



The Management and Containment of Sex Offenders

General Information

No crime other than murder invokes such negative public reaction as sexual crimes. Many sex crimes involve a male offender against a woman or child. Victim vulnerability increases societal perceptions of the dangerousness of these perpetrators as well as popular disdain for them. This imbalance of perceived strength in a period when the rights of victims are taken very serious adds to the disdain (Quinn, 2003).

Sexual offenses result in significant physical, psychological, and/or emotional distress to victims that can last for years and some victim's voices will remain entombed in silence. The most profound in its traumatic implications is the violation of trust that occurs when, as with most sexual assault, the offenders are known to their victims. Trauma and the length and level of recovery seem linked to the trust violation. Thus, what some might regard as a relatively minor type of sexual assault (e.g. "just fondling") can be extremely traumatic to a victim who trusted the perpetrator (English, 1996).

Any offender's subsequent re-offending is a serious public concern. The prevention of sexual violence is particularly important, given the irrefutable harm that these offenses cause victims and the fear they generate in the community (Bynum, 2001). In the most extreme and rare cases, sex offenders murder their victims (Terry, 2003). During the 1980s and early 1990s, the sexual homicides of Jacob Wetterling, Polly Klaas, and Megan Kanka were catalysts for the majority of sex offender legislation. Due to these homicides, it is not surprising that exceptional policies have been directed toward individuals who have committed such heinous offenses.

The prevalence of sex offenders in the criminal justice system has increased over the past several years. Much of the apparent rise in sex crimes is related to increased reporting rather than increased offending. In addition, enforcement is more aggressive and definitions of sexual offenses are more expansive than ever before. Conduct once tolerated is now criminally prosecuted (Lane, 2003). This gives the appearance of increased criminal sexual offenses when, in reality, much of the discrepancy can be attributed the education of the public by victim advocacy groups, law enforcement, and other professionals.

The key to preventing sexual abuse is to shift paradigms," wrote Robert E. Freeman-Longo and Gerald Blanchard in their 1998 book, *Sex Abuse in America*. "In addition to viewing sexual abuse as a criminal justice issue, we must also view it as a serious public

health problem and preventable social problem." A "cure" for sex offending is no more available than is a "cure" for high blood pressure (English, 1996). But with specialized offense specific treatment by qualified individuals, the majority of sex offenders can learn to manage their deviant behaviors and address their cognitive distortions.

The State of Texas has recognized the increased public awareness and concern with the chronic prevalence of sexual aggression and sexual victimization. Over the past two decades, the Council's core function has expanded from a mere regulatory agency due to increased public awareness and the concern for community safety. Today, the Council has four primary functions: 1) public safety: by administering the civil commitment program of sexually violent predators and preventing sexual assault 2) public and behavioral health: by treating sex offenders, 3) regulatory: by maintaining a list of licensed sex offender treatment providers and establishing the rules and regulations regarding the treatment of sex offenders, and 4) educational: by the dissemination of information to the public regarding the management of sex offenders. This legal mandate is an innovative domain of the law. These functions may appear to be separate and distinct, however in reality, these functions work together and if they were separated it would be deleterious to public safety. The Council's functions are synergistic with maintaining the highest level of public safety and preventing sexual assault through effective treatment and interventions in the management of sex offenders.

Common Myths about Sex Offenders

-  **Myth: "Most sexual assaults are committed by strangers"**
Fact: Approximately 80% of all sexual assault victims were abused by someone known to the victim. Only four percent (4%) of sexual assaults are committed by a stranger (Focus Adolescent Services).
-  **Myth: "Children who are sexually assaulted will sexually assault others when they grow up."**
Fact: Approximately 70% of all **adult** sex offenders **were not** sexually abused as a child.
-  **Myth: "Castration cures a sex offender."**
Fact: Castration is not a cure. Castration only reduces testosterone levels and may be helpful in controlling arousal and libido. Physical or chemical castration should only be utilized as an adjunct to treatment and not in lieu of treatment. **It should be remembered that deviant arousal is the physical response to a cognitive process (deviant thoughts).** Deviant thoughts (impulses) and fantasies are precursors to deviant arousal.
-  **Myth: "All sex offenders are sexual sadists".**
Fact: A sexual sadist gains a feeling of sexual pleasure by humiliating and by inflicting pain on the victim. Research indicates only 2-5% of sex offenders are sadists (Langevin, 1990).
-  **Myth: "All sex offenders are psychopaths".**
Fact: Research conducted by Dr. Robert Hare indicated that only 15-25% of the incarcerated population are psychopaths.

Facts

Sexual assault is the most common serious harms that a child can experience (1 in 3 girls and 1 in 5 boys). Nearly 2 million Texans were sexually assaulted in 2002. A quarter of a million children are sexually assaulted every year in Texas (National Crime Victims Research and Treatment, 2000). In 2003, there were only 45,000 sex offenders on the Texas Department of Public Safety's Database.

One reported rape or attempted rape takes place approximately every 6 minutes (Federal Bureau of Investigations). Only twenty percent (20%) of all sexual assaults are reported to law enforcement. Of that twenty percent reported only 10% result in the filing of a charge and 40% of those cases result in a conviction (Lisak, 2002). In 2002 study of 120 undetected rapists in Boston, Massachusetts, 76 serial rapists had on average attacked 14 victims and were responsible for 439 rapes and attempted rapes, 49 sexual assaults, and 277 acts of sexual abuse against children (Lisak, 2002). These statistics demonstrate the disparity between "official" sexual assault statistics and the reality of the epidemic. The disturbing reality is that the majority of individuals who abuse sexually will not end up in the criminal justice system and sex offenders on community supervision or on the public registries represent only a small portion of the actual sex offenders living in our communities.

The media's portrayal of sex offenders has continuously misled the public that all sex offenders are sexually violent predators. Commentators, the media, and even academia use the terms "sex offender" and "sexual predator" in a virtually interchangeable manner (Quinn, 2004). Scientific researched based evidence has proven that this is simply not true. The media's use of such inclusive labels of all sex offenders as dangerous psychopaths disregards the diversity of motive, commitment, and norm violation among sex offenders.

Sex offenders are an extremely heterogeneous mixture and do not fit into a standard profile but fall into numerous categories, from the voyeur, exhibitionist, statutory offender, incest offender, the pedophile, the rapists, the sexual sadist, sexual murderers, to the Sexually Violent Predator (SVP). Incarceration in a penal institution does not deter repeat sexually violent predators or the proliferation of sexual violence. Persons who abuse sexually are male and female and come from all socioeconomic and racial groups. Most sex offending begins during adolescence. It is important to remember that the diagnosis itself of pedophilia does not determine a sex offender's dangerousness. It is the sex offender's behavior that determines the level of dangerousness. Typology categories should be used with extreme caution because many sex offenders crossover to different victims, can fall into multiple categories, and have multiple paraphilias. The following are some paraphilias:

- ➔ Rape-forced sexual contact
- ➔ Child molesting-having sexual contact with a person under 18
- ➔ Bestiality-sexual contact with animals
- ➔ Frottage-touching or rubbing a person for sexual gratification without the person's consent

- ➔ Necrophilia-sexual contact with a deceased person
- ➔ Voyeurism-watching someone for the purpose of sexual gratification
- ➔ Troilism-use of dolls or mannequins during sexual acts
- ➔ Exposing-displaying of one's genitals for the purpose of sexual gratification
- ➔ Bondage-tying up a person while engaged in sexually deviant behavior
- ➔ Obscene calls-use of the telephone or other means to make sexual comments without a persons consent
- ➔ Deviant masturbation-masturbating while thinking deviant thoughts

Crossover sexual offenses are defined as those in which victims are from a multiple age, gender, relationship categories, and paraphilic behaviors (Heil, 2003).

Juveniles with Sexual Behavior Problems

Sexual abuse of children is a widespread phenomenon but childhood sexual abuse does not predict future sexual aggression. While sexual aggression may emerge early in the developmental process, there is no compelling evidence to suggest the majority of juveniles with sexual behavior problems are likely to become adult sex offenders (Hunter, 2000).

Juvenile perpetrated sexual aggression has been a problem of growing concern in American society over the past decade (Hunter, 2000). According to the 2000 Uniform Crime Statistics published by the Federal Bureau of Investigation, juveniles account for a significant number of sexual crimes. Roughly 16% of the arrests for forcible rape and 20-30% of other sexual offenses involved juveniles younger than 18 (Openshaw, 2004) and fifteen percent (15%) of all sexual assaults committed by juveniles occur on school property.

A multitude of issues contribute to sex offending behavior in adolescents. The onset of sexual offending behavior in juveniles can be associated to several factors reflected in their experiences, exposure to violence and pornography, maltreatment, and/or developmental deficits. Some children begin displaying sexually inappropriate behavior with others before they reach ten (10) years of age. Others may copy sexual behavior they have witnessed on the part of older siblings and/or adults. Therefore, early identification, assessment, and treatment are essential for those who have displayed such behaviors.

- ❑ 80-90% of juveniles with sexual behavior problems have had a profound experience with some form of victimization. Approximately 20%-50% of juvenile sex offenders were physically abused and 40%-80% were sexually abused (Hunter, 1998). Rates of physical abuse and sexual victimization are even higher in samples of prepubescent and young females with sexual behavior problems (Gray et.al, 1997, Mathews et al, 1997)
- ❑ 30-60% of juveniles with sexual behavior problems have learning disabilities (Hunter, 2000).

Juveniles are distinct from their adult counterparts. With adult offenders, arousal and interest patterns are recurrent and intense, and related directly to the nature of the sexual behavior problem. In general, sexual arousal patterns of juveniles appear more changeable than those of adult sex offenders and relate less directly to their patterns of offending behavior (Hunter, 1994). It should be noted that only a minority of juveniles manifest established paraphilic sexual arousal and interest patterns. In understanding this fact, society must recognize the other end of the spectrum; that some juveniles commit predatory sexual offenses and will continue deviant sexual behavior into adulthood. Research suggests that age of onset, number of incidents of abuse, the period of time elapsing between abuse and its first report, as well as perceptions of familial responses to awareness of abuse are all relevant in understanding why some sexually abused youths go on to commit sexual assaults while others do not (Hunter and Figueredo in press).

Therefore, the earlier treatment is offered, the more likely it is to prevent continued sexual offending. Recidivism data suggests that juveniles with sexual behavior problems are more likely to commit a property crime than another sexual offense. This suggests that juveniles with sexual behavior problems are more similar to juvenile delinquents and other antisocial teens (Openshaw, 2004). Recidivism rates for juveniles are low. Less than 10% of juveniles with sexual behavior problems recidivate with a new sex crime and 30% recidivate with non-sexual crimes (Davis, 1987, Kahn, 1988).

Female Sex Offenders

Although the majority of sex offenders are male, it is clear that female sex offenders exist and this population of offender is largely unrecognized and neglected. Recent research consistently reveals that females account for about one in four offenders (Pearson, 1997). Additionally, because females often fulfill care-taking roles, female sex offenders may abuse a child under the guise of appropriate care (Jennings, 1993; Mitchell & Morse, 1998). However, there is a paucity of professional literature and clinical practice that describes the needs of the female sex offender. Professional literature often presents females as victims even when they are identified as perpetrators. This lack of attention is regrettable for those who have been victimized by females.

A female as a sex offender is an idea that society has difficulty acknowledging and it challenges society's beliefs about females. The notion of females as aggressive, exploitive, violent, and deviant offenders is not compatible with society's picture of women as mothers, sisters, wives, and the "gentler sex". Many professionals do not accept the idea that females would use their position and power in this manner. This creates a professional and cultural state of denial.

In a 2000 study, Snyder estimated that females commit 12% of all sexual offenses against victims under the age of 6 and 6% of the sexual offenses against children between six (6) and twelve (12) years old.

It is estimated that 64% of the sexual abuse committed by females were crimes against biological relatives and 19% were against victims who were unrelated to the offender (Saradjian, 1996). The age of onset of the abuse was 3.2 years old (Rosencrans, 1997).

Recent findings strongly challenge the belief that female sex offenders are rarely violent (Marvasti, 1986, Johnson and Shrier, 1987). Seventy percent (70%) of the female sex offenders in this study used extraneous violence against their victims. It is important to acknowledge that this population of female sex offenders does exist.

Sexually Violent Predators (Texas SVP Act)

On September 1, 1999, the Governor signed Senate Bill 365, which established the first outpatient civil commitment program in the United States. The legislature found that a small but extremely dangerous group of sexually violent predators exists and that those predators have a behavioral abnormality that is not amenable to traditional mental illness treatment modalities and that makes the predators more likely to engage in repeated predatory acts of sexual violence. Thus, the legislature created a civil commitment procedure for the long-term supervision and treatment of sexually violent predators was necessary and in the interest of the state. The Council was tasked with the implementation and administration of the Outpatient Sexually Violent Predator (SVP) Treatment Program (Title 11, Health & Safety Code, Chapter 841). This Outpatient Program was chosen strictly due to fiscal constraints. The annual outpatient cost ranges between \$30,000 and \$37,000 dollars per client per year. Inpatient SVP treatment in fifteen (15) other states cost between \$80,000 to \$125,000 dollars per offender per year (AZ, CA, FL, IA, IL, KS, MA, MN, MO, ND, NJ, SC, VA, WA, and WI). The outpatient civil commitment program targets sexually violent predators being released from prison who pose a serious risk to community safety or are at high risk to re-offend.

Sexually violent predators are committed not convicted. The civil commitment program is neither a criminal charge nor punitive. The intent of the law is to provide intensive outpatient rehabilitation and treatment to the sexually violent predator. Civil commitment is different than a criminal sentence in that a criminal sentence has a definitive time frame. Civil commitment continues until it is determined that the person's behavioral abnormality has changed to the extent that the person is no longer likely to engage in a predatory act of sexual violence.

The Kansas Inpatient SVP Act (1994 Kan. Stat. Ann. 59-29a01 et seq.) has withstood the constitutional challenges and has validated identical laws in numerous other states (Kan. Stat. Ann 59-29a01 et seq., 1994). The U.S. Supreme Court in the Hendrick's (*Kansas v. Hendricks* 521 U.S. 346, 117 S.Ct. 2072 138 L.Ed.2d 501, 1997) case ruled that as long as a State's ancillary purpose is to treat the sex offender and his/her due process rights were protected, the State may commit the sex offender for an indefinite period as far as the United States Constitution is concerned. On May 20, 2005, in a landmark decision by the Texas Supreme Court- *In the Matter of Fisher* (In Re Commitment of Michael Fisher, No. 040112) upheld the Texas SVP Act as civil in nature and reversed the lower courts

rulings regarding due process and fifth amendment violations, facial vagueness, and punitive nature.

The Texas Legislature defines a **sexually violent predator** as a person who is a repeat sexually violent offender and suffers from a behavioral abnormality that makes the person likely to engage in a predatory act of sexual violence.

Texas civil commitment statute requires a “**behavior abnormality**” which means a congenital or acquired condition that, by affecting a person’s emotional or volitional capacity, predisposes the person to commit a sexually violent offense, to the extent that the person becomes a menace to the health and safety of another person.

A **predatory act** was defined as an act that is committed for the purpose of victimization and that is directed toward a stranger, a person of casual acquaintance with whom no substantial relationship exists; or a person with whom a relationship has been established or promoted for the purpose of victimization.

Sexually motivated conduct was defined as any conduct involving the intent to arouse or gratify the sexual desire of any person immediately before, during, or immediately after the commission of an offense.

A **sexually violent offense** is defined as Indecency with a Child, Sexual Assault, Aggravated Sexual Assault, Aggravated Kidnapping with Intent, Burglary with Intent, Sexually Motivated Capital Murder or Murder, any attempt, conspiracy, or solicitation of the latter, or any offense under the law of another state, federal law, or the Uniform Code of Military Justice that contains elements substantially similar. The **outpatient treatment and supervision program** begins upon the person’s release from the Texas Department of Criminal Justice-Institutional Division, discharge from a state hospital, or upon conclusion of the trial.

The Council, as administrator of the outpatient sexually violent predator treatment program, is responsible for the following but not limited to:

- ❑ Comprehensive case management supervision
- ❑ Residential housing requirements (if applicable)
- ❑ Intensive sex offender treatment (Intake, Testing, Groups, Individuals, Family Sessions, etc.)
- ❑ Global positioning satellite tracking (24 hours per day/ 7 days per week)
- ❑ Anti-androgen medication
- ❑ Mandated polygraphs (Instant Offense, Sexual History, Maintenance, and Monitoring)
- ❑ Mandated penile plethysmographs
- ❑ Biennial examinations
- ❑ Restricted transportation
- ❑ Substance abuse testing

Only **licensed sex offender treatment providers** (LSOTP) who contract with the Council may assess and provide treatment to the SVP. Sex offender treatment groups are offense specific and limited to ten (10) offenders. Self-help, drug intervention, or time-limited treatment is used only as adjuncts to more comprehensive treatment. Sexually Violent Predators subject to Civil Commitment attend group therapy two (2) times per week and have two (2) individual sessions per month. SVPs are mandated to take polygraphs regarding their Instant Offense, Sexual History, Maintenance, and Monitoring. The penile plethysmographs are utilized to assess sexual arousal.

Failure to comply with the order of commitment is a **3rd degree felony**, which may result in incarceration in the Texas Department of Criminal Justice-Institutional Division.

Society should understand that SVPs are not “typical” sex offenders. These individuals are **repeat sexually violent predators** at extremely high risk to re-offend and community safety takes precedence over all conflicting constraints.

Recidivism Rates

Sex offender typologies have been traditionally used to assess risk and assign levels of treatment and supervision (Heil, 2003). These typologies assume that rapists only sexually assault adults and child molesters only molest children. Heil, Ahlmeyer, and Simons in a 2003 study found that 52% of inmates who were known to sexually assault only adults admitted to sexually molesting children, and 78% of inmates who were known to molest children also admitted to sexually victimizing adults. Additionally, this study found that 64% of inmates known to victimize relative children admitted to victimizing non-relative children.

The recidivism rates fluctuate among different types of sex offenders and are related to specific characteristics of the sex offender and the offenses. Recidivism rates for non-sex offending criminals are higher than recidivism rates for all types of sex offenders except the sexually violent predator. Research on recidivism rates can be functional in developing intervention strategies. Recidivism research outcomes are based on the definition of recidivism used. Caution should be used in placing sex offenders in exclusive categories.

It should be noted that recidivism rates are based upon information gathered from an arrest, a conviction, or incarceration on a sexual offense. In other words, a sex offender can repeatedly re-offend before he or she is arrested and recidivates. Marshall and Barabaree (1990) compared official records with “unofficial” sources. They found that the number of subsequent offenses revealed through the unofficial sources were **2.4 times higher** than the official records.

Donna Schram and Cheryl Darling Miloy reported in *Sexually Violent Predators and Civil Commitment*, a study of sixty-one (61) incarcerated sex offenders in Washington who were **not considered eligible** for a SVP petition, revealed that on average, they had 2.6 sex convictions. Additionally, 95% were alleged to have other known offenses for which

they had not been convicted; yet these offenders spent an average of only 5.1 years in prison for their index offense.

In general, **the factors most strongly** related to violent and sexual recidivism include having the characteristics of psychopathy as defined by a high PCL-R score (Hare, 1991, 1996, Rice 1997), a history of criminal behavior, and being young. Rice and Harris (1997) reported that the combination of **psychopathy**, measured by the PCL-R, and **sexual deviancy**, based on phallometric test results, resulted in the highest recidivism in their sample of sex offenders (Wakefield, 1998).

The public would be remiss if relying on recidivism rates in determining the “dangerousness” of a sex offender. Some sex offenders will inevitably commit new sexual offenses despite our best proactive efforts. Likewise, not all sex offenders who have high probability of re-offense will recidivate. Hanson and Bourgon (2004) in a study of 31,216 sex offenders found that, on average, the observed sexual recidivism rate was 13%, the violent non-sexual recidivism was 14%, and general recidivism was 36.9%.

Characteristics of Recidivists (Center for Sex Offender Management)

- ❑ Multiple victims
- ❑ Psychopathy (Narcissism + Antisocial Personality = Psychopath. This is measured on the Hare Psychopathy Checklist. A score above 30 is considered a psychopath)
- ❑ Stranger victims
- ❑ Diverse victims
- ❑ Juvenile sexual offenses
- ❑ History of abuse or neglect
- ❑ Multiple paraphilias
- ❑ Unemployed
- ❑ Substance Abuse
- ❑ Antisocial lifestyle

Risk Factors and Warning Signs to Re-offense (Hanson, 2000)

The following are a few of the risk factors and warning signs exhibited by sex offenders prior to committing a new sexual offense:

- The offender does not understand they are at risk.
- The offender has little or no support systems.
- The offender regards sex as an entitlement.
- The offender has access to potential victims.
- The offender is not compliant or cooperative with supervision or treatment.
- The offender is hostile and angry.
- The offender is using drugs or alcohol.
- The offender is persistently in denial and blames the victim for the crime.

In the 2000 Hanson and Harris study, of 208 sex offenders who committed a new sex crime, the first three listed above were the top three risk factors shown in the month before the sex offenders committed a new offense.

Sex Offender Behaviors

Not all sex offenders exhibit all of the following characteristics, and the absence of a particular characteristic does not mean the individual is not a sex offender (English, 1996).

- ❑ Secrecy and dishonesty is a major component of sex offending behavior. Sex crimes flourish in silence and deception.
- ❑ Sex offenders typically have developed complicated and persistent psychological and social systems constructed to assist them in denying and minimizing the harm they inflict on others, and often they are very accomplished at presenting to others a façade designed to conceal the truth about themselves (English, 1996).
- ❑ Cognitive distortions allow the sex offender to justify, rationalize, and minimize the impact of their deviant behavior (i.e. “I was drunk”, “We were in love”, “She came on to me”, “The child wanted it and I did not have the heart to say no”).
- ❑ Sex offenders use thinking errors to engage in deviant sex. The following are some examples:
 - Mr. Good Guy-“I wear a mask or false front”. “I give the right answer”.
 - Poor me-“I am the victim of this unjust system”. “Everyone is out to get me”.
 - Victim stance-“I am the one hurt”. “I will convince others that I was more hurt than the victim”.
 - *Power play-“It is my way or the highway”. “I will dominate and control others”.
 - *Entitlement- “The world owes me”.
 - *Selfish-“I do not care for others”. “I want what I want when I want it”.
 - Blaming- “I blame others so I can avoid responsibility for my actions”.
 - Minimizing- “I only fondled the child”. “It wasn’t intrinsically harmful”.
 - Hop Over-“I do not answer questions when I know the answer is unpleasant”.
 - Secretiveness-“I use secrecy to control others and continue being deviant”
- *These three thinking errors, in combination, create the criminal triad.
- ❑ Sex offenders are highly manipulative and will triangulate/split those around them. The skills used to manipulate victims are employed to manipulate family members, friends, co-workers, supervision officers, treatment providers, and case managers.
- ❑ Grooming activities are not solely for potential victims. Offenders will groom parents to obtain access to children. Grooming is well-organized and can be short or long term.
- ❑ The longer a sex offender knows an individual the better they are at “zeroing in” their grooming (“I can read people like a book. I know what others need and I am available to help out”.)
- ❑ The longer a sex offender is on supervision the higher the probability staff will lose their objectivity.
- ❑ Sex offenders are generally personable and seek to “befriend” those around them (“My smile is my entrée”. “I ‘m like a salesman but I’m never off work”.)
- ❑ Sex offenders will continually test boundaries (personal/professional space).
- ❑ Sex offenders exploit relationships and social norms to test boundaries.
- ❑ Sex offenders seek professions that allow them access to victims.

Undetected Rapists Behaviors (Lisak, 2002)

The Lisak study observed several particular characteristics used by undetected rapists.

- ❑ These individuals used alcohol deliberately to render victims more vulnerable to attack, or completely unconscious;
- ❑ These individuals were extremely adept at identifying “likely” victims, and testing prospective victims’ boundaries;
- ❑ These individuals planned and premeditated their attacks, using sophisticated strategies to groom their victims for attack, and to isolate them physically;
- ❑ These individuals used “instrumental” not gratuitous violence; they exhibit strong impulse control and use only as much violence as is needed to terrify and coerce their victims into submission;
- ❑ These individuals used psychological weapons—power, control, manipulation, and threats—backed up by physical force, and almost never resort to weapons such as knives or guns; and
- ❑ The majority of undetected rapists are serial rapists who commit other forms of serious interpersonal violence.

Sex offender behaviors are extremely resistant to change, so sanctions to both control and punish deviant behaviors are necessary in protecting public safety. In order to manage their behavior, sex offenders must have external controls (i.e. supervision, support system, law enforcement, registration, child safety zones, electronic or global positioning satellite monitoring, and community notification) and develop internal controls (i.e. identifying triggers and deviant thoughts that precede their offending so it does not lead to the act). Without external restraints many offenders will not follow through with treatment. Internal motivation improves prognosis, but it does not guarantee success.

Difference between Sex Offender Treatment and Traditional Psychotherapy

The most prominent difference is that the primary client in sex offender treatment is the **community** and the goal of treatment is **NO MORE VICTIMS**. With sex offender treatment, community safety takes precedence over any conflicting consideration.

Sex offender treatment is different than traditional psychotherapy in that treatment is mandated, confrontational, structured, victim centered, and the treatment provider imposes values and limits. Providers cannot remain neutral because of the risk of colluding with, adding to, and/or contributing to the offender’s denial. In sex offender treatment, confidentiality is not maintained due to the enormous public safety issues. Because secrecy is the lifeblood of sexual offending, treatment providers cannot guarantee confidentiality. Treatment providers must not solely rely on self-report because sex offenders see trust as abuseable. Treatment providers rely on polygraphs to verify information given by the offender. Sex offender treatment is offense specific and focused on the deviant behavior.

Sex offender treatment requires the offender to face the consequences of their behavior on their victims and society. Sex offenders are expected in treatment to accept

responsibility for their sex offending behaviors. Unlike sex offender treatment, in traditional psychotherapy the client voluntarily seeks therapy and is motivated. Goal setting is a joint responsibility with the client having the final say. Therapists remain neutral and do not impose their values and limits. Confidentiality and trust are maintained and are essential to the therapeutic process.

Additionally, sex offender treatment mandates an approach unfamiliar to most mental health professionals because of the substantial control a therapist must exercise over their client due to the concern for community protection. Due to this specialization, only a practitioner licensed under the Occupations Code, Chapter 110 as a **Licensed or Affiliate Sex Offender Treatment Provider** is qualified through training and experience to conduct the assessment and provide the appropriate treatment for sex offenders in Texas.

Offense Specific Sex Offender Treatment

Offense specific sex offender treatment is effective in reducing recidivism. A multifaceted treatment program includes the following;

- **Cognitive/Behavioral group and individual sessions.** Cognitive distortions are thoughts and attitudes that allow offenders to justify, rationalize, and minimize the impact of their deviant behavior. Cognitive distortions allow the adult sex offender and juveniles with sexual behavior problems to overcome prohibitions and progress from fantasy to behavior. These distorted thoughts provide the adult sex offender and juveniles with sexual behavior problems with an excuse to engage in deviant sexual behavior, and serve to reduce guilt and responsibility.
- **Arousal control.** Control of deviant arousal, fantasies, and urges is a priority with most adult sex offenders and juveniles with sexual behavior problems. Fantasy and sexual arousal to fantasy are precursors to deviant sexual behavior. It should be assumed that most adult sex offenders and juveniles with sexual behavior problems have gained sexual pleasure from their specific form of deviance. Dr. Matthew Ferrara in “Lifestyle Enhancement and Development (2000)” describes deviant sexual behavior as behavior that meets one or more of the subsequent criteria: Sexual contact with a person under the legal age of consent (17 years old); sexual contact with a person who is unable to give consent; sexual contact that is forced, aggressive, causes physical harm, is coerced, uses intimidation or deceit, or is paid; or sexual contact that is harmful or degrading.
- **Victim empathy-** Although there is no clear evidence to suggest that all sex offenders can gain true empathy for victims of abuse, a universal goal of treatment is to learn to understand and value others. Highlighting the consequences of victimization helps sensitize the offender to the harm he or she has done. Empathy is comprised of cognitive and emotional aspects and both components may need to be addressed (ATSA). The use of analogous experiences has been shown to be effective especially with

juveniles. Sex offender treatment requires the offender to face the consequences of their behavior on their victims and society.

- **Biomedical interventions. Physical or chemical castration should be utilized only as an adjunct to treatment and not in lieu of treatment.** Antiandrogens such as depo-provera or Lupron act by reducing testosterone levels. These agents may be helpful in controlling arousal and libido when these factors are undermining progress in treatment or increasing the risk of re-offending before significant progress can be made in the cognitive aspects of therapy. Likely candidates for biomedical intervention are those clients who are predatory, violent, have had prior treatment failures, and report an inability to control deviant sexual arousal. It should be remembered that deviant sexual behavior begins with deviant sexual thoughts.
- **Offense Cycle and Relapse Prevention.** Current knowledge of deviant sexual behavior suggests that there is a cycle of behaviors, emotions, and cognitions that is identifiable and which precede deviant sexual behavior in a predictable manner. The ability to accurately identify these maladaptive behaviors is a primary goal for every adult sex offender and juvenile with sexual behavior problems in treatment. Autobiographies, sexual history polygraphs, offense reports, interviews and cognitive-behavioral chains are used to identify antecedents to offending. It is essential to examine the sex offender's deviant sexual arousal and behavior and not just the offense of conviction. Research and clinical reports have begun to demonstrate that a number of treatment methods are effective in modifying some forms of sexual deviance. It is known that very specific thoughts occur prior to the sexually deviant act. This is what is commonly referred to as an offense cycle.

IMPULSE → FANTASY → PLAN → ACT → CONSEQUENCE

Impulses are normal and natural. Everyone has impulses and impulses are automatic. An impulse is when a person recognizes an individual in terms of their sexual attractiveness. A fantasy is a mental picture of what it would be like to engage in deviant sexual behavior. The set up is the plan for victimization. The consequence for deviant sexual acts should be legal sanctions but unfortunately not all deviant sexual acts are followed by consequences. Sex offenders must recognize their deviant impulses and stop those impulses from developing into deviant fantasies. It is essential to examine the sex offender's deviant thought, sexual arousal, and behavior.

- **Polygraphs.** Because secrecy and dishonesty is the major component in sexual offending, polygraphs must be utilized. Polygraphs measure the emotional arousal that is caused by fear and anxiety. The autonomic nervous system responds to arousal with physiological reactions such as increased heart rate, depth of respiration, and sweat gland activity. There are four types of polygraphs that are used on sex offenders:
 - (1) Disclosure Polygraph- addresses the offense of conviction in

- conjunction with the official version;
- (2) Sexual History Polygraph- addresses the complete sexual history of the client up to the instant offense;
 - (3) Maintenance Polygraph- addresses compliance with conditions of supervision and treatment; and
 - (4) Monitoring Polygraph- addresses if the client has committed a “new” sexual offense.
- **Plethysmograph** is a diagnostic method used to assess sexual **arousal** by measuring the blood flow (tumescence) to the penis during the presentation of sexual stimuli (audio/visual) in a laboratory setting. The plethysmograph provides the identification of clients’ arousal in response to sexual stimuli and the evaluation of therapeutic efficacy. If offenders are internalizing methods taught to control their deviant arousal, there is a decrease in deviant arousal and an increase to positive appropriate arousal. The PPG cannot assess 25% of the population due to medical or gender reasons. In these cases, the Visual Reaction Time (VRT) is an alternative instrument, which may be utilized.
 - **Co-morbid diagnosis** In some adult sex offenders and juveniles with sexual behavior problems there are sufficient signs and symptoms to merit an additional diagnosis by DSM IV-TR criteria. These diagnoses can be anywhere in the entire spectrum of psychiatric disorder. The co-morbid diagnoses should be treated with the appropriate therapies concomitantly with the treatment for sex offending behavior except in the case of schizophrenia where the anti-psychotic therapy would obviously take precedence.
 - **After-Care** A therapeutic regime that includes after-care treatment significantly increases the likelihood that gains made during treatment will be maintained. In order for new habits and skills to be reinforced and to monitor compliance with treatment contracts, after-care treatment should involve periodic follow up sessions to reinforce and assess maintenance of positive gains made during treatment.
 - **Adjunct treatments** Substance abuse, anger management, stress management, social skills, couples/family therapy, or self-help groups shall only be used as adjuncts to a comprehensive treatment program in reducing the client’s risk to re-offend.

The Effectiveness of Sex Offender Treatment

Incarceration in a penal institution does not deter repeat sexually violent predators or the proliferation of sexual violence. Decades of research across a broad spectrum of issues show that punishment merely suppresses deviant behavior and does not eradicate it (Cole, Cory, McKenzie, and Meyer, 1997). With this in mind, over the past 30 years an enormous amount of research has shown relevant information regarding the assessment, treatment, and containment of sex offenders, which in turn has enhanced public safety. There have been considerable advances in our knowledge about the characteristics of effective treatment programs (Bonta, 2001). The purpose of treatment is to modify both

cognitive distortions and deviant sexual behavior to reduce the risk of re-offending. Research and clinical reports have begun to demonstrate that a number of treatment methods are effective in modifying some forms of sexual deviance. The following are studies that show the effectiveness of treatment:

- ❑ In a 2004 study of 31,216 sex offenders, Hanson observed on average that the sexual recidivism rate was 13%, violent non-sexual recidivism at 14%, and general recidivism at 36.9%
- ❑ In 2000 Hanson found that the overall effect of treatment demonstrated reductions in both sexual recidivism (10% of the treated subjects to 17% of untreated) and general recidivism (32% for treated subjects to 51% of untreated subjects).
- ❑ In the December 2002 publication of *Psychiatry News*, an article titled "Sex Offender Recidivism Rates Below Expectations: A 15 Year Prospective Study" concluded that more than eighty percent (80%) of sex offenders who have undergone treatment do not re-offend within fifteen (15) years. The study of 626 individuals was reported at the American Academy of Psychiatry and Law. The study found that sex offenders who were compliant with treatment were less likely to re-offend. Approximately forty percent (40%) of these individuals received anti-androgenic drugs in order to lessen their sex drive.
- ❑ Child molesters who participated in a cognitive behavioral treatment program had fewer sexual re-arrests than the sex offenders who did not receive any treatment (13.2% vs. 57.1%, respectively). Both groups were followed for 11 years. The recidivism data was obtained by official sources and self-reports. Treated exhibitionist were reconvicted or charged with a sexual offense less than the untreated exhibitionist (23.6% v. 57.1%, respectively) (Lane, Council, 2003).
- ❑ Recidivism rates for sex offenders do decrease with proper treatment. A meta-analytic study showed that treated sex offenders recidivated at a rate of 19% (Hall, 1995).
- ❑ Treated offenders are more likely to make emotional and psychological restitution for the offender's deviant behavior and be available to contribute to the victim's treatment process.
- ❑ When treatment programs are compared with criminal justice sanctions, the findings show treatment is more likely to reduce recidivism. Even detailed analyses of types of sanctions show no one particular sanction as significantly effective in reducing recidivism. If we are to enhance community safety, offender rehabilitation programs that follow the principles of effective treatment are most likely to meet with success (Bonta, 1997-2001).

The Cost of Sexual Assault

The irrefutable emotional and psychological harm caused by sexual offenses can last for a lifetime and can never be monetarily calculated. However, several studies conducted from the 1980's through the 1990's reported a cost range of \$138,000 to \$200,000 per case to prosecute a single case of child sexual abuse.

- ❑ The Lane Council study found cost experienced by victims of rape and sexual assault were \$109,778 and sexual abuse of a child was \$126,024. This included

productivity, medical care, mental health, police services, social services, tangible loss, and quality of life. These estimates demonstrate the devastating impact of a sex crime on victims

- ❑ Prentky and Burgess (1990) estimated the total expense per sexual offense to be \$183,333.00 dollars (offender cost \$169,029.00 and victim cost \$14,304.00).

Safety Tips

- ❑ Think safety first.
- ❑ Be informed and know your local resources.
- ❑ Be active in your community. Get to know your neighbors.
- ❑ **Never** assume your child could not be molested, missing, or abducted.
- ❑ Build your child's self-esteem. A child who has low self-esteem is more easily lured.
- ❑ Teach and practice decision making with your child.
- ❑ Build support systems. Children need to know where to go for help.
- ❑ Carefully interview, screen, and background check all caregivers.
- ❑ Teach age appropriate information regarding physical and sexual abuse.
- ❑ Use age appropriate role-playing with children. Play "what if" games.
- ❑ Develop a family code for emergency situations.
- ❑ Respect a child's "no". Do not force a child to hug or shake hands.
- ❑ **Never** leave young children unattended for any reason.
- ❑ Establish ground rules for your child when answering the telephone. Teach your child to screen calls through the answering machine.
- ❑ Teach and have emergency contact numbers easily accessible.
- ❑ Teach your child how to make long distant phone calls.
- ❑ Teach your child to screen telephone calls through the answering machine or caller ID.
- ❑ Monitor all computer use. Use parental controls.
- ❑ Teach your child their full name, address, and telephone number including area code. Practice calling long distance.
- ❑ Teach your child your full name (parent or guardian).
- ❑ Learn how to access registered sex offender information of the Department of Public Safety website.
- ❑ Teach your child when it is okay to "make a scene" if someone tries to abduct them. Teach children to scream "you are not my mommy or daddy!"
- ❑ Have your child's picture taken at least four times per year.
- ❑ Keep your child's records including fingerprints, footprints, dental/doctor information, birthmarks, and birth certificates.
- ❑ Tell your child that you will **never** stop searching for them if they were ever taken.
- ❑ Let kids be kids. Teach them safety but do not scare them.

Conclusion

Sex offenders cannot be "cured" but with specialized offense specific treatment and supervision, many sex offenders can manage their deviant behaviors. Society must

understand that not all sex offenders are predatory and the majority of sex offenders will not commit new sexual offenses. The public perception of sex offenders representing a high risk and the evident reality of statistics demonstrate a relatively low level of sexual reoffending. Society must be informed, aware, and think of safety first. Communities must listen to outcries regarding abuse. It is crucial to remember, there are no absolutes or “magic bullets” in the process of identifying risk factors. Some sex offenders will inevitably commit subsequent sex offenses, in spite of our best efforts at identification aimed at minimizing these conditions (Bynum, 2001).

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