

Sex Offender Treatment Skills for Corrections Professionals



Section 3 – Treatment

- Module 1: Sex Offender Treatment vs. Traditional Treatment**
- Module 2: Denial, Cognitive Distortion and Empathy**
- Module 3: Stages of Change and Motivational Interviewing**
- Module 4: Social and Emotional Competence**
- Module 5: Sexual Arousal Control**
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- Module 7: Mental Health Issues**
- Module 8: Integrating Polygraph Testing with Treatment**
- Module 9: Relapse Prevention**
- Module 10: Continuity of Care**

SECTION 3 – Treatment

Section Objectives

Participants will be able to identify the following:

- ❑ How sex offender treatment is unique;
- ❑ Core components of effective treatment programs;
- ❑ Types of offender denial and related interventions;
- ❑ Stages of change;
- ❑ Interviewing strategies which elicit cooperation and honesty;
- ❑ Social and emotional competency skills for offenders;
- ❑ Strategies for helping clients control deviant sexual arousal;
- ❑ The relationship between substance abuse and sexual offending;
- ❑ Mental health issues and medical interventions;
- ❑ Value and validity of integrating polygraph testing with treatment;
- ❑ Risk factors and interventions for relapse;
- ❑ Components of effective after-care.

Summary:

This section provides a broad overview on all aspects of treatment for sex offenders.

SECTION 3 – Treatment

**MODULE 1:
Sex Offender Treatment
vs.
Traditional Treatment**

Objectives

- ❑ Identify the latest trends and practices in sex offender assessment and treatment as presented in a national survey.
- ❑ Identify the differences between traditional treatment programs and sex offender treatment programs.
- ❑ Identify elements of the “job description” for a sex offender treatment provider.
- ❑ Identify factors to consider when matching an offender with a therapist.

Summary:

This module provides an overview of national trends in sex offender treatment and focuses on the aspects of sex offender treatment which differ greatly from traditional treatment.

Notes:



Video Presentation:

Trends in State Sex Offender Tre
August 2000

**50-State Survey Conducted by the Colorado
Department of Corrections**

NOTE: Summary document in appendix.

**INTRODUCE VIDEO PRESENTATION
ON 50 STATE PROGRAM SURVEY.**

In January 2000, the Colorado Department of Corrections distributed a 21-page survey of sex offender treatment programs to the 50 states and the District of Columbia. The survey contained 78 questions covering major program elements.

Colorado received survey responses from 43 states and the District of Columbia, including Colorado. In addition to program descriptions and legislation, many states provided related materials such as curriculum, assessment tools, standards of care, and interagency agreements.

**Differences Between
Traditional Treatment and
Sex Offender Treatment**

Providers Must Think Differently

- ❑ Not everyone tells the truth
- ❑ Shame vs. the law
- ❑ Confrontational vs. supportive continuum
- ❑ Traditional tenets of unconditional positive regard and empathy have new meaning
- ❑ Identify treatment goal and outcome

Notes:

Other Components of Correctional Treatment

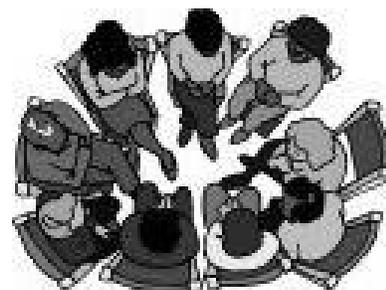
- ❑ Restrictions on visitation
- ❑ Restrictions on reading material
- ❑ Training for correctional staff
- ❑ Education and support groups for family members

Modified Therapeutic Communities

- ❑ Living unit as therapeutic community
- ❑ "Con Code" vs. accepting responsibility
- ❑ Support and model pro-social behavior

Accountability

- ❑ More victims = more charges?
- ❑ Collateral information
- ❑ Do you "fire" offenders?



Notes:

Style/Approach

- ❑ Matching therapist and offender
- ❑ More vs. less criminalized
- ❑ Incest vs. pedophile vs. rapist
- ❑ Heterogeneous vs. homogeneous group
- ❑ Open vs. closed membership

Psychoeducation vs. Process Approach

- ❑ Skills: impulse control, arousal control
emotion regulation, interpersonal
effectiveness etc.
- ❑ Reduce inappropriate behavior
- ❑ Change is stepwise: homework
- ❑ Process focus is on awareness of self and
other
- ❑ Self-understanding, self-acceptance, skill
practice



OFF-AIR Activity: Responses to Non-Cooperative Clients

Time: 1 hour

Purpose of Activity:

This activity highlights the situations therapists will encounter with difficult clients and provides practical application of various strategies for dealing with sex offenders who are non-cooperative in treatment settings.

Directions:

Divide participants into small groups of 3-5. Explain that small groups will role play responses to the following types of clients:

1. Passive / aggressive client
2. Angry client
3. Ultra-shy, non-disclosing, ashamed client

Direct small groups to assign roles of offender, therapist and observer(s) and then role play the three scenarios followed by a debrief from the observers.

Scenario 1:

Offender: Discloses the assault of daughter by being angrily offended –
“Anyone would think ill of me ... I’m not that kind of dad!”

Therapist: Gets offender to disclose.

Observer(s): What did therapist do well?

Scenario 2:

Offender: Arrogant, angry rapist has a history of three violent rapes. Offender refers in derogatory manner to therapist’s gender, race, height, weight, etc.

Therapist: Stops verbal assault and focuses session on treatment outcomes.

Observer(s): What did therapist do well?

Scenario 3:

Offender: Ultra-shy, non-disclosing, man with six male child victims.

Therapist: Have offender disclose particulars of one assault.

Observer(s): What did therapist do well?

SECTION 3 – Treatment

MODULE 2:

Denial, Cognitive Distortion and Empathy

Objectives

Participants will be able to:

- ❑ Identify three types of denial.
- ❑ Identify various categories of cognitive distortions.
- ❑ Discuss reasons why offenders may engage in denial and cognitive distortion.
- ❑ Describe and practice specific interventions to target denial and distortion (content and process).
- ❑ Describe the steps of empathic processing.
- ❑ Identify several interventions to enhance empathy.

Summary:

This module addresses denial and cognitive distortion in the sexual offender treatment process. Various types of cognitive distortion are discussed with an emphasis both on content and process of denial and cognitive distortion. The trainer reviews the types of denial and distortion, suggesting underlying reasons for denial and distortion, and describes various treatment interventions. During off-air activities, participants will describe a scenario in which they engaged in some type of problematic or transgressing behavior (e.g., exceeding the posted speed limit, cheating on a diet) outlining the cognitive distortions they utilized. In another off-air activity, participants will engage in a small group exercise designed to demonstrate the stages of empathic processing (emotional identification/recognition, perspective-taking, and emotional replication). In addition, videotaped segments of offenders in denial and offenders providing disclosures are presented, with participants identifying and categorizing the types of denial cognitive distortion and then role playing interventions.

Clients in Denial

- ❑ Most commonly reported challenge
- ❑ Unlikely to benefit from treatment
- ❑ Deny because of stigma of offense
- ❑ Can be managed in treatment

Types of Denial

- ❑ Complete denial
- ❑ Partial denial
- ❑ Denial of intent



**Videotape: Offenders
Discuss Denial**

Discuss: Denial

What effective strategies have you used to break denial?

Notes:

OVERVIEW ON DENIAL

Denial is one of the most commonly reported and significant challenges in sexual offender treatment. As long as offenders deny having engaged in offending behaviors, it is obviously difficult to assist them in identifying risk factors, recognizing abusive patterns and cycles of behavior, developing effective coping responses to intervene in these cycles, and to recognize the impact of these behaviors on others. Within mental health treatment, it is generally agreed that individuals are unlikely to benefit from treatment unless they acknowledge having a problem and have a desire to change. With sexual offenders, by acknowledging these behaviors, the threat of considerable disapproval from others exists, as does the likelihood of heightening negative self-perceptions. Because of the incredible stigma attached to sexual offending behaviors, the perceived need to maintain denial may in fact be understandable, though clearly not acceptable. Important will be the ability of the offender to recognize the positive consequences for changing far outweigh the perceived benefits of remaining status quo. While difficult, denial can indeed be effectively managed in treatment.

DISCUSS TYPES OF DENIAL

Denial can take several forms, including the following: (a) complete denial of any offensive behaviors, (b) partial denial (usually regarding frequency, duration or level intrusiveness), and (c) denial of intent (e.g., "I did touch him, but it was purely accidental and non-sexually motivated".)

Addressing Denial

- ❑ Empathize with the offender
- ❑ “Normalize” denial
- ❑ Explain consequences of denial
- ❑ Provide a sense of hope
- ❑ Create an attractive therapeutic environment

Questions

- ❑ What is the worst thing that would happen?
- ❑ What do you think about sexual offenders?
- ❑ How does that fit with your self-view?
- ❑ Do you think sex offenders can change?

Questions

- ❑ How would things change for you?
- ❑ What is different in terms of your version and what others say?
- ❑ Beyond being a convicted sex offender, who else are you?

Notes:

DISCUSS WAYS TO ADDRESS DENIAL

If managed appropriately, denial can be managed and overcome. It may be helpful to empathize with the offender, by recognizing the fear, shame, and guilt which often comes with the acknowledgement of sexual offending behaviors. Furthermore, the therapist and peers in group can “normalize” the denial process, discussing the common pattern of denial among offenders, that most offenders (and people in general) often engage in denial in some way or another. Help the offender to see that moving past denial is a first (and essential) step in the path toward wellness. Doing so may help the offender to feel less threatened and less isolated. Hearing others discuss their own patterns and reasons for denial can be therapeutic as well, with the other offenders discussing the negative consequences they experienced by remaining in denial, and more importantly, the benefits they have experienced as a result of acknowledging responsibility. It is important to note that this process of modeling empathy and support, while challenging the denial, must not be misinterpreted or delivered in such a manner which promotes colluding with the client in his denial. Conversely, as discussed earlier, utilizing a harshly confrontational or shame-based approach will likely only serve to exacerbate denial, secrecy, and resistance, and leads to anger and hostility directed toward the therapist and group members. This abusive interaction parallels the control and power based techniques in which offenders engage with their victims.

Specific lines of questioning can facilitate responsibility-taking as well. Help the offender explore why he may be unwilling to disclose. Acknowledging that behaviors are changeable, the offender may eventually feel more optimistic and hopeful.

Categories of Cognitive Distortion

- ❑ Minimization
- ❑ Justification
- ❑ Rationalization
- ❑ Externalization



Videotape: Actors Depict Offenders' Cognitive Distortions

Cognitive Distortion Process

- ❑ Suspends awareness of victim harm
- ❑ Suspends awareness of wrongfulness
- ❑ Reduces personal discomfort
- ❑ Allows for positive affect/gratification
- ❑ Mitigates culpability
- ❑ Protects esteem



Notes:

COGNITIVE DISTORTION

Put simply, cognitive distortion is the process by which offenders talk themselves into transgressions. Offenders use cognitive distortions prior to, during, and following offending. They give the offender permission to engage in the behavior while protecting their sense of esteem and thus preventing themselves from experiencing guilt, shame or other negative affect.

CATEGORIES OF DISTORTION

With a justification, the offender recognizes that the behavior in and of itself is problematic or wrong, but reports that under these specific circumstances, it was the right thing to do (e.g., "I molested her because I knew she needed to get help" or "She was feeling unloved, so I needed to show her how much I cared for her.") Rationalizations are different, in that the offender admits to having transgressed but denies that such behavior was problematic. Specifically, the offender explains that the behavior was sensible or rational, but not wrongful. (e.g., "I was teaching her about sex – she needed to learn it from someone she trusts.") Lastly, with externalization, the offender admits to the behaviors but avoids personal responsibility by placing blame on factors outside of oneself ("She was not wearing any underwear"; "He initiated it"; "I was drunk, otherwise it never would have happened.")

DISTORTION PROCESS

Beyond targeting and challenging the specific **content** of the distortions, treatment needs to focus on the **process** of distortion, as well. Generally speaking, the process of distortion suspends awareness of immediate harm and impact to the victim; suspends awareness of wrongfulness; mitigates feelings of culpability/responsibility; reduces personal discomfort; allows for experiencing positive affect and immediate gratification; and protects self esteem by ameliorating feelings of shame and guilt for having knowingly engaged in wrongful behaviors.

Notes:

Interventions

- ❑ Explain role of distortions
- ❑ Provide rationale for restructuring
- ❑ Focus on self-talk
- ❑ Identify refuting evidence

INTERVENTIONS

When addressing cognitive distortions in treatment, it is important to help the offender understand the relationship between cognitions and behaviors (i.e., thoughts relate to feelings and ultimately guide actions) and to clarify the specific role that distortions played in offending behaviors (i.e., talking oneself into prohibited behavior, avoiding negative feeling for having done so, esteem protection).

This will provide a rationale for the need to challenge, change or restructure thinking patterns. First, the offender should identify the various cognitive distortions utilized. This can be accomplished by focusing on self-talk prior to, during, and following the offense behaviors.

Therapists, other group members, and the offender himself can then offer evidence which refutes distortions, and can explore alternative interpretations of situations.

Corrective information and cognitive restructuring exercises can be provided through the use of victim statements and other materials, role plays, and paradoxical interventions.

Interventions

- ❑ Explore alternative interpretations
- ❑ Victim Statements and material
- ❑ Utilize role-plays
- ❑ Paradoxical methods



OFF-AIR Activity: Everyday Cognitive Distortions

Time: 1 hour

Purpose of Activity:

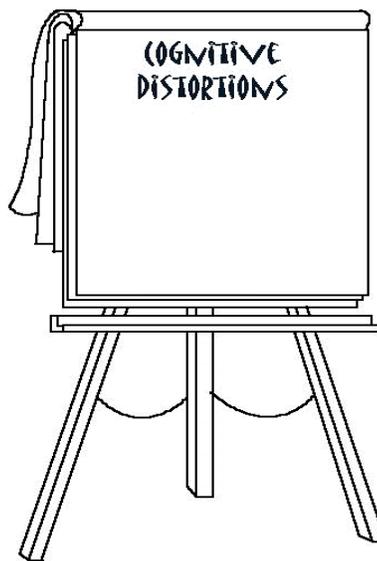
The activity gives participants a better practical knowledge of **offenders'** cognitive distortion processes through examination of their **own** everyday uses of cognitive distortions.

Directions:

Divide large group into small groups of 3-5.

In small groups, participants are asked to take a few minutes to select one problematic behavior for themselves (examples: overeating, smoking, speeding, etc.) and identify the thoughts they have prior to and during the problematic behavior.

In small group discussions, participants share the problematic behaviors and thoughts leading up to them. Discussion of the behaviors should focusing on thoughts which involve cognitive distortions that allow the problematic behaviors to continue.



Empathy Enhancement

Empathy Deficits

- ❑ General
- ❑ Class specific
- ❑ Victim specific

Empathy as a Staged Process

- ❑ Emotional recognition and anticipation
- ❑ Perspective taking
- ❑ Emotional replication
- ❑ Response decision

Cognitive Distortions and Empathy Deficits

- ❑ Interfere with emotional recognition
- ❑ Reduce accurate perspective-taking

Notes:

INTRODUCE EMPATHY ENHANCEMENT

There is no question that empathy enhancing components have long been a critical aspect of most sexual offender management programs. Some have argued that offenders lack empathy in general, while others believe that empathy deficits are limited to classes of persons (sexual abuse victims) or the offenders' own victims. It is suggested that empathy is a process that includes cognitive and affective components.

Four stages of empathic processing, reflecting both the cognitive and affective aspects, have been proposed: emotional identification and anticipation, perspective taking, emotional replication, and a response decision.

Certainly, the offender needs to be able to identify his own emotions and emotions of others. He must have the ability to put himself in another person's shoes, or perspective-take. Third is the affective component, in which the offender actually experiences the same or similar emotions. Finally, a decision is made, either to cease or continue the harmful behavior, based on the three prior steps.

If an offender has deficits in the first three steps or inhibits his abilities at any of the first three steps (or is simply indifferent) he will be more likely to continue the offending behavior.

Notes:

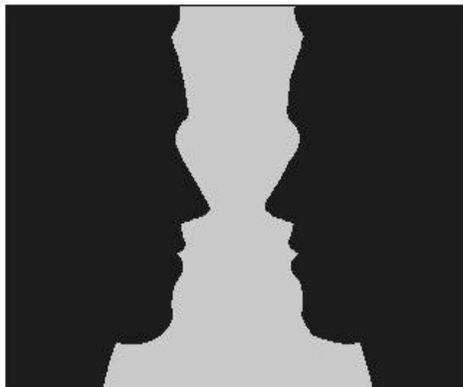
Empathy Enhancement

EXPLAIN INTERVENTIONS

Empathy-Enhancing Interventions

- ❑ Role-plays / role reversals
- ❑ Hypothetical letters
- ❑ Readings from victim accounts
- ❑ Autobiography from victim's perspective
- ❑ Videos depicting victim experiences
- ❑ Victim advocacy guest speakers
- ❑ Challenging cognitive distortions
- ❑ Processing offender's own victimization
- ❑ Sexual assault scenario involving loved-one

Common approaches and interventions to enhance empathic processing include the use of role plays and role reversals, hypothetical letters written by the offenders from their victims as well as autobiographies from the victim's perspective (perspective-taking exercises), readings from victim accounts, videos depicting victim experiences, having abuse survivors or victim advocates as guest speakers, challenging abuse-supportive cognitive distortions and myths about victims, processing of offender's own victimization, and development and discussion of a hypothetical sexual assault scenario involving a loved one or significant other who was not a victim of their own sexually offensive behaviors.





OFF-AIR Activity: Victim Empathy

Time: 30 minutes

Purpose of Activity:

The purpose of the following exercise is threefold. First, participants will be able to experience the group experience, though on a much less threatening level. Second, participants will experience and visualize first-hand the empathic process (including the stages of emotional recognition, perspective taking, and emotional recognition). Third, participants will have the opportunity to practice an intervention which is useful in empathy enhancement components of treatment.

Directions:

Participants assemble in small groups of 7-10 members. Any or all of the following 3 scenarios can be utilized:

Scenario 1: Consider a time during which you were fearful.

Scenario 2: Consider a time during which you felt considerably betrayed.

Scenario 3: Consider a time during which you were overwhelmed with sadness or grief.

Describe this incident in sufficient detail so that your peers are able to visualize (see, hear, smell, etc) the experience. However, as this involves personal disclosure, it is up to you how much you are willing to share.

After each person shares his/her example, the remaining participants are asked to identify the emotions they believed the individual experienced, or the emotions they observed. Participants should then describe any perspective taking that occurred (recalling a similar situation as the person described theirs, etc), describe the physiological and/or emotional reactions they experienced, and how they had wanted to respond or react. Lastly, as a group, discuss how and why this exercise might be used or modified to address victim empathy in sexual offender treatment.

SECTION 3 – Treatment

**MODULE 3:
Stages of Change
and
Interviewing Strategies**

Objectives

Participants will be able to:

- ❑ Identify the purpose of the interview.
- ❑ Identify the protocol for the assessment interview.
- ❑ Name and recognize the stages of change.
- ❑ Demonstrate interviewing strategies which elicit cooperation and honesty.

Summary:

This module provides an overview and examples of interview strategies effective in eliciting disclosure and accountability. These strategies are designed to facilitate the therapy process by creating an environment and therapeutic relationship that elicits trust, accountability and motivation to change.

Goals of Clinical Interviewing

Interviewing Sex Offenders

- ❑ Elicit disclosure
- ❑ Develop rapport
- ❑ Establish relationship
- ❑ Facilitate change



Notes:

PURPOSE (4 GOALS) OF CLINICAL INTERVIEWING

Elicit Disclosure: To assess risk and treatment needs, therapists cannot rely on offender self-report alone. However, it is an important source of information. A primary goal of interviewing is to elicit information from the offender. It is sometimes the case that offenders will however, disclose information and later recant the information or provide inaccurate information in an attempt to appear compliant. Aggressive interviewers who exert excessive pressure on the offender to own up to report or disclose information may find that their approach backfires in the long run. The key is to identify and use effective strategies and try to match the needs of the offender with one's interviewing approach.

Develop Rapport: Interviewing is an opportunity for the therapist to assess how the offender operates. It is also an opportunity for the offender to assess how the therapist operates. If they feel listened to, they are more likely to disclose.

Establish Relationship: This will be addressed further in this chapter and the chapter on therapist qualities. The therapeutic relationship is highly influential in client progress and the foundation for this relationship is laid in the initial interview.

Facilitate Change: The interviewing style of the therapist facilitates the client in moving through the stages of change described later in this chapter.

Notes:

Interview Protocol

- ❑ Gather collateral information
- ❑ Present as competent but not condescending
- ❑ Know your biases
- ❑ Avoidant vs. antisocial offenders
- ❑ Provide information and get consent
 - *Purpose of interview*
 - Limits on confidentiality
 - Benefits / costs
- ❑ Provide motivation for honesty

INTERVIEW PROTOCOL

Sex offenders are frequently unreliable sources of information about themselves and their behavior. Prior to interviewing an offender, it is essential that the clinician gather collateral information. It is also helpful to inform the offender that you have done so at the beginning of the interview. Doing so communicates to the offender that you will be relying on external information to validate the information he is providing.

While we all bring our own perspectives and values to this field it is important to assess how these biases impact our ability to effectively interview and treat sex offenders. If we are reluctant to ask certain questions or have a strong and obvious emotional response to the offender's disclosure, the offender may be more reluctant to disclose sensitive information.

One factor to consider in fashioning one's approach to the interview should be the personality make-up of the offender. With avoidant offenders, it is often more useful to create an atmosphere of trust and encouragement. With antisocial offenders, it is important to identify the external motivators that might elicit cooperation and disclosure. It may also be necessary to communicate more emphatically, the rules that are to be followed during the interview process and to be on guard for manipulative tactics.

What motivates an offender is specific to each individual. The interview provides an opportunity to assess and clarify what is motivating for the particular offender being interviewed. It is important to clarify the potential benefits of honesty, including a greater likelihood that they will complete treatment, etc., making them as specific to the individual as possible.

Motivational Interviewing

- ❑ Based in the Transtheoretical Model of Change
- ❑ Therapeutic Style
 - *Designed to help clients resolve ambivalence*
 - Way of interacting that elicits motivation
- ❑ Resistance = signal to change strategies



OLD VIEW: If the client is not motivated, it is the client's problem

▪

NEW VIEW: Shared responsibility in therapeutic partnership

Notes:

MOTIVATIONAL INTERVIEWING

Some participants may not be familiar with the Transtheoretical Model of Change. This model will be reviewed briefly in this chapter.

Research suggests that the extent to which clients "resist" is strongly associated with therapist style.

Therapist's approach has a powerful influence on client motivation and outcome.

Using the same basic treatment approach in a common setting, different therapists can produce dramatically different rates of client drop out and successful completion (Serin & Kennedy, 1997).

A University of New Mexico study showed that about 2/3 of the variance in 6 month drinking outcomes could be predicted from the degree of empathy shown by therapists during treatment (Miller et. Al., 1980).

Therapist's styles can change.

Therapist style in MI is one of avoiding resistance, resolving ambivalence, and inducing change.

The intervention used is contingent on which stage client is in and to which stage they are moving

OLD VIEW vs. NEW VIEW

Old view: Client motivation was attributed solely to the client; treatment was typically denied if client did not indicate motivation to change; they were labeled un-amenable.

New view: Client is ultimately responsible for their own change process but the responsibility is shared with the clinician through the development of a therapeutic partnership

Notes:

Denial and Motivational Interviewing

- ❑ Denial reflects a pre-contemplative stage of change or ambivalence.
- ❑ Motivational interviewing can facilitate movement beyond denial.

DISCUSS TRANSTHEORETICAL MODEL

The Transtheoretical Model was originally developed to describe stages people go through during the course of self-change. It was later found that these same stages occur in many change processes, whether or not the person is in therapy.

The therapist must assess where the client is at in the change cycle in order to determine a therapeutic approach and appropriate interventions.

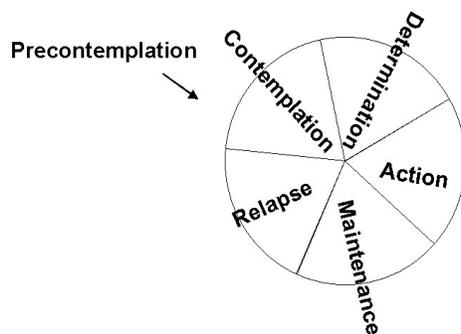
The therapist must start where the client is or meet “resistance”.

Relapse is a normal occurrence or stage of change for most problem behaviors. For sex offenders, relapse is a serious problem. As we talk about relapse prevention for sex offenders, it is useful to substitute lapse for relapse in this model. A lapse does not mean that the client has totally abandoned their commitment to change.

Transtheoretical Model

- Developed for chemically dependent clients
- Used with many other client problems
- Particularly useful with reluctant clients

Stages of Change



DIClemente and Prochaska, 1992

Phase I: Building Motivation

Precontemplation Not yet considering or wanting change

Contemplation Ambivalent about change
Maybe - maybe not

Miller and Rollnick, 1991

Phase II: Strengthening Commitment

Determination Decision to take steps to change

Action Doing things to modify behavior

Maintenance Maintaining change to permanence

Miller and Rollnick, 1991

Five General Principles

- ✓ Express empathy
- ✓ Develop discrepancy
- ✓ Avoid argumentation
- ✓ Roll with resistance
- ✓ Support self-efficacy

Notes:

DISCUSS GENERAL PRINCIPLES OF INTERVIEWING STRATEGIES

Empathy:

Acceptance facilitates change.
Reflective listening develops rapport; allows client to reduce defensiveness. Clients of empathic therapists have better outcomes, fewer drop-outs.
Empathic therapists role model empathy.

Discrepancy:

Increase awareness of consequences.
Increase awareness of discrepancy between goals and behavior and values and behavior; create cognitive dissonance.

Encourages client to develop own argument for change.

Argumentation:

Arguing = attempt to convince **yourself** that you are right.

Counterproductive.

Breeds defensiveness and resistance.

Aggressive-head on confrontation may lead to disclosure which is later recanted; increased resistance & lack of cooperation.

Resistance:

Long-term change cannot be imposed.

Self-efficacy:

Individual's confidence in their ability to make and maintain change.

Notes:

Interview Strategies

- ❑ Start with benign subject matter
 - *Develop a "yes" set*
 - Solicit cooperation
- ❑ Listen reflectively
- ❑ Allow for silence
- ❑ Reinforce progress – successive approximations
- ❑ Summarize
- ❑ Elicit self-motivational statements

Change Strategies

Precontemplation

Raise doubt

Increase perception of risks and problems

Provide information

Contemplation



Tip the balance

Explore consequences

Strengthen client's self-efficacy

Determination

Help identify best course of action

Action

Help client take steps toward change

Maintenance

Help client identify, plan And implement strategies to prevent relapse

DISCUSS INTERVIEWING STRATEGIES

By starting the interview with more benign subject matter you begin to elicit disclosure without eliciting denial. This helps in many ways. It helps to establish rapport, communicates to the offender that you recognize that there is information about them aside from their offense that is relevant to your work together. By developing a "yes" set, you are establishing a cooperative pattern of interacting with the client that will, hopefully, carry over to the discussion about their sexually deviant behavior. You also avoid setting up a situation whereby the offender has started out the interview lying to you about his offense. When this happens, it often decreases the likelihood that the offender will honestly disclose information as they not only have to admit their offense, but they now have to admit that they've lied to you about it.

Describe ways to elicit self-motivational statements:

- ask evocative questions
- explore pros and cons
- ask for elaboration
- imagining extremes
- looking forward
- looking back

DISCUSS CHANGES STRATEGIES

Ambivalence is normal - clients have an attachment to the problem behavior and are likely to be ambivalent about stopping it.

Tip the scales - Must first identify payoffs of the problem behavior, then challenge, undermine, or counterbalance.

Determination = Window of opportunity.

Action = Stage at which many therapists try to begin work with client; it is actually a later stage of change and if therapist tries to start here, the client is likely to resist.

Maintenance = Strategies for this stage of change will be covered in the section of the training on relapse prevention.

Notes:

Adjunctive Strategies

- ❑ Face-saving strategies
- ❑ Educate family and seek alliance
- ❑ Maintain open communication
- ❑ Remove barriers to treatment
- ❑ Peer pressure / peer support

DISCUSS ADJUNCTIVE STRATEGIES:

Face saving strategies might include:

- Time-out - taking a short break from the interview to allow the offender to carefully consider his options
- Paper and pencil questionnaires
- Written assignments

Family members are powerful influences on motivation and honesty. Engaging them as allies in treatment process may increase success.

Treatment is part of a system that the offender operates within. In prison, this includes the group, the therapeutic community, all members of the treatment team (including security and case management staff) and family/support group members in the outside community. It may also include former probation agents, therapists, etc. If information is shared between appropriate parties, regarding the facts of the offense and the offenders current and prior behavior, it will decrease the likelihood that secrecy can be maintained.

Barriers clients may face in treatment:

- Language barriers
- Reading/cognitive deficits
- Unresolved fears based in misinformation

The value of peer pressure/peer support will be discussed later and is an inherent benefit of group therapy and modified therapeutic communities.

SET UP VIDEO VIGNETTE AND DEBRIEF WITH QUESTIONS.



**Video Vignette :
Interviewing Strategies**

Vignette depicts a role-play in which a "therapist" demonstrates some of the interviewing strategies covered in this module.



**Video: Actors Depict
Offenders' Stages of Change**



ON-AIR Video and Viewer Discussion

Video Vignette: Interviewing Strategies

Video Purpose:

Participants observe and evaluate both effective and ineffective use of interviewing strategies in a sex offender therapy session.

Video Description:

Vignette depicts a role-play in which a “therapist” demonstrates some of the interviewing strategies covered in this module.

Procedure:

Watch the video and evaluate the therapist’s use of interviewing strategies.
Did the therapist:

- Express empathy?
- Avoid argumentation?
- Support self-efficacy?
- Develop disclosure?
- Build motivation?



OFF-AIR Activity: Stages of Change Role Play

Time: 1 hour

Purpose:

Through role-play situations, participants practice identifying stages of change in offenders and strategize ways to facilitate disclosure.

Directions:

Use attached offender scripts for role-play situations.

Prepared scripts are read out loud by volunteer participant "offenders". Participants are polled regarding which stage of change the offender's statement reflects. **(Scripts are attached.)** This may lead to some discussion when there is disagreement or some degree of ambivalence.

Participants should divide into groups of 4. Each group is given one of the attached scripts to role-play. They will need to ad lib the remainder of the role-play. Rules for role-playing should be reviewed.

Roles are selected as follows:

- ✓ Therapist
- ✓ Offender
- ✓ 2 Observers

Provide group with a few minutes to prepare. Therapist should select one or two of the interviewing skills suggested in the presentation to target in the role-play. Groups then hold 3 minute role play followed by feedback as follows:

- ✓ Self-critique by the "therapist".
- ✓ Feedback from the offender regarding what was helpful and then what might have facilitated more disclosure.
- ✓ Feedback from the observers regarding which skills they observed and where and when did they see additional opportunity to use interviewing skills in the role-play.

Follow role-play with large group discussion about participants' reactions.



OFF-AIR Activity: Stages of Change Role Play – Offender Scripts

Directions:

The following scripts are used by the participants depicting the offender in the role plays:

1. "I think this is a big waste of time. I don't have a problem with sex."
2. "I don't know what the big deal is. She wanted it too. Well, maybe I didn't really care whether she did or not, but I'm not as bad as the rest of these guys. I know she wasn't old enough, but 15 is a lot different than having sex with a six year old like some perverts in this program did."
3. "O.K. I threw out all my old Playboys and Hustler magazines. I thought about giving them to a friend, because some of them were probably collectors' items and I figured they were worth some money, but I decided that wasn't the right answer so I tossed 'em in the trash."
4. "This is really serious. I didn't expect to get arrested. I've got to do something to address this problem. But I'm working an industry job and I make a decent wage. I'd have to quit my job to enter the treatment program and that's a pretty big financial loss."
5. "Last night I was having a hard time getting to sleep. I was thinking about the argument I'd had with Tony in group today. He told me that I wasn't really working my program if I wasn't willing to ask my wife to come in for a family session with my therapist. After spending about an hour getting frustrated about that stupid conversation, I turned on the television just to get my mind on something else. There was a pretty hot show on about these police women who were posing as undercover hookers. One of them got to liking it and started turning tricks. I was getting pretty aroused when the commercial came on and I started thinking again about how Tony told me I wasn't working my program. Then I realized what I was doing and figured maybe he was right. I turned off the television and started writing in my journal about this whole situation. Instead of feeling aroused I started feeling pretty angry with myself. I also realized that I haven't wanted my wife to come in for a meeting because I'm afraid she's going to realize that I am not cured and then she might just say the hell with this loser and tell me to get lost."

SECTION 3 – Treatment

MODULE 4:

Social and Emotional Competence

Objectives

Participants will be able to:

- ❑ Identify negative affective states commonly recognized as offense precursors.
- ❑ Identify interventions (content and process variables) utilized to enhance esteem.
- ❑ Describe social competency skills necessary for developing and maintaining both general and intimate relationships.

Summary:

In this module, treatment targets in the area of emotional and social competence will be addressed. Emphasized are interventions pertaining to emotional regulation, esteem enhancement, general social skills deficits and intimacy deficits, and the enhancement of empathy. The trainer briefly reviews the relevance of emotional and social competence in sexual offender treatment programs from a dynamic risk factor perspective, followed by a discussion of various treatment interventions.

Esteem Enhancement

Offenders' Esteem Deficits

- ❑ Distorted, self-serving perceptions
- ❑ Lack of empathy
- ❑ Poor social interaction skills
- ❑ Intimacy difficulties
- ❑ Emotional distress
- ❑ Negative affect

Shame Versus Guilt

- ❑ Shame - - "bad self"
- ❑ Guilt - - "bad behaviors"

Shame is Associated With

- ❑ Overly negative self-appraisal
- ❑ Worthlessness, powerlessness
- ❑ Defensive anger and externalization
- ❑ Crippling of adaptive coping responses
- ❑ Dysfunctional interpersonal relationships
- ❑ Psychological maladjustment
- ❑ Decreased empathic responses
- ❑ Decreased self-efficacy

Guilt is Associated With

- ❑ Responsibility-taking vs. blaming
- ❑ Discomfort over harmed caused
- ❑ Motivation to repair damage
- ❑ Empathy
- ❑ Desire to change behavior
- ❑ Ability to identify coping responses
- ❑ Self efficacy

Notes:

INTRODUCE ESTEEM ENHANCEMENT

Of particular clinical significance in the treatment process is the enhancement of self-esteem among sex offenders. Sexual offenders and individuals with esteem deficits appear to share a variety of common difficulties, with such deficits associated with distorted and self-serving perceptions, a lack of empathic concern, deficits in social interactions, intimacy difficulties, emotional distress and negative affect. Again, as these elements have been implicated as immediate and distal precursors to sexually offending behaviors, addressing these factors in treatment is critical. Indeed, the importance of self-esteem and self-efficacy alone are critical in an offender's commitment to relapse prevention, for without a sense of self-efficacy, the offender may perceive himself as hopeless, and efforts directed toward the development and adherence to a relapse prevention plan are futile.

Essential to esteem enhancement approaches are both content and process issues. From a process perspective, therapists must model empathy, warmth, genuineness, acceptance, and encouragement. Similarly, group members should be expected and encouraged to parallel these behaviors in order to promote a positive and therapeutic group atmosphere.

Content of esteem enhancement approaches includes teaching offenders the importance of distinguishing between one's behaviors and the self as a whole (i.e., the guilt-shame distinction). Further addressed should be the improvement of appearance and self-presentation, development of vocational and educational skills, participation in health-promoting activities, involvement in social activities, and the identification and review of positive self-statements.

Emotional Regulation

Emotional Precursors

- ❑ Anger
- ❑ Frustration
- ❑ Rejection
- ❑ Depression
- ❑ Loneliness

Emotional Regulation

- ❑ Identifying and distinguishing between emotions
- ❑ Physiological cues signaling various emotions
- ❑ Examples of positive and negative emotional expressions
- ❑ Physiological, cognitive, behavioral management skills

Notes:

INTRODUCE EMOTIONAL REGULATION

Discussed earlier with respect to elements proximal to offending were dynamic, changeable factors such as disinhibiting thought patterns and negative attitudes toward women and children. In addition to these cognitive elements, emotional and social competency variables have been identified as significant precursors to offending. Therefore, targeting negative affect (e.g., anger, frustration, rejection, depression, and loneliness) and skills-related deficits in areas such as social competency and empathy are important in treatment. The following emotions have been frequently identified as common precursors in offending cycles.

DISCUSS EMOTIONAL REGULATION

A variety of interventions may prove useful in sexual offender treatment with respect to emotional regulation. Clearly, it will be essential to teach the offender to identify his own emotions, and to be able to distinguish between the various emotions. Also helpful for the offender is to recognize the internal or physiological cues which signal specific emotions.

The offender can also be asked to develop a list of various positive expressions of anger, as well negative expressions of anger currently or previously utilized. Important will be to develop physiological, cognitive, and behavioral management skills to more effectively regulate emotions. For example, physiological approaches can include relaxation techniques, as well as helping offenders understand the manner in which diet and exercise impact mood. Cognitive skills for emotional management include cognitive restructuring exercises such as challenging or interrupting thoughts. There are several behavioral management approaches which can be effective for emotional management, including assertiveness training, anger management, conflict resolution, problem-solving, and time management. Finally, it is important for offenders to identify the specific emotions which are associated with their own offending patterns.

General Social Competency

General Social Competency

- ❑ Communication / assertiveness
- ❑ Problem-solving
- ❑ Conflict resolution
- ❑ Interpersonal boundaries
- ❑ Social anxiety or self-consciousness



Notes:

INTRODUCE SOCIAL COMPETENCY

Research and clinical experience suggests that sexual offenders have deficits in skills necessary for healthy and effective sexual and social relationships, thus requiring attention in treatment. It may be helpful to conceptualize social competency treatment efforts in two broad areas: general social competence and intimacy enhancement.

Targeting general social competency focuses on the specific skills which are needed in order to effectively function in general social situations (e.g., in the workplace, in treatment, and in general social contexts). This can be accomplished through a combination of modeling, instruction, and role-plays. A natural first step is the identification and practicing of communication and assertiveness skills, including active listening. Problem solving and conflict resolution skills must be developed or enhanced, as well. Lastly, understanding, recognizing, and practicing healthy boundaries is a key. These boundaries are not solely limited to physical boundaries, but include an emphasis on sexual and emotional boundaries, as well. There may be more specific problems such as social anxiety and excessive self-consciousness, which may also need to be targeted.

Intimacy Enhancement

Intimacy Enhancement

- ❑ The nature of intimacy
- ❑ Defining healthy relationships
- ❑ Understanding sexual satisfaction differences between partners
- ❑ Phenomenon of jealousy
- ❑ Overcoming fears of intimacy
- ❑ Development of responses to manage loneliness
- ❑ Reciprocity
- ❑ Self-disclosure
- ❑ Physical affection
- ❑ Shared leisure activities



Notes:

DISCUSS INTIMACY ENHANCEMENT

The second category of social competency is directed at developing and maintaining intimate relationships. Intimacy deficits, and subsequent emotional loneliness, have been suggested as influential in the etiology and maintenance of sexual offending behaviors. To ameliorate the negative affective experience of loneliness, these individuals, who may equate sex with intimacy, seek out inappropriate sexual contact with inappropriate partners. Further, specific anxieties about close, intimate relationships (i.e., fear of intimacy) have also been found to be important.

Additionally, specific skills and behaviors that must be emphasized in treatment include reciprocity, self-disclosure, physical affection, shared leisure activities, and empathy. Overall, the goal is to identify and practice specific behavioral responses that have a positive impact on intimacy, while modifying those which detrimentally influence intimacy in relationships.

SECTION 3 – Treatment

MODULE 5:

Sexual Arousal Control

Objectives

- ❑ Identify the relationship between deviant sexual fantasy and behavior.
- ❑ Describe 3 methods for assessing sexual interests.
- ❑ Describe 5 strategies to help clients control their sexual arousal.
- ❑ Apply covert sensitization strategies.

Summary:

This module begins with a trainer presentation on defining and assessing sexual preference, after which, participants are asked to brainstorm the elements of a "deviant" fantasy and an "appropriate" fantasy. Videotape of one type of arousal assessment is shown and discussed - penile plethysmography. The trainer reviews the goals and types of arousal control strategies and presents an audio-taped example of an offender using one of the strategies, covert sensitization. Finally, special considerations about using these techniques are offered. As an off-air activity, participants practice developing and critiquing each other's covert sensitization scenes.



Video Vignette: Sexual Arousal Control

Domains of Sexual Interest

- Age
- Gender
- Behavior

Assessing Sexual Interests

- Self reporting
- Collateral information
- Psychophysiological testing



Video Presentation: Penile Plethysmograph Assessment

Notes:

BRIEFLY INTRODUCE TOPIC. THEN SET UP VIDEO VIGNETTE AND DEBRIEF FOLLOWING TAPE.

INTRODUCE SEXUAL AROUSAL THEMES AND ASSESSMENT OF SEXUAL INTERESTS.

Deviant sexual fantasy is strongly linked with deviant sexual behavior. In fact, the characteristic that most consistently distinguishes male sex offenders from other males is disordered sexual arousal profiles. Of most importance, sex offenders whose sexual arousal to deviant themes is greater than their arousal to non-deviant themes have higher rates of sexual recidivism. It is, therefore, critical that treatment help clients modify their disordered sexual arousal patterns.

Assessment should answer three questions. These questions concern the client's sexual interests.

DISCUSS

Discuss several methods that can be used to assess a client's sexual interests.

INTRODUCE VIDEO.

Show video clip of a penile plethysmograph assessment and facilitate a discussion afterward.

Notes:

Treatment Goals

- **Appropriate Sexual Arousal**
 - Develop
 - Maintain
 - Strengthen
- **Deviant Sexual Arousal**
 - Control
 - Reduce
 - Eliminate

DISCUSS TREATMENT GOALS.

Once a client's sexual interests have been identified, treatment should focus on achieving two broad goals.

Group Brainstorm

Appropriate Fantasy

Deviant Fantasy

In small groups, brainstorm the elements of "appropriate" versus "deviant" sexual fantasies.

SET UP BRAINSTORMING ACTIVITY.

Clearly defining "appropriate" vs. "deviant" sexual interests and fantasies is critical for helping clients develop an effective treatment plan. In small groups, participants brainstorm the elements of "appropriate" vs. "deviant" sexual fantasies. Following 10 minute activity, conduct debrief and discussion.

DEBRIEF BRAINSTORM DISCUSSION.

Elements of an "appropriate " sexual fantasy should include:

- Adult partner
- Partner's permission for sexual activity
- Care and concern for partner
- Non-sexual activity and conversation
- Sexual foreplay
- Sexual satisfaction for yourself and partner
- After-play, such as hugging and conversation

Elements of a "deviant" fantasy are the opposite of an "appropriate" fantasy.

Arousal Control Strategies

- Orgasmic Reconditioning
- Covert Sensitization
- Verbal Satiation
- Assisted Covert Sensitization
- Medication

DISCUSS AROUSAL CONTROL STRATEGIES.

The graphic "Arousal Control Strategies" and chart " Procedures for Altering Sexual Arousal" list several strategies that can help clients address their sexual arousal problems. Three of these will be described in some detail: orgasmic reconditioning, covert sensitization, and medication.

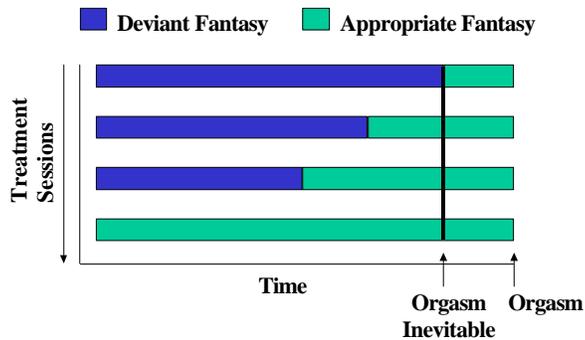
Sex Offender Treatment Skills for Corrections Professionals

Procedures for Controlling Sexual Arousal

<u>Name of Procedure</u>	<u>Type of Procedure</u>	<u>Goal of Procedure</u>	<u>Mechansim</u>	<u>Special Issues</u>
Orgasmic Reconditioning	Overt Positive Conditioning	Increase appropriate arousal.	Pair appropriate fantasy with masturbation and orgasm.	<ul style="list-style-type: none"> • Requires offender to masturbate.
Covert Sensitization	Covert Aversive Conditioning	Decrease deviant arousal.	Pair deviant fantasy with aversive imagery.	<ul style="list-style-type: none"> • Use of audio tape recorder encouraged.
Assisted Covert Sensitization	Overt Aversive Conditioning	Decrease deviant arousal.	Pair deviant fantasy with foul odor.	<ul style="list-style-type: none"> • Requires use of foul odor. • Clients with certain health problems excluded. • Use of audio tape recorder encouraged.
Verbal Satiation	Extinction and Overt Positive Conditioning	Increase appropriate arousal and decrease deviant arousal.	Pair appropriate fantasy with masturbation and orgasm and satiat deviant fantasy through boredom.	<ul style="list-style-type: none"> • Generally requires offender to masturbate. • Use of audio tape recorder encouraged.
SSRI's and Antiandrogens	Medication	Reduce intensity of sex drive.	SSRI's - unknown. Antiandrogens - alter serum testosterone levels.	<ul style="list-style-type: none"> • Expense • Compliance • Side effects

Adapted with permission from: McGrath, R. J. (2000). Using behavioral techniques to control sexual arousal. In M. S. Carrich and S.E. Mussack (Eds.), *Handbook of sexual abuser assessment and treatment* (pp. 280-306). Brandon, VT: Safer Society.

Orgasmic Reconditioning



EXPLAIN

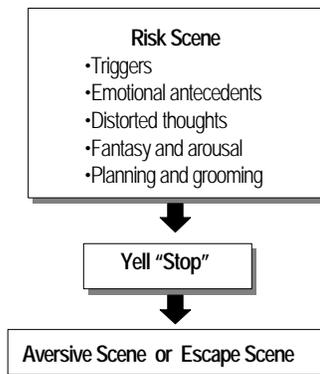
ORGASMIC RECONDITIONING.

Clients can increase their sexual interest in appropriate themes by masturbating to and pairing orgasm to appropriate fantasies. Clients who are not aroused to appropriate fantasies should begin masturbating to deviant fantasies and switch to an appropriate fantasy just before they achieve orgasm. Over time, they should begin to introduce the appropriate fantasy earlier and earlier during masturbation.



Video Presentation:
Impact on Therapists

Covert Sensitization



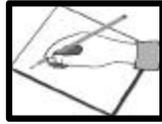
Evaluating Covert Sensitization Scripts

- Deviant scene is realistic
- Client "STOPS" before offending
- Aversive and escape scenes effective
- Scenes verbalized as if happening now

EXPLAIN COVERT SENSITIZATION.

Covert sensitization can help clients reduce deviant arousal and behavioral sequences by pairing them with imagery that interrupts the unwanted fantasies and behavior. Covert sensitization is a three-step process. **First**, the client imagines engaging in the thoughts, feelings, and behaviors that lead to committing a sexual offense. **Second**, before the client commits a sexual offense in his imagination, he yells, "STOP". **Third**, he imagines an aversive consequence and/or escaping from the high risk situation that was progressing towards an offense. Ideally, clients record these sessions on an audio-tape so that their compliance can be monitored and critiqued. Ten pairings per tape and one tape per week is a typical initial treatment frequency. As an alternative, clients can write scenes on index cards and pair their deviant fantasies with aversive and/or escape scenes by reading them several times per day.

EXPLAIN CRITERIA FOR EVALUATING HOW WELL CLIENT IS CARRYING OUT SENSITIZATION PROCEDURE.



ON-AIR Activity: Evaluating Covert Sensitization Scripts

Time: 1 hour

Purpose of Activity:

The activity gives participants practice in evaluating offenders' sensitization scripts and feedback on their evaluations as they observe for key elements of an effective sensitization script.

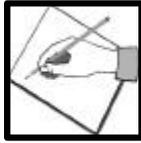
Instructions:

Participants listen to an audio tape example of a client's covert sensitization session. While listening to the tape, participants should use the following criteria to evaluate how well the client is carrying out this procedure.

EVALUATION CRITERIA:

- Deviant scene is realistic and consistent with client' offending pattern.
- Client "STOPS" before committing a sexual offense.
- Aversive and escape scenes are powerful and effective.
- Scenes are verbalized as if they are happening now.

The text of the session is outlined on the next page.



ON AIR Activity: Covert Sensitization - Case Example

"It's Saturday morning. It's been a long week and what have I got to show for it...nothing. I don't have any money. I don't have any friends. Where's my wife? She's off visiting her mother again. She should be with me. I hate feeling alone. At least it's a nice day for fishing. I'm walking down by the river. I can see some of the neighbor boys down a ways. Jimmy is over there by himself. He always looks so lonely too. I'm saying hi to him and he seems happy to see me. He looks so good in shorts. His skin's so soft. I'm taking my shirt off and telling him how much I like to get a tan in the summer. I'm telling him he should try it. He's taking off his shirt. He's so beautiful, so soft. I'm getting turned on.... wonder how it would be to touch his skin. No one would know. At least I would be showing him some attention. I care about him, his parents certainly don't. I'll see if he wants to use some of my tanning lotion. Yes, he said O.K.! I'm reaching out to touch him. --- **STOP!** --- I'm sitting in court. They're going to sentence me today. I can't stop my hands from shaking and I'm sweating and I feel like I'm going to throw up. Oh no! Jimmy's here, and his parents, and a bunch of his relatives. I'm all alone. My wife and kids didn't show up. I knew they wouldn't. They don't want anything to do with me anymore. I can't blame them. I'm a two time loser. I know I'm going to do time. I don't know if I can handle it. The judge's door is opening. Oh no! It's Judge Martin. He's looking right at me. I know he's angry. My mind is blank. It's just a garble of sounds. Then I hear it. Twenty years. There's a gasp in the courtroom. Everyone is happy. They're hugging each other. They're saying I got what I deserved. The sheriff has the handcuffs on tight now. I'm all alone. He's leading me out the side door. Oh my God! What have I done?"

A variation is for the client to use an escape scene instead of or following the aversive scene. An escape scene entails imagining oneself successfully escaping from a high risk situation. It is a way for offenders to cognitively rehearse strategies for escaping from potential real life situations. Here is part of an example. .

STOP! What am I doing. I don't want to re-offend. I'm not going to put Jimmy through this ... etc. Just because he is smiling at me **does not** mean he wants to have sex with me. He has enough problems without me adding to them ... etc. I need to keep him safe and me safe too. I can't be around young boys I know that. I'm turning around. I'm walking away. I'm starting to feel better. I know I can control my problem....etc.



**Videotape:
Martin Kafka, M.D.**

**Discusses medication to control
deviant sexual arousal.**

Notes:

DISCUSS MEDICATIONS

There are two primary categories of medications that can help clients control the intensity of their sex drive.

Medications

- ❑ Selective Serotonin Reuptake Inhibitors (SSRIs)
- ❑ Antiandrogens

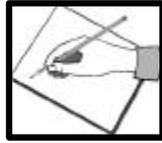
DISCUSS SPECIAL CONSIDERATIONS

Because arousal control procedures are some of the more intrusive interventions used in sex offender treatment programs, several special considerations are worth noting.

Special Considerations

- ❑ Specialized training
- ❑ Administration support
- ❑ Informed consent
- ❑ Side effects
- ❑ Client motivation
- ❑ Booster sessions

- Providers should obtain specialized training before using these techniques.
- Providers should get support from prison administrators for using these techniques.
- Client informed consent is critical.
- Client motivation is essential.
- Anxiety and depression are common side effects.
- Booster sessions are important.



OFF-AIR Activity: Writing Covert Sensitization Scripts

Time:

1.5 Hours

Purpose of Activity:

The activity gives participants practice in writing covert sensitization scripts. They should be similar to ones that might be written by offenders they treat, so that participants can identify the types of elements they should be looking for in offenders' scripts. The activity also gives participants an opportunity to explore the advantages, disadvantages, limitations and obstacles for using this strategy in the treatment of offenders they serve.

Instructions:

Each participant should take about 15 minutes to write out a covert sensitization scenario. The scenario can be based on a client the participant is treating or expects to treat.

The facilitator should divide the participants into groups of 4 or 5. Ideally, each group should have examples of covert sensitization scenarios that represent different types of sex offenders (i.e., rapist, child molester, hands-off offender).

Participants should take turns reading their scenarios in their small group, after which the group should critique the scenario using the following criteria:

EVALUATION CRITERIA:

- Deviant scene is realistic and consistent with client's offending pattern.
- Client "STOPS" before committing a sexual offense.
- Aversive and escape scenes are powerful and effective.
- Scenes are verbalized as if they are happening now.

Finally, participants should discuss that the advantages, disadvantages, and obstacles for using covert sensitization in their programs.

SECTION 3 – Treatment

MODULE 6:

**Substance Abuse
and Sexual Offending**

Objectives

- ❑ Understand the significant relationship of substance abuse / dependency to sexual violence.
- ❑ Recognize the importance of incorporating substance abuse /dependency treatment and substance abuse relapse prevention in the client's treatment plan when appropriate.

Summary:

This module is designed to provide participants with an understanding of the importance of assessing and treating co-morbid diagnoses that place offenders at increased risk for sexual offending. Specifically, the relationship of substance abuse /dependency to sexual violence will be reviewed.

Notes:

“ Substance abuse is the dark shadow behind many crimes of sexual violence: date and acquaintance rape, rape of strangers, violence among intimate partners, and child molestation.”

(CASA, 1999)

Substance Abuse Does NOT Cause Sex Offending

Alcohol/drugs combine with predisposition for sexual violence:

- ❑ Physiological factors
- ❑ Socio-cultural factors
- ❑ Psychological factors
- ❑ Situational factors

Substance abuse is not a sole causal factor in sex offending. Many people use and abuse substances but do not engage in sexually abusive behavior. For people who are predisposed toward sexual violence, however, substance abuse increases their risk for sexually violent behavior.

\$1.6 billion to incarcerate substance-abusing sex offenders in 1998.

In 1998, states spent 1.6 billion dollars to incarcerate substance-abusing sex offenders. This is a significant amount of money. This figure however, does not take into account the enormous additional emotional and financial cost of sexual offending to victims and communities.

Alcohol Abuse and Dependence in Sex Offenders

- ❑ More common than in the normal population
- ❑ More common among rapists than child molesters
- ❑ Implicated in up to 75 percent of date rapes of college women

Alcohol Abuse and Dependence in Sex Offenders

- ❑ Implicated in more incidents of sexual assault than any other single drug
- ❑ Associated with increased use of violence in the offense
- ❑ Offender history of alcohol use associated with offending showed a consistent pattern of alcohol abuse during all offenses

Sex Offenders' Use of Alcohol / Drugs

- ❑ Decrease inhibitions
- ❑ Excuse behavior
- ❑ Avoid accountability
- ❑ Manipulate victims
- ❑ Exploit vulnerable victims

Notes:

Sex offenders abuse substances in the following ways:

- **DECREASE INHIBITIONS:** Substances are often used to provide the courage to behave in ways an offender might otherwise feel inhibited about.
- **EXCUSE BEHAVIOR:** Intoxication is used as an excuse for sex offending; intoxication is blamed for abusive actions
- **AVOID ACCOUNTABILITY:** Offenders often try to avoid accountability through the claim that they have no memory of their actions due to intoxication or substance-induced blackout
- **MANIPULATE VICTIMS:** Drugs are used to lure a victim or create increased vulnerability to obtain sex or acquire submission and silence.
- **EXPLOIT VULNERABLE VICTIMS:** Offenders take advantage of victims who are under the influence of drugs and alcohol.

Effects of Drugs

- ❑ Impaired cognitive functioning
- ❑ Impaired judgement
- ❑ Euphoria
- ❑ Disinhibition
- ❑ Increased aggression

Notes:

The effects of drugs vary, dependent on the individual and the circumstances. Common effects include those listed. Drug use affects information processing, perception, and attention. Intoxication may further diminish the ability of the sex offender to read sexual cues and attend to more subtle environmental cues and inhibitors.

Alcohol Myopia

- ❑ Narrowing of attention
- ❑ Focus on most immediate or powerful cues
- ❑ Diminished awareness of other cues
- ❑ Lack of focus on inhibitory cues

Many people, when under the influence of alcohol, experience a condition known as alcohol myopia. Symptoms of this condition include those listed. For sex offenders, the occurrence of these symptoms increases their tendency to offend.

Alcohol / Drug Using Sex Offenders

- ❑ More likely than non-using sex offenders to have never been married
- ❑ Alcohol-only users are the most likely to be divorced or separated
- ❑ Estimated recidivism rates 40% higher than those without substance abuse problems

The research suggests that there are common correlates with alcohol and drug use among sex offenders. These correlates are also suggested by current research to associate with risk for re-offending.

Notes:

Substance Abuse:
“The Elephant in the Treatment Room”



THE ELEPHANT IN THE TREATMENT ROOM.

- Treatment of substance abuse and dependence is frequently overlooked.
- Only 28% of all substance-involved sex offenders report receiving substance abuse treatment while in prison. (CASA, 1999)

Sex Offender Treatment Evaluation project (SOTEP): (Marques et. al., 1992)

- Nation's most rigorous study on sex offender treatment and recidivism
- 80% of subjects rearrested had a history of substance abuse.

MnSOST-R instrument for assessing risk for recidivism

2 items highly correlated with re-arrest for sex offense:

- History of substance abuse
- Substance abuse / dependency treatment failure while incarcerated



Video Vignette: Actors Depict Offenders' Substance Abuse Issues

Substance Abusing Sex Offenders

- ❑ Significant numbers do not receive substance abuse treatment while incarcerated.
- ❑ Significant number of re-arrested have history of substance abuse.
- ❑ Re-arrests correlate with history of substance abuse and treatment failure while incarcerated.

Notes:

Focus of Substance Abuse Treatment for Sex Offenders

- ❑ Identify and own their predisposition to sex offending.
- ❑ Accept responsibility for their choice to use drugs.
- ❑ Recognize and acknowledge the role of drugs in sex offending dynamics / cycle / chain.
- ❑ Increase inhibitors to offending so they are more difficult to overcome.
- ❑ Develop healthy alternatives and coping strategies.

Focus of Substance Abuse Treatment for Sex Offenders

- ❑ Identify and address support systems enable criminal and substance abusing lifestyles.
- ❑ Treatment of sexual dysfunctions associated with substance abuse. (Male alcoholics are over 3 times more likely to suffer from impotence than non-alcoholics. Chronic use of other drugs including heroin and cocaine are also associated with impotence.)
- ❑ Provide education regarding the relationship between sex, drugs, and STD's.
- ❑ Maintain a continuum of services that addresses both issues.

Alcohol and Drug Abuse Correlates With :

- ❑ Criminal behavior and sexual assault
- ❑ Increased violence and aggression
- ❑ Failure on probation and supervised release
- ❑ Recidivism among sex offenders

SUMMARIZE.

In summary, alcohol and drug abuse correlates with the factors listed. It is a critical issue to assess and treat in sex offenders for whom this is a problem. It is also a critical component of any relapse prevention plan for the substance abusing or dependent sex offender.



OFF-AIR Activity / Discussion: Substance Abuse/ Dependency Assessment and Treatment

Time: 30 minutes

Purpose of Activity:

Helps participants assess their present skill / resources available for assessing and treating sex offenders for substance abuse/ dependency and identify additional resources they can access.

Directions:

Facilitator guides small group discussion of the following questions:

1. How much training have participants received in substance abuse/dependency assessment and treatment? Are other members of their team trained and/or certified in this area?
 2. How is substance abuse and dependency screened and assessed in the programs represented by the participants?
 3. How is this information incorporated into the sex offender's treatment and relapse prevention plan?
 4. How are these issues addressed in treatment?
- ❑ **Combined sex offender and substance abuse / dependency programs** versus referral to substance abuse / dependency program. (How is programming integrated, what is the level of cooperation, communication and collaboration across providers and programs?)
 - ❑ **Environmentally** – In what ways does the program guard against inmate access to controlled substances? (e.g., urinalysis, closed units, visiting policies, etc.)
 - ❑ **Support systems** (Family and friends that are sober or substance abusers, AA and NA groups)
 - Relapse prevention plans
 - Continuity of care (transitional programming to maintain sobriety)
 - Teaching non-substance related leisure activities

SECTION 3 – Treatment

MODULE 7:

Mental Health Issues

Objectives

- ❑ Understand the importance of mental health assessment and the relationship of mental illness to risk for recidivism among sexual offenders.
- ❑ Recognize the need to address mental illness and medication management strategies in the client's individualized treatment plan.

Summary:

This module is designed to provide participants with an understanding of the importance of assessing and treating co-morbid diagnoses that place offenders at increased risk for sexual offending - specifically mental health issues.

Medication

SSRIs

- ❑ Antidepressants
- ❑ Approved for the treatment of obsessive compulsive disorder
- ❑ Reduce sex offenders' deviant sexual thoughts and fantasies



Notes:

DISCUSS SSRIs

Selective Serotonin Reuptake Inhibitors (SSRI) are antidepressants that are also approved for the treatment of obsessive compulsive disorder. Some investigators report that SSRI medication appear to selectively decrease deviant arousal without significantly decreasing appropriate arousal (Kafka, 1993; and Bradford et al., 1995). There appear to be many potential advantages to the use of SSRIs to reduce deviant sexual arousal — less dangerous side effects than Depo-Provera, selective suppression of deviant arousal, and treatment of co-existing depression. SSRIs are safe enough to be used with adolescents and the elderly.

SSRIs may also be helpful in helping offender's modulate impulsive disorders and aggressive behavior.

Offenders using SSRI's have reported reductions in intrusive deviant fantasies and obsessive sexual thoughts.

Psychiatric Conditions

Common Conditions to Identify and Treat

- ❑ Depression
- ❑ Bipolar Disorder
- ❑ Obsessive Compulsive Disorder
- ❑ Adult Attention Deficit Disorder (ADD and ADHD)
- ❑ Anxiety
- ❑ Anger and Impulsivity

Practical Issues

- ❑ Work collaboratively with psychiatrists.
- ❑ Medication in combination with psychotherapy is more effective.
- ❑ Medication management is critical.

Notes:

DISCUSS PSYCHIATRIC CONDITIONS TO IDENTIFY AND TREAT.

Individuals who are depressed or anxious may have a difficult time responding to cognitive behavioral therapy. Many of the targeted treatment areas (relationship skills, cognitive distortions, reduction of deviant arousal, relapse prevention, etc.) in offense-specific treatment with sex offenders may be easier for sex offenders to address if coexisting depression or anxiety are reduced. Untreated depression may also increase the offender's likelihood of abusing substances. Before treating a sex offender for depression, bipolar disorder should be ruled out. Most antidepressants will aggravate hypomania and mania.

When a sex offender also has an obsessive compulsive disorder, obsessions frequently include deviant sexual fantasies. They may also be compulsive in their sex offending behavior. This disorder is often responsive to treatment with SSRIs.

Adult ADD and ADHD are not uncommon among an incarcerated population. It is unlikely that medications frequently used to treat these disorders will be prescribed in prison, as they are typically treated with a form of amphetamine.

Anxiety can also interfere with treatment. The offender may be extremely anxious about talking in group and may feel very uncomfortable and anxious around adults.

If cognitive behavioral treatment does not seem to be helping an offender with his anger or impulsivity, he may benefit from adjunct treatment with medication. As noted above, anger and impulsivity may decrease with the medications used to treat bipolar disorders or with SSRI's.

Medication alone is not sufficient to stop someone from committing sex offenses. Medication interventions should be combined with offense specific treatment.

SECTION 3 – Treatment

MODULE 8:

**Integrating Polygraph Testing
with Treatment**

Objectives

Participants will be able to:

- ❑ Identify ways in which polygraph examinations can enhance treatment and supervision of sex offenders
- ❑ Explain policies and procedures which improve the effectiveness of polygraph examinations

Summary:

This module provides an overview on the use of polygraph testing with sex offenders, its value and validity and considerations for integrating polygraph testing with treatment.

How Many Programs Use Polygraph Testing?

13 Prison Treatment Programs

Probation and Parole Jurisdictions in 35 States

Value of Polygraph Testing

- ❑ Verify self reported sexual history
- ❑ Increase information for relapse prevention planning
- ❑ Monitor current behavior
- ❑ Deter dishonesty and re-offense

Validity of Polygraph Tests

Validity:

- ❑ 12 studies of 2174 field examinations produced an average accuracy of 98%
- ❑ 41 studies of 1,787 laboratory simulations produced an average accuracy of 80%

Reliability:

- ❑ 11 studies of 1,609 charts from field examinations produced an average accuracy of 92%
- ❑ 16 studies involving 810 charts from laboratory produced an average accuracy of 81%

Notes:

INCREASED USE OF POLYGRAPH WITH TREATMENT AND SUPERVISION OF SEX OFFENDERS

Some sex offender treatment programs have been using polygraph testing since the 1970's. Within the last few years, this tool has been used on a more widespread basis. Thirteen prison treatment programs use polygraph testing. In addition, probation and parole jurisdictions in over 35 states use polygraph testing.

WHY POLYGRAPH TESTING IS USED

The polygraph is utilized in treatment to increase treatment efficacy.

- The polygraph can be used to verify the offender's self reported history of sex offense behavior, and high risk behaviors.
- The increased disclosure of past behavior can result in more comprehensive relapse prevention plans and conditions of community supervision.
- The polygraph can be used to determine if the offender is still engaging in high risk behaviors and offending.
- The polygraph can also deter offenders from attempting to deceive their therapists in treatment.
- The polygraph can increase public safety by deterring re-offense.

VALIDITY OF POLYGRAPH TESTS

When the best procedures are followed, the polygraph has been determined to be 92% to 98% accurate. Even conservative estimates state the polygraph is accurate 85% of the time. This rate is considerably more accurate than the offender's self report of his past or current behavior.

Factors Impacting Accuracy

- ❑ Skill of the examiner
- ❑ Type of test and method used
 - Validated testing method
 - Single issue most validated
- ❑ Adequate information for question formulation
- ❑ Test must be meaningful to examinee; something must be at stake

Notes:

Resources

American Polygraph Association
 Procedures and Standards
 from Other States

The American Polygraph Association publishes standards for post conviction polygraph testing of sex offenders. They also accredit courses and establish minimum standards for instruments.

Polygraph Combined with Treatment

Average # of Victims Reported / 57 Sex offenders

Official Record	Sexual History	Polygraph
2.3	37.4	100.2

Sex Offender Treatment and Monitoring Program
 Colorado Department of Corrections

Polygraph testing combined with treatment provides more information than either one alone. The following study shows polygraph testing and intensive treatment in prison resulted in significantly more information about the offender than polygraph with less intensive treatment in the community.

Notes:

Admitted # of Sex Crime Victims By Inmates and Parolees Mean (Median)

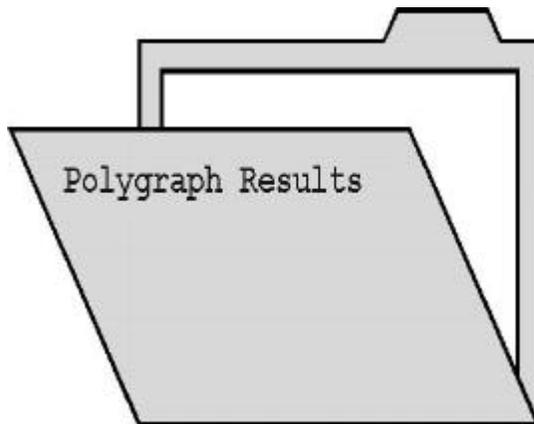
	Inmates(n=35)	Parolees(n=25)
Source		
PSIR	2(1)	2 (1)
Sexual History	83 (21)	4 (2)
1 st Poly	165 (24)	6 (3)
2 nd Poly	184 (26)	7 (3)

Includes victims of contact and non-contact sex offenses
 Ahlmeyer et al., 2000, Sex Offender Treatment and Monitoring Program, Colorado Department of Corrections

Polygraph Disclosure Differences , Inmates and Parolees

Possible explanations:

- ❑ Inmates perceive fewer consequences for disclosure.
- ❑ Intensity of treatment impacts disclosure.
- ❑ Advancement in treatment impacts disclosure.
- ❑ More complete instruction on the sexual history impacts disclosure.



Types of exams

- Disclosure
- Monitoring
- Specific Issue

Three Components of an Exam

- Pre-test
- Test
- Post-test

The majority of admissions happen during the pre-test.

Notes:

TYPES OF POST-CONVICTION POLYGRAPH TESTS WITH SEX OFFENDERS:

Three types of tests are used. There should only be three to four relevant questions on each test.

- 1.** Disclosure/Baseline/Sexual History Exam – An exam to verify an offender's self reported history of sexual offenses and high risk behaviors
- 2.** Monitoring/Maintenance Exam – An exam to verify whether the offender has engaged in any high risk behaviors or sex offenses in the time period since the last polygraph exam or a point in time (e.g. since entering treatment)
- 3.** Specific Issue Exam – An exam to determine if the offender engaged in a specific behavior during a specific time frame

THREE COMPONENTS OF AN EXAM:

1. Pre-test – The polygraph examiner interviews the offender regarding subjects the test with cover. The examiner will finalize the questions he/she will ask based on the information in the interview. Terms that will be used in the questions will be clearly defined for the offender.
2. Test – Physiological measurements which are recorded in response to questions (Cardiovascular, respiratory, and electrodermal activity)
3. Post-test – interrogation regarding areas of deception

Management Considerations

- ❑ Develop procedures
- ❑ Educate therapist
- ❑ Develop disclosure questions
- ❑ Set examiner qualifications and requirements

Management Considerations

- ❑ Videotape exams
- ❑ Develop system to track and use results
- ❑ Educate administrators & parole boards
- ❑ Develop consequences

Polygraph Sanctions Grid

The grid can address the following problems:

- ❑ Lack of consistent application of a range of sanctions for deception
- ❑ Many therapists and officers accept explanations for deception without checking with the polygraph examiner
- ❑ Frequently there is no follow-up to determine if the admission provided for a deceptive response is valid – this requires a re-test

Notes:

Management Considerations:

1. Develop polygraph procedures. Have them reviewed by your legal department. Decide how disclosures of past crimes will be handled. (See Section 5: Legal and Ethical Issues) Develop informed consent forms for the offender to sign
2. Educate therapists on polygraph procedures
3. Determine which questions should be asked on a disclosure polygraph
4. Since your age of 18 have you ever had sexual contact with anyone under the age of fifteen?
5. Have you ever forced someone over the age of 15 to have sexual contact with you.
6. To minimize confusion, work with polygraph examiner to develop common terms and definitions
7. Require polygraph examiners to be trained by an APA approved program and use validated polygraph techniques including accepted test formats
8. Require the polygraph examiner to videotape the exams and maintain the charts. The tapes and charts should be used for quality assurance reviews. The videotapes can also be used in treatment. Offenders who deny statements they made to the polygraph examiner can be confronted with the videotape.
9. Develop systems to record results of the polygraph exams and construct questions for the next test
10. Educate administrators, Parole Board, etc. not to over react to the significant increase in disclosures
11. Develop consequences for deceptive responses or privileges for non-deceptive responses. The polygraph is ineffective if nothing is at stake. (See polygraph sanctions grid)
12. Provide support for therapists – the polygraph increases the secondary trauma. (See Section 4: Staff Issues.)

SOTMP TC POLYGRAPH SANCTIONS GRID FORM – OCTOBER 2000

Use a new form for every polygraph exam

DOC# _____ Name _____ Polygraph Exam Date _____ Number of Polygraph Exam(s) (Circle)
 Sex Offender Treatment Date Placed _____ **1 2 3 4 5 6 7 8 9 10**
 Psychotropic Medications Prescribed _____

		ADMISSIONS DURING EXAM				NO
		ADMISSIONS DURING POSTTEST			ADMISSIONS	
		Admissions Prior to Pretest 1	Admissions During Pretest 2	Admissions to Non-deception/Posttest 3	Admissions to Deception/Posttest 4	No Admissions to Deception/Posttest 5
		Admissions in sexual history and/or other addendums prior to the pretest	Admissions during the pretest interview	Admissions during posttest with all responses non-deceptive or inconclusive	Admissions of related behavior during posttest	No admissions/explanations not related to the behavior during posttest
P A S T	Offenses & High Risk Behaviors A	Behavior(s)	Behavior(s)	Behavior(s)	Behavior(s)	Behavior(s)
	Before placed at TC	None	None	Low	Moderate	Moderate
P R E S E N T	Behavioral Lapses & Basic Rules Violations B	Behavior(s)	Behavior(s)	Behavior(s)	Behavior(s)	Behavior(s)
	After placed at TC	Low	Moderate	Moderate	High	High
	Cardinal Rules Violations C	Behavior(s)	Behavior(s)	Behavior(s)	Behavior(s)	Behavior(s)
	After placed at TC	Severe	Severe	Severe	Severe	High\Severe
	Offenses (or refused exam) D	Behavior(s)	Behavior(s)	Behavior(s)	Behavior(s)	Behavior(s)
	After placed at TC	Severe	Severe	Severe	Severe	Severe

****IF SANCTIONING AT A DIFFERENT LEVEL THAN INDICATED ON GRID, PLEASE FILL OUT THE SANCTIONS OVERRIDE SECTION**

SANCTIONS OVERRIDE: _____ Multiple similar violations and/or deceptions to high risk behaviors or offenses. (OVERRIDE TO NEXT HIGHEST SANCTIONS)

Please check only one result

_____ History of sadistic or lethal behavior/offenses. (OVERRIDE TO NEXT HIGHEST SANCTIONS)

_____ Sabotage (OVERRIDE TO NEXT HIGHEST SANCTIONS)

_____ No probable cause for re-mediation or arrest. (OVERRIDE TO NEXT LOWEST SANCTIONS)

_____ Other (OVERRIDE TO NEXT HIGHEST/LOWEST SANCTIONS) Explain: _____

A. Sexual History Polygraph: Test following the standardized question schedule.

B. Maintenance Polygraph: Test on similar behavioral areas.

C. Specific Issue Polygraph: First, test on the most serious behavioral area of deception or inconclusive result.

Second, test on all other areas of deception.

EXAM QUESTIONS:

Please circle only one result

Question 1: _____ Nondeceptive \ Deceptive \ Inconclusive \ Sabotage

Question 2: _____ Nondeceptive \ Deceptive \ Inconclusive \ Sabotage

Question 3: _____ Nondeceptive \ Deceptive \ Inconclusive \ Sabotage

**FOLLOW-UP
QUESTIONS:**

Question 1: _____

Question 2: _____

SANCTIONS & PRIVILEGES GUIDELINES: Please check the offender’s current treatment, result, privilege, and sanction level for this exam.

Current Treatment Level: Basic Orientation Orientation Commitment Senior Maintenance

- 1st Baseline Deceptive: Freeze\Regress Commit, probation, lose 1 day E.T.
- 2nd Baseline Deceptive: Frz.\Reg. to Commit, “ on notice”, lose 2 days E.T.
- 3rd Baseline Deceptive: Frz.\Reg. to Commit, “on notice”, lose 2 days E.T.
- 4th Baseline Deceptive: Terminate
- 1st Monitoring Deceptive Same Issue: Freeze\Regress to Commitment
- 2nd Monitoring Deceptive Same Issue: Frz.\Regress (B) or Terminate (C)
- 3rd Monitoring Deceptive Same Issue: Terminate

None – Day Hall, Unit office game check-out (ONLY)

General

- TC table game tournaments
- TC games
- Access to gym beyond the scheduled time
- Other: _____ (staff approved)

 Basic Orientation

- TC sport tournaments
- Music Library
- Music Program
- Hobby permit
- Other: _____ (staff approved)

 Orientation

- Enrichment classes
- Birthday Group pass
- Team sports outside of TC
- Other: _____ (staff approved)

 Commitment

- Bingo night
- Movie night
- Priority status for sports teams
- Garden Project
- Pizza party
- Other: _____ (staff approved)

 Senior

- Single cell or approved choice of cellmate
- Career development seminars
- Other: _____ (staff approved)

- Maintenance
- Choice of job
- Priority status for single cell
- Live outside of the unit
- Other: _____ (staff approved)

NO SANCTIONS EARNED

LOW

Maintain current level of privileges

Complete Sexual History/TC Addendum assignment

MODERATE – Refer to Probation Decision Tree

Lose current level of privileges, but maintain General privileges

One day or two days loss of earned time, depending exam on placement

Placement with TC support team

Placed on probation - loss of eligibility for work bonus or “on notice”, depending on exam placement

Contact support network

TC community service

\$3.00 polygraph exam co-pay for next exam

Complete Sexual History/TC Addendum assignment

Polygraph Retest

HIGH - Refer to Probation Decision Tree

Lose all privileges

Two days loss of earned time

Placed probation and GP ban

Placement with TC support team

Contact support network

TC community service

Loss of all appliances – secure and place under bed

\$3.00 polygraph exam co-pay for next exam

Complete Sexual History/TC Addendum assignment

Polygraph Retest within 30 days (SPECIFIC ISSUE TEST)

SEVERE

Terminate for lack of treatment progress

Sex Offender Treatment Skills for Corrections Professionals

No recommendation for TC Readiness group/transfer to FCF without admission of the specific behavior in question

*****STRIKE-OUT SANCTIONS & PRIVILEGES THAT ARE NOT AVAILABLE*****

COMPLETE THE APPLICABLE PARTS:

Name of therapist/officer:

Name of polygraphist:

Date form completed: _____

The consequences for my performance on this polygraph have been reviewed with me and I understand what is expected of me.

Signature _____

Date _____

**COLORADO DEPARTMENT OF CORRECTIONS
SEX OFFENDER TREATMENT AND MONITORING PROGRAM**

Notes:

Offender Perceptions of Polygraph

- ❑ What have offenders learned about the consequences for deception on exams?
- ❑ If offenders do not fear consequences, will the exam be less effective?
- ❑ Are there myths, beliefs, or excuses about polygraph exams that are being promoted by offenders?

Research on Deception

“Preliminary research indicates deception decreases for inmates and parolees after employing punitive sanctions as opposed to increased monitoring sanctions.”

Ahlmeyer et al., 2000
Sex Offender Treatment & Monitoring Program
Colorado Dept. of Corrections

Polygraph Increases Secondary Trauma

“I hate the polygraph,
I really hate the polygraph,
but don't get me wrong
I would never work without it.
It bursts our bubble.”

Colorado Sex Offender Therapist 10/18/00



OFF-AIR Activity: Integrating Polygraph With Treatment (Page 1 of 9)

Time: 1 Hour

Purpose of Activity:

Participants will develop an awareness of the value of polygraph evaluation in confirming self-reported sexual histories. Participants should gain an understanding of how this information can be used to develop more accurate individualized treatment plans.

Procedure:

Divide participants into groups of 3-5.
Each group should appoint a recorder and timekeeper.

Direct the small groups to read the official record documentation on the four case examples. Groups will answer the question at the end of each case example. Groups will have 15 minutes to complete this task.

Following small group work, the large group will gather together to compare and discuss the small group answers for each case example.

The large group will then break back into the smaller groups. Each small group will read the polygraph documentation on each case and answer the questions. Groups will have 15 minutes to complete this task.

One again, the large group will gather back together and discuss the small group answers for each case example.

The large group will be asked to list the benefits of integrating polygraph information in treatment plans.



OFF-AIR Activity: Integrating Polygraph With Treatment (Page 2 of 9)

Case Example #1 – Official Record Information

Offending History Documented in Official Records:

Ms. X pled guilty to sexual assault on a child. These incidents occurred between September 1991, and February 1994. Ms. X was 32 years old at the time the abuse was initiated. This involved Ms. X and her ex-husband engaging in inappropriate sexual conduct with Ms. X's daughter, who was adopted by her ex-husband. Reportedly, they forced her to have sexual relations with them during the past three years on approximately 20 occasions. Polaroid photographs were taken, which depicted the sexual acts involving the youth. When the victim was 14 years old, she reported the sexual abuse to the police. The victim reported that the sexual activities began when she was eleven years old and she was forced to stand in her parents' bedroom while they were having sex. She was eventually drawn into the sexual activity. Ms. X filmed several of the sexually explicit acts between the victim and her father. Ms. X expressed deep remorse during the interview as it pertains to the inappropriate sexual activities conducted by herself and her ex-husband. She was willing to cooperate to the fullest and admits she needs help. She stated several times throughout the interview that she was forced to have sex with her daughter. She reports that she is the victim of many rapes by strangers on the street and has even been sexually assaulted on jobs where she worked. She admits, as it relates to the first marriage, her ex-husband drank a lot, she drank a lot, and she described emotional, physical, and sexual abuse by him. She said he raped her on numerous occasions. The second husband - the current co-defendant - emotionally and mentally and sexually, abused her.

Prior to her sentencing to prison, Ms. X was evaluated by a psychologist. He recommended that Ms. X receive offense specific treatment for her sexual disorder, as well as alcohol education and treatment. It was also noted that she needed a psychiatric evaluation for medication. Diagnostic impression on Axis I includes pedophilia, limited to incest, as well as alcohol abuse, moderate, trace of dysthymia, and trace of post traumatic stress disorder, and Axis II indicated personality disorder not otherwise specified, traces of borderline and dependent personality disorders.

Based on this information what would be important to include in an individualized treatment plan?



OFF-AIR Activity: Integrating Polygraph With Treatment (Page 3 of 9)

Case Example #1 – Polygraph Information

Ms X was polygraphed and reported the following information:

Knowing that she would be polygraphed, Ms. X reported the following additional information in her self reported sexual history: When she was sixteen, she sexually abused her twelve-year-old brother on three separate occasions. She also acknowledged fondling the penis of a male dog and participating in group sex on two separate occasions. During her lifetime, she has had consenting adult sex with 12 males and one female.

During the pretest, Ms. X revealed the following additional information. During sexual activity with her husband, they would engage in bondage and discipline. She reported she fondled a male dog a couple of times.

During the exam, Ms. X was asked the following relevant questions:

- Did you ever engage in a sexual act with your son?
- Since the age of 21, besides your daughter, did you ever have physical sexual contact with anyone else who was under the age of 15?
- Not including your brother or daughter, did you ever physically force or threaten anyone to have sexual contact with you?

She answered “no” to each of these questions and produced scores within the truthful range on all three questions.

Would your treatment plan change as a result of this information?



OFF-AIR Activity: Integrating Polygraph With Treatment (Page 4 of 9)

Case Example #2 – Official Record Information

Offending History Documented in Official Records:

Mr. Y was convicted of sexual assault on a child. According to an affidavit from the police department, Mr. Y's sister-in-law reported that he sexually assaulted his seven year old nephew and his five year old niece. He reportedly exposed himself to the children, attempted to get them to touch his penis, and convinced both children to put their mouths on his penis. During the incident, Mr. Y reportedly ejaculated. No other known sex offenses were identified in official records. He was originally given a deferred judgment with the condition that he seek sex offender treatment and that he avoid being around children under 18 years old. He stated that he violated this condition when he went to a carnival. He stated that authorities at the treatment center had found out about his actions, because they constantly polygraph clients and he was forced to admit his violation to them. The center reported the information to the probation department officials who subsequently violated his probation. He was sentenced to the Department of Corrections.

Based on this information, what would be important to include in an individualized treatment plan?



OFF-AIR Activity: Integrating Polygraph With Treatment (Page 5 of 9)

Case Example #2 – Polygraph Information

Mr. Y was polygraphed and reported the following information:

During the pretest, Mr. Y reported the following information: He has never been married, however, he is currently engaged to a woman who has an 13-year-old daughter. He stated he has had approximately 20 age-appropriate sexual partners in his lifetime, indicating that all but three of these were females. Besides his two victims, he engaged in sexual contact with four other victims under the age of 15, since he was 18. These victims include a 2-year-old female, a 12-year-old female, a 3-year-old male, and a 9-year-old male. Prior to turning age 18, he reports molesting 10 victims who were four years younger than him. These victims include males and females from infancy to age 11. He reports forcing a girlfriend to have intercourse without her consent on two occasions. While working at a hospital, he fondled four elderly females and masturbated in front of one of them. He reports that there were many patients at the hospital that he touched while washing. In addition, he reports molesting two mentally handicapped females and touching a 30-year-old female while she was sleeping. He also reports fondling cats. In the past, he has driven around masturbating during the daylight hours. As a teen, he committed voyeurism on his sister and her boyfriend and made several attempts to view neighbors in their houses. He admitted to masturbating with women's underwear that he stole.

During the exam, Mr. Y was asked the following relevant questions:

- Before the age of 18, besides what you reported, did you ever have physical sexual contact with anyone else who was four or more years younger than you?
- Since the age of 18, besides what you reported, did you have physical sexual contact with anyone else who was under the age of 15?
- Did you ever physically force or threaten anyone 15 or older into having sexual contact with you?

He answered “no” to each of these questions and produced scores within the deceptive range on the first two questions. The third question was scored inconclusive.

Would your treatment plan change as a result of this information?



OFF-AIR Activity: Integrating Polygraph With Treatment (Page 6 of 9)

Case Example #3 – Official Record Information

Offending History Documented in Official Records:

Mr. A pled guilty to attempted sexual assault. At the time of the incident, Mr. A was 35 years old. On the evening of January 8, 1993, Mr. A drove to an office building and waited for his former girlfriend to leave work. She had recently broken off the relationship. He approached her in the parking lot and pulled out a gun. He forced her to get into his car and drove her to her home. After they arrived at her home, he forced her into her bedroom and made her remove her clothes. He tied her to the bed and attempted to sexually assault her. He tried to penetrate her vaginally but was unable to maintain an erection. He became angry and threatened to kill her. Eventually he left her home. The victim called the police and Mr. A was arrested. Mr. A had no other criminal history.

Based on this information, what would be important to include in an individualized treatment plan?



OFF-AIR Activity: Integrating Polygraph With Treatment (Page 7 of 9)

Case Example #3 – Polygraph Information

Mr. A was polygraphed and reported the following information:

Knowing that he would be polygraphed, Mr. A reported the following additional information in his self reported sexual history: He had been married once and had stalked his ex-wife when they separated. He denied ever forcing sex on his ex-wife. He dated several women after his marriage broke up. During this time he would use pornographic videos and magazines for sexual stimulation. Some of these depicted forced sexual acts. He also called 900 numbers. He denied ever forcing anyone else to engage in sexual contact with him.

During the exam, Mr. A was asked the following relevant questions:

- Besides your current victim, have you physically forced or threatened anyone else to have sexual contact with you?
- Since your age of 18, have you ever had physical sexual contact with anyone under the age of 14?
- Prior to turning 18, did you ever have physical sexual contact with anyone four or more years younger than you?

He answered “no” to each of these questions and produced scores within the truthful range on all three questions.

Would your treatment plan change as a result of this information?



OFF-AIR Activity: Integrating Polygraph With Treatment (Page 8 of 9)

Case Example #4 – Official Record Information

Offending History Documented in Official Records:

Mr. B was convicted of sexual assault when he was 29 years old. On the evening of March 3, 1995, Mr. B and a male co-defendant started talking to a female clerk at a convenience store. They told her they were planning to go to a bar and invited her to go along with them. She agreed and they continued to talk until the end of her shift. They went to the bar and drank together for two hours. On the way back from the bar, they told her they needed to stop off at the garage where they worked. They invited her into the garage to wait while they dropped something off. Once inside the garage, they made sexual advances toward her. She attempted to go back to the car and the co-defendant blocked her exit. Mr. B and the codefendant then forced the victim to engage in vaginal and oral sex. They then dropped the victim back at the convenience store where her car was located.

Mr. B had a juvenile conviction for burglary. As an adult, he had two DUIs and a misdemeanor conviction for assault. There was no other history of sexual assault. Mr. B participated in an evaluation prior to sentencing. The evaluator diagnosed Mr. B as having alcohol dependence, psychoactive substance abuse, and schizoid personality disorder.

Based on this information, what would be important to include in an individualized treatment plan?



OFF-AIR Activity: Integrating Polygraph With Treatment (Page 9 of 9)

Case Example #4 – Polygraph Information

Mr. B was polygraphed and reported the following information:

Knowing that he would be polygraphed, Mr. B reported the following information in his self reported sexual history: He has been married once and has two children. He is currently divorced. He has forced sexual intercourse on five other women. He also admits peeping on a neighbor when he was a teenager.

During the exam, Mr. B was asked the following relevant questions:

- Have you physically forced or threatened more than six women to engage in sexual acts against their will?
- Since your age of 18, have you had physical sexual contact with anyone under the age of 15?
- Prior to turning 18, did you have physical sexual contact with anyone four or more years younger than you?

Mr. B answered “no” to each of these questions. He produced scores within the deceptive range on question 2 and question 3.

Would your treatment plan change as a result of this information?

SECTION 3 – Treatment

MODULE 9:

Relapse Prevention

Objectives

- Understand the components of relapse prevention.
- Understand the philosophy, goals and objectives of relapse prevention.

Summary:

This module provides an overview of relapse prevention focusing on risk factors and interventions.

Notes:

Relapse Prevention Factors

- ❑ Repetitive, predictable patterns of behavior
- ❑ Includes one's thoughts, feelings, actions
- ❑ Focus is sexual acting out
- ❑ Risk factors increase likelihood of acting out: mood, alcohol, isolation
- ❑ Interventions for acting out: distraction, self-soothe, improve the moment, think pros and cons

Relapse Prevention Focus

- ✓ ID risk factors
- ✓ Teach coping skills

Relapse Prevention Should Stress:

- ❑ Negative emotional states
- ❑ Fantasy
- ❑ Plan
- ❑ Forbidden behavior

Notes:

Popularity of Relapse Prevention

- Makes sense
- Structured
- Focus on offending
- Positive outcomes

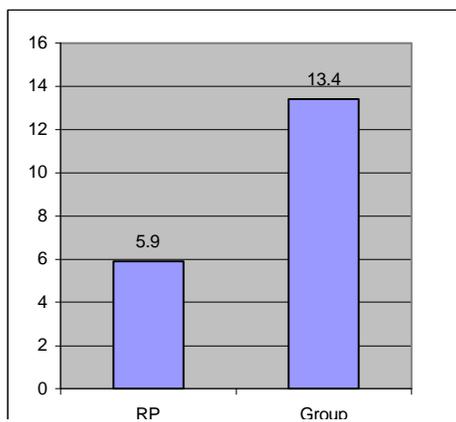
Major Treatment Models Among Sex Offender Treatment Programs

(Safer Society, 1995)

Relapse prevention	65%
Psychosocial education	20%
Psychotherapeutic	11%
Family systems	2%
Sexual addiction	0%
Psychoanalytic	0%
Behavioral	0%
Bio-medical	0%

Meta-Analysis of treatment outcome

(Alexander, 1995)

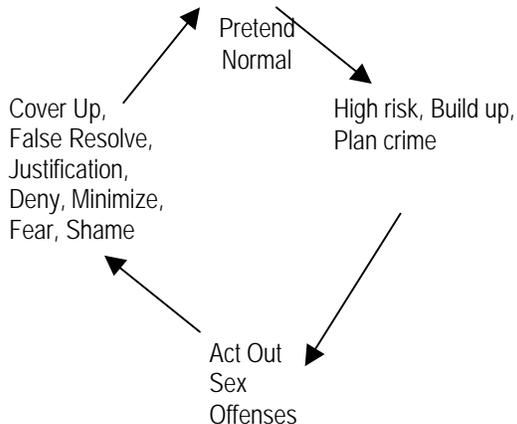


Immediate Precursors to Sexual Aggression

Pithers et al. (1988)

Precursor	Rapists (%) (N = 64)	Pedophiles (%) (N=136)
Anger		
At event	3	3
Interpersonal conflict	3	4
Generalized, global	88	32
Anger towards women	77	26
Anxiety	27	46
Assertive skills deficit	42	23
Boredom	45	28
Cognitive distortions	72	65
Compulsive overworking	0	8
Depression	3	38
Deviant sexual fantasies	17	51
Disordered sexual arousal pattern	69	57
Divorce	2	2
Driving car alone without destination	17	1
Emotionally inhibited / Over-controlled	58	51
Interpersonal dependence	30	48
Low self esteem	56	61
Low victim empathy	61	71
Opportunity (e.g., finding a hitchhiker)	58	19
Peer pressure	2	3
Personal loss	6	14
Personality disorder	61	35
Photography as a new hobby	0	4
Physical illness	14	6
Planning of sexual offense	28	73
Pornography use	2	7
Psychiatric hospitalization	0	7
Sexual knowledge deficit	45	52
Social anxiety	25	39
Social skills deficit	59	50
Substance use / abuse		
Alcohol	42	23
Other substances	14	7

Cycle of Abuse



Notes:

Static risk factors are events that appear to establish the foundation for sexual acting out. They tend to happen during the childhood and adolescent years of the offender or they occur very early during the build-up toward sexual offense. They are not – and can never be considered – excuses for committing sexual offenses. Many people who have these experiences early in life do not go on to commit sexual offenses. In fact, many survivors of these negative childhood experiences dedicate their lives toward preventing others from being sexually, physically, or emotionally offended.

Static Risk Factors : (Can Not Change)

- ❑ Alcoholism in the family
- ❑ Cognitive problems/learning deficit
- ❑ Emotional abuse as a child
- ❑ Exposure to violent death of human or animal
- ❑ Family chaos

Static Risk Factors

- ❑ Lack of assertiveness
- ❑ Lack of sexual knowledge
- ❑ Limited education
- ❑ Maternal absence/neglect
- ❑ Parental marital discord

Notes:

Ongoing risk factors are generally continuing problems and often help maintain a cycle or relapse process.

Ongoing Risk Factors

- ❑ Anger
- ❑ Abusive sexual fantasies
- ❑ Boredom
- ❑ Denial of problems
- ❑ Drug/alcohol abuse

Ongoing Risk Factors

- ❑ Dysfunctional intimate relationships
- ❑ Frequenting places that are high-risk situations (bars, taverns, adult entertainment, etc.)
- ❑ High-risk employment
- ❑ Living near places where children congregate (parks, schools, etc.)

Ongoing Risk Factors

- ❑ Marital problems
- ❑ Masturbating to abusive fantasies
- ❑ Pornography use

Coping Responses for
“Feeling Rejected”

- Call someone
- Accept limitations
- Accept “no” for an answer
- Accept disappointment
- Respect other’s position
- Ask for clarification
- Journal feelings
- Think of other’s feelings
- Take deep breaths
- Don’t blame or pass judgment
- Be aware of distorted thinking
- Look elsewhere for acceptance
- Don’t role-play for acceptance
- Be aware of need to control
- Express anger appropriately
- Remember self-worth
- Accept feelings as they are
- Think positively
- Allow others their space
- Find something else to do

Notes:





OFF-AIR Activity: Behavior Cycles and Intervention

Time: 1 hour

Purpose of Activity:

Provides a greater understanding of offenders' harmful "cycles of abuse" through identification of similar cycles or patterns of behavior with less problematic, common behaviors.

Procedure:

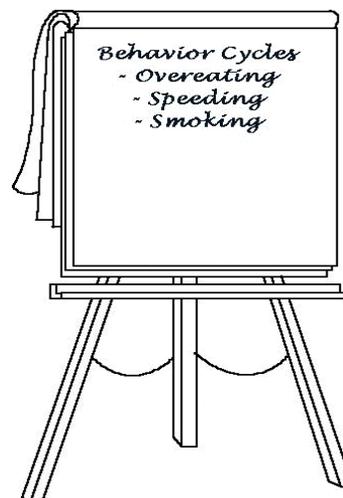
Divide large group into smaller groups of 3-5.

Direct participants to begin working individually to identify one negative behavior of their own (overeating, speeding, smoking, avoiding exercise, etc.). Then identify their thoughts, feelings and related actions before and after the problematic behavior and describe any pattern or "cycle".

Generate an intervention for every thought, feeling and behavior.

Appraise if interventions will work or not.

Share with the small group and have other participants respond and evaluate your intervention plan.



SECTION 3 – Treatment
MODULE 10:
Continuity of Care

Objectives

Participants will be able to:

- ❑ Identify components of effective treatment that must extend beyond institutions.
- ❑ Understand and identify components of successful treatment which address high-risk behaviors.
- ❑ Identify elements of stable after-care.

Summary:

This module provides an overview on community transition of sex offenders.

Notes:

Factors to Consider in Placement

- ❑ Stable housing
- ❑ Stable working
- ❑ Stable response to TX
- ❑ "Family" support

Key Skills

- ❑ Disclosure on a continuum
- ❑ Avoidance practice for high-risks

Notes:

Transitioning

- ❑ Registration requirements
- ❑ Probation/parole expectations

- ❑ Testimony from those who are out there

- ❑ Employment
- ❑ Housing

Transitioning

- ❑ Establish support
- ❑ Environmental controls

- ❑ Transportation
- ❑ Cost of living expectation

- ❑ Judgment and sentence
- ❑ Treatment agreement