Care of Sexual Offenders in the Primary Care Clinic

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"The area of a circle is pi times the square of its radius. Which means: if you're required to reside 2,500 feet away from any place where children regularly gather—a school or a playground, for instance, or a video arcade—you have to live outside a closed circle of 9.25 million feet. Since every school, playground, or video arcade lies at the center of such a circle and nearly all of the circles partially overlap and often extend well beyond the others, when you step clear of one 9.25-million-square-foot forbidden zone, you immediately step into a part of another.

Thus, if you're a sex offender tried and convicted in Calusa County and are required by the terms of your parole to stay in Calusa County, as is almost always the case, there are only three places where you can legally reside: under the Causeway that connects the mainland with the Barrier Isles; in Terminal G out at the International Airport; or in the eastern end of the Great Panzacola Swamp."

Russell Banks, *Lost Memory of Skin*, describing the fate of a sex-offender in the fictional Calusa County, Florida. Banks got the idea for this novel after reading newspaper accounts of sex offenders living under the Julia Tuttle Causeway

Introduction

- Why are we talking about Sex Offenders (SO)?
- Our patients include sex offenders
- Our interests and obligations as Primary Care Providers (think of methadone)
- What are the key things we wanted to know?

Introduction

- We wanted to improve our understanding of:
- Legal, Social and Behavioral Issues surrounding the care of Sex Offenders
- Remove some of the barriers to care for individuals who are specifically marginalized and stigmatized

Caveats

- Lots of inaccuracies in all of the data
  - Differing definitions
  - Reliance on self-reports
  - Studies come from clinical or correctional samples (not full breadth of disease)
  - Much abuse is not reported (as little as 1 in 20 cases)

QUESTIONS:

- Are all sex offenders child molesters?
- Are all child molesters pedophilic?
- How likely are sex offenders to re-offend?
- What are the main differences between pedophilic and non-pedophilic sex offenders?
- What are the main traits of pedophilia?
- What is the relationship between sexual abuse and pedophilia?

QUESTIONS:

- Do all those with pedophilia commit “contact” offenses (molest children)?
- What are the treatments for sex offenders?
- What are the main classifications of sex offenders?
- Do sex offender registries work?
- How does risk assessment try to merge the clinical/behavioral health and criminal justice systems?

Case Study #1

- Single Male 40's- twice married and divorced
- Loner-socially "uncomfortable" "short fuse"
- Aggravated sexual assault-15 y.o. daughter of GF-4 years Intensive probation and SOTP
- Admits criminality-Depression, Anxiety addressed in SOTP- treatment for underlying mental health problems and his lack of social skills with CBT/structure/engagement/Rx
- Successfully discharged from Tx after 2 years

Are all sex offenders child molesters?

- Sexual offenses can be against adults or children
- Approximately one third of reported sexual offenses are against children

Are all child molesters pedophilic?

- Child molestation ≠ Pedophilia
- Child molestation is a criminal justice term
  - Loose Definition: touching a child for sexual gratification (>4-5 years older than victim)
- Pedophilia is a clinical term
  - "a persistent sexual interest in prepubescent children, as reflected by one's sexual fantasies, urges, thoughts, arousal or behavior"

Are all child molesters pedophilic?

- Pedophilia ≠ Sexual Offender/Child Molester
- Many think otherwise, based on two false assumptions:
  1. Anyone who is sexually interested in children would act upon that interest when an opportunity becomes available
  2. No individuals would have sexual contact with children unless they were sexually attracted to children
- Pedophile vs Pedophiliac

Are all child molesters pedophilic?

- In fact, 40%–50% of sex offenders arrested with child victims are not pedophilic
- Put another way…. almost half of offenses against children are committed by non-pedophilic offenders

Sex Offender Behavior-Intro

- Traits of non-pedophilic sex-offenders
- Traits of pedophilia
  - Behaviors
  - Co-occuring disorders
  - Causes
    - Abused-Abuser Hypothesis
  - Treatment
  - Recidivism (re-offending)

What are the main differences between pedophilic and non-pedophilic sex offenders?

- Behavioral Health Perspective
  - Paraphilic, non-paraphilic
- Paraphilic Disorders: DSM diagnoses: "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving non-human objects, the suffering or humiliation of oneself or one's partner, children, or non-consenting persons”

Paraphilic vs. Non-paraphilic

- Examples of Paraphilias:
  - Exhibitionism
  - Fetishism
  - Voyeurism
  - Pedophilia

Paraphilic vs. Non-paraphilic

- Pedophilia: “a persistent sexual interest in prepubescent children, as reflected by one’s sexual fantasies, urges, thoughts, arousal or behavior”

Paraphilic vs. Non-paraphilic

- Non-paraphilic:
  - Sociopathic traits
  - Crimes of opportunity/lack of more appropriate partner
  - Drugs, Etoh, mental health
- These are the 40%-50% of offenders against children who are not pedophilic

Traits of Pedophilia

- Pedophilia: “a persistent sexual interest in prepubescent children, as reflected by one’s sexual fantasies, urges, thoughts, arousal or behavior”
- Prevalence
  - Very hard to know
  - Probably $\leq$ 5%
  - Males >> females (probably many more females the studies indicate)

Traits of Pedophilia

- Too many subgroups to have a “classic” type
- In general…

Traits of Pedophilia

- Difficulty with age-appropriate interpersonal relationships
- Leading to excessive use of defense mechanisms (globally):
  - Intellectualism
  - Denial
  - Cognitive Distortion
  - Rationalization

Traits of Pedophilia

- Defense Mechanisms (DOJ manual for law enforcement officers)
  - 1. Denial ("Is it wrong to give a child a hug?")
  - 2. Minimization ("It only happened once")
  - 3. Justification ("I'm a boy lover, not a child molester")
  - 4. Fabrication (activities were research for a scholarly project)
  - 5. Attack (character attacks on child, prosecutors, or police, as well as potential for physical violence)

Traits of Pedophilia

- About 50% will marry at some point in their lives
- Most of those diagnosed with pedophilia will have another major psychiatric disorder
  - 60%-80%-Affective Disorders
  - 50%-60%-Anxiety Disorders
  - 70%-80%-Co-occuring Personality Disorder
  - 50%-60%-Substance Abuse or Dependence

Traits of Pedophilia

- Pedophilia likely not an impulsive-aggressive personality trait...
- More likely a compulsive-aggressive personality trait (behaviors planned to relieve internal pressures)
- Mostly male (though there are female w/pedophilia)
- 50%-70% have a second paraphilia (frotteurism, exhibitionism, voyeurism, sadism)
- Typically do not engage in intercourse; most often touching

Traits of Pedophilia

- Gaining access to children
  - Child knows offender 60%–70% of the time (exceptions: violent offenses)
    - e.g. neighbor, relative, family friend or local individual with authority
  - Often intentionally place themselves where they can meet children
  - Access children by gaining trust

Traits of Pedophilia

- Do all those w/pedophilia commit “contact” offenses (molest children)?
- Pedophilia alone is not enough to explain sexual offending against children

Traits of Pedophilia

- Seto 2008 study suggests:

"Pedophiles who…pose the greatest risk of acting upon their sexual interest in children, are (those) more likely to engage in antisocial or criminal behavior of any kind–which include individuals who are impulsive, callous, and willing to take risks; individuals who become disinhibited as a result of substance misuse; and individuals who endorse antisocial attitudes and beliefs such a disregard for social norms or the laws…."

Traits of Pedophilia

- Seto 2008 study suggests:

  "In contrast, one would predict that pedophiles who are reflective, sensitive to the feelings of others, averse to risk, abstain from alcohol or drug use, and endorse attitudes and beliefs supportive of norms and the laws would be unlikely to commit contact sexual offenses against children"

Possible Causes?

- Etiology unclear. Neuropsychiatric differences could be:
  - due to disturbances during early brain development
  - a marker for co-occurring psychiatric conditions
  - a result of certain life experiences (abuse, etc...)

Abused-Abuser Hypothesis

- Although difficult to demonstrate sexual abuse as having a unique association (correlation) with sexual offending:
- because it is often accompanied by
  - other forms of abuse
  - neglect
  - witnessing domestic violence
  - severe family hardship

Abused-Abuser Hypothesis

- Lots of studies show the association
- 2009 Jesperson, et. al.
  - Sex offenders against children-more likely to have been sexually abused
  - Sex offenders against adults-more likely to have been physically abused
- About 40% pedophilic sex-offenders have been sexually abused

Explanations for Abused-Abuser Hypothesis

- 1. Learning
  - imitation of perpetrator's behavior, or conditioning (pairing of sexual stimulation with cues of the sexual abuse, such as types of acts that occurred, and reinforcing attitudes about the acceptability of adult-child sex)
- Sexual Development
  - Sexual abuse impact future sexual development
- Psychopathology
  - Does sexual abuse lead to psychopathology that leads to increased risk of sexual offending?

Abused-Abuser Hypothesis

- It cannot be the only explanation
  - especially given the overall low number of those sexually abused who go on to offend,
  - the fact that there are so few female sex offenders in spite of the large numbers of female victims of sexual abuse,
  - and that many sexual offenders have not experienced sexual abuse

Abused-Abuser Hypothesis-Summary

- Much evidence that the correlation exists, but
- We do not know if it is causal
- We do not know why it does not always occur

Case Study #2

- Single male, late 20's, Etoh, marijuana, unemployed
- Most of his girlfriends have children- puts self in "babysitter" role
- Aggravated criminal sexual abuse charge
- 24 months of SOTP- marginal engagement, denies guilt or blames being "too high"
- Despite concerns of tx provider, released from treatment by judge for "completion"- No input from SOTP sought.
- Re-offends with same M.O. 2 months later

Treatment

- No treatment effective unless offender is willing to engage in treatment

- Need to differentiate paraphilic vs. non paraphilic (pedophilia vs non-pedophilic)
  - Approximately 80% those in SOTP are non-pedophilic offenders

Treatment of Pedophilia

- Assumption:
  - pedophilia needs to be thought of as a fixed trait, not something that can be changed (Axis II diagnosis)

- Goals of treatment:
  - decrease arousal
  - manage urges
  - refrain from acting

Treatment of Pedophilia

- Behavioral Treatment

- Aversive conditioning
  - Does not work (no good studies showing a statistically significant benefit)

Treatment of Pedophilia

- Cognitive Behavioral Therapy
  - Does not work
- Relapse Prevention Model, most commonly used form of CBT
  - 1. Identify/Avoid triggers
  - 2. Identify/Avoid relapses
  - 3. Develop Strategies to avoid high-risk situations
  - 4. Develop coping strategies to use if high-risk situations cannot be avoided
  - 5. Responding effectively to relapses

Treatment of Pedophilia

- Pharmacologic Treatment:
  - Does not work
  - Paraphilia as an Obsessive-Compulsive spectrum disorder
  - SSRIs-some benefit on decreasing OCD nature of fantasies, urges. May be helpful in treating co-occurring disorders. Side effect of decreased libido

Pharmacologic Treatment:

- Hormonal Treatment (Chemical Castration)
  - Medroxyprogesterone (MPA, depoprovera)-possibly helpful in those with compelling sexual fantasies and overwhelming and uncontrollable compulsions
  - Antiandrogen-Cyproterone Acetate (CPA)- not available in the U.S. Most widely studied
  - LHRH-leuprolide (Lupron)-LHRH agonist. Decreases testosterone to castration levels
- May be of benefit in specific cases

Treatment of Pedophilia

- Pharmacologic Treatment:
  - Lots of issues
    - Side effects: weight gain, breast development, osteoporosis, liver damage
    - Compliance
- Surgical-Castration
  - Does not work

Treatment of Pedophilia–Summary

- Nothing works. Lots of studies claim success, but this is probably not the case
- The real issue is acting or re-acting (recidivism)
  - Does treatment reduce recidivism, not other associated "symptoms"?
  - Best practice is probably a combination of CBT (relapse prevention model) and meds
  - Worth repeating: No treatment effective unless offender is willing to engage in treatment

Treatment–What can we do?

- What to ask offenders?
  - What is your level/status?
  - Are you registered?
  - How often do you have to see parole officer?
  - Are you required to be in sex-offender treatment?
- What to screen for?
  - Axis I and Axis II disorders

Recidivism

- Recidivism: rates unknown: 10%-50%
- Lots of problems with the studies:
  - different definitions (some call recidivism any crime, others only sexual offense crimes, some only if convicted)
  - many rely on self-reporting
  - very short follow-up (often 1-5 years)

Recidivism

- 2003 DOJ: arrests for a new sex crime over 3-year period: 5.3%
- 1998, 2005 (Hanson & Bussiere, Hanson & Morton-Bourgon): re-arrest rate over 4-6-year period: 14%
- 2004 Harris & Hanson: over 15 years 24%

Recidivism

- Patterns vary according to different risk factors (such as criminal history, victim preferences, offender age)
  - e.g. Most likely to reoffend: pedophiles who molest boys: 35% over 15 years

Recidivism

- Most repeat offenses occur 10 years after initial offense
- Unclear if this delay is due to treatment, incarceration or other factors
- Antisocial orientation and general self-regulation problems are strong predictors of sexual and non-sexual recidivism

Recidivism

- "Pedophiles who…pose the greatest risk of acting upon their sexual interest in children, are (those) more likely to engage in antisocial or criminal behavior of any kind-which include individuals who are impulsive, callous, and willing to take risks; individuals who become disinhibited as a result of substance misuse; and individuals who endorse antisocial attitudes and beliefs such a disregard for social norms or the laws…."

Risk Assessment

- Risk assessment is about identifying who will re-offend, once they have been identified as a sex-offender
- Risk Assessments are performed by clinicians for the Criminal Justice system
- How does risk assessment try to merge the clinical/behavioral health and criminal justice systems?

Risk Assessment

- Programs most effective in reducing recidivism follow these principles:
  - Accurately identify risk
  - Focus on higher risk offenders

Risk Assessment

- Key point: need to use dynamic risk factors as opposed to static ones
  - Static risk factors can never change on an risk assessment tool, e.g., etoh history, criminal history
  - Dynamic risk factors can change: social influences, intimacy deficits, self-regulation, lack of cooperation with treatment, antisocial attitudes

Static risk assessments (bad)

- Prevalent, Inaccurate
- Enormous social costs to calling most offenders “high risk”, such as:
- Does not allow for focus on true highest risk offenders (we are not safer)
- The social marginalization of many low-risk offenders who otherwise could successfully reintegrate into society

Static Risk Assessment

- In the following two examples, both sex offenders would be indentified as having the same risk, and likely be offered the same treatments using a Static Risk Assessment Tool

Static Risk Assessment

- Two clinical examples:
  - 1. A highly antisocial, but sexually non-deviant offender who requires interventions focusing on antisocial attitudes and beliefs, lifestyle instability, association with criminal peers, self-regulation, problem solving, etc...

Static Risk Assessment

- Two clinical examples:
  - 2. A relatively pro-social, but sexually deviant offender (pedophilia) who would derive less benefit from the above interventions, but could benefit greatly from treatments to increase their voluntary control over sexual arousal, sexual self-regulation and strategies to avoid risky situations

Dynamic Risk Assessment

- Dynamic Risk Assessments better differentiate the individual needs and risk in the two examples
- One size fits all does not work well for treatment or risk assessment

Risk Assessment

- Key point: need to use dynamic risk factors as opposed to static ones
  - Static risk factors can never change on an risk assessment tool, e.g. etoh history, criminal history
  - Dynamic risk factors can change: social influences, intimacy deficits, self-regulation, lack of cooperation with treatment, antisocial attitudes

Case Study #3

- 18 y.o. male, senior in H.S. with 15 y.o. GF.
- Consensual relationship for past two years
- Girl's parents report him-charged with 3rd degree sexual assault.
- Incarcerated for 18 months, 10 years probation, 2 years SOTP. Level I SO
- Complies with SOTP (tx provider sees no reason for him to be there).
- Misses a registration deadline, automatically becomes a Level II SO-now with 25 years of notification requirements

Criminal Justice?

- Reporting Laws: Do they help?
- What are the Theoretical Pros and Cons?
- The Adam Walsh (AWA), Megan, and Jacob W Laws

Reporting Laws

- Pro Theory:
  - Laws will make sex offenders more compliant with treatment, and therefore reduce recidivism
  - Laws will function as additional deterrent to re-offending
  - Laws will provide communities with the information they need to keep children safe

Adam Walsh Protection and Child Safety Act

- Adam Walsh Child Protection and Safety Act (AWA) – signed into law by U.S. President George W. Bush on July 27, 2006
- How sex-offenders are categorized in the Criminal Justice System
- Do these reporting and registration laws help keep communities safer?
- Do they reduce recidivism?

Sex Offender Status

- AWA organizes sex offenders into three tiers Level I, II and III- What does this mean for SO and Communities?
- SO level or status predicates
  - Housing
  - Work
  - Community hostilities

Sex Offender Status

- Level I
  - offenders, which includes minors as young as 14, must update their whereabouts every year with 15 years of registration
- Level II
  - offenders must update their whereabouts every six months with 25 years of registration
- Level III
  - offenders update their whereabouts every three months with lifetime registration requirements.
- Failure to register and update information is a felony under the law

SO Reporting Laws-Level I

- The individual is charged with a sexual offense that does not meet the Level II or III category
- This is always an individual with no prior criminal record
- Employment and housing barriers
- Annual registration for 15 years
- Level I crimes include statutory rape between adolescents of differing ages

SO Reporting Laws-Level II

- Minimum of one year incarceration, often for a crime that was identical to those of a Level I defendant, but this individual has
- a prior criminal record or probation violator
- charges will be related to pornography distribution
- Registration every 6 months for 25 years
- Unable to apply for public or disabled housing
- Legally required to tell any future employer (for the next 25 years) that he/she is a registered offender

SO Reporting Laws-Level III

- Any repeat Level II offender.
- Abuse of a minor less than thirteen
- Distribution of pornography of any minor less than thirteen
- Lifelong registry every 90 days, for life
- Lifelong probation in 30 states. No public or disabled housing
- Unable to receive long term care for illness, as they will be banned from any public, skilled nursing facility

Reporting Laws

- Con Theory: Sex offenders will intentionally avoid treatment and not register for fear of/for:
  - personal safety
  - family's safety
  - inability to obtain housing/employment

Megan's Law (Hint: it's not a Law)

- Megan's Law is an informal name for state and community laws and by-laws
- Megan's law requires law enforcement authorities to make information available to the public regarding registered sex offenders
- Notices to schools
- Includes the offender's name, picture, address, incarceration date, and nature of crime
- The information is often displayed on free public websites, but can be published in newspapers, distributed in pamphlets, or through various other means

Megan's Law

- A December 2008 study of the law in New Jersey concluded
  - no effect in reducing sexual re-offenses,
  - no effect on reducing the number of victims of sexual offenses

Reporting Laws

- 2011 Craun, et. al. study of clients at a sexual assault treatment agency (i.e., victims) over a one year period found:
  - Only 3.7% of offenders could possibly have been identified as registered sex offenders at the time of the attack

Do Registries Work?

- 2008 Sandler, et. al.: “a strong majority of offenses were committed by first-time offenders, which limits the utility of sex offender registration”
  - 95.9% arrested for rape were first-time offenders
  - 94.1% arrested for child molestation

Do Registries Work?

- Important Clarification: seemingly opposite facts:
  - Most arrests are of first-time offenders
  - Most of those with pedophilia, at the time of arrest have committed multiple acts
- How do we put this together?

Do Registries Work?

- Most arrests are not of pedophilic offenders
- And though pedophilic offenders are generally higher risk, the registries include all on the non-pedophilic and lower-risk offenders

Failure to Register

- 2011 Zgoba & Levenson, Failure to Register (FTR) as a predictor of re-offending
  - No significant difference b/w those who registered and those who failed to register
  - showing that FTR is not a marker for "likely to reoffend"
  - FTR is the most common reason a sex offender is rearrested

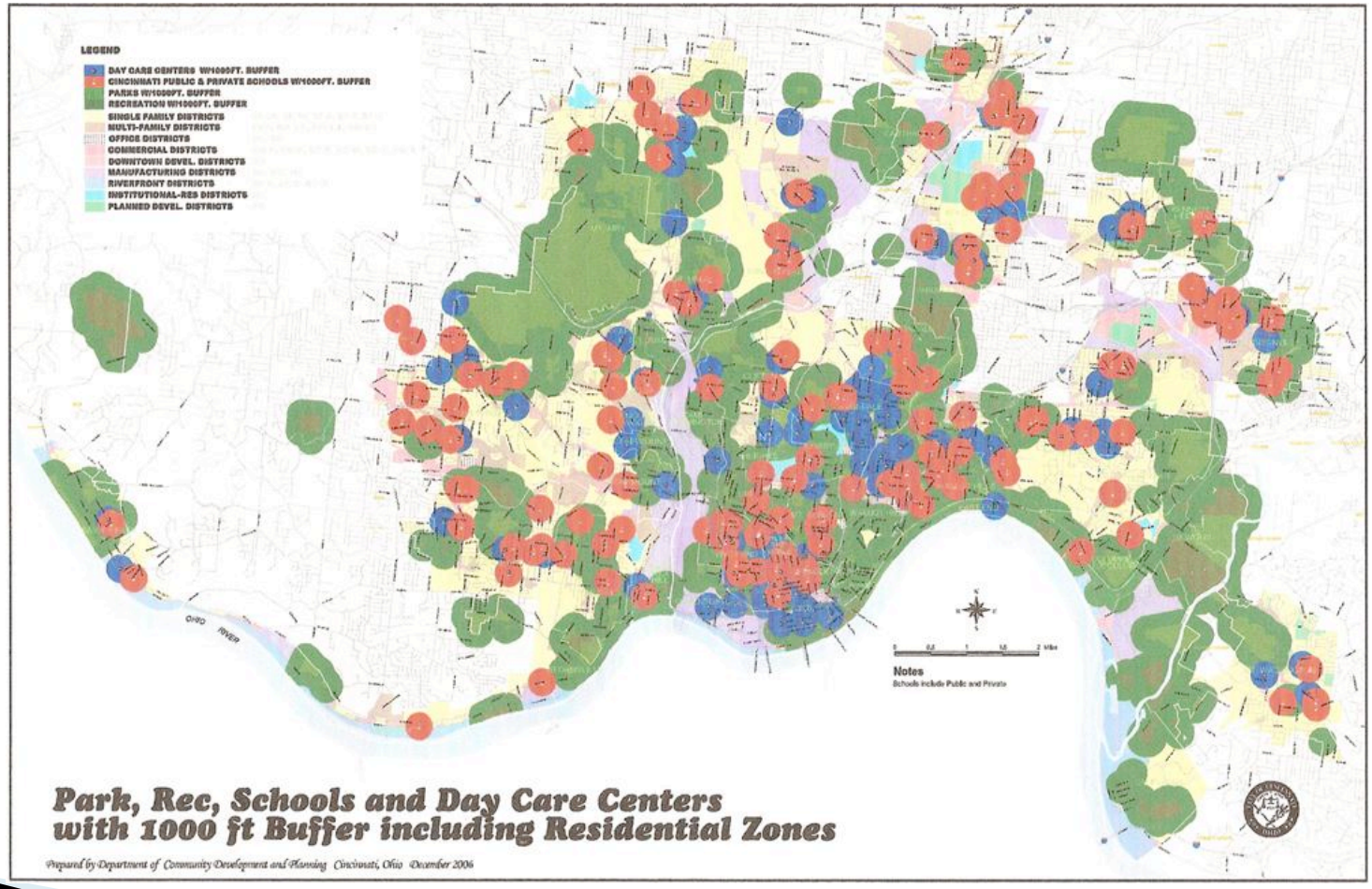
Failure to Register

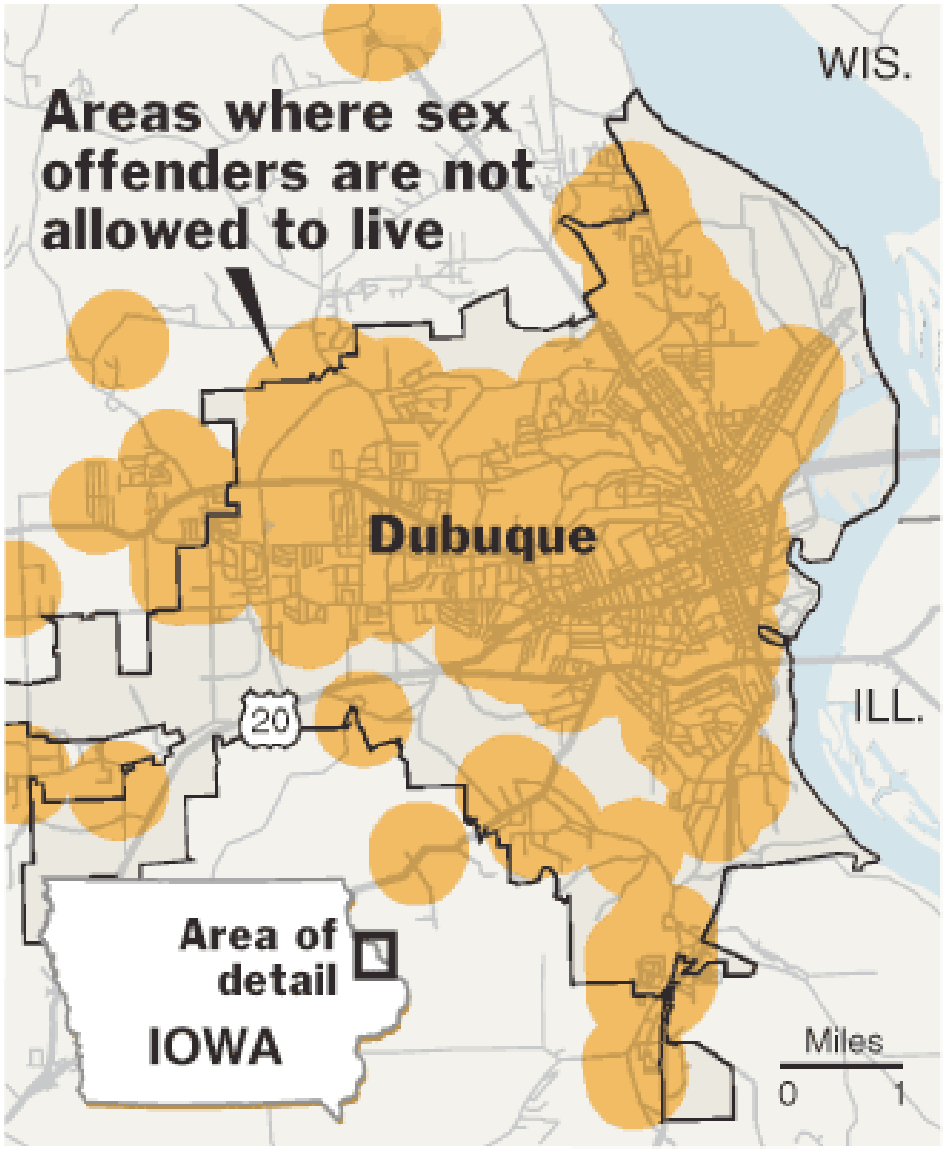
- Well documented that registered sex offenders experience:
  - Unemployment
  - Housing disruption
  - Harassment
  - Social alienation

Residency Restrictions

- Thirty states, and hundreds of municipalities have enacted some form of residency restriction that prohibits sex offenders from living within a certain distance of schools, churches, daycare centers, or “places where children may congregate”
- The least restrictive distance requirement is 500 feet, but distances from 1,000 to 2,500 feet are common (approximately 3-7 city blocks)

Residency Restrictions

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Do Registries Work?

- 2011 Zgoba & Levenson:
  - “Current legislation is broadly applied to all individual with a felony sex conviction regardless of their risk for future sexual violence and despite much research suggesting that a majority will not go on to be arrested for sexually assaulting new victims”

Do Registries Work?

- And
  - “Rather than a one-size-fits-all approach, criminal justice practices should be more carefully tailored to individual risk and offense patterns of each offender. Individualized case management relying on empirically derived risk assessment might offer more return on investment that the sweeping policies in existence today”

Do Registries Work?

- "In fact, most studies investigating the effectiveness of sex offender registration and notification policies have found that they fail to meet their goals of reduced sexual recidivism

- The two studies that detected a decline in recidivism attributable to SORN laws were conducted, notably, in states with risk-assessment procedures that employ *enhanced monitoring for those posing the highest threat of repeat sexual violence*

Do Registries Work?

- As most sex crimes are committed by first-time offenders not previously on a registry, it is perhaps unsurprising that an emphasis on publicly identifying known offenders does little to alter the rates of sexual violence”

Do Registries Work?

- Registries are designed to do two things:
  - Reduce recidivism
  - Reduce sexual offenses against children (keep us safer)

- They fail at both of these

Shock the Conscience

- A legal term meaning a law is so onerous that it literally shocks human logic and reason.
- The U.S. Supreme Court established the shock-the-conscience test using the14th amendment's prohibition against depriving any person of "life, liberty or property without due process of law"
- It may be valuable to acknowledge our collective conscience is, in fact, shocked by both the offense and the socio-legal response

Shock the Conscience

- The test prohibits conduct by state agents that falls outside the “standards of civilized decency”
- Personification of SO legal terms
- Sensationalization of SO beyond other violent crimes.
- Registry for murder?

Shock the Conscience

- Registries and Reporting Laws as they currently exist
- Very poor evidence that they increase safety
- Much evidence that they do increase:
  - Long term homelessness
  - Unemployment
  - Stigma

The End

QUESTIONS:

- Are all sex offenders child molesters?
- Are all child molesters pedophilic?
- Risk of re-offending?
- Pedophilic vs non-pedophilic sex offenders?
- Main traits of pedophilia?
- What is the relationship between sexual abuse and pedophilia?
- Do all those with pedophilia molest children?
- Treatments for sex offenders?
- Do they work?
- Sex offenders classifications?
- Do sex offender registries work?

Reference Materials

MIAMI (Reuters, Feb. 6, 2008, Jim Loney) - *Alejandro Ruiz and his neighbors served their time for sex crimes but found themselves sleeping under a Miami highway bridge because laws meant to keep them away from children leave them nowhere else to live.*

Their dismal tent camp, tucked under an overpass on a causeway linking Miami and Miami Beach, reeks of human waste and garbage. But it is the official home of a group of sex offenders caught in a dilemma echoed across the United States.

"Where are we supposed to go? The way they label you, sex offender, nobody wants you around," Ruiz said.

Cities and states have enacted a hodgepodge of laws to keep sex offenders away from victims. In the Miami area, such laws ban them from living within 2,500 feet of schools, playgrounds and other places where children might gather.

The tiny bridge encampment, home to between 15 and 30 men on any given night, is one of the few places in the booming metropolis the paroled offenders can legally live.

In some cases, their probation officers have ordered them to live there. Several have it listed as their address on their driver's licenses -- "Under the Julia Tuttle Causeway."

"I am not a monster. I am not a leper," said Kevin Morales, 40, who was convicted of lewd and lascivious conduct with a 15-year-old relative.

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Motivation Continuum

Biological/Physiological Sexual Needs — **Psychosexual/Deviant**

Power/Anger Nonsexual Needs — **Sexual Needs**

(Not one or the other, but a continuum)

Situational Sex Offender: (>More Likely)	**Preferential Sex Offender**: (>More Likely)
Less Intelligent	More Intelligent
Lower Socioeconomic Status	Higher Socioeconomic Status
Personality Disorders Such As	Paraphilias Such As
■ Antisocial/Psychopathy	■ Pedophilia
■ Narcissistic	■ Voyeurism
■ Schizoid	■ Sadism
Varied Criminal Behavior	Focused Criminal Behavior
Violent Pornography	Theme Pornography
Impulsive	Compulsive
Considers Risk	Considers Need
Sloppy Mistakes	Needy Mistakes
Thought-Driven	Fantasy-Driven
Spontaneous or Planned	Scripted
■ Availability	■ Audition
■ Opportunity	■ Rehearsal
■ Tools	■ Props
■ Learning	■ Critique
Method of Operation (MO) Patterns of Behavior	Ritual Patterns of Behavior
■ Works	■ Need
■ Dynamic	■ Static

Integrating Theory, Practice, the Individual, and the Court: Sample Cases

Thus far, this paper has provided an overview of legal history, the theory behind the ASOP program, and the role of the probation officers and clinicians in facilitating community supervision of sex offenders and providing treatment to change maladaptive behavior patterns. Even when all of these elements are balanced, however, there may still be obstacles to successfully integrating sex offenders into the community. The following case examples illustrate instances in which the theory behind community supervision of sex offenders is put into action as well as obstacles that may be encountered when implementing such a program.

Case 1

J.R. is a middle-aged, African-American man who has been employed as an auto mechanic for the last seven years. J.R. dropped out of high school, has been married twice, and is separated from his current wife. One evening, after returning from the bar, J.R.'s teenaged daughter walked in on him while he was changing. Partially clothed, J.R. requested that his daughter enter the room and touch his penis. The next morning, J.R. told his wife about the incident and turned himself in to the police at the nearest station. Prior to adjudication he enrolled on his own in individual counseling at his local community mental health center. He also began to attend and participate in Alcoholics Anonymous (AA) meetings. This continued for about a year at which point he was court-ordered into an ASOP treatment group as a condition of probation. He resisted, insisting that he had been involved in his own treatment, and had received great benefit. When asked about his relapse prevention plan, however, J.R. responded with a confused blank stare. With reluctance he left individual therapy and AA, and joined the ASOP. J.R. participated in weekly sex offender-specific group therapy. When asked about his actual offense, J.R. admitted that his judgment was impaired from heavy drinking and that he felt immense guilt when he sobered-up the following morning.

About six months into treatment, his wife initiated couples and family therapy sessions which eventually included his daughter, the victim. The family therapist, a doctoral level psychologist, engaged in this treatment with great zeal, acting as advocate, ombudsperson, case manager and therapist, to the point of advising them legally as well as appearing in court to testify on their behalf. Unfortunately, this new therapist failed to communicate with the ASOP court-appointed therapist and probation officer until immediately prior to court dates. Rather than enhancing J.R.'s sex offender treatment, the independent work of the family therapist hindered J.R.'s progress in sex-offender specific treatment, including a period during which he removed himself from ASOP treatment only to later return, exhibiting many regressive behaviors and cognitive distortions.

In *Case 1,* the goals of the ASOP program were hindered by the work of an outside therapist. While believing that his actions were in the best interests of the client and his family, the therapist's intervention, combined with his failure to understand the unique treatment needs of sex offenders, caused a setback in the offender's treatment. The offender in this case believed he would expedite his recovery and eventual reunification with his family by pursuing the additional therapy services. By not collaborating with the therapists and probation officers providing the sex-offender specific services, the family therapist in this case reinforced the offender's pattern of cognitive distortions that contributed to the commission of his original offense. Outside services such as family therapy may assist in the treatment of sex offenders in the community, but only when they are integrated with the already existing structure for the supervision and treatment of the offender.

Case 2

B.T. is a single, Caucasian man in his late twenties who has been unemployed for several years. He has a history of abusing alcohol and cannabis dating back to high school. While babysitting an 11-year-old neighbor girl, B.T. entered her room while she slept, placed his hand beneath her clothing and fondled her genitals. Several weeks later, the girl reported the incident to her counselor at school. B.T. was subsequently charged with aggravated criminal sexual abuse of a minor and sentenced to 24 months of specialized sex offender probation.

As part of his probation through ASOP, B.T. participated in weekly, sex offender-specific group therapy. At the start of treatment B.T. vehemently denied the charge against him, and argued that he signed his probation agreement under duress. After several weeks of confrontation by the other group members, B.T. admitted to the offense, but blamed his behavior on "being too high" that night.

B.T. continued to attend group meetings for almost one year and was superficially compliant, glib, and always upbeat in his responses. He was marginal in terms of meaningful internalization of the material and process, vaguely referring to various life situations regarding his relationships with adult girlfriends and their children. Despite concerns of the clinician and probation officers involved with B.T., the judge entered an order discontinuing his treatment and probation without any indication or communication to the treatment program or probation. Within two months following discharge, B.T. re-offended and was arrested and incarcerated for aggravated criminal sexual assault of a minor.

In *Case 2,* the community supervision of the offender was terminated prematurely, to the detriment of a subsequent minor victim. In this case, the offender was able to convince the judge that he was successful in treatment, without ever supporting his claims with the opinions of the therapist. Had the judge postponed his decision pending a report from the therapist, an assessment of B.T.'s true risk of reoffending would have been made available to the court. By trusting the offender to accurately report his current progress in treatment, this case resulted in an illustration of a worst case scenario when dealing with the manipulative behavior of sex offenders.

Case 3

C.J. is a single, Latino man in his early twenties. Over the past several years, C.J. has maintained intermittent employment in various fast food restaurants. As a teenager, C.J. was in foster care following his mother's death. C.J. never completed high school, where it was determined that he had a learning disability and a borderline IQ. While watching television at his aunt's home one afternoon, C.J. encouraged his six-year-old nephew to disrobe and climb onto his lap. He was subsequently arrested for aggravated criminal sexual assault, and sentenced to a term of four years of intensive probation including a sex offender treatment program. C.J. was initially enrolled in a sex offender treatment program for two years and was terminated unsuccessfully. According to this agency, C.J. apparently stole a watch and a knife from an unlocked office. When confronted about the theft on the following day, C.J. returned the watch but was ejected from the program. Probation requested that the ASOP program consider him for inclusion in their program. During his assessment interview, C.J. seemed appropriate for treatment, and was accepted into the ASOP program. Treatment records and a discharge summary were requested from the former program, but never received.

In the new program, C.J.'s attitude was that he had already learned what he needed to know

during his prior treatment. As a result, his progress, despite persistent and creative attempts at intervention, was negligible. Due to several impulsive and aggressive episodes of violent behavior in the workplace, it was determined that C.J. posed significant risk of harm to self and others and was terminated form the second treatment program from which he was deriving little, if any, benefit. The clinicians from the second agency testified concerning C.J.'s current status, including the results of an Abel assessment indicating that he actually posed a greater tendency toward sadistic pedophilia than when he was first arrested prior to treatment. Unable to find a facility willing to treat C.J. on an outpatient basis, the judge decided to allow C.J. to continue serving his term of probation without requiring any treatment.

Case 3 represents a lack of available services to meet the varied needs of different offenders. In this case, C.J. deteriorated over time, and actually posed a greater risk after treatment in the community. The judge felt that C.J. had been complying with the services to the extent that he should not be incarcerated in prison. An ideal alternative for a client like C.J. would be to provide sex offender-specific residential treatment, in which he could receive more intensive supervision and treatment services outside of prison. At the time of writing, this type of treatment was not available. It is likely that there are many sex offenders similar to C.J. who require more intensive treatment than is available within the community, but whose behaviors would likely worsen if sent to the penitentiary.

Case 4

R.M. is a single, forty-year-old Caucasian male, who has been married and divorced twice. Following his second divorce, R.M. started in a live-in relationship with a similarly aged woman and her fifteen-year-old daughter. This relationship lasted for several years. For most of R.M.'s adult life, he worked as a landscaper and was a self-described "loner," who was uncomfortable interacting with others. R.M. actively discouraged others from approaching him in part because of his "short fuse," marked by his tendency to launch into an explosive verbal onslaught without apparent provocation. R.M. committed his sexual offense against his paramour's daughter. On two separate occasions R.M. entered the fifteen-year-old's bedroom during the night, and fondled her genitals underneath her clothing. The victim was aware of these assaults and eventually reported them to her mother. The police were called and R.M. was arrested and convicted of aggravated criminal sexual assault with a sentence of four years of intensive probation including participation in ASOP.

When treatment began, R.M.'s appearance was disheveled, he exhibited poor hygiene, and was dressed in what appeared to be the same set of dirty clothes he had worn to work. During the first several months of group sessions, R.M. was quiet and withdrawn, appearing somewhat frightened. When asked during his initial evaluation, R.M. admitted to committing the offense. In group, R.M. quietly responded to questions posed to him by stating that he was not comfortable speaking in groups. He stammered and was visibly nervous. As R.M. progressed in treatment, he became less anxious and more participative, eventually contributing to the group process.

R.M. saw his probation officer as a stern, symbolic conscience and extant moral compass. The group context provided a structured support system that allowed R.M. to make the necessary behavioral changes. R.M.'s treatment goals included managing and resolving his depression, improving anger management, and developing and applying appropriate social skills and non-deviant sexual behavior. Over the course of treatment, each of these goals was addressed. Additionally, R.M. also developed and demonstrated improved self esteem, trust, and respect of others over the course of treatment. After approximately 13 months of treatment, R.M. became a peer group leader, confronting and supporting the recovery of other offenders. Following a two-year treatment regimen he was successfully discharged, and at one-year follow-up, has not re-offended.

In *Case 4,* R.M. was able to benefit from probation because his perspective that the treatment group was safe and supportive balanced his experience that his probation officer was ever vigilant and would be intolerant of his noncompliance with the terms of probation. R.M., like many sex offenders, had undiagnosed mental health problems and lacked the necessary social skills to engage in appropriate relationships with others. Rather than voluntarily seek services to help him address his deficits, R.M. tried to meet some of his unsatisfied needs through committing a sex offense against a minor. Fortunately, R.M. was caught, placed on probation, and succeeded in treatment that addressed both his mental health problems and his lack of appropriate social skills. It is unlikely that R.M. would have resolved his difficulties and attained these skills if he had been incarcerated rather than placed on probation. Similarly, it is doubtful that R.M. would have succeeded in treatment without the strong influence of his probation officer. It is clear that R.M required the services of both probation and mental health treatment providers to resolve his clinical and interpersonal problems and to address the problems that contributed to his offending behavior. Through collaboration with the therapists and probation officers providing the sex-offender specific services, R.M. was able to correct his deviant cognitions and behaviors, greatly decreasing the likelihood of committing subsequent sex offenses.

Case 5

S.B. is a single African-American male in his mid-twenties. He had a history of special education and unemployment. While babysitting his four-year-old niece, he "took a nap with her" which resulted in S.B. sexually molesting this young girl. S.B. was convicted of aggravated criminal sexual assault and was sentenced to a term of five years of intensive probation including completion of a sex offender treatment program. It was apparent early on that S.B. was cognitively limited (exhibiting borderline intellectual functioning) and was socially maladjusted. S.B. initially denied the offense. During the post conviction polygraph, S.B. admitted the offense, although he minimized his responsibility.

Throughout treatment, S.B.'s participation was limited, despite always completing all assignments to the best of his ability. His responses both in group and to the written assignments were brief and concrete, but accurate as to the core issues at hand. His regularly scheduled individual sessions were productive, allowing S.B. a greater opportunity to express himself verbally and emotionally, and permitting him to reveal more aspects of himself than he was able to discuss in the group setting. Throughout the course of treatment, S.B. revealed family dynamics of abuse and rejection, his own lack of social skills, and a deep dependency on others.

The most significant turning point of S.B.'s treatment program, however, occurred during the few sessions in which his probation officer participated. The officer carefully confronted S.B. with facts of his daily life that were not known to the group or the therapist. These events were crucial in bringing secrets into the open and pointing out stressors and challenges that had to be reckoned with in order to facilitate S.B.'s positive behavior change. In part, S.B. didn't raise these issues voluntarily because of his limited cognitive abilities. It is likely that he

was unaware how these outside issues could possibly help him in his treatment as a sex offender. Examining these issues, however, was a crucial part of S.B.'s treatment.

S.B. was required to extend his treatment and probation to allow him to make the necessary changes in his behavior. Eventually, S.B. completed the treatment program, created a personal relapse prevention plan, and passed the discharge polygraph examination.

During the last half of the treatment process, S.B. was employed as a stock clerk at a food mart in his neighborhood and later attained a supervisory position. He also initiated and maintained a long-term relationship with an age- appropriate female. Through combined treatment and probation, S.B. worked through the interpersonal problems cited above and developed many other positive coping skills, and correcting other deficits. One year following discharge, S.B. has not re-offended.

Case 5 illustrates the unique problems posed by sex offenders with limited cognitive abilities. S.B. was able to succeed with probation and his treatment, but only after the group leader recognized his limitations during group sessions. By supplementing S.B.'s treatment with individual sessions, treatment providers were able to help S.B. more fully understand his personal issues, and usefully engage in the group sessions. If the treatment component included solely group sessions with a rigid curriculum, S.B. would likely have continued to struggle, superficially completing assignments while never coming to understand how his personal issues related to his offending behavior. It would be dangerous to lower the expectations of probation and treatment for cognitively limited offenders like S.B. By providing additional individual sessions and lengthening the time spent in treatment, S.B. was able to fully benefit from treatment and decrease his potential to re-offend. Such flexibility by both probation and clinical staff is necessary to ensure that offenders receive the maximum benefit of probation and treatment, and to reinforce the skills and insights necessary to protect society from future sex offending by these individuals.

Conclusion

The Cook County ASOP program was designed and implemented as a unique approach to the supervision and treatment of sex offenders in the community. This program represents a successful integration of the prevailing theories of sex offender treatment with quality supervision by probation. The extensive collaboration between probation officers and therapists lends itself to the success of such a program. Even when probation and treatment providers closely communicate with each other, outside forces need to carefully consider the recommendations of this treatment team when deciding the disposition of the legal cases of convicted sex offenders on probation.

Based on our collective experience of working with sex offenders on probation, the authors assert that treatment within the context of the "containment model" indeed works. Although it is not a panacea, we have seen numerous offenders change their offending behavior with abatement in re-occurrence rates and lifestyle changes that manifest effective problem-solving skills and pro-social and productive lives. The research data supports this contention and is encouraging in this regard.

As the field continues to evolve, three major issues must be addressed before they pose more prominent impediments to successfully ameliorating this destructive social problem: 1) legislation needs to be amended to avoid the exceedingly punitive effect of generalizing punishment while ignoring differences in offenses and perpetrators; 2) individuals within the justice system need to be better informed and educated of the epidemiology, dynamics, and responsiveness to treatment of this at-risk population; and 3) the front-line criminal justice and clinical treatment professionals need additional support in their collaborative efforts.

As has been cited elsewhere, particularly in the literature on adolescent sex offenders, the punishment must fit the crime. A clear focus on the individual act and contingent penalty is needed. Lifetime registration may not be an adequate societal safeguard where lifetime parole would be more appropriate for some offenders. Additionally, mandating treatment immediately upon case disposition and incorporating it into an offender's sentencing to a detention facility may provide a more proactive solution, as opposed to proceeding with civil commitment after the fact. Extended probation sentences must be considered and used to provide ample time for the offenders to engage in treatment as well as to comply with the structured requirements of counseling. By ordering offenders to financially contribute to their treatment through payment of probation fees and a portion of counseling costs, offenders are more likely to feel committed to fully participating in treatment, and can also help to partially defray the costs of providing these rehabilitation services.

More recently, special training events on treatment of sexual offenders have been made available to the legal and criminal justice communities. Professionals need to take advantage of these educational opportunities so that they can make informed decisions when working with sex offenders in their practice, and can better protect former and potential victims. Similarly, training programs should be continually revised and updated to reflect the latest empirical findings and advances in treatment practices. The importance of educating and updating the judiciary and attorneys cannot be overemphasized. Obviously, judges are the engines of ensuring a safer society and empirical data concerning best treatment practices can provide the fuel needed to achieve that goal.

The challenge faced by front-line criminal justice and clinical staff in dealing with the sex offender population on a daily basis is both daunting and dangerous. In order for them to stem the frightening social epidemic of deviant and predatory sexual behavior, people working with sex offenders must be supported and recognized for their difficult work. Imposing fair, reasonable, and consistent standards for dealing with sex offenders will facilitate this task.

Facilitating partnerships between probation and clinical professionals should further develop and advance the continually evolving field of sex offender assessment and treatment. Both clinicians and probation officers share the ultimate goal of rehabilitating offenders and enhancing community safety. Collaborative ventures such as the ASOP need to be continually assessed and adjusted so that they may continue to function effectively. These efforts can then contribute to the repair of a social fabric too often damaged by adults committing sexual offenses against children.

Endnotes

[1] Lawrence A. Greenfeld, Sixty Percent of Convicted Sex Offenders Are on Parole or Probation, Bureau of Justice Statistics News Release, Feb. 2, 1997, available in 1997 WL 53093 (D.O.J.).

[2] Kimberly English, Personal Communication, August 27, 2003.

[3] Eric S. Janus & Paul E. Meehl, Assessing the Legal Standard for Predictions of Dangerousness in Sex Offender Commitment Proceedings, 3 Psychol. Pub. Pol'y & L., 33, 51-59 (1997).

[4] *Id.*

[5] J.K. Marques et al., Effects of Cognitive-Behav-

Motivation is most often evaluated and determined by behavior patterns as well as other indicators and evidence *(see* "Table 2" below).

Motivation Continuum **Biological/Physiological Sexual Needs** — **Psychosexual/Deviant** **Power/Anger Nonsexual Needs** — **Sexual Needs** **(Not one or the other, but a continuum)**	
Situational Sex Offender: (>More Likely)	**Preferential Sex Offender**: (>More Likely)
Less Intelligent	More Intelligent
Lower Socioeconomic Status	Higher Socioeconomic Status
Personality Disorders Such As	Paraphilias Such As
■ Antisocial/Psychopathy	■ Pedophilia
■ Narcissistic	■ Voyeurism
■ Schizoid	■ Sadism
Varied Criminal Behavior	Focused Criminal Behavior
Violent Pornography	Theme Pornography
Impulsive	Compulsive
Considers Risk	Considers Need
Sloppy Mistakes	Needy Mistakes
Thought-Driven	Fantasy-Driven
Spontaneous or Planned	Scripted
■ Availability	■ Audition
■ Opportunity	■ Rehearsal
■ Tools	■ Props
■ Learning	■ Critique
Method of Operation (MO) Patterns of Behavior	Ritual Patterns of Behavior
■ Works	■ Need
■ Dynamic	■ Static

Table 2

At one end of the continuum are the more "situational" sex offenders. Although they can be smart and rich, they tend to be less intelligent and are over represented in lower socioeconomic groups. Their criminal sexual behavior tends to be in the service of basic sexual needs *(i.e.*, "horniness," lust) or nonsexual needs *(i.e.*, power, anger). Their sexual behavior is often opportunistic and impulsive, but primarily thought-driven. They are more likely to consider the risks involved in their behavior, but often make stupid or sloppy mistakes. If they collect pornography,