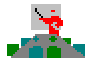
# Short Version

## Section 3: An Overview of Sex Offender Treatment for a Non–Clinical Audience

### *Elements of Sex Offender–Specific Treatment*

**25 Minutes**

 **TOPIC: INTRODUCTION**
**(2 Minutes)**

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

**Learning Objectives**

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

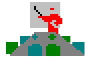
- Identify some of the components of sex offender–specific treatment;
- Identify the four domains of sex offender–specific treatment; and
- Identify several ethical issues in the treatment of sex offenders.

***Use Slide #2:*** **Two Facets of Sex Offender Management: Addressing both External and Internal Controls**

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.

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 (5 Minutes)**

## Introduction

***Use Slide #3:* Characteristics of Sex Offender–Specific Treatment**

What is done in treatment is not random or haphazard.[1] The primary methods used in sex offender treatment are based on a combination of a number of theories. 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

Treatment must address the factors that lead people to commit sex offenses. Wherever possible, sex offenders' criminogenic needs should be the beacon that guides treatment.

## Treatment Strategies

What sex offender treatment methods have been found to be most effective? The one type that has emerged as the most consistently effective in reducing recidivism is a group of interventions described as cognitive–behavioral.[2]

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.

***Use Slide #4:* 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.

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 #5:*** **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.

## The 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. Research by Beech et al. (1998) indicates that the length of treatment is best determined by the specific needs of each offender and the risk that they present to the community.[3] 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.

***Use Slide #6:*** **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.[4] 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.

**TOPIC: ADDRESSING SEX OFFENDER DENIAL (5 Minutes)**

***Use Slide #7:*** **Treatment of the Denying Sex Offender**

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.

**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.[5] 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.[6] 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.[7] Interestingly, the largest study of factors that predict risk for sex offender reoffense 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.[8] 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.

**TOPIC: THE FOUR DOMAINS OF TREATMENT (10 Minutes)**

## Introduction

***Use Slide #8:*** **The Four Domains of Treatment**

Research has found that sex offender treatment must include four general domains:[9]

- Deviant sexual interests, arousal, and preferences;
- Distorted attitudes;
- Interpersonal functioning deficits; 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. Let's look generally at what we mean by these four areas of focus.

## Deviant Sexual Interests, Arousal, and Preferences

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.[10]

## Distorted Attitudes

It is almost universally true that sex offenders have distorted attitudes. 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.

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.

***Use Slide #9:*** **Behavior Management—The Fourth Domain of Treatment**

## Behavior Management

The fourth 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.[11] 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. 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. This is the rationale underlying covert sensitization.

***Use Slide #10:*** **Goals of Covert Sensitization**

***Use Slide #11:*** **Relapse Prevention**

Thus, the primary goal of covert sensitization is to help offenders substitute thinking about what is appealing about sex offending with considering instead possible aversive consequences of committing sex offenses. 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.

## Relapse Prevention

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.[12] 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.[13]

***Use Slide #12:*** **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.[14]

Relapse prevention involves sex offenders learning that they must be extremely vigilant to avoid committing new offenses throughout their lives. Relapse prevention also involves offenders learning that a chain or cycle of thoughts and behaviors can take them from self–control to committing additional sex crimes.[15]

## 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.[16] 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.

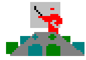
Interventions to assist offenders to engage in this self–examination can include writing an autobiography to gain a greater understanding of life patterns that result in offending, learning more effective problem–focused rather than emotion–focused coping strategies, avoiding high–risk situations, learning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

***Use Slide #13:*** **Adjunctive Therapies**

## Adjunctive Therapies

Before we move on to the topics of ethical standards, I would like to point out that, 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 (3 Minutes)**

***Use Slide #14:*** **Ethical Practice Standards**

As you might imagine, there are many ethical issues relating to the delivery of sex offender treatment. 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.

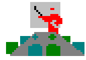
An international organization of sex offender treatment providers, evaluators, and researchers called the Association for the Treatment of Sexual Abusers (ATSA), has provided the field with some guidance in managing these many ethical challenges. ATSA has a Code of Ethics with which all members agree to comply.[17] Additionally, ATSA has codified practice standards (meaning requirements) and guidelines (meaning suggestions) for the delivery of sex offender evaluation and treatment.[18] 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. And of those who aren't, many are still 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—and document ordering information—can be obtained from their Web site (www.atsa.com).

***Use Slide #15:*** **A Major Ethical Issue: Informed Consent**

***Refer to Handouts:*** "Sex Offender Treatment Contract" and "Acknowledgement of Limited Confidentiality and Waiver" handouts 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.[19] 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: SUMMARY**

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

- Deviant sexual interests, arousal, and preferences;
- Distorted attitudes;
- Interpersonal functioning deficits; 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.

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## NOTES

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2. 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.

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5. 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.

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

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

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

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

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

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