facilitator stands next to an empty chair and asks the group to imagine that in the chair is an 11–year–old boy. The facilitator tells the group that he will be playing the role of a sex offender who believes what the group just concluded, namely that in order for children to give consent to sex, they must have a great deal of information. As a child molester who believes in children's right to consent, he will be telling the child what he needs to know about having sex with him, then ask him if he wants to have sex.

Standing next to the empty chair, the facilitator speaks loudly enough for the group to hear as he looks at the imaginary child in the chair and says,

Johnny, I want to talk with you about something. I want to have sex with you.

You look puzzled. Let me tell you what I mean, and what I hope we'll be doing. I know that you like to be with me, to come over to my house, and for us to do stuff together. You've been coming over here after school now since October, right? You like to play my video games, drink the Mountain Dew I always keep in the refrigerator for you, stuff like that, don't you?

I know that you really like me, and I've acted like I really like you. I don't actually like you that much, but I've pretended that I do, and I think that's made you feel really good. It's not that I don't like you, it's that if I get you thinking I like you really a lot, then you might be more willing to do what I want you to do.

Anyway, let me tell you about what I'm hoping will be happening between us.

The instructor then proceeds to explain to the mythical child exactly what having sex with him means, graphically describing the physical act, describing the consequences he (the offender) will suffer if anyone finds out about it, and the great lengths he will go to in order to avoid being discovered and punished. This,

of course, involves making the child out to be a liar if he were ever to disclose the behavior. He also goes into great detail about what the child will have to face should he have to go to court and all the different people who will know about what has happened. He also describes in detail how the child will feel—including physical pain, feelings of guilt and isolation—immediately after the abuse and later, as an adult. He goes on to indicate that, when the child grows to the age of puberty, this experience may have longer–term consequences on his comfort with his adult sexuality. He concludes…

So, Johnny, now that you know about all this stuff, would you like to have sex with me?

After this role–play demonstration, the facilitator asks the group for their reactions. Typically, there is considerable discussion about the fact that no child would voluntarily have sex with an adult. The facilitator points out that the information given to the child in the role–play is the information that most adults know. That is, by the time people become adults, they have learned about sex, about how people get other people to have sex with them, and so forth. But kids don't know this information and, therefore, in order to give consent, they need just as much information as an adult typically has in order to give consent to sex. In fact, children need even more information because they are in an inferior power position to adults in other ways as well.

Use Slide #13: **Methods to Address Cognitive Distortions (cont.)**

Another Approach to Addressing Cognitive Distortions

Other concepts that are introduced during the course of this 12–18 week series of group sessions include sexual boundaries and cognitive distortions. As is the case with other concepts such as informed consent, there are many ways to present this material to sex offenders. One such method will be detailed here to illustrate how this work can be done.

A group facilitator asks the offenders in the group to think about how a sex offender might complete the sentence, "Even though I knew my sex offenses are wrong or at least illegal, what I said to myself to make it seem okay was ________________________." Since at this point in treatment the denial group members have not been asked to reveal their offense histories, they are not asked what excuses and cognitive distortions they used personally; instead they are asked to suggest what excuses other offenders might use to justify their behavior. Of course the cognitive distortions group members give are those that come to them most readily, typically ones they have used themselves.

Common examples include the child wanting sex, that the child is old enough to have sex, that women like to be forced sexually, that the sex is okay because the offender loves the child, and the offender promising himself that he won't do it again. Group members tend to readily identify what is wrong with the various justifications, especially those of others because they recognize these rationalizations as well or better than most people.

Following this exercise, the group facilitator inquires of the group the purpose of these cognitive distortions, that is, why sex offenders use them. Some group members typically understand and can explain that people justify their misbehavior to enable them to continue to do it because it brings them pleasure. Finally, the facilitator asks the group to discuss whether any of these cognitive distortions—or even all of them together—justify or make sex offending acceptable. Typically among group members there is unanimous agreement that they do not.

Use Slide #14: **Increasing Victimization Awareness**

Increasing Victimization Awareness

As we've already observed, most sex offenders don't enjoy harming their victims; nonetheless, they cause trauma because they selfishly use their victims as objects and they disregard the harmful effects they cause. The exceptions to this are sexual sadists, who derive erotic arousal from causing victims to suffer, and psychopaths, who are indifferent to others' discomfort. Therefore, it may not be appropriate to include sexual sadists or psychopaths in the following treatment component—victimization awareness and empathy.

The overarching purpose in increasing victimization awareness and empathy with sex offenders is the belief that if they come to understand the harm they cause, primarily psychological harm, they will be more reluctant to commit future sex offenses because they will find it more difficult to disregard the consequences of their actions to their victims and others.[21] Research suggests that many sex offenders don't have generalized empathy deficits; rather they have empathy deficits related specifically to their sex crimes and victims.[22] Therefore, the development of victimization awareness and empathy needs to be quite specific to their own sexual assault behavior.

Victimization awareness is a component of sex offender treatment for offenders in denial for the above reasons and because many sex offenders deny that their victims were truly victims, that is, they fail to see the harm done.[23] By coming to understand such harm, they are more likely to view themselves as sex offenders and less as misunderstood lovers. This revised definition of their behavior makes it more likely that they will come to acknowledge what they have done, because they no longer see themselves as misunderstood victims of "the system" but instead people whose sexual behavior has harmed others.

Use Slide #15: **Methods to Address Victimization Awareness**

Victimization awareness can be addressed in treatment groups in a variety of ways. First, by showing videotaped programs of sexual assault victims describing how they have been traumatized by sex offenders and second, by a live version of that—namely having actual adult survivors of sexual assault visit the group to describe their experiences of trauma.

The obvious advantage of using videotape material is its accessibility and control—group facilitators choose the audiovisual materials carefully and they know exactly what the content will be. On the other hand, the advantage of live sexual assault survivors is that their presence is much more powerful than videotape, and there can be interaction in the form of questions and answers between the offenders and the survivors. (These, of course, are always volunteers who have worked with offenders before. Sex offender treatment group facilitators can locate potential volunteers by contacting treatment providers at treatment facilities for sexual assault survivors.)

The purpose of the group meeting involving sexual assault survivors is not to enable aggressive confrontation or anger. Instead, it is to provide a forum for important education and thoughtful discussion, which occurs when the intervention is carefully organized. The intervention takes considerable therapeutic skill on the part of the group facilitators to set up the necessary expectations, requirements including mutual respect and boundaries, and so forth. Sex offenders and survivor volunteers alike almost always report that the experience was powerful, instructive, and important for their growth and understanding.

Use Slide #16: **Involving Sex Offenders Formerly in Denial**

Note: Elicit answers to question, focusing on pro–social role modeling effects

Involving Sex Offenders Formerly in Denial

The next component of treatment of sex offenders in denial involves a visit to the group by sex offenders who formerly were in denial but now admit their offense histories.

Why do you suppose this might be a valuable component of treatment for sex offenders who are in denial?

These sex offender visitors are carefully chosen by the group facilitators; often they are "graduates" of previous sex offender denial treatment groups. In this group session, the visitors describe to the group members how they initially denied having committed their offenses, sometimes for years after they were convicted; how they came to abandon that denial and admit to their assault histories; and how doing so has been positive for them. These men become role models for the denial group members, essentially suggesting, "If I can do it, then so can you."

Use Slide #17: **The Culmination of Denier's Treatment**

The Culmination of Deniers Treatment—Providing a Sexual Offense History

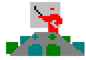
The interventions described thus far have consumed most of the 12–16 weekly meetings of the deniers group. As we discussed before, until this time the group

members have been prohibited from talking about their own offenses. The last phase of the group process is to have each participant take his turn describing his offense history.

As the various group members take their turns describing their offenses, the earliest volunteers are the most forthright and the last volunteers are the most reluctant to admit. Sex offender treatment providers who conduct this sort of group therapy for deniers find that usually about 80% of the group members admit to the offenses they were convicted of, which is sufficient to make them eligible for sex offender treatment. Treatment providers take different approaches to those offenders who persist in denial even after they have received significant therapy to assist them to break through denial. Some proceed to use the polygraph, or provide another opportunity for these offenders to participate in deniers treatment, citing instances of success in breaking through denial after a subsequent treatment experience. Others no longer consider such offenders candidates for treatment. Of course, the implications for community safety will depend in part on whether the offender is receiving treatment in a secure facility as opposed to in the community. If the offender is confined, the consequences of continued denial are not as significant as they would be for an offender residing in the community.

Note: Ask audience, capture responses on a flip chart or white board.

We've described in considerable detail one common treatment group method, in order to give you a sense of what treatment providers do when working with sex offenders—particularly around the issue of denial. Does this discussion of handling sex offenders' denial raise any questions for you about how to respond to denial as a probation or parole officer? Next we'll look at the treatment methods typically used with sex offenders who admit their offenses.

 **TOPIC: THE FOUR DOMAINS OF TREATMENT (30 minutes)**

Introduction

Now let's talk about what should comprise sex offender treatment, that is, what should be addressed in a comprehensive sex offender treatment program?

What thoughts do you have?

Note: This can be done with the large audience, or participants can be broken into smaller groups to list suggested sex offender treatment content areas. Note these, preferably on easel–size paper, and post in the large group.

Use Slide #18: **The Four Domains of Treatment**

You all have identified a large number of treatment targets, meaning the areas that you think should be addressed in sex offender treatment. Let's put them into categories according to what we have learned about sex offender treatment outcomes. Research has found that sex offender treatment should include four general domains:[24]

- Deviant sexual interest, arousals, and preferences;
- Distorted attitudes;
- Interpersonal functioning; and
- Behavior management.

Although not all sex offenders have difficulties or deficits in each of these four domains, most do. Thus, it is essential that treatment programs address all four, and for the exceptional cases where one or another of these domains is not relevant for a particular offender, he can be exempted from that treatment domain. We will discuss interventions in each of these domains shortly, but for now let's look generally at what we mean by these four areas of focus.

Deviant Sexual Interest, Arousal, and Preferences

Note: Ask audience; elicit answers related to deviant sexual arousal.

What specifically do we mean by "sexual interests, arousal, and preferences?"

We've already established that people commit sex crimes for a wide variety of reasons, some of which are secondary to deviant sexual arousal. For example, the offender who fondles the breasts of his 14–year–old stepdaughter likely is not motivated by having sex with children as much as he is acting on his normal

sexual arousal with a readily available, easily accessible victim. Assuming he has no other criminal sexual history, if we measured his sexual arousal pattern in the laboratory, we likely would find he is most erotically attracted to adult women, followed in intensity by adolescent girls, which is a normal sexual arousal pattern for a heterosexual adult male. Thus, we might conclude that his principal problem is not one of sexual interests; rather, the reasons he molested his stepdaughter likely have more to do with his having used extremely poor judgment, having difficulties of impulse control, poor self–management, problems in his personal relationships, and other problems.

On the other hand, the person who is motivated to commit sexual assaults to satisfy his sexual arousal to children, or to force people to have sex with him, or to expose his genitals to strangers, has problems in the area of sexual interests. And although it may be surprising to you, some sex offender treatment programs do not directly and effectively address this domain of treatment—sexual interests—a major and powerful motivator for many sex offenders.[25]

Distorted Attitudes

It is almost universally true that sex offenders have distorted attitudes (see, e.g., Bumby, 1996; Hanson and Harris, 2000; Hanson and Morton-Bourgon, 2004; Langton and Marshall, 2000; Marshall, et al., 1999; Murphy, 1990). Distorted attitudes are used by everyone, not just sex offenders, to help justify and sustain behavior that we know, at some level, is wrong, harmful, or inappropriate. It is vitally important to treat distorted attitudes, because these attitudes help to "rationalize" further offenses.

Note: Elicit examples and ideas from audience.

What are some examples of distorted attitudes that child molesters might have? How about rapists? How might these distorted attitudes influence these men's behavior?

You've identified many common attitudes held by child molesters and rapists, including the frequently–cited statement by child molesters that they are not really harming the child because there are no physical injuries, that the child was old enough to give consent, that the child enjoyed the sexual behavior, and so forth. Common rape myths include that the victim really wanted to be raped, that she deserved it, that she couldn't have been that harmed because she had had sex before, or that as the offender's wife, she couldn't be a rape victim. Some sex offenders convince themselves that these cognitive distortions are true, and others profess to believe them but really don't. In any case, a necessary component of sex offender treatment is to elicit sex offenders' thinking errors, examine them for accuracy, and have them learn accurate, functional thinking about these matters.

Interpersonal Functioning

Now let's talk about the third treatment domain, namely interpersonal functioning.

Sex offenses are violations of other people, often related to difficulties in offenders' lives in the realm of interpersonal functioning. Examples of this include the husband who is so poor at managing his adult responsibilities that he deals with his conflictual relationship with his wife in part by sexually assaulting his daughter; the man who forces sex on women he dates; and the man who is unable to develop appropriate, satisfactory peer relationships who then uses children to meet his emotional intimacy and sexual needs. Many sex offenders need interventions to assist them to function more responsibly and effectively as adults.

Behavior Management

The fourth domain is behavior management.

Although deviant sexual arousal can motivate sex offending, distorted attitudes can promote it, and problems of interpersonal functioning can contribute to it, ultimately sex offenders need to learn to manage their behavior. Deviant sexual arousal, distorted attitudes, and poor interpersonal functioning do not cause sexual offending, though they are correlated (see, e.g., Hanson and Bussiere, 1998; Hanson and Morton-Bourgon, 2004). They do not explain the motivation to act out. So, the focus must be on both the underlying issues and the behavioral acting–out.

An essential component of sex offender treatment is teaching sex offenders very specifically how to manage their behavior. Behavior management is particularly important in situations where an offender easily could commit a sexual assault, such as being in the presence of someone whom he could readily victimize.

Use Slide #19: **Sex Offender Treatment Goals and Plans**

Sex Offender Treatment Goals and Plans

Let's look at common sex offender treatment goals and plans. As we know, sex offenders are not all the same; likewise, not all of their treatment should be the same. Before treatment begins, sex offenders should be assessed by treatment providers so that they understand what has motivated them to offend, what reoffense risk each poses, and other relevant information. Based on an initial assessment, each sex offender should have an individualized treatment plan that addresses his particular criminogenic needs and his reoffense risk. As treatment progresses, treatment plans should be modified based upon further assessments, and additional information derived from victims, the offender, laboratory testing of sexual arousal, and the polygraph, or other sources. In general, though, some common treatment goals include: (see, e.g., Association for the Treatment of Sexual Abusers, 2005; Becker and Murphy, 1998; Laws, 1989; Laws, Hudson, and Ward, 2000; Marshall, et al., 1998, 1999; Salter, 1988; Schwartz and Cellini, 1995, 1997; Wars, Laws, and Hudson, 2003).

- Acknowledging and accepting personal responsibility for a complete sexual assault history;
- Improving social, relationship, and assertiveness skills;

- Appropriately managing anger;
- Learning about the traumatic effects of sexual assault behavior and developing empathy; and
- Learning to separate anger, power, and other motivational issues from sexual behavior and improving understanding of human sexuality.

We expect sex offenders to acknowledge and accept responsibility for all of their sexually exploitative behaviors, not just those they've been caught for. Sometimes we learn about additional offenses because sex offenders reveal them during group meetings or in their homework assignments; sometimes we learn about additional offenses when sex offenders complete sexual history questionnaires in preparation for polygraph examinations; and sometimes we learn about previously undisclosed offenses from other sources, such as from victims.

We expect that sex offenders will examine all their offenses, not just the ones for which they were apprehended. All of their offenses are important, not just those for which they were criminally charged. We also expect sex offenders will improve their social, relationship, and assertiveness skills in order to assist them to function more appropriately and effectively as responsible adults.

Some sex offenders are motivated to commit sexual assaults in part because of mismanagement of anger. For example, they may displace their anger toward one person or a group of people onto a victim, or they may "punish" their wives or children by sexually assaulting them. Helping sex offenders effectively manage their anger can reduce their risk for subsequent sexual assaults and other forms of violence.

Many sex offenders don't commit sexual assaults with the goal of harming their victims. Instead, they selfishly use their victims for their own gratification, discounting the harm to the people they are abusing. When these offenders come to understand the enormous trauma that their sexual assaults typically cause, it makes it more difficult for most of them to continue these activities. Exceptions to this are sexual sadists, whose erotic arousal is to victim suffering, and psychopathic offenders, who are unaffected by others' distress. As mentioned earlier in the denial group section, treatment for sexual sadists and psychopaths—a small sub–group of sex offenders—needs to differ in the realm of victimization awareness. For the majority of sex offenders, however, we expect them to develop empathy for their victims.

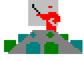
Many sex offenders confuse non–sexual matters with sex, such as anger, power, control, affection, and so forth. Sex offenders often do not understand that sexual behavior isn't appropriate when it is used to gain control over someone, express anger or power, or otherwise exploit others. We expect sex offenders to separate sexuality from these other issues, and we accomplish this in part by teaching them about normal human sexual behavior and attitudes. Other goals include: (see, e.g., Association for the Treatment of Sexual Abusers, 2005; Becker and Murphy, 1998; Laws, 1989; Laws, Hudson, and Ward, 2000; Marshall, et al., 1998, 1999; Salter, 1988; Schwartz and Cellini, 1995, 1997; Ward, Laws, and Hudson, 2003).

Use Slide #20: **Sex Offender Treatment Goals and Plans (cont.)**

- Recognizing and changing cognitive distortions;
- Minimizing deviant sexual arousal;
- Understanding the offender's own offense cycle and developing the skills to interrupt that offense cycle; and
- Adopting a non–exploitative, responsible lifestyle.

Research has taught us that a disproportionately larger number of sex offenders were victimized when compared to other adult males (see, e.g., Dhawan and Marshall, 1996; Garland and Dougher, 1988; Hanson and Slater, 1998; Lambie, Seymour, Lee, and Adams, 2002; Langevin, Wright, and Handy, 1989; Prentky, Knight, Sims-Knight, Strauss, Rokous, and Cerce, 1989; Seghorn, Prentky, and Boucher, 1987). Not surprisingly, sex offender treatment often elicits unresolved issues of offenders' own histories of victimization. Although victimization per se has not been shown to be associated with reoffense risk[26], it is often beneficial to assist sex offenders in their recovery from the trauma of their own victimization.[27] Thus, although not directly a criminogenic need, to discount this aspect of sex offenders' lives is to send them a hypocritical message, namely that we want them to understand and recognize how sexual assaults have hurt their victims, but that their own suffering from having been assaulted is not our concern. Skilled treatment providers can assist sex offenders with their own trauma recovery, as necessary, often separate from the work done in sex offender treatment. This work needs to be carefully managed, however, to avoid the pitfalls of over–focusing on sex offenders' personal assault histories as a distraction from the primary tasks of sex offender treatment directed at reducing recidivism risk.

One of the vexing problems of sex offender treatment is knowing when offenders have made actual progress, as opposed to simply performing well in group or professing changes, such as in attitudes, that they don't really believe. While there are pre– and post–measures of such progress, sex offenders sometimes pretend—quite convincingly—to have made more progress than is actually the case. Perhaps the best measures of risk reduction are more global indicators of attitude and behavior change, such as the adoption of a non–exploitative, responsible lifestyle. People who live responsibly and don't exploit others don't commit sex offenses. Therefore, as another way to evaluate progress, probation and parole officers, treatment providers and others assess the extent to which sex offenders conduct themselves responsibly and non–exploitatively in all areas of their lives, not just when they are focused in treatment on their sex offending attitudes and behaviors. Indeed, a better indicator of progress is an offender's behavior in his ordinary life, not while being scrutinized in treatment.

 **TOPIC: SEXUAL INTERESTS—THE FIRST DOMAIN OF TREATMENT (30 minutes)**

Use Slide #21: **Sexual Interests—The First Domain of Treatment**

Introduction

You will recall that we identified four domains that are important to address in sex offender treatment: sexual interests, distorted attitudes, interpersonal functioning, and behavior management. We'll look at some very specific interventions in each of these domains in order to give you examples of what occurs in cognitive–behavioral sex offender treatment. In each case, we'll examine the rationale for the intervention, its goals, and the specific methods that treatment providers use. Let's start with some treatments directed toward the reduction of deviant sexual arousal.

Use Slide #22: **For Offenders with Deviant Sexual Arousal**

As we discussed before, some but not all sex offenders are motivated to commit sexual assaults in part because they are sexually aroused to activities—such as rape or types of people such as children—where to act on these arousal patterns constitutes criminal behavior. If this deviant arousal could be diminished, the motivation to commit sexual assaults also would be diminished. There are two principal ways this can be accomplished: through the use of behavioral interventions and through medications that reduce sexual arousal and/or control of deviant inclinations. Let's first look at an example of behavioral treatment to reduce deviant sexual arousal, one that is called masturbatory satiation.

Use Slide #23: **Behavioral Intervention to Reduce Deviant Sexual Arousal**

Behavioral Intervention to Reduce Deviant Sexual Arousal

The primary goal of behavioral treatments to reduce deviant sexual arousal is just that—to diminish deviant sexual arousal. In order to do this, we have learned that it is much more difficult for men to reduce deviant sexual arousal alone than it is for them to replace that arousal with non–deviant arousal. Therefore, behavioral treatments involve substituting non–deviant erotic fantasies as a replacement for deviant fantasies (see, e.g., Abel and Blanchard, 1974; Abel, Blanchard, and Becker, 1978; Berlin, 2000; Dougher 1995; Laws, 1995; Laws and Marshall, 1991; Laws and Osborn, 1983; Maletzky, 1991; Marshall, et al., 1999; Marshall and Eccles, 1995; Marshall and Laws, 2003; Quinsey and Marshall, 1983). Another component of this intervention is to have sex offenders react to their deviant behaviors in the way that most people do, namely to have no arousal and even to find the deviant thoughts repugnant.

Before proceeding with a discussion about how to affect deviant sexual arousal, it is important to note the range of severity of sexual interest problems evidenced by sex offenders. In particular, some sex offenders' deviant sexual interests are so exclusive and ingrained that they are destined to struggle with

controlling them for the rest of their lives (see, e.g., Berlin, 2000; Laws and O'Donohue, 1997). For example, men who have an overarching, primary, and exclusive sexual interest in pre–pubescent boys are referred to as fixated male pedophiles. Even state–of–the–art behavioral and medication treatments will, at best, only help these men control their deviant urges, not eliminate them. In addition, although social learning theory seems to be the most effective way to think about the etiology (or cause) of sexual offending and how to treat sex offenders, some researchers posit that sexual interests may have some biological basis and consequently are very resistant to long–term change.[28] These are important caveats to keep in mind as we move on to discuss methods we use to reduce deviant sexual arousal.

So how do we do this? We'll describe what is involved with the technique known as masturbatory satiation (see, e.g., Dougher, 1995; Laws and Marshall, 1991; Maletzky, 1991; Marshall, et al., 1999; Marshall and Laws, 2003). It is based on behavioral learning principles that suggest that deviant sexual arousal is, to some degree, learned behavior and that arousal can be reduced by "unlearning" the deviant thoughts and behaviors, and replacing them with non–deviant thoughts and behaviors. This method is one of the clearest examples of behavioral conditioning in sex offender treatment, the "behavioral" part in the "cognitive–behavioral" sex offender treatments.

When teaching this technique, the treatment provider starts by explaining to the offender that he will be involved in a treatment method to reduce his deviant sexual arousal and, to some extent, increase his arousal to non–deviant stimuli. The treatment method will involve his performing some very specific homework in private. It is important that the offender understand the intervention well in order to consent to it, increase his compliance and motivation, and ensure that he does the treatment properly. The offender records the homework on an audiocassette so that it can be performed at home, in private, yet can be monitored later by the treatment provider.

The general idea of this technique is to pair the intense physical pleasure of orgasm with healthy sexual fantasies, followed by pairing discomfort and boredom with deviant fantasies (see, e.g., Laws and Marshall, 1991; Maletzky, 1991; Marshall, et al., 1999). Typically, attempting to masturbate during the refractory period (i.e., the period of time following the initial orgasm in which continued physical arousal and orgasm are generally not physically possible) causes boredom and in some instances, a degree of physical discomfort. Therefore, the purpose of this second aspect of the exercise is to have the offender experience negative reactions to his deviant fantasies—namely to find them non–erotic, boring, and physically uncomfortable. Ideally, the attractiveness of the previously erotic (and deviant) stimulus is substantially diminished. By focusing on one aspect of his deviant arousal pattern, he pairs physical discomfort and extreme boredom with what typically would be arousing and pleasurable to him. Taken together, the pairing of healthy fantasies with the intense and positive experience of an orgasm is designed to strengthen healthy sexual interest and arousal patterns, while the pairing of discomfort, boredom and deviant fantasy can assist him in reducing deviant fantasies and interests.

The offender is instructed to make about three audiotapes per week consisting of one hour homework assignments. The purpose of his making the audiotapes is for the treatment provider to monitor his compliance and ensure that he is doing the exercise properly. The audiotapes are to be submitted during weekly therapy sessions for a period of about seven weeks for a total of about 20 hours of homework.

Offenders typically find this exercise to be awkward to do at first, but relatively quickly become accustomed to it. Their cooperation is less of a problem than one might expect, especially when the purpose of the intervention is well understood, the method is well described, and it is clear that other offenders are completing their homework.

Use Slide #24: **Common Questions**

Commonly Asked Questions

The question sometimes arises as to whether or not it is easy for offenders to sabotage this intervention, such as by pretending to go through the motions as instructed, but actually continuing to engage in their deviant fantasies even while supposedly doing their homework properly. The answer is that, of course, they can. However, these matters are discussed very openly in treatment. The treatment provider can ask the group, "What if someone wants to fake the exercise in some way? Could he do it? Who would he be harming, or fooling?" Invariably, group members will articulate the self–defeating nature of such attempts as treatment sabotage, often more pointedly than treatment providers might. For example, a group member might say, "Sure, you could pretend to do this and not really do it. But you'd be the fool, because when you get caught for your next offense, it won't be the treatment provider who gets sent to jail, it will be you."

Another frequent question is whether or not sexual arousal patterns can really be changed, by this or other methods (see, e.g., Berlin, 2000; Laws and Marshall, 1991; Laws and O'Donohue, 1997; Marshall, et al., 1999; Marshall and Laws, 2003). Some professional opinion in this regard is that a mechanism that underlies sexual interest other than gender orientation is primarily one mediated by learning or experience, and the preponderance of professional opinion in this regard is that the mechanism that underlies sexual interest other than gender orientation is primarily one mediated by learning, and principally by learning that occurs during critical periods in development, perhaps around puberty or a bit before (see, e.g., Marshall, et al., 1999; Marshall and Laws, 2003; Sieger and Ward, 2003 (in Ward, Laws, and Hudson, 2003). This is exactly what the mechanism of behavioral treatment is attempting to mimic, only this time the stimulus of the intended arousal is purposefully chosen to be non–deviant.

Who is this behavioral intervention best suited for? For sex offenders whose offenses are most strongly motivated by deviant sexual arousal. As we've discussed, not all sex offenders commit offenses because they have deviant arousal. For example, most incest offenders who molest post–pubescent children have normal, non–deviant sexual arousal. Like normal heterosexual men, they

are most aroused by adult women, followed by adolescent girls, followed by female children. The incest offender who fondles his 14–year old stepdaughter as she sleeps is responding—obviously very inappropriately—in part to his attraction to the child's adult female secondary sexual characteristics. What motivates his sex offending likely is not deviant sexual arousal as much as it is extremely poor judgment, poor impulse control, lack of awareness or concern for the child's welfare, those sorts of things. Had he done the same things to a six–year–old girl, this would suggest deviant sexual arousal, because a six–year–old child doesn't look like a young version of an adult, whereas a 14–year–old may very well look like a young version of an adult.

Another frequently asked question is whether or not this behavioral technique is essential to sex offender treatment? In fact, it is not. However, what is essential is that some interventions be included that address issues of deviant sexual interests in offenders who have such arousal. The most extensive description of the various behavioral methods used to reduce deviant sexual arousal in sex offenders is found in a book by Maletsky (1991), "Treating the Sexual Offender."

Sometimes training participants ask whether or not offenders can be treated successfully using this behavioral method alone. The answer to that question is "No." Because the reasons that people have for committing sexual assault are varied and are almost never accounted for by a single explanation, it is important that any approach to treatment combine techniques, each addressing the domains we have mentioned earlier—sexual interest being only one of those.[29]

For example, there are people who have deviant sexual arousal and never act on that arousal because of their use of self–control, their concern about people they might victimize, and so forth. Other people might get better control over their deviant sexual arousal, but being unconcerned for others or uninformed about the harm sexual assault causes victims, they might commit offenses even though their sexual arousal was fairly minimal.

Use Slide #25: **Pharmacological Interventions to Address Deviant Sexual Arousal**

Pharmacological Interventions to Address Deviant Sexual Arousal

An entirely different treatment approach for reducing or helping sex offenders manage their deviant sexual arousal is through the administration of prescription medications (see, e.g., Association for the Treatment of Sexual Abusers, 2005; Becker and Murphy, 1998; Berlin, 2000; Bradford and Greenberg, 1998; Craissati, 2004; Glaser, 2003; Greenberg and Bradford, 1997; Grubin, 2000; Harris, Rice, and Quinsey, 1998; Kafka, 1994, 2000; Prentky, 1997). Very few sex offender treatment providers are physicians. Thus, treatment providers must collaborate with physicians to obtain appropriate medication for offenders who might benefit from it.

Note: Elicit answers from audience, focusing on offenders for whom sexual preoccupation is a salient feature of their personality and offending.

Can you think of examples of sex offenders who might have the greatest likelihood of benefiting from medications that reduce sex drive? What about types of sex offenders for whom medication likely would have no benefit?

Use Slide #26: **Selective Serotonin Reuptake Inhibitors**

Selective Serotonin Reuptake Inhibitors

One class of medications commonly used for reducing or helping sex offenders manage their deviant sexual arousal is referred to as Selective Serotonin Reuptake Inhibitors, or SSRI's.[30] These are medications that are very commonly prescribed for the treatment of depression and obsessive–compulsive disorders. Although SSRIs are quite effective with these mental health problems, they also can be helpful in the treatment of sex offenders.[31] This is because these medications reduce libido—sexual urges—in most patients and they also reduce aggression. For many patients they decrease deviant sexual fantasies. They often empower people to better manage their behavior in general, and they reduce the intensity of compulsive aspects of sex offending that are a part of many offenders' patterns.[32] SSRIs are the medications most frequently used with sex offenders because of these treatment effects. Because they are very commonly prescribed medications, physicians typically have considerable experience with them, and, therefore, doctors have little reluctance to prescribe them when deemed appropriate. The therapeutic dose for sex offenders is the same dose that is used for depression and obsessive–compulsive disorders, again something that physicians are familiar and comfortable with.

Use Slide #27: **Anti–androgen Medications**

Anti–androgen Medications

Other medications that are commonly thought of in the treatment of sex offenders are hormonal agents known as anti–androgens.[33] These are the medications often referred to in the popular media as "chemical castration," because they reduce the male sex hormone, testosterone, in men, much as physical castration does when a man's testicles are removed.[34] These medications may be thought of as "sexual appetite" suppressants. They don't remove all appetite; they just make it easier for the offender to manage his behavior, because the intensity of his appetite is diminished.[35] Offenders who are taking anti–androgen medications such as Provera or Lupron continue to get aroused and have erections and orgasms, but they are less highly motivated. But like diet pills, although they can be quite effective, they only are effective with people who otherwise are motivated to lose weight or in the case of sex offenders, not to commit further sexual assaults. As is the case with behavioral interventions to reduce deviant sexual arousal, these medications should be administered in conjunction with cognitive–behavioral sex offender treatment.[36]

Unlike SSRIs, Provera and Lupron are medications physicians are quite reluctant to prescribe and manage.There are two reasons for this. First, there are many

side effects associated with these medications.[37] You can see on the slide what these side effects are, and the percentage of patients who experience each of these effects.

Following are the side effects experienced by patients using anti–androgens:[38]

***Use Slide #28 and Slide #29:* Incidence of Side Effects with Anti–androgen Medications**

- Erectile dysfunction
- Decrease amount of ejaculate
- Decrease sex drive
- Decrease in size of sexual organs
- Weight gain
- Lethargy
- Headaches
- Hot/cold flashes
- Nightmares
- Hyperglycemia
- Insomnia
- Nausea
- Muscle cramping
- Irritability
- Shortness of breath

***Use Slide #30:* Some Physicians are Reluctant to Prescribe Anti–androgens**

The other reason physicians may be reluctant to prescribe Provera and Lupron is that they are not approved by the FDA for the treatment of sex offenders.[39] Although this also is the case with the SSRIs, their very common use renders this less of an issue. But anti–androgens are medications that are relatively rarely prescribed to men and doctors consider themselves going much further outside normal clinical practice to use them, especially when they have not been approved for use with sex offenders. It is not improper, unethical, or even especially unusual for physicians to prescribe medications that have not been approved for a particular use, but doctors understandably feel there is greater risk when there is not FDA approval for the use for which they are employing the medication.

***Use Slide #31:* Methods of Administration and Costs: Anti–androgens**

The particulars of prescribing these medications are described on this slide. You will note neither medication is inexpensive, but Lupron is especially costly at about $400 per month. Many sex offenders simply cannot afford this medication.

Compliance can be an important concern to keep in mind when it comes to medication. Although offenders may reliably report to the clinic or to their doctor for their medication, the effects of the medication can essentially be neutralized by steroid hormones that can be purchased on the street. In essence, someone may appear to be taking his medication regularly and at the same time offsetting

the effects of the medication by taking hormones that he buys on the street. The only way to examine this possibility is with random urine tests.

Note: Elicit answers from audience, focusing on offenders for whom sexual preoccupation is a salient feature of their personality and offending.

We've reviewed the use of prescription medications with sex offenders. Although the notion of a pill or an injection to solve the problem of sex offending is very attractive to the general public, why, upon closer examination, is this intervention so far from being the complete answer for all sex offenders?

We have, of course, already discussed the answer—that the motivations for sexual offending are influenced by a complex set of issues that go beyond the realm of sexual interests. Those issues include distorted attitudes, poor behavior management, and lack of interpersonal skills. In the following sections of this training, we will treat each of those topics in turn. Before we leave the topic of psychopharmacological interventions, we should note that often the question is raised, "If we have a medication–based therapy, why waste our time with other types of treatment that seem costly and lengthy?" In fact medication only addresses the issue of sexual arousal—which is one domain of treatment.[40] When prescribed in a manner that complements the cognitive–behavioral model of treatment—which addresses the other domains of treatment (distorted attitudes, interpersonal functioning and behavior management), it can be very helpful in facilitating treatment.

If our goal is to reduce recidivism, and medication will help maintain an individual long enough to help him assimilate the cognitive–behavioral response, we are impairing our effectiveness if we don't use it with those for whom it would be beneficial. Conversely, given the current body of evidence, it would be irresponsible only to medicate and not include a cognitive–behavioral treatment component.

TOPIC: DISTORTED ATTITUDES—THE SECOND DOMAIN OF TREATMENT (40 minutes)

Use Slide #33: **Distorted Attitudes—The Second Domain of Treatment**

Use Slide #34: **Cognitive Restructuring**

Now let's turn our attention to the second domain that sex offender treatment should address, namely distorted attitudes. Our purpose here is to identify and alter offenders' justifications for sex offending. One particular aspect of this is an intervention referred to as cognitive restructuring (or identifying and addressing thinking errors). As we discussed when addressing these issues with sex offenders who deny their offense histories, almost all sex offenders know that sex offenses are harmful to victims, and even if they aren't clear about that, they typically well understand that committing sex offenses is against the law.

Cognitive Restructuring

Knowing that sex offending is harmful and illegal, in order for sex offenders to justify their behavior to themselves, they must create rationalizations, excuses, and minimizations to reduce the dissonance that they would otherwise feel.[41] These become the "thinking errors" or "cognitive distortions" that are so common in the minds of sex offenders. Although lots of people develop idiosyncratic thoughts on various subjects, these thoughts typically are questioned or challenged by others when they are shared. However, since sex offenders rarely share their cognitive distortions with others, their dysfunctional thinking isn't challenged by others. For example, the sex offender who is molesting his step–daughter, believing this is a trivial event in her life, doesn't tell anyone he is doing this and, therefore, his analysis of his abusive behavior remains unchallenged.

The purpose of cognitive restructuring with sex offenders is to have them identify and examine their cognitive distortions and obtain information and feedback about the errors in their thinking.[42] In so doing, we expect that they will become more aware of victim issues. The overall goal is to stop offenders from utilizing their rationalizations and excuses to justify future sex offending behavior. As we've noted before, since most offenders do not seek to harm victims per se, this is thought to make it more difficult for them to decide to commit sexual assaults in the future. In addition, attitudes supportive of abusive or criminal behaviors have been found to predict sexual recidivism (see, e.g, Hanson and Bussiere, 1998; Hanson and Morton-Bourgon, 2004; Hudson, Wales, Bakker, and Ward, 2002).

Use Slide #35: **Methods of Cognitive Restructuring**

This intervention is done with sex offenders often by beginning with a discussion of why people use cognitive distortions to excuse or justify behaviors with which

they are uncomfortable, such as overeating, smoking, or speeding. Through group discussion, offenders come to acknowledge that even though cognitive distortions commonly are used in a variety of contexts, no amount of excuse–making alters the underlying reality that the behavior is wrong, harmful to health, or whatever the case may be. Discussion usually includes offenders' noting that excusing personal matters such as overeating results in relatively minor consequences, but excusing sex offending can lead to severe consequences.

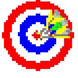
As was described in the interventions with sex offenders who deny their offenses, group members next are asked to complete a sentence like "Even though I knew my sex offenses were wrong, or at least illegal, what I said to myself to make it seem okay was _______________." Offenders are requested to write anonymously on paper a list of their cognitive distortions and turn them in to the group facilitator. These lists of thinking errors then become the content of group discussion, in which the facilitator reads them off one at a time and the group discusses the errors in the cognitions.

Another method for offenders learning the problems with these thinking errors involves a series of role–play exercises. One such role–play method involves group members playing the role of the father of the victim, a long–time friend of the perpetrator who promotes the offender taking appropriate responsibility, and a supervision officer. In this exercise, the group facilitator plays the role of a sex offender who professes to believe various cognitive distortions and he states and defends these distortions to the three offenders playing their respective roles. It becomes the task of the group member role–players to explain to the facilitator/offender what is faulty with his thinking. This is relatively easy for offenders to do, because although they might have trouble challenging their own cognitive distortions, they readily can see the distorted thinking that others engage in. This is especially true when different types of sex offenders, such as rapists and child molesters, are mixed in the same group.

This exercise can be especially useful because it causes offenders to go beyond the simple explanation of the illegality of the behaviors to explicate the underlying reasons (for example, why it is never beneficial for a child to have sexual contact with an adult). Not incidentally, this also provides some empathy–building, because having people play roles often results in the actors experiencing emotions of the person in that role. Therefore, a sex offender playing the role, for example, of the father of a victim, frequently feels some of what a victim's father might feel. After each exercise, the content of the role–play is discussed by the entire group.

Refer to Handout: Learning Activity 3–1: Dealing with Sex Offenders' Cognitive Distortions.

Note: Review the Learning Activity aloud with participants, and seek two volunteers from the audience to assist with the role–play. Limit the role–play to no more than 5–10 minutes.

 **Learning Activity**

Although we've been talking about role–playing as a treatment technique, today we will also use role–playing as a learning activity. Refer to Exercise 1, which outlines a role–play exercise that will help us to identify some of the common distortions that sex offenders use and to brainstorm some of the ways in which a collaborative management team may be able to respond to those distortions in positive ways.

Note: Process each of these questions for a few moments, summarizing or repeating the salient points. Take no more than 5–7 minutes to process this Learning Activity.

Processing of Learning Activity

To those of you who were observing this role–play:

- What was the value of follow–up questions and statements from the probation/parole officer to the offender's cognitive distortions?
- What advantage does the brother offer as a participant in the management of this offender? Could the brother continue to reinforce the messages being sent by the probation officer?
- Could the brother make it more difficult for the offender to continue his thinking errors during the time when he is at home, or spending time with his brother?
- Should information about this exchange be shared with the offender's treatment provider?

Use Slide #36: **Rationale for Victimization Awareness/Empathy Training**

Victimization Awareness/Empathy Training

As we discussed when talking about treatment with sex offenders who deny their offenses, another aspect of addressing distorted attitudes with sex offenders is to increase their awareness of issues of victimization and, to the extent possible, increase empathy.[43] As we have discussed, this material may not be relevant in the treatment of psychopaths or sexual sadists because studies have shown that efforts to increase victimization awareness in people who apparently have no capacity for empathy or real concern for others might make them more likely, rather than less likely, to commit subsequent offenses.[44] In the case of sadists, since they are erotically aroused by pain, suffering, and humiliation in their victims, increasing their awareness of how victims suffer risks teaching them how to be more effective sadists. For these reasons, many programs exclude sadists and psychopaths from empathy training.

As we discussed previously, it appears that most sex offenders minimize the harmful effects of their offense behaviors. They don't necessarily intend to cause harm to others, but they do so because their sex offending involves a selfish pursuit of gratification with extreme disregard for the welfare of their victims. For

the majority of sex offenders who don't derive pleasure from hurting other people, the rationale for providing this information is that by heightening offenders' awareness of victim trauma, it will make it more difficult for them to commit further sexual assaults. In the area of empathy, it has been found that although sex offenders often experience empathy similarly to non–offenders in many realms, it is their sex offending behavior that does not provoke empathic responses.[45]

Use Slide #37: **Goals of Victimization Awareness/Empathy Training**

Use Slide #38 and Slide #39: **Methods of Victimization Awareness/Empathy Training**

Thus, the goals of this component of treatment are for offenders to:

- Understand the pervasive negative effects of sexual assault on victims and others;
- Know the likely consequences of their assaults on their victims and their families; and
- Learn empathy skills, especially the ability to empathize with their victims.

We've already discussed two typical methods for increasing victimization awareness when we talked about working with sex offenders in denial, namely the use of videotaped materials and sexual assault survivors visiting treatment groups.

Other methods that often are utilized to enhance this component of treatment include having offenders complete written assignments describing the offenses they have committed. However, instead of writing from their own perspective, they are instructed to write the narrative from the perspectives of their victims. This is a direct attempt to build feelings of empathy. This kind of homework is read and critiqued by the group facilitators, often with instructions for offenders to rewrite sections where minimization is evident.

After each offender has had the opportunity to describe in writing his offenses from his victims' perspective, a variation of this exercise often is done verbally in group treatment settings. Each offender is asked to describe to the group his worst offenses from his victim's perspective, that is by playing the role of his victim so his description is in the first person of the victim. In role, the offender introduces herself/himself and indicates her or his age, and then describes how the offender accessed or groomed him or her, what specific behaviors the offender used in the assault, what the offender did to influence the victim not to report the offenses, how the victim is faring now, what the victim would like to say to the offender, and what the victim would like to ask the offender.

This is a very challenging assignment for most offenders, primarily because they lack empathy skills. They are very uncomfortable embracing the role of their victim because it puts them in touch with how their victims likely have suffered as a result of their assaults.

This treatment component is critically important because offenders tend to avoid thinking about the consequences of their actions in the lives of their victims.

Refer to Handout: Learning Activity 3–2: Victimization Awareness/Empathy Training.

Learning Activity

In order to examine more clearly the consequences of cognitive distortions for victims of sexual assault, we will now pause and try to generate a list of the distorted attitudes that offenders often have about their victims. With the sexual assault described in the previous learning activity, and using Learning Activity 2 as an aid, consider the list of cognitive distortions that might be associated with a crime such as the one we've just discussed. Take a moment and jot down, in the spaces provided, the **correct** thinking on each matter and how correcting that thinking can be of benefit to the victim and also to the offender.

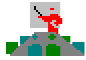
Note: Take about five minutes and ask several participants to read their responses to these questions. Following each individual's report, you might ask how many others noted this same distortion, whether they would suggest the same correction, and whether they saw the same or different benefits to correcting the distortion.

Processing of Learning Activity

Let's talk for a moment about some of the other distortions that surfaced during our role–play, or ones you might imagine would surface if you were working with this offender. Can someone share with us another distortion and correction and discuss the benefits to both victim and offender?

Wrap Up

This has been a good discussion and a helpful way to summarize our discussions about the second domain of treatment, distorted attitudes. Let's now move on to talk about the third domain, interpersonal functioning.



TOPIC: INTERPERSONAL FUNCTIONING – THE THIRD DOMAIN OF TREATMENT (30 minutes)

Use Slide #40: **Interpersonal Functioning–The Third Domain of Treatment**

Note: Elicit answers from audience, focusing on the connection between difficulties in functioning in social environments as a causative factor in sex offending.

Rationale

As you recall, another focus of treatment relates to offenders' interpersonal functioning. A treatment provider would probably refer to this as socio–affective functioning. One aspect of this is social skills training.

Why do we care about sex offenders' social skills? Might learning social skills only improve an offenders' ability to manipulate victims?

The rationale behind our concern about sex offenders' social skills is that many of them lack basic adult interpersonal interactive abilities.[46] Low self–esteem and loneliness are common traits among sex offenders. It also has been noted that rapists are less adept than other men at accurately interpreting non–verbal messages from women. Further, many child molesters and rapists are quite unskilled in interacting with adults.

In this section of the training, we would simply like to point out the rationale for targeting interpersonal functioning as a domain for sex offender treatment and provide some examples of the targets of change and techniques that could be part of a treatment plan.

The consequences of poor interpersonal skills—combined with other factors such as deviant sexual arousal, distorted attitudes, and poor behavior management—can have dire consequences for victims. For example, individuals who are poorly skilled in adult social interactions may become angry when their overtures toward women are rebuffed and channel their anger into abusive actions. They may turn to children as the focus of their social lives. Of course this is an overly simple and incomplete explanation for what might underlie an individual's decision to commit sex offenses, but because these dynamics are frequently part of the histories of sex offenders, they have become one of the targets of treatment (see, e.g., Marshall, 1989). Generally speaking, the belief is that if offenders can learn to live more functionally in the world of adults, they will find life more satisfying, thereby diminishing their likelihood of reoffending. This is not to suggest that a lack of social skills is either the primary reason why people commit sexual assaults, or even that poor social skills have been associated with sex offender reoffense risk. However, intimacy deficits and conflicts in intimate relationships have in fact been found to predict sexual recidivism.[47] Thus, as is true with empathy development, the case for criminogenic needs in the area of social skills training for sex offenders is less clear than, for example, the clear–

cut rationale for reduction of deviant sexual arousal. Nonetheless, if only because self–esteem and loneliness influence an offenders' ability to function effectively in society, enhancing social skills appears to be an appropriate target for treatment.[48]

Use Slide #41 and Slide #42: **The Goals of Increasing Interpersonal Functioning**

Use Slide #43: **Methods of Social Skills Training**

Targets for Change

The areas of specific focus in social skills training for sex offenders are listed on the screen. They include a wide range of interactions from meeting strangers to maintaining friendships over a considerable period of time. A part of the focus is also on respect for women and children. And because sex offenders often are extremely self–centered, treatment includes learning the importance of attending to the needs and rights of others.

Appropriate Interactions in Social Situations

This treatment component stresses that satisfying sexual interactions are extensions of social relationships and that sexual contacts should not be viewed as isolated events that have little to do with friendship and intimate bonding with others. In line with the principle of creating opportunities to practice skills, these treatment targets are often addressed through role–plays. Offenders may also be given homework assignments to, for instance, initiate a conversation with three adult strangers over the course of a week and to report their experiences in carrying out the assignment at the next group session. Supervision officers who are aware of the nature and schedule of such assignments can inquire about offenders' progress in completing their homework, suggest appropriate and safe opportunities to carry out their assignments, and provide support and encouragement to the offenders for whom they have supervisory responsibilities.

Use Slide #44: **Rationale for Assertiveness Training**

Assertiveness as a Tool to Avoid Frustration and Poor Anger Management

Another aspect of social skills is assertiveness (see, e.g., Becker and Murphy, 1998; Hudson, Wales, Bakker, and Ward, 2002; Marshall, 1989; Marshall, et al., 1998, 1999; Marshall, Barbaree, and Fernandez, 1995). This area is relevant in the treatment of sex offenders for a variety of reasons. Sex offenders often mismanage anger and assertiveness plays a significant role in anger reduction. For example, there is a significant body of research and other literature that highlights the relationship between attachment style, intimacy, and the ways in which adults interact with others—and this research has been applied to sex offenders. Some individuals who have insecure or fearful attachment difficulties may struggle with establishing intimate relationships with adults in part due to fears of rejection and because they lack self–confidence and assertiveness skills. As a result, they may seek out contacts with people who are less likely to be

rejecting, such as children. Other problematic attachment styles are associated with mistrustful and hostile approaches to interacting with others. Rather than dealing effectively and assertively with others, they may harbor resentment and experience pervasive anger, which may lead them to act out aggressively. Assertiveness training promotes more effective means of managing anger and teaches individuals how to more effectively interact with others, and as a result, it can promote self–confidence, enhance self–esteem, and promote intimacy. Again, this is important, because intimacy deficits and conflicts in intimate relationships have been found to be associated with sexual recidivism.[49]

Use Slide #45: **Goals of Assertiveness Training**

Use Slide #46: **Rationale for Sexual Values Clarification Training**

Use Slide #47: **Goals of Sexual Values Clarification Training**

Assertiveness training involves teaching offenders to articulate their needs and feelings in ways that are respectful to the recipients of their messages and themselves. Treatment emphasizes that the goal of assertiveness is not to change others' behavior, but rather to increase one's own self–respect.

Adult Sex Education to Increase Knowledge about Healthy Sexuality and Responsible Behavior

Another aspect of socio–affective functioning is the area of sexuality. At first glance, it may seem that the best message to give sex offenders is that they should not engage in any sexual thoughts, fantasies or behaviors. Of course to expect this would be entirely unrealistic, even impossible. On closer examination, we realize that sex offenders' underlying sexuality is not the problem; rather it is that they have used sexual behavior to violate others. Thus, the goal of treatment is to assist sex offenders in learning to function not as asexual beings, but rather as the sexual beings that they are but in ways that do not harm or violate others.

Basically, this is adult sex education, with an emphasis on the promotion of respect toward women, understanding basic human sexual behavior, sexually transmitted disease (STD) protection, and the like.

Teaching aids can be utilized in the area of sexuality as well. For example, a true/false test can be completed anonymously by the offenders. After completing the test, they are asked if they noticed anything unusual about the test. Often they do not notice that the correct answer for all the items is false. The test contains common misperceptions and misinformation about a variety of sex–related topics. This activity can provide a springboard for discussion of areas about which group members have questions.

Additional information is provided to offenders on sex–related topics, including sexually transmitted disease prevention. Throughout the educational component of sex offender treatment, considerable emphasis is placed on the importance of

verbal communication to promote clarity and ensure consent (because of their histories of having violated others). Facilitators promote open, respectful, and clear communication related to sexual matters, teaching by example that sex is an important area for people to be able to talk about.

TOPIC: BEHAVIOR MANAGEMENT—THE FOURTH DOMAIN OF TREATMENT (60 minutes)

Use Slide #48: **Behavior Management — The Fourth Domain of Treatment**

Rationale

The final domain that is necessary to address in sex offender treatment is self–management. Of course, sex offending is mismanagement of behavior by the offender; thus, the purpose of intervening in this treatment domain is to assist offenders to manage their behavior related to sexual and non–sexual matters in responsible and non–victimizing ways. We will discuss two treatment methods to address behavior management.

One of the things we will emphasize in particular in this section is the degree to which treatment providers and criminal justice supervision agencies can partner in teaching and reinforcing responsible behavior management on the part of sex offenders.

In essence, criminal justice supervision agencies and treatment providers work collaboratively, each bringing a unique set of tools and resources to the task of sex offender management.[50] Supervision agencies have the legal authority to provide a set of external controls (e.g., surveillance, restricting access to victims, reducing opportunities to engage in high–risk behavior, and the like). On the other hand, sex offender treatment providers have a set of therapeutic tools that are aimed at assisting the offender to develop his or her own internal controls over his behavior. In some areas, these functions overlap and support one another. Together the two sets of controls can contribute to successful offender management.

Covert Sensitization: Visualizing the Consequences of Sexual Assault

One behavior management technique that is taught as a part of sex offender treatment is something called covert sensitization (see, e.g., Abel, Blanchard, and Becker, 1978; Dougher, 1995; Laws, 1995; Marshall, et al., 1999; Marshall and Eccles, 1995). As sex offenders contemplate committing sexual assaults, they seldom consider the long–range consequences of their behavior to their potential victims or even to themselves. Instead, they focus on the anticipated immediate pleasure they expect to experience during the commission of the crime. If offenders can learn to anticipate and consider the likely potential consequences of their sexual assaults, it is expected that they will more realistically consider the costs of their behavior and, hopefully, divert themselves from offending.[51] This is the rationale underlying covert sensitization.

Use Slide #49: **Goals of Covert Sensitization**

Use Slide #50: **Methods of Covert Sensitization**

Thus, the primary goal of covert sensitization is to help offenders substitute thinking about what is appealing about sex offending with considering instead possible negative consequences of committing sex offenses.[52] Treatment efforts are directed toward offenders taking a broader, more long–range view of their behaviors, rather than thinking solely of themselves and their immediate gratification.

The specific steps of covert sensitization begin with facilitators describing the reasons for the intervention, as we've just outlined. Group members then are encouraged to identify the antecedent thoughts, behaviors, and cognitive distortions that precede their particular sex offenses. Consistent with what we know about sex offending patterns, offenders typically traverse a number of steps (that create circumstances where they can commit sexual assaults), both internally in their thinking and externally in their behavior. Group members are assisted in identifying these offense precursors, and the patterns and strategies they utilize.

Following the identification of these offense precursors, offenders are asked to identify several imaginary neutral scenes. Neutral scenes are those which each individual offender can associate with being very relaxed and comfortable, such as lying in a hammock on a warm afternoon, or enjoying a leisurely talk with an old friend. Next, offenders also are asked to identify several imagined aversive scenarios, reality–based scenes that, if they actually occurred, would be extraordinarily unpleasant for the offender. Examples of aversive scenes include having an offender's wife walk in on him while committing a sexual assault and telling him that their marriage and his relationship with his family are over, or being described in the newspaper as a sex offender.

Offenders are instructed to create audiotapes as homework. In the case of covert sensitization, the offender starts each audio taped homework assignment by describing one of his neutral scenes, followed by a description of his antecedent behaviors that might lead to a sexual assault. Offenders are encouraged to discuss the early stages of sexual offense behaviors, such as the arrangements the offender might make to isolate his victim, gain trust, and so forth. Next, the offender is instructed to describe in detail an aversive scene, such as being taken from his workplace by the police while being observed by his co–workers. He spends two to five minutes focused on this aversive scene, then repeatedly goes back and forth between antecedent behavior scenes and aversive scenes. The purpose of this aspect of the exercise is to pair thoughts of setting up sex offending situations with thoughts of aversive consequences. The offender is instructed to use an escape scene occasionally instead of an aversive scene, which consists of fantasies of pleasurable adult consenting sexual activity. The use of the escape scene is to underscore that if the offender avoids sex offending, he can have a more pleasurable and satisfying life.

Offenders typically are assigned to complete about ten, 15–minute covert sensitization audiotapes. Treatment providers review the covert sensitization audiotape homework, provide feedback to the offenders, and erase and return the cassette tapes.

Use Slide #51: **Relapse Prevention**

Relapse Prevention

Another and probably the best known treatment component related to sex offender behavior and self–management is relapse prevention. Relapse prevention first was used in the treatment of alcohol and other drug abuse, where it was found that getting people to stop drinking and using drugs was not nearly as difficult as was getting them to continue their abstinence.[53] Chemical dependency treatment providers discovered that alcohol and other drug abusers were especially vulnerable to relapse when they found themselves in specific situations that were, for them, previously associated with drinking or using drugs. Thus, if they could be taught to manage their lives to either avoid these situations or, if they found themselves in such circumstances, to use strategies to keep from returning to chemical use, they would be less likely to relapse.[54]

Sex offender treatment utilizes many of these relapse prevention principles (see, e.g., Laws, 1989; Pithers, et al., 1983, 1988). Although there are similarities between chemical abusers and sex abusers, there are differences as well. Principal among these differences is that occasional relapses by drug abusers typically harm only themselves, however, relapses by sex offenders harm others and are, therefore, enormously serious. Thus, when persons who abuse alcohol and other drugs occasionally relapse, treatment providers use this information as important feedback to guide further treatment. But sex offenders must maintain uninterrupted abstinence, since even one more sex crime translates to one more victim.

Use Slide #52: **Rationale for Relapse Prevention**

Over the years, many sex offender relapse prevention strategies have been posited (see, e.g., Laws, 1989; Laws, Hudson, and Ward, 2000; Marshall, et al., 1999; Pithers, et al., 1983, 1988; Pithers and Cumming, 1995). Generally speaking, they all share certain underlying principles. Among these are the belief that sex offenders must not assume that treatment has eliminated their risk for reoffense, and that offenders who believe they are "cured" are, in fact, more likely to recidivate. Sex offenders must recognize their particular offense precursors and avoid the specific thoughts, feelings and behaviors that place them at risk to reoffend. Essentially, relapse prevention is a maintenance model designed to provide sex offenders with strategies to sustain the positive changes made during treatment—changes that hopefully will last throughout their lifetimes.[55]

Use Slide #53: **Relapse Prevention Cycle**

Use Slide #54 – #56: **Goals of Relapse Prevention**

Relapse prevention involves sex offenders learning that they must be extremely vigilant to avoid committing new offenses throughout their lives. Sex offenders are taught that certain situations, chains of events, or cycles place them at

increased risk for committing sex offenses.[56] "Seemingly unimportant decisions," or "SUDs" are decisions sex offenders make that are a part of their pre–offense cycles that may seem unimportant or irrelevant to offending, but are not. Examples might include an individual who initiates an argument with a spouse to provide an excuse to leave the household, which places him in a situation where he can offend. Another example might be an individual who leaves work early, providing him with time that he won't have to account for to a probation officer or his family. Of course, SUDs are extremely varied and can be quite idiosyncratic to each offender, based on his mental and behavioral offense precursors.

Relapse prevention involves offenders learning that a chain or cycle of thoughts and behaviors can take them from self–control to committing additional sex crimes.[57] Here is a simplified example: Many sex offenders can progress quickly and easily from a positive to a negative mood state (such as anger, depression, or loneliness). Such feelings are often followed by fantasies involving criminal sexual behaviors that may lead to the actual planning of an offense and by the use of alcohol or other drugs, which disinhibit impulses. The result, if the chain or cycle is not interrupted, is the commission of a sex crime.

Of course not all sex offenses neatly follow this pattern. Nonetheless, this thought and behavior cycle appears to describe accurately the pattern of precursors to offending for many sex offenders.[58] The goal, of course, is for sex offenders to develop the skills and coping methods necessary to interrupt their pre–offense cycles long before they perpetrate sexual abuse. Sex offenders are taught to differentiate lapses—defined as the initial occurrence of a prohibited behavior (such as being alone with a child) from relapses—the actual commission of the crime (such as child molestation). As we addressed in the covert sensitization segment, interrupting the pre–offense behavior chain is easiest to do in its early stages. Offenders find it much more difficult to stop themselves after they have created a sex offending situation, and they are psychologically prepared to commit an assault.

Use Slide #57 – #59: **Methods of Relapse Prevention**

Relapse Prevention Methods

In sex offender relapse prevention treatment, most of the focus is on offenders assessing their own offense patterns, their particular high–risk situations, and their coping strategies.[59] Offenders learn how they can avoid lapses and relapses, and how to monitor themselves for mood states and behaviors that might place them at increased risk for reoffense.

Interventions to assist offenders to engage in this self–examination can include writing an autobiography to gain a greater understanding of life patterns that result in offending, learning more effective problem–focused rather than emotion–focused coping strategies, avoiding high–risk situations, learning that urges that are not acted upon diminish with time, and practicing, such as with

role–playing, how best to manage risky situations. Do you know what we mean by problem–focused and emotion–focused coping strategies?

- Problem–focused coping strategies involve examining alternative methods to address the problem, deciding on the most effective strategies, and implementing the plan utilizing those strategies.
- Emotion–focused coping strategies involve actions derived primarily from immediate emotions rather than considering various alternatives and the efficacy of each.

Note: Elicit ideas from participants.

Can you think of an example of a risky situation that we might want to role–play in sex offender treatment to prepare sex offenders to manage such a challenge?

Ultimately, sex offenders are expected to make global lifestyle changes that promote their behaving in pro–social, responsible ways in all areas of their lives, to assist them in not violating others in sexual and non–sexual ways. Additionally, sex offender management may be enhanced by having others in their lives, such as friends and family, who know their offending patterns and history and provide them with instructive feedback about their positive and negative behaviors.[60] These individuals can be particularly helpful to treatment providers and supervision officers by providing feedback regarding the offenders' efforts to assimilate the information they have learned during the treatment process and develop strategies to avoid (and respond appropriately to) lapses.[61]

Recent adaptations of the relapse prevention model emphasize the acquisition of more functional problem–solving and coping strategies with less emphasis on the particulars of relapse prevention principles and coping methods described above (see, e.g., Laws, Hudson, and Ward, 2000; Ward, Laws, and Hudson, 2003). This is one of many examples of evolution in the field of sex offender treatment. Further research will guide practice toward increasingly effective methods.

Refer to Handout: Refer to Handout: Learning Activity 3–3: How Supervision Officers Can Support Relapse Prevention.

Learning Activity

Let's go back to the list of relapse prevention methods, so that we can discuss some of the ways in which a supervision officer can support the relapse prevention process. Refer to the handout that we're distributing. Please take a few moments and review the list of relapse prevention methods. In the adjacent column, jot down a few strategies you have employed—or think you might employ—to support offenders in their efforts to address each relapse prevention method. Once you've had the opportunity to record your thoughts and suggestions, we'll share some of our ideas and experiences with one another.

Note: Take about five minutes to hear from a few participants regarding their answers to these questions. This is an opportunity for participants to integrate the information they have just heard and apply it to their own work; it is also an excellent opportunity for participants to learn from one another.

Processing of Learning Activity

Let's select a few of these strategies and hear from some of you about the ways in which you have supported offenders' relapse prevention efforts. For example, did any of you note things you've done in the past to help offenders assess their high–risk situations? Tell us first who you are (probation officer, parole officer, etc.) then share one thing you have done in the past to help an offender assess his high–risk situations.

Let's shift our focus to another one of the strategies: designing intervention plans to avoid a first lapse. Does anyone have experience assisting an offender with this strategy? Let's hear two or three things a supervision officer can do to assist offenders in this way.

Use Slide #60: **Adjunctive Therapies**

Adjunctive Therapies

Before we move on to the topics of ethical standards and treatment provider characteristics, I would like to point out that we have focused on four domains of treatment: sexual interests, distorted attitudes, interpersonal functioning, and behavior management—and have given some examples of relapse prevention methods. Of course, depending on the specific issues that individual offenders are facing, there are other adjunctive therapies that may be appropriate in our work with them. These would include family and marital therapy, family education seminars and couples' groups, substance abuse treatment, educational/vocational supports, and individual therapy (usually for other interpersonal issues). It is important to remember that these other therapies must always be designed and undertaken in the context of the offender's sexual abuse history and his treatment goals regarding sexual offending should not be subordinated to other treatment goals. Further, if a combination of therapies are employed, they should be coordinated to assure their effectiveness.

TOPIC: ETHICAL PRACTICE STANDARDS (10 minutes)

Use Slide #61: **Ethical Practice Standards**

As you might imagine, there are many ethical issues relating to the delivery of sex offender treatment. As we've discussed before, the global issue of who is identified as the client—the offender or the community—raises countless issues in itself. This fundamental conceptual question relates to the dynamic struggle between respect for sex offenders' privacy versus the need to protect the community. In the delivery of sex offender treatment, numerous issues arise.

An international organization of sex offender treatment providers, evaluators, and researchers called the Association for the Treatment of Sexual Abusers (ATSA), has provided the field with some guidance in managing these many ethical challenges. ATSA has a Code of Ethics with which all members agree to comply. Additionally, ATSA has codified practice standards (meaning requirements) and guidelines (meaning suggestions) for the delivery of sex offender evaluation and treatment.[62] Although the ATSA code of ethics and these standards and guidelines strictly affect only members of ATSA and are not legal regulations, in fact they have considerable influence because many sex offender treatment providers, at least in North America, are ATSA members.[63] And of those who aren't, many are influenced by this self–regulating professional body.

We invite you to peruse the ATSA Code of Ethics and the standards and guidelines manual, called "Practice Standards and Guidelines for the Evaluation, Treatment, and Management of Adult Male Sexual Abusers." It is very specific about what professionals can, cannot, should, and should not do in their work with sex offenders. Information on ATSA can be obtained from their Web site (http://www.atsa.com); these documents can also be ordered through their Web site.

Use Slide #62: **A Major Ethical Issue: Informed Consent**

Refer to Handouts: "Sex Offender Treatment Contract" and "Acknowledgement of Limited Confidentiality and Waiver" that are included in the participant materials.

The range of specific ethical challenges that arise in sex offender treatment is beyond the scope of this presentation. However, as an illustration of the importance of respect for the rights of sex offenders in the delivery of treatment, we want to call your attention to one specific and fundamental aspect of sex offender treatment ethics, namely informed consent. Sex offenders entering treatment should have spelled out to them at a minimum, and preferably in writing, information about the purpose and nature of treatment, its expected duration, its anticipated benefits, costs and risks, and the limits of confidentiality.[64] Although this seems fundamental on its face, it is not always the case that sex offenders are informed and given the opportunity to consent to or decline treatment based on this information. Examples of informed consent

documents, entitled “Sex Offender Treatment Contract” and “Acknowledgement of Limited Confidentiality and Waiver” are included in your handouts for review.

TOPIC: TREATMENT PROVIDER CHARACTERISTICS (10 minutes)

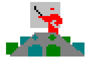
Use Slide #63: **Treatment Provider Characteristics**

Now that we've reviewed the content areas that comprise effective sex offender treatment, let's briefly look at treatment style variables. Here our focus is not the content of the curriculum, but rather how treatment providers deliver the program. As we've observed before, sex offender treatment often has involved a quite punitive treatment style, that is, one characterized by aggressive verbal confrontation by treatment providers and other group members, a sort of "in-your-face" drill sergeant approach. Also, as we've discussed before, this may feel satisfying to some treatment providers and even to some group members, but the salient issue is whether this treatment style actually promotes the kinds of changes we are interested in having sex offenders make—those that reduce the likelihood of sexual recidivism.

Over the past several years, experts in the field have begun to question the wisdom, value, and ultimate impact of this harsh confrontational approach (Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005; Blanchard, 1995; Bumby, Marshall, & Langton, 1999; Fernandez & Marshall, 2000; Marshall, 1996, 2005; Marshall et al., 1999, 2003; Marshall & Serran, 2004; Serran & Fernandez, Marshall, & Mann, 2003). In fact, drawing on the general psychological literature on variables that enhance treatment outcomes, several studies have examined the relationship between therapist characteristics, group climate variables, and other process-related and contextual factors on sex offender treatment specifically, and have found support for the importance of a warm, empathic, and genuine style within a therapeutic climate—both in terms of client engagement, treatment progress, and treatment outcomes (see, e.g., Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005; Fernandez & Marshall, 2000; Marshall, 2005; Marshall et al., 1999, 2003; Marshall & Serran, 2004; Serran & Fernandez, Marshall, & Mann, 2003).

Use Slide #64: **Treatment Provider Characteristics (cont.)**

These findings are very consistent with other social psychological and educational research—namely that people are more likely to be responsive to new information when it is delivered in a non–hostile and non–threatening manner—and suggest that the hostile, cold, punitive approaches are unlikely to produce the desired results with sex offenders and, in some cases, may have a more negative impact.



TOPIC: SUMMARY

Use Slide #65: **Summary**

We've looked in considerable detail at much of what is useful to know about sex offender treatment: some of its history, current practices, the most effective methods, some particular techniques, how long offenders should be in treatment, and the style with which treatment is most effectively delivered.

To sum up briefly, the four domains of sex offender–specific treatment are:

- Deviant sexual interest, arousals, and preferences;
- Distorted attitudes;
- Interpersonal functioning; and
- Behavior management.

We hope this overview equips you to interact more effectively with sex offender treatment providers in the various collaborative roles that we all play in managing this challenging population.

REFERENCES AND RESOURCES

Association for the Treatment of Sexual Abusers (2001). *Association for the Treatment of Sexual Abusers Professional Code of Ethics.* Beaverton, OR.

Association for the Treatment of Sexual Abusers (2001). *Practice Standards and Guidelines for Members of the Association for the Treatment of Sexual Abusers.* Beaverton, OR.

Beech, A.R., Fisher, D., & Beckett, R.C. (1998). An evaluation of the prison sex offender treatment programme. *Research Findings, 79, 1–4.* Research and Statistics Directorate, Home Office. Available from Home Office Publications Unit, 50, Queen Anne's Gate, London, SW1 9AT, England.

Berlin, F.S. (1989). The paraphilias and Depo–Provera: Some medical, ethical, and legal considerations. *Bulletin of the American Academy of Psychiatry and the Law, 17* (3), 233–239.

Bradford, J.M. (1985). Organic treatment for the male sex offender. *Behavioral Sciences and the Law, 3* (4), 355–375.

Bradford, J.M. (1996). The role of serotonin in the future of forensic psychiatry. *Bulletin of the American Academy of Psychiatry and the Law, 24* (1), 57–72.

Carich, M.S. & Mussack, S.E. (2001). *Handbook for Sexual Abuser Assessment and Treatment.* Brandon, VT: Safer Society Press.

Fedoroff, J.P. (1993). Serotonergic drug treatment of deviant sexual interests. *Annals of Sex Research, 6*, 105–121.

Gendreau, P. (1996). The principle of effective interventions with offenders. In A.T. Harland (Ed*.), Choosing Correctional Options that Work: Defining the Demand and Evaluating the Supply,* pp. 117–130. Thousand Oaks, CA: Sage.

Greenberg, D.M., & Bradford, J.M., (1997). Treatment of the paraphilic disorders: A review of the role of the selective serotonin reuptake inhibitors. *Sexual Abuse: A Journal of Research and Treatment, 9* (4), 349–360.

Kafka, M.P. (1995). Current concepts in the drug treatment of paraphilias and paraphilia–related disorders. *CNS Drugs, 3* (1), 9–21.

Kiersch, T.A. (1990). Treatment of sex offenders with Depo–Provera. *Bulletin of the American Academy of Psychiatry and the Law, 18* (2), 179–187.

Knowles, M.S., Holton, E.F. II, & Swanson, R.A. (1998). *The Adult Learner: The Definitive Classic in Adult Education and Human Resource Development.* Woburn, MA: Butterfield–Heinemann.

Laws, D.R., Hudson, S.M., & Ward, T. (Eds.) (2000). *Remaking Relapse Prevention with Sex Offenders: A Sourcebook.* Thousand Oaks, CA: Sage Publications.

Sexual Deviance: Theory, Assessment and Treatment. New York: The Guilford Press.

Treating the Sexual Offender. Thousand Oaks, CA: Sage Publications.

Marshall, W.L., Anderson, D., & Fernandez, Y.M. (1999). *Cognitive–Behavioral Treatment of Sexual Offenders.* New York: Jon Wiley and Sons, Inc.

Marshall, W.L., Laws, D.R., & Barbaree, H.E. (1990). *Handbook of Sexual Assault: Issues, Theories and Treatment of the Offender.* New York: Plenum Press.

Marshall, W.L., Fernandez, Y.M., Hudson, S.M., & Ward, T. (Eds.) (1998). *Sourcebook of Treatment Programs for Sexual Offenders.* New York: Plenum Press.

Marshall, W. L., Serran, G., Moulden, H., Mulloy, R., Fernandez, Y. M., Mann, R., & Thornton, D. (2002). Therapist features in sexual offender treatment: Their reliable identification and influence on behavior change. *Clinical Psychology and Psychotherapy*, 9, 395–405.

Marshall, W.L., Serran, G., Fernandez, Y.M., Mulloy, R., Mann, R.E., & Thornton, D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behaviour change. *Journal of Sexual Aggression*, 9, 25–30.

Melella, J.T., Travin, S., & Cullen, K. (1989). Legal and ethical issues in the use of anti–androgens in treating sex offenders. *Bulletin of the American Academy of Psychiatry and the Law, 17* (3), 223–232.

Pithers, B. (1990). Relapse prevention with sexual aggressors: A method for maintaining therapeutic gain and enhancing external supervision. In W.L. Marshall, D.R. Laws, & H.E. Barbaree (Eds.), *Handbook on Sexual Assault: Issues, Theories and Treatment of the Offender.* New York: Plenum Press.

Treating Child Sex Offenders and Victims: A Practical Guide. Thousand Oaks, CA: Sage Publications.

The Sexual Predator: Legal Issues, Clinical Issues, Special Populations. Kingston, NJ: Civic Research Institute, Inc.

Schlank, A. & Cohen, F. (Eds.) (1999). *The Sexual Predator: Law, Policy, Evaluation and Treatment.* Kingston, NJ: Civic Research Institute, Inc.

Schwartz, B.K. & Cellini, H.R. (Eds.) (1995). *The Sex Offender.* Kingston, NJ: Civic Research Institute, Inc.

Schwartz, B.K. & Cellini, H.R. (Eds.) (1997). *The Sex Offender, Vol. II.* Kingston, NJ: Civic Research Institute, Inc.

Schwartz, B.K. & Cellini, H.R. (Eds.) (1999). *The Sex Offender, Vol. III.* Kingston, NJ: Civic Research Institute, Inc.

Stein, D.J., Hollander, E., Anthony, D.T., Schneier, F.R., Fallon, B.A., Liebowitz, M.R., & Klein, D.F. (1992). Serotonergic medications for sexual obsessions, sexual addictions, and paraphilias. *Journal of Clinical Psychiatry, 53* (8), 267–271.

Van Derber Atler, M. (Producer) (1994). *Once Can Hurt a Lifetime* [Videotape]. Washington, DC: One Voice.

Varied Directions International (Producers) (1991). *Four Men Speak Out on Surviving Child Sexual Abuse* [Videotape]. Camden, ME: Varied Directions, Inc.

Varied Directions International (Producers) (1988). *Why God—Why Me?* [Videotape]. Camden, ME: Varied Directions, Inc.

NOTES

1. Association for the Treatment of Sexual Abusers, 2005; Cumming and McGrath, 2000, 2005; English, et al., 1996, 2003; Laws, 1989; Laws, Hudson, and Ward; 2000; Marshall, et al., 1999; Pithers, et al., 1983,1988.

2. Becker and Murphy, 1998; Berlin, 2000; Laws, Hudson, and Ward, 2000; Laws and Marshall, 2003; Laws and O'Donohue, 1997; Marshall, Anderson, and Fernandez, 1999; Prentky, Janus, and Seto, 2003; Ward, Laws, and Hudson, 2003.

3. Association for the Treatment of Sexual Abusers, 2005; Becker and Murphy, 1998; Laws, Hudson, and Ward, 2000; Marshall, Anderson, and Fernandez, 1999; McGrath, Cumming, and Burchard, 2003; Ward, Laws, and Hudson, 2003.

4. Knowles, 1998.

5. Knowles, 1998.

6. Knowles, 1998.

7. Beech and Fordham, 1997; Beech and Hamilton–Giachritsis, 2005; Blanchard, 1995; Bumby, Marshall, and Langton, 1999; Fernandez and Marshall, 2000; Kear–Colwell and Pollack, 1997; Marshall, 1996, 2005; Marshall, Anderson, and Fernandez, 1999; Marshall, Fernandez, Serra, Mulloy, Thornton, Mann, et al., 2003; Marshall and Serran, 2004; Marshall, Serran, Moulden, Mulloy, Fernandez, et al., 2002; Proeve, 2003; Serran, Fernandez, Marshall, and Mann; 2003.

8. Beech, Fisher, and Beckett, 1998.

9. Andrews and Bonta, 2003; Cullen and Gendreau, 2000; Gendreau, 1996.

10. Hanson and Bussiere, 1998; Hanson and Harris, 2000; Hanson and Mourton–Bourgon, 2004.

11. Cumming and McGrath, 2005; Hanson and Bussiere, 1998; Hanson and Harris, 2000, 2001; Hanson and Mourton–Bourgon, 2004.

12. Association for the Treatment of Sexual Abusers, 2005; Carter, et al., 2004; Cumming and McGrath, 2005; Hanson and Harris, 2000, 2001.

13. Brake and Shannon, 1997; English, et al., 1996; Maletzky, 1991, 1996; Marshall, Anderson, and Fernandes, 1999; Marshall, Serran, Marshall, and Fernandez, 2005; Marshall, Thornton, Marshall, Fernandez, and Mann, 2001; O'Donohue and Letorneau, 1993; Salter, 1988; Schlank

and Shaw, 1996, 1997; Winn, 1996, 1997.

14. Brake and Shannon, 1997; English, et al., 1996; Marshall, et al., 1999, 2001; Maletzky, 1991, 1996; Salter, 1988; Schlank and Shaw, 1996, 1997.

15. English, et al., 1996; Marshall, et al., 2001; Salter, 1998; Schlank and Shaw, 1996, 1997.

16. Ahlmeyer, et al., 2000; English, et al., 1996, 2003; Hindman and Peters, 1998; O'Conell, 2000.

17. Brake and Shannon, 1997; Maletzky, 1991, 1996; Marshall, 1994; Marshall, et al., 1999, 2001; O'Donohue and Letorneau, 1993; Salter, 1988; Schlank and Shaw, 1996.

18. Brake and Shannon, 1997; Marshall, 1994; O'Donohue and Letorneau, 1993; Schlank and Shaw, 1996, 1997.

19. Brake and Shannon, 1997; Marshall, 1994; O'Donohue and Letorneau, 1993; Schlank and Shaw, 1996, 1997; Winn, 1997.

20. Brake and Shannon, 1997; Marshall, 1994, 1997; O'Donohue and Letorneau, 1993; Schlank and Shaw, 1996; Winn, 1996.

21. Bumby, 2000; Marshal, et al., 1999; Marshall, Hudson, Jones, and Fernandez, 1995;; Pithers, 1994, 1999; Polaschek, 2003; Salter, 1988.

22. Fernandez, Marshall, Lightbudym and O'Sullivan, 1999; Hayashino, Wurtele, and Klebe, 1995; Marshall, et al., 1995; Marshall, Hamilton, and Fernandez, 2001; Marshall, O'Sullivan, and Fernandez, 1996; McGrath, Cann, and Konopasky, 1998.

23. Hildebran and Pithers, 1989; Marshall, et al., 1999; Marshall, O'Sullivan, and Fernandez, 1996; Pithers, 1994, 1999.

24. Becker and Murphy, 1998; Hanson and Bussiere, 1998; Hanson and Morton-Bourgon, 2004; Laws, 1989; Laws and O'Donohue 1997; Marshall, et al., 1999; Marshall and Laws, 2003; Ward, Laws, and Hudson, 2003.

25. McGrath, Cumming, and Burchard, 2003.

26. Hanson and Bussiere, 1998; Hanson and Morton-Bourgon, 2004.

27. Dhawan and Marshall, 1996; Lambie, et al., 2002; Marshall, et al., 1998.

28. Berlin, 2000; Laws and O'Donohue, 1997; Maletzky, 1991; Marshall, et al., 1999; Marshall and Laws, 2003.

29. Association for the Treatment of Sexual Abusers, 2005; Becker and Murphy, 1998; Berlin, 2000; Laws, Hudson, and Ward, 2000; Laws and O'Donohue, 1997; Marshall and Laws, 2003; Prentky, Janus, and Seto, 2003; Quinsey, Lalumiere, Rice, and Harris, 1995; Ward, Laws, and Hudson, 2003.

30. Association for the Treatment of Sexual Abusers, 2005; Bradford, 1997, 1998; Glaser, 2003; Greenberg and Bradford, 1997; Grubin, 2000; McGrath, Cumming, and Burchard, 2000.

31. Bradford and Greenberg, 1998; Glaser, 2003; Greenberg and Bradford, 1997; Grubin, 2000; Kafka, 2000; Kafka and Prentky, 1992.

32. Glaser, 2003; Greenberg and Bradford, 1997; Grubin, 2000; Kafka, 2000; Kafka and Prentky, 1992.

33. Association for the Treatment of Sexual Abusers, 2005; Bradford and Greenberg, 1998; Craissati, 2004; Glaser, 2003; Grubin, 2000; Prentky, 1997.

34. Berlin, 2000; Glaser, 2003; Grubin, 2000; Prentky, 1997.

35. Berlin, 2000; Bradford and Greenberg, 1998; Glaser, 2003; Prentky, 1997.

36. Association for the Treatment of Sexual Abusers, 2005; Becker and Murphy, 1998; Berlin, 2000; Craissati, 2004; Glaser, 2003; Grubin, 2000.

37. Association for the Treatment of Sexual Abusers, 2005; Craissati, 2004; Glaser, 2003; Greenberg and Bradford, 1997; Grubin, 2000; Prentky, 1997.

38. Schwartz and Cellini, 1995.

39. Add a footnote at the end of that sentence: Association for the Treatment of Sexual Abusers, 2005

40. Association for the Treatment of Sexual Abusers, 2005; Becker and Murphy, 1998; Berlin, 2000; Craissati, 2004; Glaser, 2003; Grubin, 2000; Prentky, 1997.

41. Abel, Gore, Holland, Camp, Becker, and Rathner, 1989; Bumby, 1996; Langton and Marshall, 2000; Marshall, et al., 1999; Murphy, 1990; Salter, 1988.

42. Association for the Treatment of Sexual Abusers, 2005; Becker and Murphy, 1998; Marshall, et al., 1999; Murphy 1990; Schwartz and Cellini, 1995, 1997.

43. Becker and Murphy, 1998; Bumby, 2000; Fernandez, Anderson, and Marshall, 1999; Marshall, et al., 1999; Marshall, Hudson, Jones, and Fernandez, 1995; Marshall, O'Sullivan, and Fernandez, 1996; Polaschek, 2003.

44. Ogloff, Wong, and Greenwood, 1990; Rice and Harris, 1997; Rice, Harris, and Cormier, 1992; Seto and Barbaree, 1999.

45. Bumby, 2000; Fernandez, Anderson, and Marshall, 1999; Marshall, et al., 1995, 1996, 1999; Polaschek, 2003.

46. Association for the Treatment of Sexual Abusers, 2005; Becker and Murphy, 1998; Bumby, 2000; Bumby and Hansen, 1997; Marshall, 1989; Marshall, et al.,1999; Marshall, Barbaree, and Fernandez, 1995; Schwartz and Cellini, 1995; Seidman, Marshall, Hudson, and Robertson, 1994.

47. Hanson and Bussiere, 1998; Hanson and Morton-Bourgon, 2004.

48. Bumby, 2000; Bumby and Hansen, 1997; Marshall, 1989; Marshall, Anderson, and Champagne, 1996; Seidman, et al., 1994; Ward, Hudson, Marshall, and Sieger, 1995.

49. Hanson and Bussiere, 1998; Hanson and Morton-Bourgon, 2004.

50. Association for the Treatment of Sexual Abusers, 2005; Center for Sex Offender Management, 2000; Cumming and McGrath, 2005; English, et al., 1996.

51. Abel, et al., 1978; Laws, 1995; Marshall, et al., 1999; Marshall and Eccles, 1995.

52. Abel, et al., 1978; Laws, 1995; Marshall, et al., 1999; Marshall and Eccles, 1995.

53. Marlatt, 1982; Marlatt and George, 1984; Marlatt and Gordon, 1985.

54. Marlatt, 1982; Marlatt and George, 1984; Marlatt and Gordon, 1985.

55. Laws, 1989; Marshall, et al., 1999; Pithers, et al., 1983, 1988; Pithers and Cumming, 1995.

56. Pithers and Cumming, 1995.

57. Laws, 1989; Marshall, et al., 1999; Pithers, et al., 1983.

58. Laws, 1989; Marshall, et al., 1999; Pithers, et al., 1983; Pithers and Cumming, 1995.

59. Laws, 1989; Marshall, et al., 1999; Pithers, et al., 1983; Pithers and Cumming, 1995.

60. Center for Sex Offender Management, 2000; Cumming and McGrath, 2000; Marshall, et al., 1999; Pithers and Cumming, 1995.

61. Center for Sex Offender Management, 2000; Cumming and McGrath, 2000, 2005; Marshall, et al., 1999; Pithers and Cumming, 1995.

62. Association for the Treatment of Sexual Abusers, 2001.

63. Association for the Treatment of Sexual Abusers, 2005.

64. Association for the Treatment of Sexual Abusers, 2001, 2005; Cohen, 2005.