

# California Coalition on Sexual Offending (CCOSO)

The logo is a circular seal with a light green border. Inside the border, the words "CALIFORNIA COALITION" are written in a semi-circle at the top, and "ON SEXUAL OFFENDING" is written in a semi-circle at the bottom. In the center of the seal is a map of California with several red stars scattered across it.

## Guidelines and Best Practices: *Adult Male Sexual Offender Treatment* 2010

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**The California Coalition on Sexual Offending (CCOSO)** was formed in 1986 in response to California's growing need for a formally structured resource for professionals working with people who have acted in sexually inappropriate and illegal ways (e.g., rape, child sexual abuse, incest, and other forms of sexual assault). Encompassed in our Mission, "*Together we can end sexual abuse*", CCOSO developed a Core Purpose: "*Stop sexual abuse by supporting, educating, and training professionals and the community*". To this end, CCOSO is a multi-disciplinary organization that is comprised of mental health professionals, probation officers, parole agents, law enforcement, criminal justice professionals (judges, defenders, and prosecutors), and others who work with sexually abusive individuals in a variety of capacities.

*This paper is the first in a series of documents that will educate readers about how to competently apply contemporary strategies to achieve CCOSO's goal of stopping sexual abuse. Attaining this goal requires close collaboration between key stakeholders (therapists, evaluators, probation/parole officers, the court, officers of the court, policy makers, educators, and community members). Thus, four "Guideline" papers will be completed, one for each essential collaborative component of an interdisciplinary team: Treatment, Supervision, Polygraph, and Victim Advocacy. The introduction below provides a brief overview of sexual abuse statistics and prevention strategies, identifying tactics directed at preventing sexual abuse at primary, secondary, and tertiary levels. This paper focuses principally on guidelines and best practices for sexual offender therapists who work toward preventing recurrent sexual abuse and re-offense (tertiary prevention). Although the primary target readership of this paper is sexual offender therapists, it is also intended to be utilized by other professionals and laypersons alike who seek to understand sexual offender treatment and aid in reducing the likelihood of the reoccurrence of sexual abuse.*

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## Introduction

The prevalence of sexual abuse is difficult to determine. In 2007 an estimated 248,300 reported sexual assaults occurred against individuals above the age of 13 years in the United States<sup>1</sup>. In 2006, 79,000 cases of substantiated instances of sexual abuse occurred against children under the age of 13<sup>2</sup>. It is estimated that less than 10% of sex crimes are detected. Research on un-disclosed sexual abuse suggests that the actual number of sexual abuse incidents per year could exceed 400,000 for victims over the age of 13 and more than 500,000 for victims under the age of 13<sup>3</sup>.

Ending sexual abuse will involve a multisystem approach that integrates three prevention interventions. These strategies are commonly used in the health field and are adapted here to focus on sexual abuse. These prevention interventions are:

- 1) Primary Prevention. Primary prevention interventions are directed toward the entire community and are intended to prevent abuse before it occurs. Primary prevention interventions aim to educate the general public about healthy sexual practices, healthy sexual boundaries, and safety. Interventions on the primary prevention level aim to prevent sexual abuse from occurring in the first place;
- 2) Secondary Prevention. Secondary prevention strategies focus on detecting and correcting pre-existing conditions or risk factors (e.g., deviant sexual interests) in individuals who are likely to engage in sexually abusive behavior. In other words, secondary prevention strategies target high-risk populations who are at risk of sexually victimizing others and/or at risk of being sexually victimized;
- 3) Tertiary Prevention. Tertiary prevention strategies identify current or past sexual offender-clients and engage them in practices that reduce the likelihood of re-offense. Individuals who have engaged in sexual misconduct and then enter treatment are subject to tertiary prevention strategies. The fact that they have previously acted in sexually harmful ways requires intervention at the tertiary level.

### PRIMARY PREVENTION INTERVENTIONS

- ✓ Primary prevention averts the occurrence of sexual abuse. Most population-based health promotion activities are primary preventive measures, e.g., eating healthily to avoid obesity.  
*Preventing Sexual Abuse Before it Starts*
- ✓ Educating juveniles and adults about healthy sexual expression and boundaries helps reduce the number of future sexual offenders.
- ✓ Educating potential victims about self-protection (boundaries, safe practices, etc.) to preclude a potential offender from acting out.

### SECONDARY PREVENTION INTERVENTIONS

- ✓ Secondary prevention is aimed at early disease detection, thereby increasing opportunities for interventions to prevent the manifestation of sexual acting out/abuse, i.e. maintaining a diet and exercise regimen for an overweight person.  
*Preventing Sexual Abuse When Risk Factors are Identified*
- ✓ Teaching juveniles and adults about sexual behavior and how to respond to/inhibit problematic arousal or to avoid sexually abusive situations.

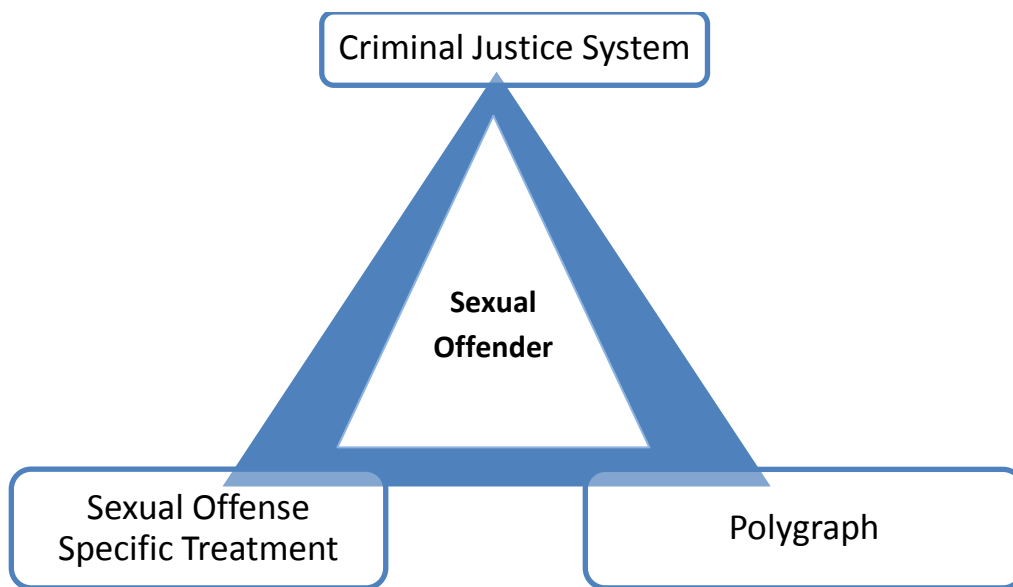
### TERTIARY PREVENTION INTERVENTIONS

- ✓ Tertiary prevention reduces the negative impact of an already established disease by restoring function and reducing disease-related complications, e.g. taking Diabetes medication.  
*Reducing the Risk of Future Offending*
- ✓ Educating and empowering victims to respond to sexual abuse by seeking resources and reporting abuse if it occurs.
- ✓ Utilizing interventions to prevent those who have acted in sexually abusive ways from repeating misbehavior.
- ✓ **Rehabilitating the offender to engage in sexually healthy, non-abusive behaviors (or if deemed not amenable to change, applying strategies to control the offender's behavior).**

While preventing sexual abuse before it begins is paramount to ending sexual abuse, CCOSO recognizes that tertiary prevention interventions are vital to stopping sexually abusive individuals from continuing to engage in harmful behavior. A majority of individuals referred to sexual offender therapists have previously engaged in sexually abusive behavior. Therefore most of the interventions employed by CCOSO members are *tertiary prevention strategies*.

## The Containment Model

The most utilized form of systemic intervention and tertiary prevention is the Containment Model<sup>4</sup>, also commonly referred to as the Containment Approach to Sex Offender Management.



\*In some cases, the model will include other interested parties such as a victim advocate or a family member of the offender.

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The Containment Model is an interdisciplinary strategy to manage sexual offenders that combines elements of treatment, supervision, monitoring, and risk management. It includes interventions designed to produce behavioral changes that are supported by modifications in the offender’s daily lifestyle and psychological condition. The Containment Model is built upon two observations: 1) The majority of criminally detected sexual offenders eventually return to communities under some form of mandated community supervision, and 2) The likelihood of re-offense is reduced when well planned mechanisms are in place that support full and productive participation of offenders in community life, while holding them accountable for the harm they have created and choices they make. The model is implemented on a case-by-case basis through collaboration of the various stakeholders involved in each case. For example, a team that includes a parole agent, a specialized law enforcement officer, inpatient and outpatient treatment providers, a medical doctor, a polygraphist, a conditional release supervisor, and in some cases, a victim advocate, acts to “contain” the rehabilitating sexual offender. In some cases, a responsible family member or friend may be integrated into this model. Each agent thoroughly learns the sexual offender’s pattern of sexual offending, participates in ongoing regular discussions that identify any resurfacing of key risk factors, and collaboratively strategizes and coordinates services (e.g., treatment, probation, etc.) to interrupt the cycle of re-offense.

The Containment Model asserts that reduction in recidivism is achieved only when the multiple criminal justice agencies involved in each case proactively strategize to close the gaps that naturally occur when multiple systems work together to promote change. A thorough understanding of, and full participation in, the

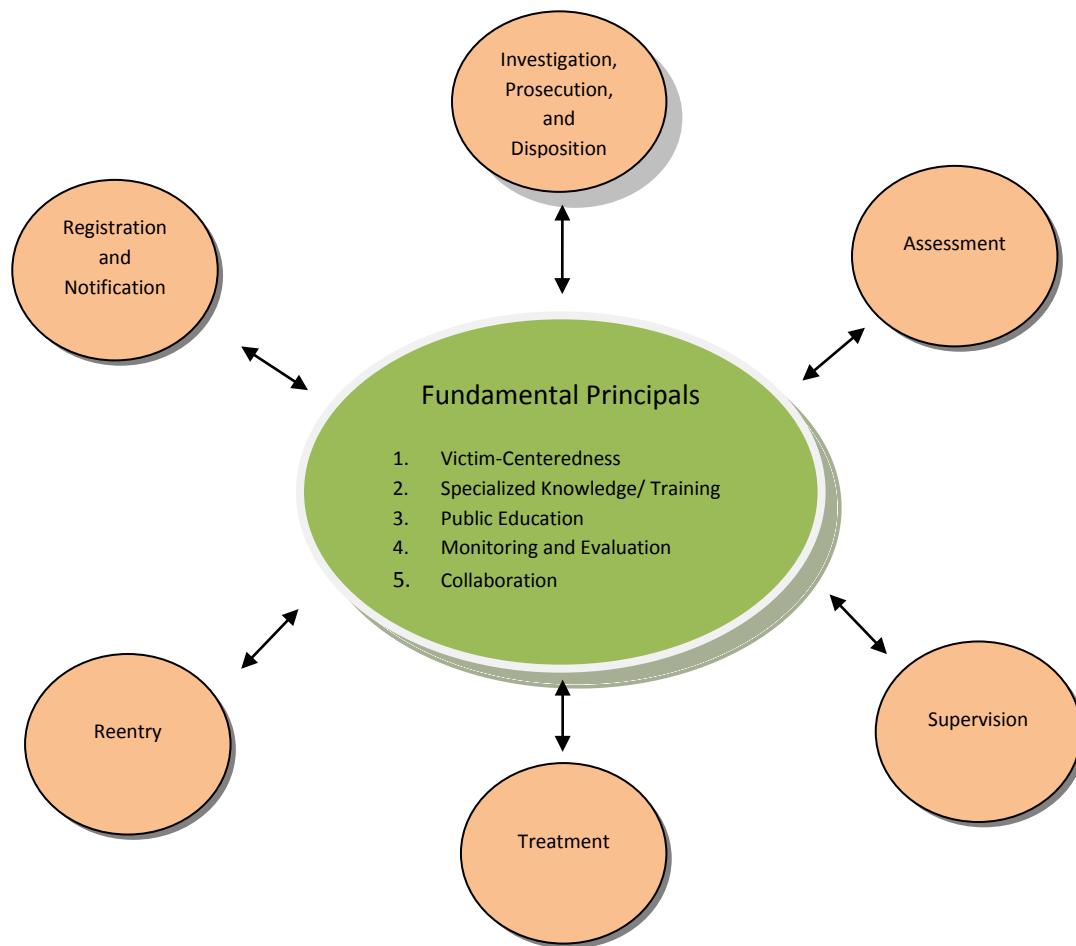
Containment Model by all involved agencies is essential to public safety and vital to the success of externally motivated change. Ideally, externally motivated change can be internalized and the offender will continue to live a prosocial lifestyle when supervision ends and legally mandated monitoring mechanisms are discontinued. (Appendix A describes empirical support for the Containment Model.)

## **A Comprehensive Approach to Sexual Offender Management**

A *Comprehensive Approach* to sexual offender management attempts to address three crucial issues. Specifically, (1) “Who are the stakeholders who need to be involved in sex offender management efforts in order to have the most potential impact?”; (2) “What is the range and scope of activities that are central to managing sex offenders and reintegrating them into the community in a way that is safe and effective?”; and (3) “How should professionals approach the sex offender management process (i.e., what are the foundational tenets and philosophies of the work and what are the evidence-based practices professionals should employ)?”<sup>5</sup>

The Comprehensive Approach clarifies crucial core components of sex offender management. Like the Containment Model described above, the Comprehensive Approach recognizes the complex nature of sex offending and the need for key system stakeholders to facilitate accountability, rehabilitation, and victim and community safety throughout all phases of the justice system. However, the Comprehensive Approach reaches beyond the primary focus on the treatment–supervision–polygraph triad, and expands to a strategy that includes a broader sphere of partnerships and influence. The fundamental principles of this approach revolve around 1) Victim-centeredness; 2) Specialized Knowledge and Training; 3) Public Education; 4) Monitoring and Evaluation; and 5) Collaboration.

- 1) *Victim-centered* approaches recognize the impact of sexual abuse on victims and the community. Sex offender management efforts therefore are attentive to the perspective of victims and their families and do not focus solely on the offender.
- 2) The complexity of offender, victim, and community issues necessitate *Specialized Knowledge*. Stakeholders in the comprehensive approach are aware of the importance of comprehensive knowledge regarding sexual offending and offenders. Such knowledge requires specialized, intensive, and continuous training on these topics.
- 3) *Public Education* is a fundamental part of prevention and management strategies. Providing accurate information to the community at large in regard to sexual offenders and their management will enhance the community’s ability to employ self-protection strategies and effectively respond to problems associated with sexual offending.
- 4) *Monitoring and evaluating* the way in which we manage sexual offenders will facilitate practices that are successful and evidence based.
- 5) *Collaboration* is crucial to successful management of sexual offenders. The Comprehensive Approach relies on stakeholders from varying disciplines, working together in order to pool resources, knowledge, and strategies to increase the efficacy of sexual offender management.



### A Comprehensive Approach to Sexual Offender Management

*Investigation, prosecution, and disposition* define the offender’s relationship with the criminal justice system from the time of the offense through supervision. Investigators must have sound knowledge in terms of victim issues, forensic investigation, and victim interviewing. Decisions made during the investigative and dispositional stages have an impact on later stages of management including monitoring strategies, risk assessment, and offender accountability.

*Assessments* are crucial to informed decision making throughout the management process. Information gleaned from well executed assessments help stakeholders to understand the static (or unchangeable) risk factors and identify dynamic (changeable) risk factors that influence long term risk.

*Re-entry* in the community is imminent for most incarcerated sex offenders. Stakeholders must work together to develop strategies to respond to the unique dynamics and barriers to successful re-entry.

*Supervision* of sexual offenders has become the cornerstone of effective management. Anos (2006) has demonstrated that a combination of supervision and sex offender-specific treatment reduces recidivism<sup>6</sup>.

*Treatment* is an integral part of reducing re-offense risk and promoting healthy living among sexual offenders.

*Registration and notification* of sexual offenders has increasingly become a major part of sex offender management. Registration policies should encourage collaboration and coordination of efforts among all stakeholders. These and other sex offender-specific laws and legislation should continue to be evaluated in order to assess their impact and effectiveness. Public education efforts regarding these laws may reduce unintended consequences (e.g., vigilantism, homelessness) and encourage the community to promote offender success as a way to increase public safety<sup>7</sup>.

## Sexual Offender Treatment

These guidelines are focused on the role and implementation of adult male sexual offender treatment, which is one part of an entire system that works toward the prevention of sexual abuse.

The primary aim of sexual offender treatment is to enhance community safety and employ effective tertiary prevention interventions. Sexual offender therapists accomplish this directive by implementing interventions that focus on change within the offender-client and encouraging practices that limit the offender's likelihood of repeating harmful and self-defeating behaviors that ultimately culminate in sexual abuse. Internal change within the offender is crucial because external prohibitions are time limited and, in some cases, counter to the goal of reducing recidivism. Relying solely on external controls will ultimately not reduce recidivism. This notion was illustrated by Prescott and Rockoff (2008) who found that while community notification may discourage first-time sex offenses, it increases recidivism by registered offenders. This finding is consistent with work by criminologists who assert that notification may increase recidivism by imposing social and financial costs on registered sex offenders, thereby making criminal activity relatively more attractive.<sup>8</sup> Therapists who develop sound therapeutic relationships with offenders may be in a strong position to decrease their risk of re-offense while at the same time assisting them in enhancing the quality of their life by instilling a commitment to prosocial, legal lifestyles.

A strong therapeutic alliance between offender and clinician is key to facilitating change; at the same time CCOSO acknowledges that sexual offender therapy is fundamentally different from traditional therapy. Specifically, sexual offender therapists prioritize the need for others' safety over the psychological needs of the offender-client in treatment. The direct objective is to minimize the offender-client's likelihood of harming others, partly by focusing on the offender-client's internal motivation. In doing so, sexual offender therapists collaborate with other professionals on the containment team and work within the parameters set by the judicial system for sex offender treatment (e.g., mandating treatment attendance).

As in traditional therapy, sexual offender therapists work to enhance the offender's life in order to facilitate healthy and self-sufficient ways for the offender to get his or her needs met and become a functioning and integrated member of society. Research indicates that therapy provided to sex offenders needs to be consistent with many of the validated approaches that have proven to be effective with traditional, non-forensic psychotherapy populations<sup>9</sup>. With this research in mind, therapists who work with sexual offenders also have an obligation to recognize and work toward the offender-client's well-being. Therapists who do not approach their offender-clients in a respectful, compassionate manner are likely to have high drop-out rates and/or non-compliant offender-clients. This ultimately undermines the goal of facilitating prosocial change and eliminating future sexual abuse.



The following chart illustrates the differences between traditional therapy and sexual offender treatment.

<b>SEXUAL OFFENDER THERAPY</b>	<b>TRADITIONAL THERAPY</b>
<b>Entering Therapy</b>	
<p>Most sex offender-clients arrive by decision of a court and its supervising agency. These agencies act on behalf of the community and advocate risk reduction regardless of the offender-client's desire for change. In this sense, the community is the primary client. In addition to a focus on community safety, sexual offender therapists endeavor to instill self-motivated participation by promoting the awareness that change is in the best interest of the offender-client.</p>	<p>Traditional therapy clients arrive by their own volition, seeking change for themselves. The therapists focus on self-awareness and internal change that is evaluated by the clients' self appraisal.</p>
<b>Completing Therapy</b>	
<p>Because most sexual offenders are required or otherwise externally motivated to be in therapy, completion generally occurs when the therapist/treatment team determines the person has successfully achieved the treatment goals. It should be noted that sexual offender clients usually do not participate voluntarily and may terminate when the term of their probation or parole has ended. This should not be confused with treatment completion.</p>	<p>Because clients generally enroll on their own, they discontinue therapy whenever they choose, with no external consequences if the therapist does not agree to their decision.</p>
<b>Confidentiality</b>	
<p>Due to an emphasis on collaboration, containment, and community safety, sexual offenders participating in this type of therapy must consent to the therapist's obligation to disclose issues related to risk and therapy progress to supervising agencies.</p>	<p>In traditional therapy confidentiality is absolute outside of exceptions mandated by state reporting laws.</p>

## Who Enters Sexual Offender Treatment?

Individuals in sexual offender therapy typically have been referred or mandated by the criminal justice system because they have been charged or convicted of a crime that was sexual in nature. In some cases, sexual offender-clients, or individuals at-risk to abuse<sup>a</sup>, enter therapy on their own accord in order to address risk.

## Does Sexual Offender Treatment Reduce Recidivism?

In the not too distant past, researchers asserted that sexual offenders were un-treatable. More recently, treatment efficacy research has produced mixed, but encouraging, results<sup>10</sup>. In 2005, the Sex Offender Treatment and Evaluation Project (SOTEP) compared treated and untreated cohorts of rapists and child molesters. The researchers failed to identify significant differences between treated and untreated cohorts in terms of sexual or violent recidivism during an eight-year follow-up (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005)<sup>11</sup>. However, it was noted that those offenders who had successfully completed treatment recidivated at a rate 50% less than those who participated in but did not complete treatment (Marques et al., 2005)<sup>12</sup>. Similarly, a 2003 study by McGrath, Cumming, Livingston, and Hoke found that over a six-year follow-up, offenders who had “completed” a cognitive behavioral program recidivated less (5.4% overall) than offenders who had “some” treatment but did not complete the program (30.6% overall)<sup>13</sup>. Interestingly, the “some treatment” groups’ recidivism rate did not differ from that of the “no treatment” cohort. Nevertheless, the overall finding is consistent with a 2002 study by Hanson, Gordon, Harris, Marques, Murphy, Quinsey, & Seto that concluded that sex offenders who did not participate in psychological treatment had a higher recidivism rate (17%) than those who completed cognitive behavioral therapy (10%)<sup>14</sup>. In short, the research suggests that *treatment completion* is a crucial key to treatment success.

Although these mixed results may raise concern, more contemporary research gives us reason to believe that sexual offender therapy is effective in reducing recidivism. It is possible that some studies have not found positive treatment outcomes because they have failed to properly operationalize, or define, the interventions used. As a result, less effective interventions are sometimes evaluated alongside empirically-based interventions. Sexual offender therapists should note that when positive treatment outcomes are identified in the research, these outcomes are linked to *cognitive behaviorally-based interventions*. In a 2005 meta-analysis by Losel and Schumacher regarding the efficacy of sexual offender treatment, only cognitive behavioral methodologies had a significant impact on recidivism<sup>15</sup>. Further support for the effectiveness of sexual offender therapy is the finding that crime records and victim reports show that sexual recidivism has decreased in the past 10 years. Sexual offender therapists have played a key role in the reduction in threat of sexual re-offense through increased collaboration with agencies and the use of models such as the Containment Model.

Most significantly, a very recent meta-analysis of 23 recidivism studies indicates that programs that utilize the *Risk-Need-Responsivity Model* evidenced lower sexual and general recidivism (Hanson, Bourgon, Helmus, and Hodgson, 2009)<sup>16</sup>. This finding is considered very important to the current state-of-the-art sexual offender treatment because it provides evidence that the *content* of sexual offender treatment is as important as *how* the treatment is delivered. This is a positive finding and it is important that sexual offender therapists employ the Risk-Need-Responsivity Model in sex offender treatment.

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<sup>a</sup> Few, but some, individuals enter therapy because they believe that they are at risk of committing sexual crimes but have yet to do so.

## Principles of the Risk-Need-Responsivity Model

The Risk-Need-Responsivity Model (RNR) was developed in the 1990s by Andrews, Bonta, and Hoge<sup>17</sup> and applied to a wide range of criminal populations. Since its inception, the RNR model has been influential role in facilitating effective interventions amongst sexual offenders. The RNR<sup>18</sup> is based on three principles:

1) **The Risk Principle** – The *risk principle* asserts that criminal behavior may be anticipated and that treatment should focus on the highest risk offenders. In addition, the level, or intensity, of services should match the offender’s risk level. Specifically, treatment plans for high risk offenders should reflect that risk (high intensity treatment) and treatment plans for low risk offenders should accordingly reflect their risk of re-offense.

2) **The Need Principle** – The *need principle* highlights the importance of criminogenic needs in the design and delivery of treatment. Specifically, treatment plans should highlight and target those factors that are directly related to the offender’s risk of offending. Commonly noted criminogenic needs include, but are not limited to, sexual deviancy, antisocial orientation, sexual attitudes, ability/tendency to regulate emotions and behavior, and intimacy deficits. Treatment should also include a comprehensive assessment of the client’s early trauma history as it relates to problems with impulse control, attachment deficits, and lack of empathy;

3) **The Responsivity Principle** – The *responsivity principle* emphasizes the importance of constructing treatment plans and interventions that match the offender’s learning style and abilities. At present, current research indicates that the offender’s ability to learn and instill self-prohibitions against offending is most effective through the application of cognitive behavioral treatment methods. In addition, therapeutic interventions should be consistent with the offender’s skills, motivation, abilities, and strengths. Recognizing that therapy may be frightening and painful, and is occurring in a somewhat adversarial context, it should be expected that some offender-clients will exhibit a certain level of resistance. Efforts should be made to promote participation in offenders-clients who are reluctant to participate in therapy by utilizing recent research findings on “treatment engagement.” Empathic, direct, genuine therapists who positively regard offender-clients are more likely to elicit participation. Conversely, confrontational, argumentative, punitive therapists increase defiant, uncooperative responses from offender-clients. For some clients, therapy modes must expand beyond “talk” therapy to include role play, written exercises, art, biblio, video, and other experiential therapies.

### Applying the Risk-Need-Responsivity Model

**The Risk Principle** -The importance of applying the appropriate treatment by differentiating between higher risk and lower risk offenders cannot be understated. Before beginning therapy with an offender, sexual offender therapists identify the offender’s risk of re-offense as well as factors that may increase or decrease risk. CCOSO acknowledges that un-structured clinical judgment is inferior to objective, actuarially based risk assessment; however, empirically guided structured clinical assessments may be comparable to some actuarial measures (Hanson et al, 2009)<sup>19</sup>. Bengtson and Langstrom (2007)<sup>20</sup> report that un-structured clinical judgments may mis-categorize 88%–95% of actual criminal recidivists. The high rate of instances in which clinicians underestimate an offender’s risk when using un-structured clinical judgment bears obvious consequences to community safety. Therefore, the use of multiple risk assessment methods (including actuarial and empirically guided structured clinical assessments) will increase predictive accuracy and assist in developing treatment plans that will reduce abusive behavior.

At this point in time there are no clinical tools that can definitively determine the required intensity of treatment for any offender. For example, most actuarial measures determine risk by identifying static factors that would not be altered by treatment intervention. The intensity of treatment should be determined by the clinician, using

sound and current diagnostic methods. Ideally, the clinician considers a variety of factors in making such decisions such as risk, sexual deviancy, past behavior, current environment, psychosexual functioning, socialization, and other mental health issues. No one tool or measure, or unstructured clinical judgment should be relied upon alone. Clinicians tailor treatment regimes by utilizing a variety of methods to assess offenders. Structured, empirically guided clinical judgment is based on research-selected factors that incorporate historical and current dynamic factors and individual-offender specific factors. Structured Empirically Guided Clinical Judgment has moderate reliability and validity comparable to that of actuarial assessment in some situations (Hanson & Morton-Bourgon, 2007)<sup>21</sup>.

**The Need Principle** – Appropriate treatment plans target criminogenic issues such as sexual deviancy, antisocial orientation, sexual attitudes, and intimacy deficits. In addition, some offender-clients also present with unique issues that contribute to their potential for sexually abusive behavior. Special efforts should be made to understand the dynamics of each offender-client’s personal history and their triggers for re-offense. These unique factors may include, but are not limited to, a history of various forms of early trauma including sexual victimization, substance abuse, lack of prosocial involvement, impulsivity, anger problems, self-esteem issues, distorted beliefs, family and relationship conflict, sexual identity issues, health concerns, or major mental illness.

**The Responsivity Principle** - Once treatment objectives are identified, sexual offender therapists work toward identifying each offender’s mode of understanding and learning. Applying modalities of treatment that best fit each individual client is crucial since a vast majority of sexual offenders will not remain under supervision for life and will need to rely on internal change to maintain abstinence from sexually abusive behavior.

As discussed above, current research suggests that cognitive-behaviorally based programs evidence the highest success rates. In some cases, cognitive behavioral therapy may be applied in conjunction with another complimentary form of treatment, such as medication. This being said, there may be unique situations with an individual offender for which another modality of treatment is more applicable. For example, some offenders may present with Attachment Disorders, or Anxiety Disorders, and thus require special attention. In addition, some current theories stress more ecological and holistic approaches such as the Self-Regulation Model (Ward & Gannon, 2005<sup>22</sup>) and Good Lives Model (Whitehead & Ward, 2007<sup>23</sup>).

## **Sexual Offender Treatment Intervention Approaches**

### **Cognitive Behavioral Therapy**

Cognitive Behavioral Therapy (CBT) is an empirically grounded method of therapy that changes behavior by addressing the interaction of thoughts, behaviors, and emotions. First developed by Aaron Beck in the 1970s, this therapeutic modality requires collaborative interactions between client and therapist in which the participants focus on the accuracy and utility of thoughts, ideas, and beliefs in shaping emotion and behavior (Beck, 1976)<sup>24</sup>. In order to facilitate change, CBT utilizes a number of interventions such as relapse prevention, psycho-education, cognitive restructuring, emotional management, impulse control, arousal management, social skill development, and victim awareness.

The role of cognitive distortion experienced by those who exhibit sexually abusive behavior has long been documented in the literature (Finkelhor, 1984<sup>25</sup>; Marshall, 2006<sup>26</sup>). This means that the thoughts of sexual offenders are often inconsistent with reality in that they are skewed to serve the goal of sexual offending. For example, some offenders express distorted beliefs such as, “She wanted it” or “I was educating him not abusing

him”. CBT is an empirically supported modality of change for sexual offenders. Sexual offender therapists should be trained in the use of CBT techniques.

One type of cognitive behavioral therapy is Dialectical Behavior Therapy (DBT), initially developed by Marsha Linehan<sup>27</sup> to treat individuals with Borderline Personality Disorder. Its aim is to teach clients how to tolerate strong negative emotions, how to identify situations that are likely to elicit such emotions, and how to deal with such situations more effectively. Some therapists have found it to be useful in treating a subset of offenders whose offenses are impulsive and who, overall, have general problems with self-regulation. In addition it prepares those offenders to deal with strong emotions, such as shame, often triggered in relapse situations. DBT offers strategies for the offender-client to use so that he doesn't become overwhelmed, act out or flee treatment.

### **Self- Regulation Model**

The Relapse Prevention Model was adapted from the field of substance abuse to apply to sexual offenders; however it was not a perfect fit for this population. Specifically, it failed to address different pathways (also called precipitants) to sexual offending. The Self-Regulation Model proposes that there are four pathways to offending which vary based on offense-related goals and strategies. Applying the model to therapy, offender-clients learn to understand that their beliefs, thinking patterns, and emotional states facilitate their behavior as it pertains to an offense pathway. The aim of therapy rooted in this model is for the offender-client to develop skills and competencies in order to attain their goals in healthy and non-abusive ways.

### **Good Lives Model**

Many of the treatment approaches used with sexual offenders are risk-need models, which are concerned with risk management. Simply, risk management is moving away from unhealthy thoughts, feelings, behaviors, places, and contexts while moving toward more healthy, prosocial ways of living. The Good Lives Approach (Ward & Gannon, 2007) augments other models by emphasizing the importance of a holistic approach to offender treatment. The model focuses on enhancing offender-clients' lives so that they can meet their own needs in more adaptive and prosocial ways. The basic assumption underlying the model is that sex offenders have the same human needs and aspirations as others. Failing to meet these aspirations contributes to increased risk. These needs are referred to as “Primary Goods” in the Good Lives Model (GLM). Primary Goods are defined as actions, states of affairs, characteristics, experiences, and states of mind that are intrinsically beneficial to human beings, and therefore sought for their own sake rather than as a means to a more fundamental end. Simply, GLM targets the things offenders should move toward by focusing on offenders shared humanity as opposed to their pathology.

The GLM asserts that “...sexual offending reflects socially unacceptable and often personally frustrating attempts to pursue human goods.<sup>28</sup>” In order to attain a good life, offender-clients explore and develop ten human goods (life/healthy living, knowledge, excellence in work and play, self determination and agency, inner peace, relatedness, community, spirituality, happiness, and creativity).

GLM asserts a proactive, positive approach toward treating offender-clients that conceptualizes dynamic risk factors as distortions of both internal and external conditions that limit the acquisition of human goods. GLM-based treatment plans take into account offender-client's personal preferences and strengths in relation to primary goods and relevant environments, and specify exactly what competencies and resources are required to achieve specific goals. GLM explicitly addresses the question of clinician attitudes toward the offender and the relationship between these attitudes and factors such as forgiveness, evil, and the therapeutic alliance.

# The Process of Sexual Offender Therapy

Sexual offender therapy is a specialized field that requires specialized training. In addition, sexual offender therapists have an obligation to both the offender-client and the community. As a result, sexual offender therapists take special care to be aware of, and inform their clients and others involved in managing the offender in the community, of the process and expectations of sexual offender therapy. The following section outlines the course of sexual offender treatment practices.

## Beginning Sexual Offender Treatment

### Sexual offender assessment and treatment procedures:

1. The offender-client is provided with an informed description of the purpose and process of treatment;
2. The offender-client provides informed consent to participate in therapy;
3. The offender-client provides appropriate waivers of confidentiality;
4. The offender-client is provided an opportunity to ask questions about the course of therapy;
5. The offender-client is provided an opportunity to contribute to the treatment plan;
6. The offender-client is informed of treatment completion requirements.

### **Initial Intake Assessments**

*Initial assessments* for treatment (e.g., intake assessments) combine sound and empirically guided clinical assessment with the appropriate assessment protocols and measures.

### Intake assessment procedures should include, but are not limited to:

1. Empirically guided, structured clinical interviews
2. Collateral interviews
3. Assessment of the offender-client's current learning and communication ability
4. Psycho-physiological measurements of sexual interest/arousal
5. Actuarial instruments (e.g., Static-99R, Static-2002R, and MnSOST-R, etc)

### An intake assessment produces a formal statement about:

1. A particular offender-client's potential risk that he/she presents during community placement and treatment
2. A treatment plan for reducing risk which would include:
  - a. Specific deficits related to sexual offending
  - b. Individual and environmental strengths and resources available for managing and mitigating deficits
  - c. Measurable goals related to managing and mitigating the deficits
  - d. Interventions used to enhance strengths and reduce deficits
  - e. Treatment completion criteria

## Treatment Implementation

Today's standard in either medical or psychological treatment is the implementation of evidence-based, best practices. Scientific, empirically-based research should guide professionals in regard to how to assess, treat, rehabilitate, manage, and supervise the offender-client and his or her respective diseases and/or disorder. The lack of funding for research in the area of sexual offender treatment has not thwarted researchers who have made notable gains in the areas of research on risk assessment, treatment, and/or the rehabilitation of sexual offenders. Limitations to these gains are: (a) a limited number of studies, available specific to the different types and kinds of sexually abusive individuals, i.e. females, low intellectually functioning individuals and the elderly, (b) studies with small sample sizes limiting generalize-ability of the findings, (c) limited longitudinal (long-term) studies, (d) an inadequate number of studies on the various treatment modalities, (e) an inadequate number of comparison studies on the various treatment modalities, (f) a lack of outcome research studies addressing a variety of issues related to treating the sexually abusive individual, and (g) the sustainability of the treatment benefits. Nevertheless, sound sexual offender treatment maximizes current and available research.

It is important that therapists stay abreast of factors identified in sex offender research in regard to re-offense risk and effective interventions. More recent research has identified variables, or factors, that have been correlated with risk and/or recidivism of sexual offending. As a result, both static and dynamic variables have become targets of treatment, rehabilitation, and supervision of adult sex offenders (Andrews and Dowden, 2006<sup>29</sup>; Antonowicz and Ross, 1994<sup>30</sup>; Hanson and Bussière, 1998<sup>31</sup>; Hanson et al., 2002<sup>32</sup>; Lipsey, 1992<sup>33</sup>). Sexual offender therapists are aware that research is frequently being updated and thus the flexibility to adapt new and current approaches is essential to successful therapeutic outcome and risk reduction.

### Treatment Goals

Sexual offender therapy aims to achieve specific goals. Basic goals are listed below. This is not an exhaustive list and goals may be added that apply to a specific offender-client.

1. Goals:

- a. Increased community safety through reduced risk of re-offense
- b. Improved capacity for a responsible lifestyle and healthier relationships
- c. Accountability –full disclosure of the offense(s) is a basic requirement for successful completion of therapy. Exceptions must be reviewed with, and approved by, the treatment team. (The treatment team is minimally comprised of the offender, treatment provider, the supervising agent, and/or a court representative.)
- d. Resolution of issues related to the offender-client's sexual, physical and emotional victimization (if applicable)
- e. Reparations to victim(s) and community
- f. Offender-client determined goals- Drapeau et al. (2004), found that offenders who felt able to participate in their own treatment planning maintained a greater sense of mastery and were more likely to successfully complete treatment<sup>34</sup>

## Interventions

Sexual offender therapists must be knowledgeable and skilled in the application of appropriate treatment interventions. Interventions that are currently supported in professional literature as having significant treatment value with this population include:

- a. Cognitive restructuring
- b. Sex offender relapse prevention
- c. Self-regulation
- d. Education regarding victim impact awareness
- e. Empathy development
- f. Education related to appropriate and healthy sexual functioning
- g. Full disclosure/accountability for all past sexual offenses
- h. Relationship skills
- i. Parenting classes
- j. Anger management skills training
- k. Social skills training
- l. Arousal management/urge control
- m. Behavior modification addressing sexual arousal control
- n. Medication for mood disorders and/or arousal control
- o. Substance abuse management
- p. Life enhancement training (Good Lives Model)
- q. Vocational training

## Progress Assessment

An assessment of the offender-client's risk and progress should be an ongoing process. Updated or progress assessments should utilize empirically validated and reliably supported measures. Update or progress assessments shall occur:

A minimum of every six months, to:

- a. Monitor progress
- b. Adjust goals and plans
- c. Monitor sex offender compliance with the supervising agency and treatment program requirements
- d. Monitor compliance via periodic polygraph examinations
- e. Polygraph utilized in a manner consistent with standards supported by the American Polygraph Association (APA)

## Treatment Completion

Sexual offender completion is based on an evaluation of:

- a. Goal attainment (see above)
- b. The offender's strengths, residual deficits, and continuing risk to the community
- c. The offender's lifestyle including support system, e.g., their friends, family, and community contacts
- d. The ability to continue self-imposed prohibitions against abusive behavior and participate in self-maintenance (e.g., coping skills, ongoing promotion of healthy attitudes) as well as the willingness to seek help when needed
- e. Treatment completion is *never* based on time spent/number of sessions in therapy. It is based on the reduction of risk of re-offense.



# Sexual Offender Treatment Modalities

## Individual versus Group Therapy

Empirical research has not established the comparative efficacy of the group versus the individual mode of therapy. Different modalities work best for addressing particular issues with particular offender-clients and may need to be adjusted based on the responsiveness of the offender-client. At present, the current state of science cannot reliably indicate when to use which modality, thus this issue is resolved by clinical judgment.

Some notable benefits of the group modality are: affiliation and kinship with peers struggling with similar life issues, reduced isolation, increased social skills, increased communication skills, emotional connection, positive role modeling, assistance in overcoming shame, and comprehending/sharing the benefits of treatment. Group therapy is presently the most widely used modality, and there is consensus that a significant intensity and length of group therapy experience is ideal for most sex offenders. Some clinical assessment factors indicate that group therapy, in specific cases, may be detrimental to goal attainment. These are: the offender-client or another member of the group does not feel adequately safe in the group constellation; the offender-client suffers extreme social phobia or post-traumatic stress; or situations wherein the offender-client does not have the cognitive or emotional abilities to meaningfully participate in the group. Highly psychopathic individuals and those who need to address other clinical conditions before entering the group process are also examples. In many cases, therapists utilize the individual therapy mode during the initial assessment period, then transition the offender-client to the group therapy format.

## Family Resolution

In years past, sexual offender treatment has been criticized for overly focusing on the offender's deviancy. The field has generally moved toward consensus on a holistic paradigm of etiology and recovery. Issues related to the impact on the family must be resolved as part of sexual offender treatment. Family resolution may take many paths, with family disruption and family reunification among the many possible outcomes. The specific course of treatment will depend on the family resolution pathway chosen by the family, the sexual offender, and representatives of the court. When integrating sexual offenders into families, CCOSO members shall adhere to guidelines set forth in CCOSO's Position Paper on Family Resolution.

*Family therapy* is an essential modality in the treatment of many sexual offenders. Sexual offender therapists who have been trained in family therapy use an integrated approach with offender-clients who will re-unify with families post-conviction or post-incarceration, as well as offenders who are developing new families and relationships. In some cases, the offenders will be reunifying with a family member whom he/she has victimized. The Center on Sexual Offender Management (CSOM) asserts that effective and responsible sexual offender management requires that while addressing the needs of the offender, the safety and protection of victim(s) must remain an overriding consideration. Sexual offender therapists recognize that regardless of an offender-client's desire for contact or reunification with the family, any reunification process must be driven by a victim-centered approach that always puts the best interest of the victim first (Gil & Roizner-Hayes, 1996)<sup>35</sup>.

Effective family therapy addresses issues related to "negative social influences" and "intimacy deficits", two factors that are known to correlate with sexual and general criminal recidivism<sup>36</sup>. Family therapy also allows for an examination of "hidden" risk factors that may have been overlooked during the course of working solely with the offender. In short, family therapy is a crucial tool that promotes the client's healthy re-integration into the community and reduces the risk of recidivism.

## Treating Deniers

“Deniers” are offenders who have been convicted but deny their offense. Treating this group of individuals is one of the most controversial and divisive topics in the management and treatment of sexual offenders. CCOSO supports the attempt to treat post-conviction denying offenders. However, clinicians treating deniers should be aware that simple attendance or even participation does not equate progress or risk reduction. In addition, those denying offenders who “term-out” of treatment should not be considered treatment completers. Again, treatment completion is determined by reduction in risk of re-offense.

Why treat deniers? Although most therapists agree that offenders who are accountable are easier to treat, assess, and assist in promoting a group and program culture of accountability, there is little empirical evidence that accountable offenders who participate in treatment re-offend at a lower rate than those who do not admit to their offense (Hanson and Bourgon, 2004<sup>37</sup>; Seager, Jellicoe, Dhaliwal, 2005<sup>38</sup>). In fact, Maletzky and Steinhauer (1998)<sup>39</sup> found that treated categorical deniers recidivated at a rate similar to treated admitters, and were much less likely to reoffend than untreated deniers. Additionally, addressing issues related to sexual offending such as cognitive distortions and dynamic risk variables (intimacy deficits, social influences, sexual self-regulation, general self-regulation and substance abuse, etc.) does not necessarily require that one admit his offense. Finally, and probably most importantly, some offenders who initially deny their offense later admit to it even after extended periods of treatment.

As discussed by Brake and Shannon (1997)<sup>40</sup>, allowing denying offenders to stay in a program indefinitely runs the risk of building antisocial self confidence in their ability to “get away with it.” To mitigate this risk, it is recommended that denying offenders who participate in treatment be assessed with a formal evaluation every three to six months in regard to the benefits of being in sexual offender treatment. Although complete disclosure may not come within that period of time, observable movement in the direction of reduced risk may reduce recidivism. Flinton and Scholz (2006<sup>41</sup>) suggest that a time period of six to nine months is usually sufficient to observe and assess amenability to change; however, each case should be evaluated individually. This being said, the goal of accountability should remain a priority, and program completion requirements should include full disclosure and accountability. Note: the use of pretreatment programs has been shown to reduce denial in offenders by 58% (Brake and Shannon, 1997).

Sexual offender therapists never determine guilt or innocence. If a convicted, denying offender enters therapy and there are no identifiable goals or objectives related to sexual offending, it is strongly encouraged that the therapist terminates the therapy and refers the offender back to his or her court agent. As such, many therapists find that offender-clients who never admit, or are not fully accountable for, their sexual misbehavior do not successfully complete treatment programs.

## Who Provides Sexual Offender Treatment?

In addition to meeting the sexual offender therapist qualifications articulated below, sexual offender therapists understand their role in maintaining public safety, while at the same time listen and attend to the needs of offender-clients. Fernandez and Serran (2002)<sup>42</sup> state that an effective sexual offender therapist emphasizes the necessary characteristics initially highlighted by Carl Rogers (1951)<sup>43</sup>, namely, genuineness, empathy, and warmth. These authors also suggest that therapists who provide support, encouragement, flexibility, and self-disclosure are most successful in facilitating change. Horvath (2000)<sup>44</sup> noted the cumulative evidence that these conditions, as well as a number of other features, support the contention that treatment outcome is to varying degrees dependent upon the interpersonal skills of the therapist. Similarly, W. Marshall and L. Marshall (2005)<sup>45</sup> stated that effective therapists are directive and rewarding. On the other hand, therapists who aggressively confront sex offenders to break down their personal defenses with the aim of achieving an admission of guilt will end up with a sexual offender who responds with disagreement, resistance, poor cooperation, insincere agreement, an adoption of a position of “not having a problem”, and/or dropping out of treatment.

### Qualifications of a Sexual Offender Therapist

Sexual offender therapy is highly specialized and requires special training for those who work with sexually abusive individuals. Therapists performing sexual offender therapy shall be currently licensed in a mental health profession/medical field (i.e. psychiatry, psychology, social work, or marriage and family therapy). Clinicians will adhere to the legal mandates of their licensing agency.

Unlicensed clinicians such as interns and pre-licensed practitioners must be supervised by a qualified, licensed clinician. It is expected that the licensed professional adheres to all of the licensure requirements and parameters regarding supervision and the number of individuals he/she is allowed to supervise.

#### *Experience*

A qualified therapist responsible for the treatment of a sexual offender shall have at least 2000 hours of face-to-face clinical experience in the assessment and/or treatment of sexual offenders. Therapists with less than the above-delineated education and experience should not have primary responsibility for an offender in therapy but may provide psychotherapy and other services to sexual offenders under supervision of a therapist who has such education and experience.

#### *Training*

Sexual offender therapists should obtain 30 hours of bi-annual sexual offender continuing education that is specific to their work with sexual offenders. The table below highlights critical areas of education and training. CCOSO maintains that topics denoted with an asterisk (\*) should be mandatory for any clinician providing services to sexual offenders.

## Specialized Training Areas For Sexual Offender Therapists

Sexual Offender Management	Therapy Models/Interventions	Assessment	Specialized Sexual and Relationship Issues
<p><b>*The Containment Model</b></p> <p><b>*The Role of the Supervising Agency</b></p> <p><b>*The Role of the Polygraphist and the Utility of Polygraphy</b></p> <p><b>*Ethical and Legal Issues</b></p>	<p><b>*Cognitive Behavioral Therapy</b></p> <p><b>Dialectical Behavior Therapy</b></p> <p><b>*Behavioral Therapy</b></p> <p><b>*Good Lives Model</b></p> <p><b>* Relapse Prevention</b></p> <p><b>*Social Skills Training</b></p> <p><b>Dating Skills Training</b></p> <p><b>*Self-Regulation Model</b></p> <p><b>Psychoeducation</b></p> <p><b>Chaperone Training</b></p> <p><b>Pharmacology</b></p> <p><b>Motivation Interviewing</b></p> <p><b>Humanistic Approaches</b></p> <p><b>Anger Management</b></p>	<p><b>*Actuarial Risk</b></p> <p><b>*Dynamic Risk</b></p> <p><b>*Sexual Offender Specific</b></p> <p><b>*Psychosocial</b></p> <p><b>Psychological Diagnosis</b></p> <p><b>Character Disorders</b></p> <p><b>Developmental Disorders</b></p> <p><b>Substance Abuse</b></p> <p><b>*Assessment of Sexual Deviance</b></p> <p><b>Empirically Guided-Structured</b></p> <p><b>Assessment and Interviews</b></p>	<p><b>*Victim Issues/Awareness</b></p> <p><b>*Sexual Development</b></p> <p><b>*Sexual Deviance</b></p> <p><b>*Sexual Dysfunction</b></p> <p><b>*Healthy Sexuality</b></p> <p><b>*Hyper-sexuality</b></p> <p><b>*Sexual Compulsivity</b></p> <p><b>Domestic Violence</b></p> <p><b>Family Issues</b></p> <p><b>Attachment Issues</b></p> <p><b>Substance Abuse</b></p> <p><b>Lifestyle Issues</b></p>

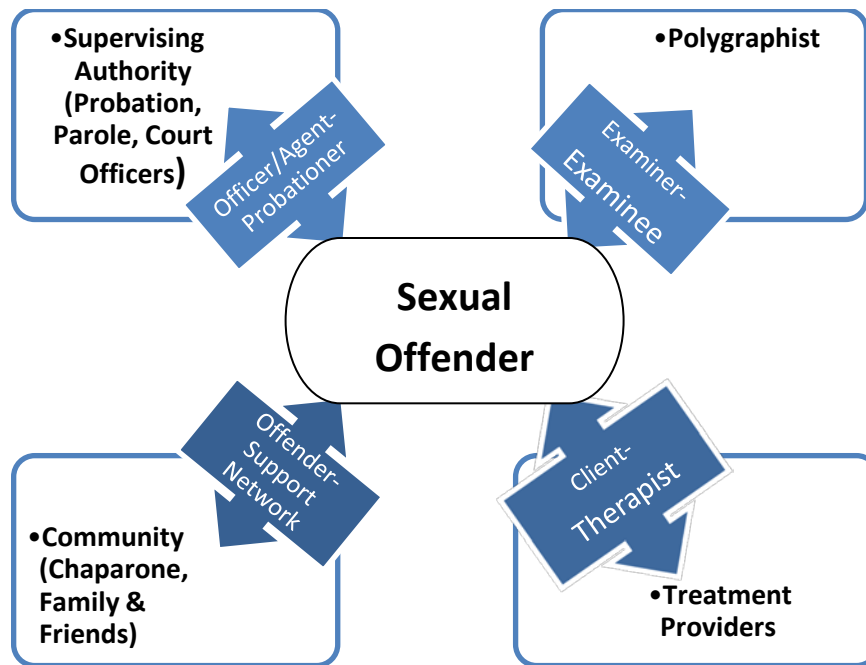
### *Safety*

Special considerations regarding offender-client and staff safety are necessary depending on the treatment setting (outpatient, inpatient, or custodial settings). While the focus of sex offender treatment is predominantly focused on community safety, the safety of clients and staff cannot be ignored. In terms of offender safety, clinicians are encouraged to be cognizant of situations or circumstances that endanger the offender which may arise from the community or other clients who may act out toward the offender in harmful ways.

Clinician safety is also important. Gately and Stabb's (2005) study indicated that simple safety issues are not adequately discussed in psychology training programs, which suggests that clinicians may underestimate safety concerns. In 2004 the Occupational Safety and Health Administration (OSHA) created measures for the healthcare and social service industries intended to eliminate or reduce worker exposure to conditions that could lead to death or injury from violence. OSHA offers guidelines for workplace safety that include management commitment and employee involvement, workplace analysis, hazard prevention and control, and safety and health training. Sexual offender therapists are encouraged to familiarize themselves with guidelines, and seek ongoing consultation regarding treatment setting safety. In addition, violence risk assessments are encouraged for all clients.

## Understanding Collaborative Partnerships

Sexual offender therapists should be familiar with the roles of other members of the Containment Team. Below is a basic description of the role of the supervising agency (e.g., parole/probation) and the polygraphist. It is the therapist's responsibility to remain aware of current literature in regard to each member's role on the Containment Team. It is also important to understand the role that stakeholders have in relation to the offender. The model below illustrates the different relationships that stake holders have with sex offenders.



### Supervising Authority

As outlined by the Center for Sex Offender Management (CSOM), collaborative efforts between supervision and treatment are crucial in the effective management of a sexual offender. Following are important facets to consider in the collaborative effort. The cornerstone of the management practice is included below:

- Shared, consistent philosophy, and strategy (the Containment Model)
- Primary concern for victim safety and recovery
- Prevention of future victimization
- Accountability of sex offenders for their actions
- Understanding that some offenders can be managed safely and some cannot

The supervision agent or officer is a member of the multidisciplinary team and often acts as the liaison between the team members. Supervision agents often play a very active role in keeping the team together and

functioning in a collaborative and mutually beneficial way. Regular contact between the team members is strongly essential to successful implementation of the Containment Model.

As the representative of the criminal justice system, the supervision agent is the primary person that oversees the conditions imposed by the court. Supervision agents do this through a range of different types of monitoring and casework and the use of restrictive intermediate sanctions. They ensure that relevant and important information is exchanged between supervision officers, treatment providers, victim advocates, and polygraph examiners. For example, information regarding an offender's use of pornography, dishonesty (e.g., with significant others), inappropriate fantasies, and other problematic behavior is immediately made known to all parties of the containment team. Supervision agents are responsible for making recommendations to the court based on the information provided by treatment providers and polygraph examiners (if available). They also work to ensure the safety of past and potential victims by restricting offenders' activities, responding to inappropriate behavior with appropriate controls, and rewarding progress when appropriate.

In some jurisdictions, supervision agents interact directly with victims, keeping them informed of the case progress, eliciting input, and assisting in the development of a victim safety plan. In other jurisdictions, direct contact with the victim may be handled through another agency, such as a freestanding victim advocacy organization or a staff person located within a prosecutor's or probation/parole office. However, the supervision agent is always responsible for using victim impact information from available sources to accommodate victim concerns in the supervision plan.

#### *The Treatment Provider and Supervision Agent Relationship*

Treatment providers work to create internal controls within the offender. These internal controls work in tandem with the external controls implemented and managed by supervision to ensure victim and community safety. Treatment providers offer information about treatment progress that may affect the supervision plan created by supervision officers. They may modify the treatment plan based on information from supervision agents or polygraph exams and provide valuable insights for supervision agents regarding offender risk and dangerousness.

Treatment providers may also help other members of the supervision team understand the offense so the overall supervision can better protect victims and potential victims. Treatment providers help sex offenders to develop coping skills regarding the constraints of supervision and to learn how to handle stress and anger appropriately. They teach offenders self-management approaches, such as relapse prevention, that help them understand and recognize the triggers that are precursors to offending behavior. They also help offenders develop victim empathy (which may lessen the likelihood of re-offense), work with offenders to manage and reduce deviant arousal patterns, and reward progress toward treatment goals. Treatment providers may also help educate family members and other associates of the offender about sex offender behavior.

Treatment providers always obtain signed authorization from the offender to exchange information about the offender. The ability to communicate is crucial to reducing recidivism and treatment success. In addition, treatment providers provide supervision agents with a written report that includes attendance, goals, progress, and risk factors relevant to a specific offender; these reports are provided to the supervising agent no less than once every 90 days.

## Polygraph and Polygraphist

One important component of the Containment Model is sexual offender specific polygraph testing. The value of polygraph examinations as a major component of quality sex offender-specific assessment, treatment, and management cannot be underestimated. CCOSO strongly encourages sexual offender treatment providers to understand and utilize the three most common kinds of polygraph exams: (1) Sexual History, (2) Instant Offense, and (3) Maintenance. It is incumbent upon qualified sexual offender treatment providers to seek education on these exams and communicate regularly with a qualified polygraph examiner. Sexual Offender Polygraph examiners are certified in Post-Conviction Sex Offender Testing (PCSOT).

*Note: Before utilizing polygraph in a treatment setting, therapists should be aware of mandated child and elder abuse reporting laws. Most polygraphists are not mandated reporters but therapists are mandated by law to report unreported instances of child and elder abuse. In addition, offender-clients should be fully informed of purpose and goals of the polygraph and therapists' obligation to report previously unreported child and elder abuse.*

Although an exhaustive explanation of polygraph testing is not provided in this document, it is worth explaining that polygraph results are not *intended* to aid in the prosecution of new sexual crimes that were possibly committed by offenders. Rather, the purposes of this instrument with regard to “*Instant Offense*” and “*Sexual History*” exams are to assist in determining the appropriateness of sex offender-specific treatment for denying offender-examinees, to effectively counter a denying an offender’s resistance to treatment, to promote disclosures of information, and to shed light on an offender’s sexual history. (The information that emerges from a “*Sexual History*” polygraph exam may also be relevant to a risk assessment.)

1) An “*Instant Offense*” exam is often conducted as a component of an initial psychosexual evaluation of examinees who deny responsibility for their sexual conviction(s), seeing that such denial may act as a barrier to treatment success. The Instant Offense (IO) exam is an event-specific polygraph for examinees who deny any or all important aspects of the allegations pertaining to their present sex offense crime(s) of conviction. Exams in which deception is indicated *do not necessarily* result in the offender-examinee’s termination from, or lack of admission into, the program. Rather, the results indicate that these offenders may require specialized interventions.

2) “*Sexual History*” polygraph exams are possibly the most significant type of polygraph. These exams are typically completed within the first six months of treatment, after a basic level of rapport has been established between the offender-examinee and therapist, but early enough so that important data can be integrated into the diagnosis and the treatment plan. There are two basic types of “*Sexual History*” polygraphs examinations used to investigate the offender’s history of involvement in unknown or unreported offenses, other types of sexual compulsivity, sexual pre-occupation, or sexual deviancy behaviors. The result of the examination is shared with professional members of the supervision and treatment team.

When an offender-examinee obtains deceptive results on this kind of polygraph exam, he/she is at a therapeutic crossroads: if he/she chooses to make new admissions related to the test questions, his/her treatment may proceed from there, regardless of whether or not the newly disclosed information significantly alters the treatment plan.

3) “*Maintenance*” polygraph exams are used to ensure an offender-examinee’s compliance with his/ her supervision conditions and verify his/ her lack of reoffending. “*Maintenance*” polygraph exams are relevant to an offender’s stability of functioning and any changes in dynamic risk factors as determined by compliance or non-compliance with the terms and conditions of his/ her supervision and treatment (e.g. contact with children, etc). “*Maintenance*” polygraph exams should emphasize the development or verification of information that would assist in the detection of an increasing threat to the community or to potential victims.

## **Community Support**

### *Chaperone*

In some cases, an offender’s family member or community support person (a friend, employer, co-worker, etc.) may cooperate with the containment team as a chaperone. A chaperone is someone who provides support and structure to an offender living in the community. The chaperone is typically approved by a supervising officer (e.g., probation or parole agent) and is fully aware of the offender’s background and offense history. The chaperone is also aware of risk factors that may proceed or contribute to sexually abusive behavior, particularly factors specific to that particular offender. The therapist may be called upon to provide education to the chaperone regarding the dynamics of sexual offending behavior as well as how to recognize and respond to the signs of relapse behavior. Qualified therapists may train/educate chaperones to understand risk factors and triggers, grooming practices, offense cycles, beliefs, and thinking patterns that often precede an offense and the victimology related to a particular offender.

### *Circles of Support and Accountability*

Circles of Support and Accountability (COSA) are a community based reentry programs that assists sexual offenders to re-integrate into society. Each circle comprises of 4 to 6 trained community members who form a “circle of support and accountability” around the offender. The group, or circle, meets regularly to provide emotional, practical, and spiritual support to the offender while at the same time holding the offender accountable for safe behavior. The primary goal of COSA is “no more victims”.

## **Conclusion**

These guidelines are intended to provide standards and guidelines for effective and responsible sexual offender treatment. While recognizing that sexual offender therapists are part of a systemic approach to the management and containment of sexual offenders intending to reduce the threat of re-offense, sexual offender therapists must also remain cognizant that the offenders are psychotherapy clients in need of nurturance, insight, and sustainable prosocial change. To this end, sexual offender therapists must be astute in remaining aware of current trends and empirically-tested effective practices. As highlighted in this paper, much remains to be achieved in the development of successful interventions. The goal is to improve psychotherapeutic interventions, while at the same time work within a collaborative system that facilitates healthy personal change and promotes public safety.



## Appendix A

The following is a list of studies on the efficacy of the Containment Model, summarized from the 2006 Office of Research and Statistics Report, Crime and Justice in Colorado<sup>46</sup>:

- A 2004 study of 130 sex offenders, mostly high-risk, found that during the first 15 months of community supervision, 41% of high risk behaviors were disclosed during polygraph, treatment, and probation officer detection. The study concluded that the close monitoring element of the Containment Model resulted in obtaining information that would otherwise remain unknown.
- A 2003 study on the effectiveness of the Colorado Department of Corrections Sex Offender Treatment Program found that 84% of the offenders who received full Containment Model services (inpatient treatment, inpatient polygraph, outpatient supervision, parole, outpatient polygraph) successfully completed parole, compared to only 52% of the sex offenders paroled without having participating in similar services. Thus the Containment Model approach, when implemented at the inpatient and outpatients levels, maximally enhances a reduction in recidivism.
- A 2001 study of the Jackson County Probation and Parole Program found that offenders who stayed in treatment with polygraph testing and specialized supervision for at least one year were less likely than the comparison group to be convicted of a new felony.

The Containment Model has been adopted by the California Sex Offender Management Board (CSOMB), and is implemented in many local communities across the state of California. It is also endorsed by the Association for the Treatment of Sexual Abusers (ATSA) and the Center on Sexual Offender Management (CSOM). In addition, this model is identified as vital to public safety and essential to externally motivating change in sexual offenders, according to the Best Practices and Guidelines for Sexual Offender Treatment by the California Coalition on Sexual Offending (CCOSO). For further information on the Containment Model, see the position paper by the California Coalition on Sexual Offending ([www.ccoso.org/papers/containment.html](http://www.ccoso.org/papers/containment.html)).

Appendix B  
**Summary Points**  
Guidelines and Best Practices:  
*Adult Male Sexual Offender Treatment*

1. Ending sexual abuse will involve a multisystem approach that integrates Primary, Secondary, and Tertiary Prevention interventions. Most of the interventions employed by sexual offender treatment providers are *tertiary strategies* which aim at preventing re-offense in known offenders.
2. The form of systemic tertiary prevention recommended by the CCOSO is the Containment Model which is an interdisciplinary strategy to manage sexual offenders. This strategy combines elements of treatment, supervision, monitoring, and risk management. The premise of the Containment Model is that the likelihood of re-offense is reduced when well planned mechanisms are in place that support full and productive participation of offenders in community life while holding them accountable for the harm they have created and choices they make.
3. The Comprehensive Approach recognizes the complex nature of sex offending and the need for key system stakeholders to facilitate accountability, rehabilitation, and victim and community safety throughout all phases of the justice system. The Comprehensive Approach reaches beyond the primary focus on the treatment–supervision–polygraph triad, and expands to a strategy that includes a broader sphere of partnerships and influence.
4. CCOSO acknowledges that ongoing therapy of sexual offenders is often necessary to foster internal motivation for non re-offense and maintenance of treatment gains after the intense supervision component of the Containment strategy ends.
5. CCOSO acknowledges that sexual offender therapy is fundamentally different from traditional therapy in that the primary directive of sexual offender treatment providers is to enhance community safety by preventing sexual offender clients from creating further victims.
6. Sexual offender therapists work to limit an offender’s likelihood of engaging in harmful and self-defeating behaviors.
7. Sexual Offender Treatment Programs that utilize the Risk, Need, Responsivity Model yield the best results in lowering recidivism.
8. Clinicians always consider a variety of factors in formulating opinions about risk and treatment planning, such factors include sexual deviancy, past behavior, current environment, psychosexual functioning, socialization, and co-occurring mental health issues. No one tool or measure, or unstructured clinical judgment should be relied on alone to assess risk.
9. Therapists acknowledge treatment of very high risk sexual offenders requires intensive treatment generally in an inpatient setting.
10. Applying modalities of treatment that best fit each individual client is crucial since a vast majority of sexual offenders will not remain under supervision for life and will need to rely on internal change to maintain abstinence from sexually abusive behavior.
11. Sexual Offender treatment providers should be knowledgeable about current research on treatment efficacy and strive to provide evidence based treatment.
12. All sexual offenders who live with significant others or those who will imminently be living with significant others should be referred to family therapy.
13. CCOSO supports the attempt to treat post-conviction denying offenders. However, clinicians treating deniers should be aware that simple attendance or even participation does not equate progress or risk reduction. In addition, those denying offenders who “term-out” of treatment should not be considered treatment completers. Treatment completion is determined by reduction in risk of re-offense.
14. Sexual offender therapists understand their role in maintaining public safety, and attend to the needs of offender-clients.
15. Sexual offender therapy is highly specialized and requires special training for those who work with sexually abusive individuals. Therapists performing sexual offender therapy shall be currently licensed in a mental health profession/medical field (i.e. psychiatry, psychology, social work, or marriage and family therapy). Clinicians will adhere to the legal mandates of their licensing agency.
16. Special considerations regarding offender-client and staff safety are necessary depending on the treatment setting (outpatient, inpatient, or custodial settings).
17. Sexual offender therapists should be familiar with the roles of other members of the Containment Team. Below is a basic description of the role of the supervising agency (e.g., parole/probation) and the polygraphist. It is the therapist’s responsibility to remain aware of current literature in regard to each member’s role on the Containment Team.
18. While recognizing that sexual offender therapists are part of a systemic approach to the management and containment of sexual offenders intending to reduce the threat of re-offense, sexual offender therapists must also remain cognizant that the offenders are psychotherapy clients in need of nurturance, insight, and sustainable prosocial change.

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