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Sexual Offender Treatments

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Description of a Sexual Offender

Definition

- A sexual offender is a legal, non-psychological term used to describe an individual who has been convicted by a court of law of a sexual offense, which may include abuse of another individual. These sexual offenses most often include rape, sodomy, and/or sexual abuse.
- Sexual abuse is any unwanted sexual activity, occurring when perpetrators use force, make threats, or take advantage of those unable to offer consent. Most often, victims and perpetrators maintain some level of familiarity with one another (Worling & Langstrom, 2006).

Prevalence

- There are over 636,000 registered sex offenders in this country – approximately one in every 500 Americans (National Center for Missing and Exploited Children, 2008). This figure has more than doubled in the last 10 years (Adams, 2002; Vera Institute of Justice, 2008).

Resources:

Center for Sexual Offender Management: A Project of the U.S. Department of Justice, Office of Justice Programs - http://www.csom.org/index.html

Vera Institute of Justice – Treatment and Reentry Practices for Sex Offenders: An Overview of States http://www.csom.org/pubs/Treatment%20and%20Reentry%20for%20SO%20an%20overview%20of%20states.PDF

IDENTIFICATION/ASSESSMENT STRATEGIES

Researchers have identified various risk factors related to sexual offending in adults. Jespersen, Lalumiere and Seto (2009) conducted a meta-analysis and found that a history of sexual abuse was more prevalent among sexual offenders than non-sex offenders. This was also the case in a previous study conducted by Kaplan and Green (1995) who discovered that sexual offenders had higher incidents of childhood sexual abuse and higher rates of victimization by family members than the comparison group. The duration of childhood abuse also appears to be a much stronger predictor of sex-offending than the experience of abuse alone (Christopher, Lutz-Zios, & Reinhardt, 2007), in that the greater the number of abuse types an individual experiences, the greater the likelihood he or she will act out through sexually violent behaviors (Hamilton, Falshaw, & Browne, 2002). In addition, many sexual offenders exhibit insufficient assertiveness skills, low self-esteem, and substance abuse (Marshall, 1996); therefore the assessment of psychological adjustment may also be relevant.

Researchers have also identified factors related to recidivism. These include deviant sexual arousal, interest and preference; sexual preoccupation; pervasive anger; self-regulation difficulties; emotional management issues; antisocial personality; cognitive distortions highlighting pro-offending attitudes; and difficulties with intimacy (CSOM, 2006; Hanson & Bussiere, 1998; Hanson & Harris, 2000; Hanson & Morton-Bourgon, 2004). Individuals who deny issues and resist change are more likely to reoffend than those who show remorse, accept responsibility for their actions, comply with treatment, and demonstrate motivation to change (Hanson & Bussiere, 1998). Decreasing recidivism is one of the central goals in sex offender treatment (CSOM, 2006). Enhancing offenders' empathy for victims is a common element of sexual offender treatment, but its effectiveness in actually reducing recidivism is hotly debated (CSOM, 2006).

Moreover, associations have been found between recidivism and juvenile sexual offenders. Similar to adults, deviant sexual interests, antisocial values and behaviors, and cognitive distortions were related to reoffending (Hunter, Figueredo, Malamuth & Becker, 2003; Longo & Prescott, 2006; Worling & Langstrom, 2006). In addition, problematic parent-child relationships, social isolation and low social self-esteem, impulsivity, and treatment non-completion were also linked to recidivism in adolescents (Hunter et al., 2003; Longo & Prescott, 2006; Worling & Langstrom, 2006).

It is important to note that these findings are identified relationships between risk factors and offending or recidivism, and not necessarily causal in nature. Furthermore, while some sexual offenders engage in a fixed, chronic pattern of wrongful behavior (Abel, Becker, Cunningham-Rathner, Rouleau, & Murphy, 1987), some offenders' abuse patterns are intermittent (Kennedy & Grubin, 1992; Langevin, 1988). Therefore, continual formal and informal assessments are vital to avoid making inaccurate assumptions about the sexual offender.

Resource:
Center for Sexual Offender Management: A Project of the U.S. Department of Justice, Office of Justice Programs – Training Curriculum - http://www.csom.org/train/index.html

What follows are several instruments which may be helpful in assessing sex offenders.

Sexual Violence Risk-20 (SVR-20; Boer, Hart, Kropp, & Webster, 1997). The SVR-20 is a 20-item assessment designed to identify individuals who are at risk of committing an act of sexual violence, and to rate the likelihood they will offend in the future. The SVR-20 delineates 20 factors associated with sexual violence, which are placed into three categories: Psychosocial Adjustment (11 items), Sexual Offenses (7 items), and Future Plans (2 items). The Psychosocial Adjustment and Sexual Offense categories are predominantly comprised of relatively stable factors, including being a victim of child abuse, having a history of weapon use, and making death threats in sex offenses. These categories also assess attitudes that condone or encourage sexual offending. The Future Plans category examines past and current risk factors associated with offending.

Cost: $199.95 (https://shop.psych.acer.edu.au/acer-shop/group/SVR)
Administered by: A masters' level clinician with training and education in testing and psychometrics

Multiphasic Sex Inventory II (MSI II; Nichols & Molinder, 2005). The MSI II is a 560-item self-report questionnaire that was created to assess a range of psychosexual characteristics. It is comprised of 13 indices (Sex Knowledge/Beliefs, Obscene Call, Pornography, Fetishism, Bondage/Discipline, Sado-Masochism, Physiological Dysfunction, Impotence, Premature Ejaculation, Gender Identity, Body Image, Substance Abuse, and Treatment Attitude) and 17 scales (Social Sexual Desirability, Sex Obsessions, Lie, Child Molest, Rape, Exhibitionism, Voyeurism, Sexual Inadequacies, Hypercritical Sexuality, Sexual Repression, Emotional Neediness, Cognitive Distortion/Immaturity, Conduct Disorder, Sociopathy, Scheming, Superoptimism, Manipulation Awareness). For each statement, respondents endorse "True," "False," or "Not Applicable." The MSI II is based on a 'cognitive-emotional-behavioral' model of sexual deviance generated by the authors and the instrument attempts to capture the theoretical constructs related to sexual motivation, sexual socialization, and deviant arousal. Nichols and Molinder (2005) hypothesized three levels in the behavioral sequence of any sexual offence: deviant arousal, pre-assault behavior, and sexual assault.

Cost: $350.00 (http://www.nicholsandmolinder.com/sex-offender-assessment-order-msi.pdf)
Administered by: A masters' level clinician with training and education in testing, testing ethics, and measurements

Psychopathy Checklist Revised: 2nd Edition (PCL-R; Hare, 2003). The PCL-R is one of the most widely used measures of psychopathy. It is a 20-item instrument which draws on information from a semi-structured interview and collateral data. PCL-R (Hare, 2003) is commonly used to identify a criminal offender's risk of sexual violence and courts often accept its use as support for such risk (DeMatteo & Edens, 2006). Empirically, however, the association between the PCL-R and sexual offending is modest. Utilizing 13 studies, Hanson and Morton-Bourgon (2005) reported an effect size of $d = .29$ for the correlation between sexual recidivism and the PCL-R total scores. Nonetheless, other studies have reported larger effect sizes ($d = .59$; Firestone et al., 1999; $d = .86$; Hanson & Harris, 2000). Despite the variability in reported effect sizes, the manual states, "the PCL-R has relatively good

predictive validity with respect to sexual offenses, particularly when combined with measures of sexual deviance" (Hare, 2003, p. 154). Meta-analyses have shown that Facet 4 (antisocial behavior) shows greater predictive validity of sexual deviance than any of the other facets (e.g., Walters, Knight, Grann, & Dable, 2008).

Cost: $387.00 (http://www.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.hm?Pid=PAap-clr&Mode=summary)

Administer by: A doctoral level clinician in psychology or related field (e.g., counseling, education) *or* being directly supervised by a psychologist or qualified mental health profession (i.e., this assessment is considered a level C assessment)

INTERVENTION STRATEGIES

In various countries (e.g., USA, Canada, Great Britain, Germany), punishment has been the common response to dealing with sexual offenders (Losel & Schmucke, 2005). Incarceration has been the overwhelming response to sexual offenders, yet with the increasing criminal justice costs, many states have rendered it an ineffective long-term solution (Vera Institute). This reliance on punishment-oriented interventions has had minimal effect on community safety and well being (Andrews & Bonta, 2003; Aos, Miller, & Drake, 2006), considering that many offenders eventually return back to the community (Losel & Schmucker, 2005). Therefore, interventions that maintain a rehabilitative focus generally produce more favorable outcomes (Aos et al., 2006), determining and applying effective treatment modalities is essential (Losel & Schmucker, 2005).

Most treatment programs, for both juveniles and adults, utilize components of cognitive-behavioral and relapse-prevention models (McGrath, Cumming, & Burchard, 2003). Within these programs, there are several broad goals, including managing risk factors, addressing denial, and developing empathy and prosocial skills (CSOM, 2006). In addition, assessments are used to identify needs and risks, specific to each individual (CSOM, 2006). Hanson (2006) established that the findings concerning general criminal offenders (i.e., treatment outcomes are more promising when interventions are tailored to specific needs and risks) could be applied to sexual offenders as well.

In the treatment of sex offenders, it is important to avoid simply defining individuals in terms of their sexually abusive behaviors, instead opting for a more holistic view that considers psychiatric, health, vocational or educational, family, and peer concerns as well (CSOM, 2006). Traditional approaches tend to focus on deficits, and such a problematic-approach may impair motivation, engagement, investment in the process of change, and the overall effect of the intervention (Thakker, Ward, & Tidmarsh, 2006).

In a meta-analysis conducted by Losel and Schmucker (2005), only cognitive-behavioral and classic behavioral modalities produced significant effects on sexual reoffending. The effect size in voluntary participation was significantly higher than in those mandated to treatment. Additionally, individuals who completed intervention programs had considerably lower rates of recidivism than those who did not. Sexual offenders who dropped out of programs demonstrated higher rates of re-offense than the control group, doubling the likelihood that they would relapse.

Behavioral Treatments

Sexual arousal retraining, or a form of classical conditioning, has been a standard treatment procedure for use with sexual offenders for decades. Initially pioneered by Freund (1965), this technique utilizes a penile plethysmograph. A penile plethysmograph evaluates the penile tumescence while the individual is viewing appropriate and inappropriate sexual arousal stimuli (i.e., nude children pictures, masochistic photos, benign nude adults photos, neutral pictures). Reactions are measured with the aim of reducing inappropriate arousal while maintaining or increasing appropriate arousal (Correia, 2001).

However, there are several issues with this approach. First, erections can be produced or inhibited under conscious control. Therefore, favorable results may not be due to the treatment itself. The second issue involves generalizability. There is no guarantee that the results from a laboratory will transfer into real-life settings. Lastly, this modality assumes a connection between arousal and offending behaviors (Correia, 2001), which is a bold and not necessarily accurate assumption.

Cognitive Interventions

Relapse Prevention Model. Since its establishment in the 1970s, relapse prevention (RP) has become a core model in the treatment of a range of disorders and issues (Thakker & Ward, 2010). It was first developed as drug and alcohol post-treatment care, and is now utilized for various problems, including sexual offending (Laws, Hudson, & Ward, 2000; Witkiewitz & Marlatt, 2004). The model proposed by Marlatt (1985) is founded on cognitive-behavioral principles, such that thoughts and behaviors are assumed to impact the development and maintenance of problems. Relapse Prevention involves the exploration and untangling of thoughts and actions that may promote relapse, as well as the development of strategies to prevent setbacks. Therefore, key tenets are risk avoidance (Larimer, Palmer, & Marlett, 1999) and development of appropriate coping skills when managing high-risk situations (Larimer et al., 1999; Rawson, Obert, McCann, & Marinelli-Casey, 1993). Relapse Prevention treatment also includes psychoeducational interventions, modification of lifestyle behaviors, and development of positive self-efficacy (Rawson et al., 1993). Despite its focus on avoiding relapse and managing high-risk situations, the modality focuses on eliciting strengths and assets (Thakker & Ward, 2010).

Self-Regulation and Pathways Model. Ward and Hudson (1998) created a multiple pathway model that takes into account biological, cultural, environmental, and other underlying factors resulting in sexual abuse towards children. Each pathway is defined by the individuals' goal (avoidance or approach) and strategy (passive or active) in engaging in deviant sexual behavior. The avoidant-passive pathway is marked by underregulation, in that the individual maintains a desire to avoid sexual offending but lacks the appropriate skills to stop it. The avoidant-active route is evidenced by misregulation, such that the individual attempts to prevent deviant fantasies but employs ineffective tactics. The approach-automatic pathway is demonstrated by underregulation, in that the individual continues utilizing overlearned sexual scripts and poorly planned behavior. Lastly, the approach-explicit path is marked by effective regulation, and the individual maintains a harmful goal to offend and uses methodical planning to perform the offense.

A thorough understanding of the behaviors and pathways of a sexual offender, rather than assuming each follow a similar trajectory, may allow for more tailored and effective treatment interventions. Bickely and Beech (2002) proposed various objectives depending on the pathway of the offender. For example, a focus on embedded beliefs about sexual contact with children and attention to the harm imposed might be most beneficial for offenders with approach goals. Conversely, a greater emphasis on developing more appropriate strategies to manage threats to restraint goals, rather than attempting to counter distorted thoughts and beliefs, might be most useful for offenders with avoidant goals. In addressing self-regulation goals, such as underregulation and misregulation, Bickley and Beech (2002) recommended that attention be given to taking responsibility and developing a more internal locus of control, increasing self-efficacy in beliefs about being able to manage high-risk circumstances, and developing more helpful coping strategies.

Motivational Interviewing

Sexual offenders' motivation to change their behavior may be related to recidivism (Hanson & Bussiere, 1998). Those who are able to take responsibility for actions, feel remorse for their victims, and engage in treatment should maintain a lower risk for reoffending than those who deny problems and are resistant to change (Hanson & Bussiere, 1998). Motivational Interviewing (MI; Miller & Rollnick, 2002) has become an increasingly common modality in work with sexual offenders (Ginsburg, Mann, Rotgers, & Weekes, 2002). MI posits that the nature of interaction with clients should be determined by the client's motivation and readiness for change. Rather than using confrontation, counselors are encouraged to invite individuals to take responsibility for their actions as a way to develop an internal locus of control and motivation which can ultimately reduce resistance and foster engagement in the process (Jenkins, 2006).

Such positive treatment goals and strategies enhance motivation and represents a more positive approach to treatment with sex offenders (Ward & Stewart, 2003) which is vital because research demonstrates that those adolescents and adults who are engaged and complete treatment are less likely to reoffend than those who do not (Worling & Langtstrom, 2006). Nonetheless, it is important to note that motivation is difficult to assess because appearing motivated and willing to change may provide benefits, and sexual offenders generally have the necessary skills to gain the assurance of supportive clinicians (Hanson & Bussiere, 1998).

TREATMENT MODELS FOR SEX OFFENDING YOUTH

Researchers have proposed that the value of commonly used interventions, such as cognitive-behavioral therapy, individual and family therapy, relapse prevention, and psychoeducational interventions, for adult sex offenders can be extended to adolescents with minimal modifications (Worling & Curwen, 2000). Cognitive-behavioral (CBT) modalities generally involve confronting the offense, developing empathy, understanding one's own experience as a victim, stress and anger management, social skills training, relapse prevention, and attention to substance abuse issues (Kolko, Noel, Thomas, & Torres, 2004). Cognitive-behavioral therapy approaches can also be used to decrease frequency of sexual arousal (Walker, McGovern, Poey, & Otis, 2004). Relapse prevention targets factors that may result in recidivism and attempts to anticipate and manage those (Walker et al., 2004). Psychoeducational approaches tend to focus on knowledge of sexuality, problem-solving skills, empathy training, and moral reasoning (Walker et al., 2004). Interventions using CBT have demonstrated the greatest effect sizes (Walker et al., 2004).

Another promising avenue is the integration of a Multisystemic Therapy (MST) approach, which focuses on community- and family-based interventions (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998) into sex-offender treatment. This method aims to improve functioning within the individual's family, enhance peer relationships, draw upon community resources, and improve academic involvement and performance. Such positive goals are likely to be cost-effective and result in reduced reoffending (Henggeler et al., 1998).

While there are some advantages to group treatment with adolescent sex offenders, the benefits can be comprised if it is the only approach utilized (Worling, 2004). Juveniles who suffer from a mental health disorder or who are emotionally immature may lack the cognitive functioning necessary to comprehend the subjects and concepts being discussed in the group (CSOM, 2006). In addition, sensitive issues may be avoided due to fear of others' reactions or the limited time available (CSOM, 2006). Therefore, individual therapy may be more appropriate for this age group, as topics and skills can be tailored to the individual in a private setting (CSOM, 2006). Family therapy, among other treatments, may be integrated with individual and group formats to optimize positive outcomes in this population (Thomas, 2004; Worling, 2004).

Compared to those who were untreated, adolescents who received cognitive-behavioral treatment in conjunction with family therapy had lower rates of sexual re-offense, as well as for non-sexual violent offense (Worling & Curwen, 2000). MST has also demonstrated favorable outcomes in youth and effects that were superior to individual therapy alone (Borduin, Henggeler, Blaske, & Stein, 1990). Those individuals taking part in MST displayed fewer behavioral problems, improvement in relationships and school performance, and lower rates of recidivism (Borduin & Schaeffer, 2002)

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