Sex Offender Treatment Plan

by Emily Michael

This article outlines a sample behavioral treatment plan for an adult male sex offender. Treatment techniques were derived from empirically supported studies that are reviewed throughout the text. The history, evolution and efficacy of sex offender treatment strategies are discussed. Relapse prevention and follow-up strategies are recommended, as is the need for future research.

“Jack” is a 32-year-old man who was recently arrested for molesting a 12-year-old boy.[1] This is his first reported offense. At Jack’s arraignment, he was fined for court fees and sentenced to 5 years probation with a minimum of 1 year of mandatory psychological treatment at a community-based sex offender treatment program. As a staff social worker at this sex offender treatment program, I was assigned Jack’s case. By the time I first met Jack, he had already been seeing a therapist for 2 months, he had accepted responsibility for this and other unreported offenses, claimed to understand how his actions affect his victims and was ready to commit to a treatment program.

Definition and Goal of Treatment

O’Connell et al. (1990) define a sexual offense as “a criminal offense involving sexual behavior when one party does not give, or is incapable of giving, fully informed consent…[this definition] also includes situations where the difference in power between the two parties is such that one is not in a position to make a truly free choice [i.e. child molestation]” (p. 11). The goal of behavior therapy with sex offenders is not to cure the offender of his deviant sexual fantasies; in fact, it is unlikely that a treatment program could completely reorient a pedophile’s arousal pattern to one that is aimed exclusively at consensual sexual activities with adults (Crolley et al., 1998, p. 486; O’Donohue et al., 2000)[2]. Instead, treatment is aimed at lessening the intensity of the offender’s deviant fantasies; incorporating new, appropriate fantasies into his repertoire; helping him to identify his negative cognitive-behavioral offense chain; and

developing appropriate coping mechanisms to help him control his responses to deviant fantasies and impulses as they occur (O'Donohue et al., 2000; Stoner and George, 2000; Marshall, 1999).

BEHAVIORAL TREATMENT TECHNIQUES

Before 1970, the treatment of sex offenders was largely psychoanalytic in nature. The growing presence of behavior therapy provided clinicians with an empirically based treatment modality that addressed offenders' problems more comprehensively. However, because deviant sexual behavior has strong cognitive antecedents, cognitive therapy techniques are combined with behavioral interventions in order to achieve the best results (Polizzi et al., 1999; Marshall, 1999). There are several cognitive steps preceding the behavioral portion of most sex offender treatment programs. Offenders are asked to disclose all offenses, analyze thoughts and feelings during perpetration, restructure cognitive distortions and pro-offending attitudes (such as, "she liked it, it did not hurt him, laws do not apply to me"), and explore overall social functioning (Marshall, 1999; Schwartz and Canfield, 1998).

The preceding cognitive techniques occur during the first stages of treatment. Once the offender accepts responsibility for his actions, is able to empathize with his victim(s) and has cultivated significant motivation to change his behavior, the behavioral (and cognitive-behavioral) reshaping techniques are implemented (Aubut et al., 1998). Those most widely discussed in behavior therapy literature include tracking deviant fantasies, impulses, and behaviors; covert sensitization; orgasmic reconditioning; and relapse prevention. They are implemented in different ways, but most of the programs I surveyed include a combination of these techniques into their treatment structures.

Tracking Deviant Fantasies, Impulses and Behaviors

This tracking process (Marshall, 1999; Aubut, et al., 1998) involves listing all fantasies (both appropriate and deviant) that occur during masturbatory and non-masturbatory fantasies and daydreams. The importance of this distinction is twofold. First, sexual fantasies do not occur exclusively during masturbation, therefore it is important to examine whether the content is different in different contexts. Second, because masturbation serves as a reinforcer for fantasies, it is necessary to record the conditions surrounding the occurrence of deviant fantasy in order to effectively implement an intervention. The client then describes any attempts made to resist acting upon the fantasies. If the client was successful in resisting, he describes how he was able to resist. If unsuccessful, he records how he acted upon his fantasy and what he could have done instead.

During therapy, the client is asked to ascribe meaning to his fantasies and explore how they serve to maintain offending tendencies and behaviors.

Covert Sensitization

The goal of covert sensitization (Barlow, 1998, Crolley et al., 1998; Schwartz and Canfield, 1998; O'Connell et al., 1990) is to integrate long-term consequences into the mind of the sex offender. To achieve this goal, strongly arousing sexual fantasies are paired with worst-case scenario consequences (e.g., "imagine you are touching your daughter's breast and your wife and the family priest walk in the room and catch you. They react with horror, your wife faints, your daughter runs out of the room screaming, the priest is speechless...") (Barlow, 1998, p. 458). The therapist dramatically recreates these scenes for the client during several sessions in order to solidify the scenario in the client's imagination. The client is then asked to rehearse the scenario in his head over and over again outside of therapy until he is no longer aroused. This process is then recorded on an arousal chart.

Orgasmic/Arousal Reconditioning

With orgasmic/arousal reconditioning (Barlow, 1998; Crolley et al., 1998; Schwartz & Canfield, 1998; O'Connell et al., 1990), the client is asked to masturbate to deviant sexual fantasies followed by the insertion of an appropriate fantasy just before ejaculation. Eventually, insertion of the appropriate fantasy should begin to occur closer and closer to the beginning of the masturbatory session. Ideally, after much practice, the client should still be able to reach orgasm while masturbating to an appropriate fantasy.

Then, while the client is in a nonaroused state, he is asked to verbalize an inappropriate sexual fantasy for a specific amount of time. If at any point he becomes aroused while verbalizing this fantasy, he is to continue verbalizing until the arousal subsides, thus proving to himself that he is able to control his arousal in the face of his deviant fantasies.

Relapse Prevention

In relapse prevention (Barlow, 1998; Marshall, 1999; Crolley et al.; Schwartz and Canfield, 1998; O'Donohue et al., 2000; Stoner and George, 2000), the offender identifies his victimization cycle and the cognitive-behavioral offense chain within that cycle. For example, if his offenses are against young boys, the offender is asked to explore factors that make him vulnerable to reoffending, such as the use of child pornography, his proximity to children, the use of substances to lower his inhibitions, or a desire for closeness. It is important that

the therapist and client identify a list of coping strategies that the client can use when he is overcome with the impulse to offend. The client's cognitive-behavioral chain is diagramed so that he can see exactly where he needs to implement these coping strategies to keep himself from reoffending or, if he does offend, he knows how to take steps to keep it from happening again. The chain might look something like Figure 1 (Stoner and George, 2000, p. 68):

FIGURE 1

LAPSE

RELAPSE

Willful and elaborate fantasizing or return to sources of stimulation associated with offense cycle

Failure to abstain

Abstinence violation

First occurrence of sexual offense

Failure to abstain

Abstinence violation

Full-scale return to previous sexual offending pattern or worsening

COPING STRATEGIES: Engage in covert sensitization fantasy, leave tempting situations, call therapist or group member, etc.

The client is then asked to develop two lists (Figure 2) of warning signs: one consisting of signs that only he can identify, the other of signs that are visible to others (Marshall, 1999). These lists are both kept by the client, and list two is distributed to others with whom he has close contact so that they can intervene if they suspect that warning signs are present.

FIGURE 2

LIST ONE (self-identifiable)

- Return of deviant fantasies
- Desire to get drunk
- Loneliness
- Etc.

LIST TWO (other-identifiable)

- Excessive time spent with children
- Being unaccountably alone
- Social withdrawal
- Etc.

EMPIRICAL FINDINGS

It is extremely difficult to eradicate all traces of deviant sexual fantasies. However, cognitive-behavioral interventions have been shown to reduce or prevent sex offender recidivism. Crolley et al. (1998) conducted a recidivism study with 16 offenders who received cognitive-behavioral therapy at a treatment program in Atlanta. During the post-treatment follow-up period (approxi-

mately 26 months in duration), only one of the 16 clients reoffended and is now in jail. Although single-incidence studies like this cannot be generalized to the entire group of sex offender treatment programs, this data certainly supports the notion that "behavior therapy can be effective in reducing deviant sexual arousal and in enhancing appropriate consensual sexual behavior" (Crolley et al, 1998, p. 1).

In a meta-analysis of 13 sex offender treatment programs, Polizzi et al. (1999) conclude that "cognitive-behavioral treatment programs appear to be effective in reducing recidivism among sex offenders" (Polizzi et al., 1999, p. 364). Specifically, these researchers find that nonprison-based sex offender treatment programs had the best results in reducing deviant sexual arousal and recidivism. Their findings suggest that prison-based programs were less scientifically meritorious; therefore results from many of the prison-based programs carried less weight in the meta-analysis. Perhaps this is an indication that community-based alternatives are more comprehensive and rigorous in their treatment design. Options such as halfway houses, where offenders live together and abide by strict house rules (e.g., curfew, attendance at therapy groups, etc.) may be good solutions for keeping the community safe while also providing effective treatment for sex offenders.

Barlow (1998) cites a study by Maletzky (1991) in which he and his staff report on success rates of about 5,000 sex offenders who received cognitive-behavioral therapy at a sex offender treatment clinic.[3] The data were collected over a period of up to 17 years. Criteria for treatment success in his follow-up were as follows: client completed all treatment sessions, client demonstrated no deviant sexual arousal on plethysmograph testing at any annual follow-up testing session, client reported no deviant arousal at any time since treatment ended, client had no legal record of any charges of deviant sexual activity (pp. 459-60).[4]

The results of Maletzky's research (displayed in table 1) strongly support the efficacy of cognitive-behavioral treatment of sex offenders.

TREATMENT PLAN FOR "JACK"

Problem

Jack is sexually attracted to young boys and has acted on that attraction on more than one occasion. His actions have included fondling boys' genitals and making young boys masturbate him to orgasm. Jack is suffering from the consequences of his actions. His story was published in the local newspaper, he was imprisoned for a short period of time, he lost his job, most of

TABLE 1	
DIAGNOSTIC CATEGORY	% SUCCESSFUL AT TIME OF LAST FOLLOW-UP
Heterosexual pedophilia (n=2,865)	94.7
Homosexual pedophilia (n=855)	86.4
Hetero & Homo pedophilia (n=112)	75.7
Other multiple paraphilias (n=54)	71.7
Exhibitionism (n=770)	93.1
Rape (n=145)	73.5

ADDITIONAL DIAGNOSTIC CATEGORIES ARE LISTED BELOW:
Public Masturbation (n=75), 91.1; Voyeurism (n=70), 88.1; Frotteurism (n=60), 80.6; Transvestitism (n=60), 91.7; Fetishism (n=30), 88.8; Obscene telephone callers (n=25), 100; Sadomasochism (n=25, 80; Zoophilia (n=20), 100.

his friends have turned their backs on him and his family is deeply ashamed.

Goal

Jack would like to learn how to control his impulses and lessen their intensity so as not to endanger other children. He wants to begin to rebuild his life.

Assessment Procedures

I will start by administering a battery of tests in order to determine Jack's current state of mind, his current sexual interests, and his level of sexual deviance. First, I will use the Structured Clinical Interview for the DSM-IV (SCID) to complete a diagnostic evaluation with Jack in order to screen for personality and mood disorders. If he tests positive for either or both of these, I will adjust my treatment plan accordingly (i.e., refer him to a psychiatrist for psychopharmacology and implement additional behavioral techniques specific to his comorbid disorder(s)). Next, I will administer the Multiphasic Sexual Inventory II (MSI-II), which is a "self-report questionnaire that consists of various scales addressing sexual knowledge, validity, and sexual deviance" (Crolley et al., 1998, p.489). The MSI-II has been proven to be a reliable measure of sex offender sexual characteristics.

Sexual History

It is important to gather a comprehensive history of Jack's sexual life. I will assess his own sexual abuse history to see if perhaps he was abused or mistreated as a child. I will assess his attraction to both men and women, and

obtain the numbers and types of appropriate sexual encounters he has experienced. I will then examine his deviant sexual history, assess when it started, how many people he has victimized, the circumstances surrounding victimization, and the length of time between offenses. Together, Jack and I will chart this history so that we are both able to refer to his historical patterns throughout treatment.

Fantasy Tracking

In the next part of treatment, I will ask Jack to begin tracking his sexual fantasies, both appropriate and deviant. To facilitate this baseline gathering process, I have designed a Sexual Fantasy Tracking Sheet that he can use to chart his experiences. If it proves to be difficult for him to use, we will make any necessary changes to simplify the structure. Over time, these charts will help us to see Jack's progress in reducing the number and intensity of inappropriate sexual fantasies. When we develop coping strategies for him to use in helping resist deviant impulses, he will start charting those on this sheet as well.

Arousal Reconditioning

The next phase of treatment involves sexual arousal reconditioning techniques including covert sensitization and orgasmic reconditioning. Jack will use covert sensitization by pairing strongly arousing sexual fantasies with worst-case scenario consequences (e.g., "imagine you are being masturbated by a young boy. You are about to reach orgasm when your mother, your boss, and the boy's father enter the room. Your mother screams, your boss leaves in disgust and will tell all of your coworkers what has happened, and the boy's father runs at you with clenched fists…"). I will dramatically recreate this and other scenes for Jack during several of our sessions in order to solidify the scenario in his imagination. I will then ask Jack to repeat the scenario in his head outside of therapy until he no longer achieves an erection from the thought of being masturbated by young boys. This process will then be recorded on an arousal chart.

Jack will also engage in orgasmic reconditioning exercises. I will ask Jack to privately masturbate to deviant sexual fantasies followed by the insertion of an appropriate fantasy just before ejaculation. This will continue until he reports that he is able to have an orgasm that results from an appropriate fantasy (e.g., consensual sex with an adult). Then, I will ask Jack to verbalize one of his inappropriate sexual fantasies for a specific length of time. f at any point he becomes aroused while verbalizing this fantasy, he is to continue verbalizing until the arousal subsides, hopefully proving to himself that he has the ability to become aroused by sexually appropriate fantasies.

Relapse-Prevention

In relapse prevention, Jack will identify his negative behavior cycle and the cognitive-behavioral offense chain within his cycle. We will explore factors that make him vulnerable to reoffending, such as those previously described (e.g., the use of child pornography, his proximity to children, the use of substances to lower his inhibitions, a desire for closeness, etc.). Then we will identify a list of coping strategies that he can use when he is overcome with the impulse to offend. We will explore where these coping mechanisms should be implemented within his cognitive-behavioral chain so that he can clearly identify times in which he needs to take steps to stop his cycle (see Figure 1).

A second part of relapse prevention is the development of lists of warning signs. One will contain signs that only Jack can identify; the other will consist of signs that are visible to others. Jack will keep both of these lists; I will keep list two and also give it to his probation officer and housemates. Throughout the course of treatment, the effectiveness of these interventions will be evidenced in Jack's Fantasy Tracking Sheets, his covert sensitization graphs and the reports of others involved in his treatment and life.

Follow-Up

Once Jack has completed his treatment, I will follow-up with him on a biweekly basis for 3 months and then monthly for the following 9 months. We will meet to discuss any problems he has had and whether or not there has been a resurgence of deviant arousal or behavior. Jack will also be assessed using plethysmograph testing to ensure that his self-report is accurate.

CONCLUSION

Just as it is impossible for substance abuse treatment programs to completely remove their clients' cravings for drugs and alcohol, it is also extremely difficult to eradicate all traces of deviant sexual fantasies in sex offenders. All pleasurable-yet-undesirable behavior has high recidivism rates, for obvious reasons. Fortunately, cognitive-behavioral interventions have been shown to reduce or prevent sex offender recidivism. Programs that aim to help sex offenders identify and control their responses to deviant fantasies and impulses and offer alternatives to victimizing behavior continue to achieve new successes with clients. Further research, development and implementation of these effective treatment regimes will continue to help save children from becoming victims of sexual crimes and will assist offenders in rebuilding their lives. ■

FOOTNOTES

[1] Jack is a fictitious man who was conceptualized using information from a variety of sex offender cases I have read about or encountered.

[2] Throughout this article I use male pronouns to refer to sex offenders because men were the subjects of all of the empirical research I reviewed.

[3] Attempts to obtain the original study from the University of Chicago libraries were unsuccessful.

[4] Plethysmograph testing is a procedure in which sexual arousal to various stimuli is measured through penile responses.

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