

**Successful Interventions
With Sex Offenders:**
Learning What Works

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**U.S. Department of Justice
National Institute of Justice**

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*Washington State
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Washington State Institute For Public Policy

Community Protection Research Project

The mission of the Washington State Institute for Public Policy is to assist policymakers, particularly those in the legislature, in making informed judgments about the important, long-term issues facing Washington State.

The Institute conducts research on issues of major importance to the state using academic specialists from universities in Washington State. Staff of the Institute work closely with legislators and legislative, executive, and agency staff to define issues that can benefit from academic involvement. New activities are initiated at the request of the legislature or executive branch agencies. A board of directors governs the Institute and guides the development of new projects.

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During its 1990 session, the legislature passed an ambitious community protection law that received national attention. The legislation increased prison terms for adult sex offenders as well as authorizing treatment funds for sexually aggressive youth, developmentally disabled sex offenders, juvenile sex offenders, and adult sex offenders. Services for victims are also included.

The legislature directed the Institute to evaluate the effectiveness of these state-supported programs. An advisory panel of academics, legislators, state administrators, and a citizen representative is assisting the Institute in setting the research agenda for the remainder of this biennium and outlining a long-term research plan. Roxanne Lieb directs this project.

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Conference Summary

During its 1990 session, the Washington State Legislature passed one of the country's most comprehensive reforms addressing community protection from sex offenses. One of the unique provisions of the Community Protection Act was the inclusion of funds to evaluate the law's effectiveness. The Washington State Institute for Public Policy was directed to guide this evaluation.

As part of this effort, the Institute sponsored a conference on September 19, 1990. Top researchers and practitioners discussed the current state of knowledge regarding successful interventions with sex offenders and their victims. Issues addressed included treatment and supervision of sex offenders, as well as prevention of sexual abuse and treatment for victims. Over 260 people attended the conference, including representatives from the fields of adult and juvenile corrections, law enforcement, victim and offender treatment, research and policy, and citizen organizations. State legislators and staff members also attended.

What Was Learned At The Conference?

- Different approaches to sex offender intervention include efforts to teach self-control and relapse-prevention skills, individual and group psychotherapy, attempts to evoke empathy for victims, hormonal treatment, and various forms of supervision. All aim to reduce repeat criminal behavior and protect the public.

- The best treatment programs address the causes of sex offenses, are acceptable to offenders, and are designed for those at highest risk of reoffending.

- Sex offenders are a very diverse group, and successful assessment, treatment, supervision, and other interventions must necessarily be individualized.

- Adolescent sex offenders have characteristics and needs that are different from adult offenders and need distinct kinds of intervention. Treatment for them must take a developmental approach with attention to many aspects of their lives, particularly their families.

- While we have substantial information on the characteristics of sex offenders, we know much less about whether treatment is effective.

- The quality of evaluation of offender treatment programs has increased in recent years, with attention on producing carefully controlled studies.

- Victims of sexual offense, particularly children, suffer long-term harm including anxiety, depression, impaired self-image and personal relationships, and continued victimization.

- Families can contribute to the successful treatment and recovery of child sex abuse victims. Families also contribute to and exacerbate the distress of child victims.

- The monetary costs to society of sex offenses are great, and successful treatment of both victims and offenders can be cost-effective.

- Children can absorb the message of sex abuse prevention programs, but we do not know whether such programs are effective ultimately in preventing abuse.



Introduction

Norm Maleng, King County Prosecutor and chair of the Governor's Task Force on Commu-

nity Protection, opened the conference by describing the failure of most legislative reforms to acknowledge that success is not achieved with the passage of a new law. Maleng emphasized that in complex areas addressing criminal law and social service, victory cannot be declared when the legislative session ends. Instead, he said, those interested in the reform must pay close attention to how the laws are implemented and determine whether or not they achieve their intended goals. By funding an evaluation project for the Community Protection Act, the legislature demonstrated its ongoing commitment to interventions that make a real difference in protecting the public from sex offenses.

Lucy Berliner, research director at the Harborview Sexual Assault Center in Seattle, and also a member of the task force, emphasized the breadth of the recommendations within the Community Protection Act. This breadth is demonstrated by the law's balance between preventive and punitive responses to sexual abuse. Berliner also stressed the wisdom of the legislature in committing funds for evaluation.

Both Maleng and Berliner closed their remarks by restating the conference's theme: to learn which interventions are successful with sex offenders and their victims, and to identify the areas where future research is needed.

Types of Sentences Received by Adults Convicted of Sex Felonies Fiscal Year 1990

Jail or Prison Term
Within Sentencing Guidelines
50%

Outpatient Treatment
(SSOSA)*
39%

Exceptional Sentence** **11%**

Total Number = 1019

***SSOSA:** A suspended sentence, allowing outpatient community treatment with supervision. Eligibility determined by type of sex offense and prior sex convictions.

****Exceptional:** Sentences outside the guidelines can be higher or lower than the standard range.

Sex Offenses Accounted for 11 Percent of All Adult Felony Convictions in FY 1990

Number = 17,202

Non-Sex Felonies
89%

Sex Felonies 11%

BUT 17 Percent of All FY 1990 Prison Inmate Admissions Were For Sex Offenses

Number = 4,284

Non-Sex Offense Admissions
83%

Sex Offense Admissions 17%

AND 23 Percent of FY 1990 Prison Inmates Were Convicted of Sex Offenses

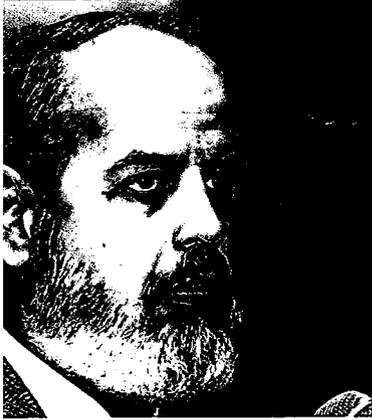
Number = 7,477

Non-Sex Offenders
77%

Sex Offenders 23%

Sources: Washington State Sentencing Guidelines Commission, and Washington State Department of Corrections.

Approaches to Treating Adult Offenders



Vernon Quinsey is professor of forensic/correctional studies in the Psychology Department

of Queen's University in Ontario, Canada. Quinsey provided a conceptual framework for assessing the relative merits of state policies regarding sex offenders.

Policies concerning the treatment of sex offenders are inherently complex because they relate simultaneously to sentencing, probation, and parole policies, civil liberties of offenders, community safety, and issues of treatment efficacy. Additionally, intervention with sex offenders requires a coordinated effort across a variety of jurisdictions such as criminal justice, mental health, and social services. Treatment must be seen as one of many interventions directed towards reducing the probability that a sex offender will reoffend. Therefore, treatment should be evaluated in the same manner as other efforts intended to prevent future victimization, such as incapacitation, community service, and parole supervision, and must address efficacy, cost, and humaneness.

Generally, sex offender treatment programs employ three approaches:

- **Pharmacological**, which are usually based on anti-androgen (male sex hormone) medications with the goal of reducing sexual arousability and the frequency of deviant sexual fantasies:

- **Psychotherapeutic or evocative**, which are designed to increase offenders' empathy for the victims of sexual assault and to evoke a sense of responsibility for their sexual crimes.

- **Cognitive-behavioral**, where the goal is to remedy skill deficits, alter thought patterns believed to be related to sexual offending, and alter patterns of deviant sexual arousal.

Treatment programs commonly include all three approaches to varying degrees. Many programs also employ a relapse prevention orientation in which the focus is on defining precursors of offense behavior and teaching offenders more effective ways of coping with these precursors during an extensive period of follow-up supervision.

Developing Effective Programs

Programs for sex offenders must be developed in the context of imperfect but increasing knowledge. Much is known about characteristics of sex offenders, less is known about treatment efficacy, and rather little is known about the causes of sexual offending. This state of knowledge has several implications for the development of sex offender programs.

First, there is no identifiable "gold standard" treatment that can be adopted without further evaluation. This is not to say that treatment does not work or that all treatment approaches are of equal efficacy. Based on what is known, the best treatment approaches for sex offenders will be those that:

- Fit with what is known about effective treatment of criminal offenders in general.
- Have a convincing theoretical rationale in that they are motivated by what is known about the characteristics of sex offenders, and address issues that are believed to be causally related to sex offending.
- Are feasible in terms of acceptability to offenders and clinicians, cost, and ethical standards.
- Are described in sufficient detail that program integrity can be measured.

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“Programs for sex offenders must be developed in the context of imperfect but increasing knowledge.”

To advance our knowledge, we must base intervention on theory so that when the intervention is tested, we simultaneously test the theory. The literature on “program development evaluation” by Gottfredson describes this approach.

The principles that should govern offender treatment have perhaps best been conceptualized by D.A. Andrews as risk, responsivity, and need. Andrews argues that treatment works best when targeted at the criminogenic needs of offenders at highest risk to reoffend. The conclusions from the general literature on offender treatment can be applied to sex offender treatment as well. Based upon this literature, characteristics of programs with some hope of success in reducing recidivism include:

- A skill-based training approach.
- The modeling of prosocial behaviors and attitudes.
- A directive but nonpunitive orientation.
- A focus on modifying antecedents to criminal behavior.
- A supervised community component in order to assess and teach the offender relevant skills.
- A high-risk clientele.

Characteristics of those programs that are not likely to be effective, or may even be associated with increased recidivism, include:

- Confrontation without skill building.
- A nondirective approach.
- A punitive orientation.
- A focus on irrelevant (non-criminogenic) factors.
- The use of highly sophisticated verbal therapies such as insight-oriented psychotherapy.

Addressing Differences Among Offenders

The probability and type of recidivism among sex offenders are strongly affected by: (1) victim age, sex, and relationship to the offender; (2) the seriousness and nature of the sex offense; and (3) the number of previous sex offenses. Beyond this, what we know is that sex offenders are diverse, even if they have similar offense histories.

Perhaps the most important difference among offenders—and the most relevant for the design of individual treatment programs—is the nature of the offender’s sexual preferences. The laboratory evaluation of sexual preferences usually includes the presentation of a variety of sexual stimuli in the form of photographic slides, audiotapes, or videotapes while measuring changes in either penile circumference or volume. This assessment is called phallometric or erection measures. It can help treatment providers identify which type of stimuli are arousing to an offender. The stimuli vary by the age and sex of the individuals who are depicted, as well as the degree of consent in the interactions.

Another relevant individual difference among sex offenders involves psychopathy. Hare’s Psychopathy Checklist is an instrument that relies on interview information and history to measure psychopathy. One measure of psychopathy, for example, is a “parasitic lifestyle” in which a person exploits people for various purposes. High scores on this instrument predict sexual and violent recidivism.

Based on what we know about sex offenders, the best approach to treatment is individualized, using the results of a variety of standardized assessments to formulate a theory of the offender’s motivation, and selecting a combination of specific interventions to prevent recidivism. The approach that most closely fits this description is the cognitive-behavioral approach, which is very widely accepted among clinicians, offers treatment manuals, and can be replicated.

Sex offenders generally prefer individual treatment or counseling. Cognitive-behavioral interventions typically employ both group and individual treatments and are acceptable to a substantial proportion of offenders. It is incumbent upon treatment providers to find ways to make treatment attractive to offenders.

Supervision

Sex offender treatment programs must involve follow-up while the offender is in the community because this environment presents the greatest temptations for reoffense. Supervision, as with treatment, needs to be arranged according to the risk that each offender presents and must be concentrated on high-risk offenders. It should include such methods as electronic monitoring, home visits, and supervised living situations. Supervision needs to be tight so that offenders can be given increasing responsibility and continue to be monitored as to how well they are doing in the community. This is crucial, because in the final analysis the best assessment of policies and programs concerning sex offenders is based upon how well offenders behave in the community.

Assessing the Adolescent Offender



Bill Murphy is Director of the Special Problems Unit in the Department of Psychiatry at the

University of Tennessee. He discussed clinical approaches to assessing adolescent sex offenders and reviewed current clinical knowledge regarding this group.

Murphy stressed that assessment of the adolescent sex offender must first focus on the reason for the assessment. Three interrelated questions are critical in assessing adolescent sex offenders:

- What is the degree of dangerousness in terms of violence and recidivism?
- Based on the degree of dangerousness, what is the most appropriate treatment environment?
- What are the treatment needs?

The subjective nature of the first question often leads to an over-prediction of dangerousness. But until better data are available, over-prediction is preferable to under-prediction because of the consequential risks to the public.

Once dangerousness is assessed, the type and level of treatment (community, residential, or correctional) can be identified. This part of an assessment should focus on the adolescent's development. Murphy stressed that one should not intervene with adolescents without taking developmental issues into account. One of the most important developmental issues is the adolescent's status in terms of developing deviant arousal patterns and criminal attitudes. Will this youth progress into committing more serious sex offenses? This question is crucial because of the magnitude of sex offenses committed by juveniles.

Other developmental issues include school and family. Does the offender have a learning problem or other problems with school? Assessing family functioning is important because most juveniles return to their families.

Juveniles may need more than sex offender-specific treatment, so an assessment should explore a number of areas of a juvenile's life. A number of variables are believed to be linked to adolescents' sexual offense behavior. These include:

- General psychological/psychiatric disturbance.
- Poor social competence.
- Family dysfunction.
- Sexual abuse history.
- Sexual knowledge/experience.
- Generalized delinquency.
- Intellectual/neurological deficits.

These variables are not absolute predictors of sex offending, but they may be important for defining the treatment needs of individuals.

Questions

Question: Is an offender's prior victimization by others a mitigating or an exacerbating factor in his own offense behavior?

Murphy: These offenders appear to be more disturbed people. One can always feel empathy for them as prior victims, but that does not change the seriousness of what they have done. It may be dangerous to focus on victim issues early in treatment, for offenders love to use their victimization as an excuse. Some of these offenders have terrible lives in general, but that still does not give them a right to offend.

Question: Is the current direction of juvenile assessment and treatment to look beyond sex offense behavior to dysfunctional families?

Murphy: Juvenile offenders have to live in families. These relationships must be a part of the assessment, but family therapy alone is not the answer. Part of reducing recidivism with sex offenders may be good supervision, and families may serve that purpose for adolescents.

“It may be dangerous to focus on victim issues early in treatment, for offenders love to use their victimization as an excuse. Some of these offenders have terrible lives in general, but that still does not give them a right to offend.”

Question: *To what extent are erection measures important in assessing adolescent sex offenders?*

Murphy: Those who do not use erection measures with adolescents cannot be criticized, because there are little normative data available. It has been difficult to determine how to obtain normative data. My clinical experience has been that such measures are useful and not controversial in that very few of our clients refuse to be assessed. There may be some people with whom we would be cautious about using the plethysmograph (a device to measure sexual arousal), such as very young adolescents, and those charged with “hands-off” offenses.

Question: *It has been reported that incest offenders have the lowest likelihood of reoffending. Does the emphasis on treating high-risk offenders suggest that incest offenders should have the least intrusive or least restrictive level of treatment and supervision?*

Murphy: This question raises several issues. For example, when sex offenders come in for assessment, their prior criminal acts are not always clear. The offender may have been caught molesting their own child but could have molested children outside of the family as well. Also, the goal of treatment must be explored. Is the only goal to reduce recidivism? It is difficult to design a program for incest offenders that will reduce their already low rate of reoffense. Thus, in incest cases we must ask other questions besides the probability of recidivism.

Finally, what type of offenders do we admit into our treatment programs? If we admit mostly high recidivistic groups like homosexual child molesters with a long history of offenses, then the treatment program’s evaluation may still show a high overall rate of reoffense even if the program has success with some of these offenders. Do we then not admit these people to treatment? These issues need to be addressed.

Quinsey: Father/daughter incest perpetrators, on average, have fairly normal sexual preferences and their probability of recidivism is lower, according to much of the published data. With respect to supervision, it is family members rather than the general community of children who need protection. The primary decision concerns whether the offender will return to the family and under what conditions.

Therefore, issues of supervision are generally much easier to address with respect to incest perpetrators.

The basic question to ask about sex offenders is: Why are they doing this? The intervention is then tailored according to our assessment of this question.



Evaluating Treatment

How Do We Know What Works?

Janice Marques is project director of the Sex Offender Treatment and Evaluation Project

(SOTEP) with the California Department of Mental Health. Marques gave an overview of trends in both treatment and evaluation and described her project.

Trends in Treatment

Marques stated that treatment methods have definitely improved over time. Treatment has become a sophisticated clinical endeavor dominated by interventions designed to modify determinants of sexual offending.

Deviant sexual interest is only one such determinant. Other factors include distorted thinking about deviant and harmful acts and a broad range of deficits in areas such as social skills and self-management skills.

As a result of this understanding, today's state-of-the-art treatment programs include conditioning, skill training and cognitive interventions. Programs are based on an understanding that sex offenders are a very diverse group, and thus treatment tends to be individualized.

Another promising development is the focus on teaching specific relapse prevention skills to offenders. This approach alerts offenders to the chain of events that leads to sexual offenses, and teaches them how to interrupt that chain early to avoid reoffense.

There is a trend toward establishing a longer period of supervision coupled with treatment for sex offenders.

Therapists have broadened their focus to include more emphasis on public safety rather than simply psychotherapy for offenders.

Trends in Evaluation

Historically, evaluation research on this subject has not been of very high quality. Some earlier studies did not even describe the subjects or the particular treatment approach. In addition, the effects of treatment were difficult to evaluate because the treatment groups were usually fundamentally different from the control groups, which did not receive treatment. Finally, outcome studies traditionally relied on only one measure of outcome, that of recidivism data derived from official sources.

The current trend is to use more rigorous designs for program evaluation. Researchers also have a greater appreciation for the complexity of the question: Does treatment work? Instead, we are asking: What kind of treatment, with what kind of offender, in what kind of setting, and with what definition of success?

California's Sex Offender Treatment and Evaluation Project

This project, conducted by the California Department of Mental Health, illustrates some of these trends in both treatment and evaluation. SOTEP originated with recent legislation in California that allows a small number of sex offenders to voluntarily transfer to a treatment program during the final two years of their prison terms. The program provides intensive cognitive-behavioral inpatient treatment that is specifically designed to prevent relapse. Following release, the offender is maintained on the program for one year with community supervision and therapy.

One distinctive element of SOTEP is a rigorous experimental design for evaluation purposes. Three study groups are used: a volunteer treatment group, a volunteer control group, and a non-volunteer control group of convicted sex offenders in California prisons. Potential participants are screened, interviewed, and asked if they are willing to volunteer for treatment. Those who volunteer are randomly assigned to either treatment or non-treatment conditions. The volunteer control group remains in prison as does the non-volunteer control group. The volunteer groups are then matched by type of offense, criminal history, and age.

“We have a greater appreciation for the complexity of the question: Does treatment work? We are asking instead: What kind of treatment, with what kind of offender, in what kind of setting, and with what definition of success?”

The treatment phase lasts two years. Pre-release assessments are conducted for all of the groups prior to leaving treatment or prison. Following release from prison, the treated group attends relapse prevention therapy twice a week for one year. The project was recently funded to interview participants annually for five years after release. Interview information will be used to supplement reoffense data from official records.

Throughout their time in the prison program, members of the treatment group participate in a relapse prevention group meeting for five hours each week. Subjects may also participate in groups covering issues such as substance abuse, sex education, and stress and anger management, in addition to individual therapy. Behavior therapy is offered to offenders with deviant sexual arousal patterns.

Each therapy component follows treatment manual guidelines that specify the goals for each week's session. The guidelines include specific pre- and post-treatment measures which help to determine if the treatment goals are being reached. The overall effects of the program are tested by a series of measures administered at admission and at discharge. These include both standardized self-report measures and behavioral measures.

The pre-release assessment for both of the volunteer groups includes an interview about the program and the individual's post-release situation, two self-report measures, and the randomized response technique (a statistical technique to guarantee anonymity of the respondent).

Preliminary Findings

Behavioral and self-report measures, taken before and after treatment, indicate that completion of the SOTEP program is associated with the following changes:

- An increase in personal responsibility and a decrease in the use of justifications for sexual crimes.
- Fewer symptoms of depression, thought disturbance, and social introversion.
- Improved self-esteem.
- A decrease in sexual arousal.

At this time, the small sample size (116 subjects admitted to the treatment program) and the short follow-up period (an average of 18 months since release for 66 discharged subjects) preclude firm conclusions about the impact of treatment on recidivism. However, the preliminary results show the following re-arrest rates:

- **Treatment group:** 66 subjects who were in treatment at least a year, including 9 who left the program after a year. Re-arrest rate = 20%.
- **Ex-treatment group:** 6 subjects returned to the Department of Corrections before a year of treatment. Re-arrest rate = 83%.
- **Volunteer control group:** 66 subjects. Re-arrest rate = 32%.
- **Nonvolunteer control group:** 56 subjects. Re-arrest rate = 50%.

The Costs of Sexual Offending



Bill Pithers is director of the Vermont Center for Prevention and Treatment of Sexual

Abuse in Waterbury, Vermont. Pithers presented information on the fiscal impact of sexual offending and discussed assessment and intervention techniques used with sex offenders.

Pithers pointed out that a full accounting of fiscal impact must assess costs to both the victim and the government. For the victim, the costs may include medical and therapeutic care, and lost wages, in addition to emotional damage which may be life-long. For the state, costs include police investigation, prosecution, judicial time, court time, supervision and incarceration of offenders.

When a treatment program reduces the re-offense rate of sex offenders, the fiscal savings can be significant even if the program does not cure each offender. In Pithers' view, effective treatment of sex offenders should not be considered an unnecessary expense during tight fiscal times. Rather, treatment will result in spending less money and building fewer correctional institutions.

Assessment and Intervention

Pithers stressed that we cannot evaluate sex offenders using traditional psychological assessment techniques. Rather, we need more comprehensive assessments to identify social and psychological deficiencies and strengths of individual offenders to determine the treatment focus. Also, given our current state of knowledge, only some offenders can be treated successfully. A thorough assessment can help distinguish offenders who can be treated on an outpatient basis as opposed to those who should be treated in a prison setting, or those who must be removed from society through incapacitation, perhaps permanently.

The primary reason for working with sex offenders, Pithers emphasized, is that sexual abuse creates victims, and he described the long-term trauma frequently experienced by victims. A victim empathy group, he said, is an essential component of treatment for sexual abusers. The purpose is to have the abuser recognize the victim's trauma. Given this understanding, an abuser may pause before repeating past behavior, allowing an opportunity to make different choices.

Pithers also discussed his use of the Relapse Prevention (RP) model. The original RP model, as applied to sex offenders, was designed to strengthen an offender's self-control. The focus was on internal self-management to prevent relapse. It was found that, while this focus worked well, it should be supplemented by external supervision for critical times when an offender is likely to relapse. This supervision should come from officials, such as community corrections officers and mental health professionals, and from people in the offender's daily life, such as employers and family members. Thus, a support system is established of individuals who understand the offense patterns and can help avoid reoffense.



The Human Costs Treating Victims

Lucy Berliner is a member of the faculty of the School of Social Work at the University

of Washington and research director for the Harborview Sexual Assault Center. She is also a therapist who treats victims of sexual assault.

Berliner discussed the state of knowledge about the effects of sexual victimization, treatment approaches for victims of sexual abuse, and the role of families in victimization and treatment.

Effects of Sexual Victimization

There are two general sources of harm to a victim of sexual assault that are related to the criminal experience. These apply to both child and adult victims, although they may manifest themselves in different ways.

The first source of harm consists of the negative feelings evoked during the actual victimization experience, feelings typically described as fear and anxiety. These feelings then become associated with the memory of the experience and with events that remind the victim of the experience. Known as Post-Traumatic Stress Disorder (PTSD), this anxiety disorder is connected to a traumatic event and recurs in the form of intrusive thoughts, flashbacks, nightmares, and other kinds of responses to a fear-producing experience.

The second source of harm involves alterations in the victim's beliefs about themselves, about other people, and about the world. Victims come to believe that they were changed by the experience, that other people are untrustworthy, and that the world is a dangerous place.

Much information has been accumulated regarding the initial psychological effects victimization has on children who are seen by professionals soon after their abuse is discovered or revealed. Most child victims have moderate rather than severe levels of psychological distress, and a fair proportion do not exhibit any initial psychological distress. However, child sexual abuse victims differ on various measures from children who were not abused, from children who were not abused but who have general psychological or psychiatric problems, and from children who were physically abused.

The research findings available on adults who were abused as children are the most dramatic. According to Berliner, adults who were abused as children are suffering fairly consistently. These adults show higher levels of psychological distress, particularly anxiety symptoms, than adults who were not victimized. They are twice as likely to be diagnosed with depression. Adults who were victimized as children are also at greater risk of being revictimized in other situations and having difficulties with interpersonal relationships.

The question we face is: What happens between the childhood event, followed by relatively minimal levels of distress, and the continuing distress or the development of serious mental health problems many years later? With no longitudinal studies available, we can develop only a conceptual understanding of this question. The general thinking is that children cope with victimization experiences primarily through avoidance or denial strategies in order to relieve their distress temporarily. Unfortunately, it appears that these kinds of strategies do not really help a victim fully integrate and process the experience. Therefore, the experience can remain alive and untouched even though a great deal of energy has been expended to keep it at bay.

“Victims come to believe that they were changed by the experience, that other people are untrustworthy, and that the world is a dangerous place.”

Treatment for Victims of Sexual Abuse

Berliner reported that we have learned more about the characteristics of victimization experiences, who is victimized, and the after-effects than we have about which interventions are successful. Yet, all of this information does give some general direction to treatment approaches that may be effective. Treatment ought to be abuse-specific, and the focus with children should be on the prevention of later serious problems. Generally, treatment needs to be more systematic and specifically related to the typical problems abuse victims experience.

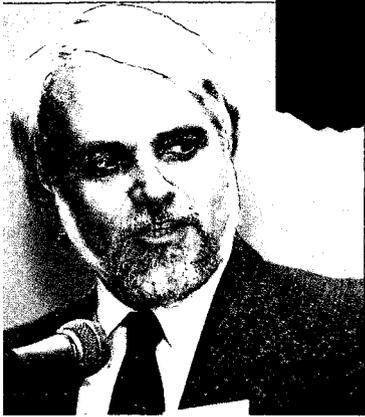
One such problem is that of cognitive distortions. There are no effective treatment methods for preventing or eliminating these ideas or beliefs, the most common and tenacious of which is self-blame. There are many complex reasons why victims hold on to self-blame. Thus, treatment research must address how to influence the beliefs people have about themselves and the world after their victimization.

The Role of the Family

While it is clear that the harm suffered by child victims derives from the abuse itself, families may contribute to the problems these children experience. For example, there is evidence that:

- Family problems place children at risk of abuse either in the home or outside the home.
- Family dysfunction exacerbates the psychological effects of abuse.
- Siblings of victims have elevated levels of psychological distress.
- Child victims (of abuse both inside and outside the family) perceive their families as more abnormal than do other children who have not been victimized.

Families can play an important role in increasing the distress that victims experience, as well as helping them recover. According to Berliner, families should be helped and involved in treatment, as long as it is not at the expense of the victimized children.



Towards Prevention Victims and Offenders

Jon Conte is an associate professor in the School of Social Work at the University of Washing-

ton. Previously, he was at the School of Social Service Administration at the University of Chicago. Conte discussed the boundaries between victim and offender interests and the state of knowledge regarding prevention of sexual abuse.

The traditional desire to keep victim and offender interests separate sometimes works against the best interests of effective victim treatment. For example, those who treat adult survivors of childhood abuse often do not like to think of survivors as engaging in any kind of sexual offense behavior. Therefore, therapists have tended to ignore aspects of the survivors' experience, such as deviant sexual fantasies, that are quite important to treatment.

A host of problems are associated with a history of childhood sexual abuse, and when we work with child victims, part of our goal is to prevent those problems from occurring later in the victim's development.

Professionals who work with victims and those who work with offenders can share ideas about ideal treatment. At this time, offender treatment is more advanced than victim treatment, which needs standards and a way to maintain treatment quality. Therapists for both victims and offenders need to balance the forensic and rehabilitative aspects of treatment.

Thus, blurring the boundaries between victim and offender interests may allow more opportunities for comparison and information sharing which can enhance treatment for both victims and offenders.

Programs for Children

Prevention programs are designed to help children avoid, escape, or prevent their own abuse. They can be presented in any format, including songs, plays, coloring books, and videos, and can consist of anything from single one-hour sessions to thirty classroom sessions over a year. To be effective, the prevention message should be repeated periodically through "booster" sessions, and children should have a chance to role-play and thus practice what we are trying to teach them.

The key concepts of effective programs include:

- Children have a right to control access to their own body, and have a right to say no.
- There are different kinds of touches.
- There is a difference between a secret and a surprise.
- There are different people that children can approach if they have been victimized, and if the first person does not respond, they can turn to someone else.

Teaching children abstract ideas is much more difficult than teaching them specific safety rules. Young children have more difficulty learning the more subtle prevention concepts, such as that a good person can do a bad touch, a bad touch can feel good, family members can do a bad touch, or that victims are not responsible for abuse.

The majority of studies report that most children learn most of the program content, but not all of them master the concepts. Those who do not master the concepts should go through the program again, although it is not clear how much knowledge or skill must be gained to prevent sexual abuse.

There has been some debate over the possible consequences to children of prevention programs. Conte noted that several methodologically sound studies indicate no significant increase in behavioral problems or anxiety among children who participate in prevention programs. Studies also demonstrate no increase in general or specific fears and fearfulness.

Thus, prevention programs do not appear to be associated with negative consequences. The ultimate question that parents, researchers, and evaluators need to pay attention to is: Can children actually use this program content to escape, avoid, or prevent their own abuse? At present, this question remains unanswered.

Who Is at Risk?

Learning more about how offenders select or recruit victims will help determine what to teach children so they are more resistant to abuse.

Conte described one of his research projects that interviewed male sex offenders about their methods for victim selection. The research indicated that vulnerable children were those who exhibited depression or appeared to be needy. These offenders used coercion extensively. One method was to separate the child from his or her support systems. The offenders also used manipulation and systematic desensitization of a child to touch. The interviews revealed that the offender's abuse patterns were anything but impulsive.

We must pay more attention to specialized programs for children at risk of sexual abuse. While all the risk factors have not been identified, they definitely include poverty, family discord, and chronically mentally ill or addicted parents.

Finally, attending to the weakest link, the young child, may or may not be the best way to prevent sexual victimization. But until effective methods of early identification and treatment of offenders exist, a good prevention strategy requires both treating offenders and educating children.

Question: What is the danger of failing to train all children in prevention techniques?

Conte: Some suggest that until all children are exposed to prevention training, we are simply shifting the risk to children who, because of where they live and which schools they attend, have not been trained. To circumvent this access issue, programs were developed for use on television, on cereal boxes, and in games, thus spreading the message to a wider group of children. It is clear that universal coverage is not a reality, and until it is, some children will be at greater risk.

Question: What about female sex offenders?

Quinsey: Female offenders do exist, but in very small numbers. For the most part in criminal justice statistics, females show up as accomplices to males.

Murphy: It has been estimated that of all children who are sexually abused, approximately 20 percent of boys and 5 percent of girls are abused by females.

Question: How useful are erection measures in assessing whether treatment programs have reduced an offender's likelihood of committing another offense?

Quinsey: A relationship has been found between phallometric or erection measures taken before treatment and the offender's reoffense behavior, but that relationship is not demonstrated between post-treatment measures and reoffense patterns. One major problem with erection measures is that even when deviant sexual interest is not revealed in the laboratory, it still may be

present; the findings are uncertain since people are so motivated to appear normal and offenders can fake their responses. Treatment exacerbates this problem rather than reduces it and, thus, we are more skeptical of post-treatment phallometric data. We have to be very careful using these results to make decisions about which offenders are safe to be released. Such data are better used for assessment than for treatment.

Question: Is there a demonstrated relationship between exposure to violence and pornography and sexual offending behavior?

Quinsey: The literature is silent on the causal direction or developmental sequence: Do people with developed deviant sexual interests buy or view pornography, or does reading or viewing pornography develop the deviancy?

Marques: In the case of adolescents, if you compare sex offenders and non-offenders, there is no significant difference in the use of pornography. But adult offenders do seem to use pornography more extensively than do non-offenders.

Murphy: If we assume that attitudes have some relationship to sexual acting out, violent behavior, or disregarding the rights of others in general, then the question becomes: What shapes attitudes that allow us to accept violent and abusive behaviors? We should broaden our view beyond pornography and include other important factors, such as advertising and certain religious beliefs which emphasize male dominance.

Question: What does current research say about castration and the use of pharmacological interventions?

Quinsey: These interventions have not been popular in North America, partly on ethical grounds. The principal ethical difficulty with castration, given that it is irreversible, is that it creates an incentive for the state to mete out either longer or harsher sentences so that offenders will be forced to accept this treatment.

There is evidence that anti-androgen medications can reduce recidivism in the short run. The difficulty with these medications in the long term is low compliance. But pharmacological interventions can be used as an adjunct to other kinds of treatment and also to facilitate supervision.

Murphy: Drugs have a place in treatment, but we should not be seduced into thinking they are the answer. They may work if they are used, but again, low compliance is a problem. Therefore, we have to look closely at studies that demonstrate success with these interventions.

Question: How does one determine the appropriate length and intensity of supervision?

Pithers: Community supervision is essential, for we cannot think that treatment alone is enough. The kind of supervision necessarily varies with the client. One thing that facilitates supervision is an air of openness rather than secrecy about the abuser's history, as well as patterns of behavior and risk factors for these specific offenders.

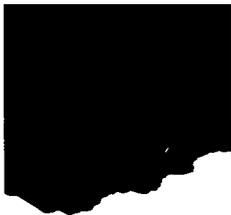
Quinsey: We have a trade-off in terms of risk when we think about what level of supervision we need. If we have an effective treatment, then we need less supervision. We want to develop interventions and supervision methods that are cheap and simple enough to apply to a large number of people, many of whom will, in fact, turn out not to need them. Therefore, rather than trying to put all our efforts into predicting recidivism, we are better off emphasizing improvements in treatment methods and supervision. We should be focusing particularly on methods that are ethical, that are not incredibly intrusive or aversive, and that people will find acceptable.

We should try to supervise people for as long as we think they need it. There are a few people who will require supervision (or incarceration) forever. It is not that treatment methods are unknown for these people, but rather that there is no conceivable treatment outcome that ensures the necessary confidence about the public's safety to recommend release or a reduction of supervision.

Question: Is it better for children to respond to a sexual abuse situation by threatening to tell on the offender as opposed to saying no?

Berliner: When child victims were asked in a study if they believed that a "no" response or some other prevention message would have worked, none believed such a response would have prevented the abuse. Additionally, the children had no idea about the intentionality or the calculated nature of the victimization process until, in retrospect or through therapy, they were able to identify these various elements.

One thing the children said they would do differently was to tell after the first incident. To some extent, telling was helpful and made the abuse end. Offenders also said the threat to tell would have influenced them. Thus, the value of telling or threatening to tell should be incorporated into prevention programs. **Conte:** We asked offenders about this. Some of the men said that their response to a threat would depend on whether the child was convincing. Some said that their response to such a threat would be to escalate the violence and could lead as far as murder. Teaching a child to tell on the offender serves as a means of stopping the abuse from continuing. Thus the focus on telling is to get children to disclose their abuse earlier in the abuse cycle.



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The following publications are recommended to those interested in learning more about these topics. Publication references for the six conference presenters are available from the Washington State Institute for Public Policy.

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Robert Prentky, Ph.D.
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Community Resources For Sexual Abuse Victims

The Office of Crime Victims' Advocacy will be publishing a directory of victim services provided throughout the state. For information, contact:

Office of Crime Victims
Advocacy
4315 6th Avenue S.E.
MS: QJ-12
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