Short Version

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

The Basics of Sex Offender–Specific Treatment

30 Minutes

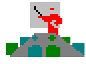
TOPIC: CURRICULUM GOALS AND CONTENT (2 minutes)

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

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

The goals of this 90 minute training on the treatment of sex offenders are to:

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

 **TOPIC: INTRODUCTION**

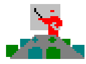
Use Slide #3 and Slide #4: **Learning Objectives for Section 1**

Refer to Handouts: Refer participants to the handout "Terms and Concepts Related to Sex Offender–Specific Treatment" for definitions of terms used in this curriculum. These documents are included in the participant materials.

Learning Objectives

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

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

 **TOPIC: THE GOAL OF SEX OFFENDER–SPECIFIC TREATMENT (6 minutes)**

Reducing Future Victimization

Use Slide #5: **The Goal of Sex Offender–Specific Treatment**

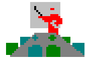
The thought of providing treatment to sex offenders elicits varying reactions from different people. Some people believe that sex offenders don't deserve anything but punishment and that they should not be provided treatment because of the terrible acts they have committed. Although this attitude may satisfy understandable urges to punish sex offenders, punishment alone is unlikely to lessen the risk that they will recidivate. Unlike other forms of mental health treatment where the goal is to reduce clients' distress and improve their well–being, the goal of sex offender treatment is to reduce offenders' likelihood of committing another sex offense. In other words, we provide treatment not to make the sex offender feel better or function better in general, but rather to protect the community. As we will see, sex offender treatment has been shown to reduce the likelihood that sex offenders will reoffend.[1] Thus, if we embrace the concept that our ultimate goal in managing sex offenders is fewer victims, then sex offender treatment is not only consistent with, but is an important part of, achieving that goal. In fact, since sex offender treatment reduces reoffense risk, you can make the argument that failure to provide treatment makes communities less safe.

You'll notice the term on the slide "criminogenic needs." What does this mean? It means that in order for sex offender treatment to be effective, it must address the characteristics in the offender that contribute to his committing sex crimes. In other words, if depression significantly contributes to the commission of a sex offense, then we must treat that offender's depression. However, if depression is unrelated to sexual offending, then it should not be a part of the offense–specific treatment plan for that offender.

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

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

In summary, it is important to understand that we treat sex offenders to make our communities safer, and we do it by targeting the aspects of offenders' lives that contribute to their likelihood of committing future sex offenses.

 **TOPIC: DIFFERENCES BETWEEN SEX OFFENDER–SPECIFIC TREATMENT AND OTHER FORMS OF MENTAL HEALTH TREATMENT (10 minutes)**

Use Slide #6: **Differences from Other Forms of Metal Health Treatment**

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

Involuntary Clients

First, sex offender treatment almost always involves working with involuntary clients. A limited number of sex offenders seek treatment on their own before they are criminally apprehended, and they initially enter treatment either because they know they will be ordered by the criminal justice system to participate, or they do so to make themselves look good for the court. This raises the question of whether treatment can be effective if you compel someone to participate in it. Voluntary sex offender clients often enter treatment because they had a close call with apprehension and they are frightened of being caught. When that acute fear abates, they often drop out of treatment prematurely, against the advice of their treatment providers. This failure to complete treatment might make them more likely to reoffend.[2] Another reason why voluntary sex offender treatment is not as effective may be because, as we will see later, sex offender treatment may be more effective when combined with community supervision and other interventions.[3] In other words, sex offender treatment providers can't work alone as effectively as they can in collaboration with supervision officers and other professionals. In practice, offenders often demonstrate signs of resistance at the beginning of treatment. However, as treatment progresses and they begin to experience it as helpful, their resistance usually begins to dissipate.

Use Slide #7: **Differences from Other Forms of Metal Health Treatment (cont.)**

Victim and Community Focus

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

Limited Confidentiality

It is said that some sex offenders thrive in the shadows of secrecy. Secrets are the power base of these offenders. Without the ability to hide their behaviors, it is more difficult for sex offenders to continue to commit crimes. Sex offenses almost always occur after the offender has isolated his victim and his behavior from others' awareness, and many offenders generalize this strategy to numerous aspects of their lives to avoid detection or responsibility for their behaviors. To counteract these manipulative tendencies in sex offenders, it is essential that treatment providers and other professionals maintain open and frequent communication with each other about those offenders who are in treatment and under supervision.[4] This doesn't mean sex offenders who are in

treatment have no privacy; rather, it means that the professionals working with them will communicate with each other to assure that each is operating with the same information and, in particular, that their collective strategies for working with these offenders are completely consistent.

Provider Sets Treatment Goals

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

Collaboration Among Professions

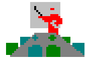
A central theme of sex offender–specific treatment is collaboration. As previously indicated, unlike other forms of mental health treatment, sex offenders are typically not granted confidentiality. For treatment and other interventions to be most effective, the regular exchange of information—among treatment providers, probation/parole officers, and others—is critical.[5]

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

Local collaborative policy teams also play key roles in addressing policies and practices that guide how sex offenders are managed.[6] These teams benefit from involving officials representing every aspect of the system, including treatment providers, probation and parole representatives, prosecutors, defense attorneys, judges, corrections officials, victim advocates, and others.

Statewide policy teams are generally formed to address policies and procedures at a state level, including the establishment of standards for sex offender management, treatment, and supervision that apply to all localities.[7] The composition of these teams mirrors local policy teams.

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

 **TOPIC: CHARACTERISTICS OF CURRENT SEX OFFENDER–SPECIFIC TREATMENT METHODS**
(10 Minutes)

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

Use Slide #8: **Characteristics of Current Sex Offender–Specific Treatment Methods**

Group Treatment

First, most sex offender treatment takes place in a group treatment setting. Although individual treatment sometimes accompanies group treatment (and, under certain circumstances, might replace group treatment altogether), there are a number of advantages to group treatment.[8]

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

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

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

Cognitive–Behavioral Therapy

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

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

that thoughts can both promote and discourage sex offending behavior requires that offenders' cognitions (thoughts) be addressed in the therapeutic environment.

The *behavioral* component in cognitive–behavioral treatment refers, of course, to offenders' behaviors. But more than that, it speaks to particular treatment methods that are effective in changing behavior. Just because offenders have assimilated non–distorted or appropriate thoughts doesn't necessarily mean that their behavior will always reflect their thinking. Relapse prevention is an intervention strategy that is designed to assist offenders to implement new behaviors and to recognize—and take specific actions—to avoid high–risk situations that increase the likelihood that they will reoffend.[9]

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

Psychopharmacology: Treating Sex Offenders with Medication

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

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

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

Use Slide #9: **Specialized Sex Offender Assessment**

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

Specialized Sex Offender Assessment

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

We'll begin our discussion of sex offender assessment with an overview of empirically validated, actuarial–based risk assessment instruments. (These are often referred to simply as actuarial tools.) It is likely that many of you have heard of—or are already using—one or more of them in your work with sex offenders. Examples include the RRASOR and the Static–99.[10]

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

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

Criminal Justice Assessments

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

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

Pre–Sentence Investigation Assessments

Those (usually supervision officers or staff) responsible for conducting a pre–sentence investigation (PSI) rely on many different kinds of information about sex offenders from a variety of sources to assess the risk that offenders pose, and to make disposition recommendations based on that assessed level of risk.[11] The information considered in a PSI assessment includes an instant offense summary, the offender's prior criminal record, offender statements, a victim impact statement, the offender's social history, the offender's substance/drug history, the offender's level of admission of the instant sex offense, the offender's willingness to enter sex offender–specific treatment, the risk posed by the offender as determined by one or more empirically validated risk

assessment, and the results of a sex offender–specific (psychosexual) evaluation (which we will discuss in a moment).

Assessments for Supervision Case Management

Planning assessments for supervision case planning are conducted by supervision officers and—like pre–sentence investigation assessments—rely on information from many different sources, including treatment providers. A primary purpose of these assessments is to identify the unique dynamic risk factors that are related to the risk that each offender poses to the community so that individualized case management plans can be designed that respond appropriately to these factors.[12]

Assessments for Ongoing Case Management

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

Clinical (or Treatment) Assessments

Clinical assessments are undertaken by sex offender–specific treatment providers and are used to help guide the treatment process. Their results are also shared with supervision officers to inform their work with sex offenders. There are two types of clinical assessments: sex offender–specific (psychosexual) evaluations and ongoing assessments of risk and criminogenic needs.

Sex Offender–Specific (Psychosexual) Evaluations

Ideally, sex offender–specific evaluations are conducted prior to community supervision and entrance into treatment. Their purposes are to:[13]

- Assess the risk that sex offenders pose to the community (using one or more of the actuarial tools we just discussed);
- Identify specific criminogenic needs (which we also covered earlier) that are related to the risk that each offender poses and that must be addressed in treatment—these become specific targets of treatment;
- Determine the most appropriate method of treatment delivery (based upon each offender's learning style); and
- Determine the most appropriate treatment setting (i.e., institutional or community) and level of treatment intensity for each offender.

Ongoing Assessment of Risk and Criminogenic Needs

Like supervision officers, treatment providers continually monitor and assess short–term (hourly, daily, or weekly) changes in sex offenders' risk and criminogenic needs to inform their treatment decisions and to update offender treatment plans. During this ongoing process, treatment providers seek input

from supervision officers and other professionals to assure that treatment plans are responsive to current offender–risk levels and needs.

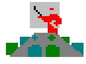
Because the information from the different types of assessments informs the responses of treatment providers and supervision officers to sex offenders, it is critically important that treatment providers and supervision officers communicate clearly and consistently about the assessment process.

Psycho–Physiological Assessments

Although we do not have time to cover them in any detail, you should be aware that there are three other assessment tools that are often used as part of sex offender assessment: the polygraph, the penile plethysmograph, and the Abel Assessment of Sexual Interest.

- The polygraph is used to assess whether sex offenders are being deceptive.
- The penile plethysmograph is a laboratory device that measures increments of erection of the penis to different stimuli. It is used to identify deviant sexual arousal.
- The Abel Assessment of Sexual Interest involves offenders' viewing slides of clothed males and females (adults and children) and measuring their level of attraction to each. This determination is made by measuring small differences in the visual reaction time of the person being evaluated; that is, how long they look at each slide, with longer reaction time being associated with increased sexual interest.

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

 **TOPIC: SUMMARY**

Use Slide #10: **Summary**

In summary:

- Sex offender–specific treatment can be an effective tool in preventing future victimization.
- Sex offender treatment varies significantly from other forms of mental health treatment and employs specialized intervention and assessment methods.
- For sex offender treatment to be as effective as possible, sex offender treatment providers must work in close collaboration with other professionals involved in the management of these offenders.

REFERENCES AND RESOURCES

American Psychiatric Association (1999). *Dangerous Sex Offenders: A Task Force Report of the American Psychiatric Association*. Washington, DC: American Psychiatric Association.

Carich, M.S. & Adkerson, D.L. (1995). *Adult Sexual Offender Assessment Packet*. Brandon, VT: Safer Society Press.

Laws, D.R. & O'Donohue, W. (1997). *Sexual Deviance: Theory, Assessment and Treatment*. New York: The Guilford Press.

Maletzky, B.M. (1991). *Treating the Sexual Offender*. Thousand Oaks, CA: Sage Publications.

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

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

Schwartz, B.K. & Cellini, H.R. (Eds.) (1995). *The Sex Offender*. 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.

NOTES

1. Aos, et al., 2001; Gallagher, et al., 1999; Hanson, et al., 2002; Losel and Schmucker, 2005.

2. Hanson, et al., 2002; McGrath, Cumming, Livingston, and Hoke, 2003; McGrath, Hoke, and Vejtisek, 1998.

3. McGrath, Cumming, Livingston, and Hoke, 2003; Wilson, et al., 2000.

4. Association for the Treatment of Sexual Abusers, 2005; Carter, et al., 2004; Center for Sex Offender Management, 2000a, 2000b; Cumming and McGrath, 2000, 2005.

5. Association for the Treatment of Sexual Abusers, 2005; Carter, et al., 2004; Center for Sex Offender Management, 2000; Craissati, 2004; Cumming and McGrath, 2000, 2005; English, et al.,1996, 2003; Robinson, 2003.

6. Center for Sex Offender Management, 2000; Craissati, 2004; English, et al., 1996, 2003.

7. Berliner, 2003; Center for Sex Offender Management, 2000; English, et al., 1996.

8. Jennings and Sawyer, 2003; Marshall, et al., 1999; Proeve, 2003 (in Ward, Laws, and Hudson, 2003); Salter, 1988; Sawyer, 2002; Schwartz, 1995.

9. Laws, 1989; Laws, Hudson, and Ward, 2000; Pithers, et al., 1983.

10. Hanson, 1997; Hanson and Thornton, 2000.

11. Center for Sex Offender Management, 2000; Cumming and McGrath, 2005.

12. Center for Sex Offender Management, 2000; Craissati, 2004; Cumming and McGrath, 2005; English, et al., 2003; Hanson and Harris, 2000.

13. Association for the Treatment of Sexual Abusers, 2005; Becker and Murphy, 1998; Carter, et al., 2004; Marshall, et al., 1999; Ward, Laws, and Hudson, 2003.