Offender Treatment Philosophy, Techniques and Approaches

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According to accumulation of outcome research, one of the most effective approaches to treatment is cognitive-behavioral therapy. The cognitive-behavioral approach has been utilized in the past to decrease the recidivism rates of sexual offenders. This theoretical orientation provides the underlying theory of our program for the treatment of the sexual offender. There is promise that the specific elements of therapy that are effective will be clarified by future research. Therefore, we believe it is important to strive to keep abreast of the literature, to be open to new research, to develop new skills as clinicians, and to strive to insure that what we are doing is having the intended effect by measuring outcome and incorporating the feedback into the treatment plan and therapy. We attempt to keep up to date through using the latest references, reviewing journal articles, and attending conferences, workshops, and special training on offender assessment and treatment. We believe that understanding sexual offenders, the distorted thinking patterns, the risks and precautions to take, the technical therapeutic strategies, and not being misled by the offender's suave rationalizations requires specialized skills and training. All interaction with clients should be carried out according to high professional standards and ethics (according to APA ethical principles and professional standards as well as ATSA ethical principles). We try to conduct research and program evaluation to validate the therapy and insure that all clients are making progress.

A strong therapeutic respectful relationship is important but offender therapy is more confrontive, closely monitored, focused, directive, and structured than even regular cognitive-behavioral therapy. Offenders are held to stringent rules, and if broken, there are financial and possibly probationary consequences. Of course, offenders come with other problems than just the offending such as major depression, suicidal attempts, anger control problems, poor communication and conflict resolution skills, and dysfunctional thoughts that interfere with their developing healthy, productive, happy lives. Each of these problems need to be addressed and both cognitive and behavioral approaches are used to help clients learn how to effectively manage their emotions and their lives.

Treatment Steps. Both offender assessment and treatment are empirically based.

1. **Assessment.** -provide a very thorough assessment to determine whether or not he/she is appropriate for our therapy and our program:

    a. an initial interview covering demographic data, family psychiatric history, history of sexual abuse and other traumatic events, work performance, social relationships with peers, children, and adults; and current behavioral symptoms.

    b. Standardized measures are given such as: Structured Interview looking at variables that have been found in research to relate to treatability and risk assessment, Lazarus' Multimodal Questionnaire, Minnesota Multiphasic Personality Inventory-II, Abel & Becker Cognitions Scale, Buss –Durkee Hostility Inventory, Shipley Hartford Institute of Living Scale, Beck Depression Inventory, and The Hare's Psychopathy Checklist, and a structured measure of relapse prevention skills.

2. **Screening Criteria** for acceptance into treatment are:

a. client admits to a sexual offense,

b. is willing to undergo alcohol and drug rehabilitation if needed,

c. has not committed violent physical offenses or other criminal activity,

d. are incest sexual offenders,

e. are not psychotic,

f. do not meet criteria for antisocial personality disorder,

g. are not better treated at other facilities, and

h. they wish to work hard and benefit from treatment.

3. **Treatment Plan.** Individualized treatment goals as well as specific offender related treatment goals are established in a detailed treatment plan.

4. It is determined what **additional resources** are needed to accomplish the plan.

5. **Group Therapy**. The group is our primary mode of treatment so that experienced group members can model appropriate behaviors, share their experiences and means of coping and handling their problems, and exert pressure on each other to comply to treatment and utilization of therapeutic techniques. We keep our group small from three to ten offenders where the group can more readily identify the offender's denial or minimization of the abuse and powerfully confront yet support the offender. The group focuses on confrontation, acceptance of responsibility, decreasing deviant arousal, covert sensitization, victim empathy, cognitive restructuring, anger management, role playing, relapse prevention, adult intimate relationship enhancement, and victim, family and society restitution. Weekly homework is required working through very structured and psychoeducational workbooks.

6. Course of treatment:

a. **The initial sessions** help the offender understand the treatment program and their role and responsibilities in treatment to set them up for success in the group.

b. **Disclosure.** In order to begin to learn to control the abusive behaviors, the offender needs to not be in denial and be motivated to work. So the first step is disclosure of the offense to the group. Most offenders are initially unwilling to disclose full details of their sexual offending behaviors because of shame, guilt, fear of going to jail, and/or humiliation. These are quite normal reactions to facing up to a serious wrongdoing. Part of the need for full and honest disclosure is to begin to identify what the situation was, what led up to the abuse (including the thoughts, fantasies, justifications, rationales, feelings), and what were the consequences.

c. **Confrontation.** Offenders need to develop the ability to give and receive feedback to and from the other group members and the therapists. This is difficult to learn as it may be the first time in their life

that they have heard honest and empathic information about their personal characteristics and behaviors. If the offenders resist disclosure or feedback or try to get out of complying with the group rules, they are confronted directly, put on the "hot seat" and made to think about and face their responsibilities. Confrontation is done in a kind, respectful way not in a humiliating or aggressive "drill sergeant" manner.

d. **Emotional Control.** Often offenders initially come into treatment with intense feelings generated by being caught and losing job, family, intimate relationships, and friends (depression, intense anger), and alcohol or drug problems. The offender needs to learn how to control these emotions and problems before the offender can deal effectively with the sexual offending.

e. **Skill training** is provided as needed:
   - impulse control skills
   - assertiveness and anger management training
   - problem solving and conflict resolution
   - anxiety reduction techniques
   - depression coping skills
   - communication skills

f. Relapse prevention training.

What causes child sexual abuse? We teach that abusive sexual behavior patterns are learned. Most offenders don't look like they have a disorder, having few problems other than molesting. Research indicates offenders can come from any class, level of income, occupation, personality, and race. The abuse is not caused by a disease but multiply determined by:

- situational antecedent influences
- biological influences including alcohol and drug disinhibitors, cognitive capacities
- beliefs, attitudes, and cognitive expectations
- behaviors learned in the past and present skills
- emotional conditioning and arousal patterns
- current reinforcement contingencies (both rewards and punishments are present in the abuser's environment that maintain the abusive behavior).

The goal of treatment is to help the offender analyze all of these factors and implement techniques and skills to change all of these factors so they will set themselves up for success. Sexual behaviors lie on a continuum: from non problematic expression (hugging, kissing a child) to abusive or problematic expression (sexually molesting children). Therefore, the same principles can be used to understand how non abusive as well as abusive behaviors are acquired and maintained. Abusive sexual behaviors are maladaptive responses for coping with life stressors and dissatisfactions or for gaining pleasure, and that means more adaptive coping or pleasurable responses are not used.

Since there are multiple causes starting early in childhood, and the sexual abusive behavior may be similar to a long ingrained habit, treatment needs to be comprehensive and long term. The goal is to help the sex offenders learn how to control their behavior using specific techniques for the rest of their life. Emphasis is on self-management including asking for and seeking help. Clients are not responsible for problem etiology but for problem solutions. Therefore, active client collaboration, involvement, and hard work is required.

The Relapse Prevention Model is taught so that the offender can identify the sequence or chain of events which comes before a typical offense (e.g. first having a deviant sexual thought or urge, then choosing to engage in deviant fantasizing, masturbating while further fantasizing, planning an offense, engaging in rationalizing and justifying the deviant behavior, choosing to put oneself in a sexually stimulating high risk situation, and finally re-offending). . A sexual abuse relapse is defined as a single occurrence of a sexual offense. A lapse is defined as a single instance of violating a self-imposed rule of putting oneself in a high risk situation that might lead to a re-offense such as willfully and elaborately fantasizing about sexual offending. If lapses which lead up to relapses are prevented, relapses are less likely. Certain situations are more likely to lead to a relapse. For example, being around children in close physical contact, masturbation and exposure to child pornography, deliberately fantasizing about children, planning an offense, being depressed, lonely, angry or bored, needing excitement, getting into an argument with others, being under job stress, or using substances which reduce inhibitions would be **high risk situations**. The offender is taught to search out and identify their own high risk situations and actions, develop a plan and 'personal rules' to avoid them, and know how to escape or cope with the high risk situation if they find themselves in the midst of one. Daily monitoring of their own thoughts, sexual arousal, sexual fantasies, negative emotions, high risk situations, and coping or escape responses is a way to make their understanding related to their real life and practice and correct their use of the control techniques. Specific maintenance of change strategies needs to be learned and implemented in order to prevent relapse.

g. **Cognitive therapy** or working to change offenders' distorted attitudes and thoughts that tend to justify or rationalize their abusive behavior is an important part of treatment. They are taught to identify their own thoughts that cause them and others' distress, and dispute and challenge these thoughts. Readings, homework assignments, role playing, and group discussion help offenders change their thinking.

    1) **Victim empathy training**, perspective taking is included. They usually have little empathetic feelings toward the child. In the beginning offenders may not have any idea what impact their behavior had on the child or their spouse, or other family members, how they betrayed their trust, and hurt and manipulated the child.

    2) Frequently they have misconceptions about their own **sexuality,** sexual and parental role, and sexual functioning.

    3) **Values and philosophy of life**, getting involved in making themselves a better person, and arranging a satisfying and meaningful lifestyle are a focus.

    4) **Restitution.** Making amends to the victim, all family members, and giving back to their community is an ultimate goal.

h. **Behavioral techniques** such as thought stopping and covert sensitization (using aversive imagery following deviant arousal to teach more appropriate responding) are utilized to change deviant arousal, while sexual communication assignments are used to enhance responding in appropriate adult relationships. Arousal control techniques do not do away with sexual arousal, but try to control and redirect sexual arousal.

i. **Biological interventions** such as medications to alleviate negative emotional states and to decrease male sexual arousal, e.g. hormonal agents (Depo-Provera-nonspecific reductions in sexual arousal) will certainly be explained and considered and the client referred to appropriate consultation, if needed.

j. **Reunification.** Most of our offenders have families with whom they wish to reunite and are very motivated. Communication, visitation and reunification with the family is only considered if offenders have control over their deviant arousal, progress in treatment is made, safeguards are set up, the court allows it, and the child as well as the non offending parent are willing and ready. Couples, individual, and family therapy is provided as needed when all are ready and willing to begin the gradual process of reunification…usually over 1-2 years. We do treat the whole family if they are appropriate and willing. A strict, closely supervised and graduated plan for visitation and reunification are agreed upon by all parties beforehand.

k. **Improving appropriate adult sexual and primary relationships.** If reunification is considered or new relationships, couples or partner therapy is essential to focus on improving their sexual and intimate relationship and together instituting house rules to avoid the antecedents to sexual deviance and plan consequences if these rules are violated.

l. **Involving outside support systems** in monitoring and assisting with treatment. The team is committed to full cooperation and collaboration with probation officers and polygraphers. Methods of documenting and reporting treatment progress (as well as violations of rules) to authorities are specified. Progress in treatment is based on specific, measurable objectives. Offenders must show understanding of their deviant behavior and empathy for their victim, make measurable behavior changes, demonstrate their ability to apply the learned techniques and skills in their daily life, and seek help and support when needed. If no progress is made, if compliance to treatment rules are violated, or if children are at risk, it is our ethical duty to inform relevant judicial and protective service authorities and to refer the offender to more extensive treatment. Full progress reports are provided monthly to probation. Criminal investigation, prosecution, and the judge's court orders for treatment and rules for probation are important parts of effective treatment. Without this external pressure, many offenders will not pay for, do the work needed, and stay in long term treatment. However, we also have volunteer clients who have elected to fully participate and stay in treatment for several years. Coordination with correction officers, child protection workers, and family and victim therapists are essential.

Success of each client depends on their ability and willingness to fully disclose deviant and criminal history, learn and try new procedures and skills, bring up issues in the group therapy, and work hard to overcome the deviance and the particular problems they have. We try to encourage this and work on motivation and excellence. Therapy for victims, siblings, and non-offending parents as well as offenders increases everyone's knowledge of sexual abuse, deals with the emotional trauma of sexual abuse, and how to prevent the reoccurrence of sexual abuse and thereby increases the likelihood that the children will be protected and not re-experience abuse in the future.

Why do parents come to sexually abuse their children?

A developmental process: people learn to become sexually abusive

Factors which increase likelihood	Factors which decrease likelihood
1. Society's exploitation and heightening of sexual arousal; Violent/child Pornography Some are raised to sexualize their emotions, unable to be close in a non sexual way.	1. Parent classes/books which encourage understanding of child needs, adults own sexuality, child sex and child rights.education; Teach full range of emotions, intimacy
2. Child considered "possession" anything can be done to them; child is parents' property	2. Understanding of children as persons. Children's rights.
3. Women viewed as inferior Dependency of women, parent childhood sexual abuse	3. Men and women seen as having equal rights and individual competencies
4. Distress, stressful life events Unemployed, low SES; single parent Drug/alcohol problems, health Reduced tolerance of stress	4. Socio-economic stability Life skill training; job training Financial management supportive spouse/social network
5. Poor management of acute crises; lack of power Poor conflict resolution, communication, marital dissatisfaction	5. Coping strategies training Problem solving training Community resources; Crisis lines Homemaker, family support services
6. Social isolation (U.S. attitudes towards privacy) Single parents, working mothers; Time alone with child . Opportunity to take advantage of child. Child is needy.	6. Neighborhood "community" Church/school involvement Adequate workplace childcare. Screening of child care personnel
7. Misattribution of sexual needs and seeing child as seductive; Child's ignorance of rights, sexual practices, "secrecy," inability of adults to discuss sex with children	7. Knowledge of child development stages Education of child in sex and sexual abuse, ways to protect themselves, assertiveness training
8. Society's encouragement of alcohol & drug use; Drug/alcohol problems	8. Drug/Alcohol Education. Encourage positive outlets for creative energies
9. Glorification of youth by society	9. Acceptance of self, aging, spouse Respect for truth, wisdom, experience.
10. Overconcern with touching, Inappropriate child expectations	10. Teaching parents how to play, have fun with their children, be intimate, yet non sexual.

CHILD SEXUAL OFFENDER BIBLIOGRAPHY

Due to the serious nature of the offenses committed and the high potential for re-abuse, it is extremely important that professionals engage in specialized training for this population. These books give a good overall introduction to the topic of Child Sexual Offender Treatment. Those * indicate I find particularly comprehensive, sound basis in research, proper attitudes toward offenders, or effective in designing treatment for offenders.

*Association for the Treatment of Sexual Abusers, Hensen, S.H. (Ed.). (1993). *The ATSA Practitioner's Handbook.* The Association for the Treatment of Sexual Abusers, P.O. Box 866, Lake Oswego, OR, 97034-0140, (503) 238-0210.

Bays, L. & Freeman-Longo, R. (1989). *Why did I do it again? Understanding my cycle of problem behaviors.* S.O.S. Series Number Two. Orwell, VT: The Safer Society Press.

Bays, L., Freeman-Longo, R., & Hildebran, D.D. (1990). *How Can I stop? Breaking my deviant cycle.* S.O.S. Series Number Three. Orwell, VT: The Safer Society Press.

Bolton, F. G., Morris, L.A., and MacEachron, A.E. (19). *Males at risk, The other side of child sexual abuse.* Newbury Park, CA: Sage Publications.

Coleman, E., Dwyer, S.M., & Pallone, N.J. (1996). *Sex Offender Treatment, Biological dysfunction, intrapsychic conflict, interpersonal violence.* NY: Haworth Press, Inc.

Freeman-Longo, R. & Bays, L. (1988). *Who am I and why am I in treatment?* S.O.S. Series Number One. Orwell, VT: The Safer Society Press.

Freeman-Longo, R., Bays, L. & Bear, Euan. (1996). Empathy & Compassionate Action. Issues & Exercises: A Guided Workbook for Clients in Treatment. S.O.S. Series Number Four. Orwell, VT: The Safer Society Press.

Gonsioreck, J.C., Bera, W.H., & LeTourneau, D. (1994). Male Sexual Abuse, A Trilogy of Intervention Strategies. Thousand Oaks: Sage Publications.

*Greer, J.G. & Stuart, I.R. (Eds.). (1983). *The sexual aggressor: Current perspectives on treatment.* NY: Van Nostrand Reinhold.

Groth, A. N. (1979). *Men who rape: the psychology of the offender.* NY: Plenum Press.

Hotaling, G.T., Finkelhor, D., Kirkpatrick, J.T. & Straus, (1988). *Family Abuse and Its Consequences, New Directions in Research*. Sage Publications.

Horton, A.L., Johnson, B.L., Roundy, L.M., & Williams, D. (Eds). (1990). *The Incest Perpetrator, A family member no one wants to treat.* Newbury Park, CA: Sage Publications.

Ingersoll, S.L. & Patton, S.O.(1990). *Treating Perpetrators of sexual abuse*. Lexington, MA: Lexington Books.

Knopp, F.H. (1984). *Retraining Adult Sex Offenders; Methods and Models*. Orwell, VT: Safer Society Press.

Laws, D.R. (Ed). (1989). *Relapse Prevention with Sex Offenders*. NY: The Guilford Press.

**Laws, D.R., Hudson, S.M., and Ward, T. (Eds.) (2000). *Remaking Relapse Prevention with Sex Offender, A Source Books*. Thousand Oaks, CA: Sage Publications, Inc.

Lew, Mike. (1988). *Victims No Longer: Men Recovering from Incest and Other Sexual Child Abuse*. NY: Harper & Row.

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

Marshall, D.R., Laws, D.R., & Barbaree, H.E. (1990). *Handbook of Sexual assault: Issues, theories, and treatment of the offender*. NY: Plenum Press.

Mayer, A. (1990). *Child Sexual Abuse and The Courts, A Manual for Therapists.* Holmes Beach, FL: Learning Publications, Inc.

*Salter, A.C. (1988). *Treating Child Sex Offenders and Victims, A Practical Guide.* Newbury Park, CA: Sage Publications.

Sgroi, S. M. (1982). *A Handbook of Clinical Intervention in Child Sexual Abuse.* Lexington, Mass: Lexington Books.

**Steen, C. (1993). *The Relapse prevention workbook for youth in treatment.* Orwell, VT: The Safer Society Press.

*Schwartz, B.K. & Celini, H.R. (Eds.) (1995). *The Sex Offender: Corrections, Treatment, and Legal Practice*. Kingston, NJ: Civic Research Institute, Inc.

*Schwartz, B.K. & Cellini, H.R. (1997). The Sex Offender. New Insights, Treatment Innovations and Legal Developments. Kingston, NJ: Civic Sgroi, S. M. (1982). *A Handbook of Clinical Intervention in Child Sexual Abuse.* Lexington, Mass: Lexington Books.

<u>Research, scholarly refereed publications</u> which are helpful

Behavioral Sciences & the Law

Child Abuse and Neglect

Child Maltreatment

Journal of Child Sexual Abuse

Journal of Interpersonal Violence

Journal of Research in Crime and Delinquency

Journal of Trauma

Journal of Traumatic Stress

Sexual Abuse: A Journal of Research and Treatment

Publishers web site:

Safer Society Press.