The Practice & Ethics of Counseling Sexual Offenders

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TN BOARD APPROVED SEX OFFENDER TREATMENT PROVIDERS

Financial Disclosures

We have nothing to disclose.

“Begin with the end in mind.”

-DR. STEPHEN COVEY, THE 2ND OF THE 7 HABITS OF HIGHLY EFFECTIVE PEOPLE

Conference Objectives

#1 To learn the differences between traditional mental health clientele and sex offender clientele, dynamics, and effective treatment techniques including an overview of the containment model, the preconditions that lead to sexual abuse and the categories of offending behavior;

#2 To understand the special requirements and ethics of becoming an appr offender treatment provider; and

#3 To differentiate appropriate treatment goals a non-board approved coun develop with members of this population.

#1 The Difference in Clientele

TRADITIONAL MENTAL HEALTH

Not court ordered

Unconditional positive regard

Support Group / 12 Step Group = OK

Confidentiality

The client is the client

Duration of Tx varies

SEXUAL OFFENDER

Primarily Court ordered

Conditional positive regard

“No cure” (see TSOTB Policy #1)

Not a “class” or “support group”

The client = the victim & community

Tx Provider is not a social worker.

Goal is to reduce their risk of re-offense

Specialized Sex Offender Training

Both need an Installation of Hope (Yalom)

The Containment Approach to Managing Sexual Offenders in the Community:

A Practitioner's Guide

Charles F. Edson · Robert G. Lundell · David R. Robinson

Types of Offenders

Sex offenders can be categorized in several ways, including by legal typology, offense severity, and type of victim:

- *Legal typology* - Offenders can be categorized as sexually oriented, habitual, or predatory.
- *Offense severity* - the Adam Walsh Act categorizes registered sex offenders by tier based on the severity of their offense: Tier I, II & III (Misdemeanor, Less serious felony sex crimes, Serious felony sex crimes
- *Type of victim* - Some typologies suggest that sex offenders specialize in certain types of victims.

  - Rapists (often younger, more socially competent, in a relationship with their victim, use of force / aggression)

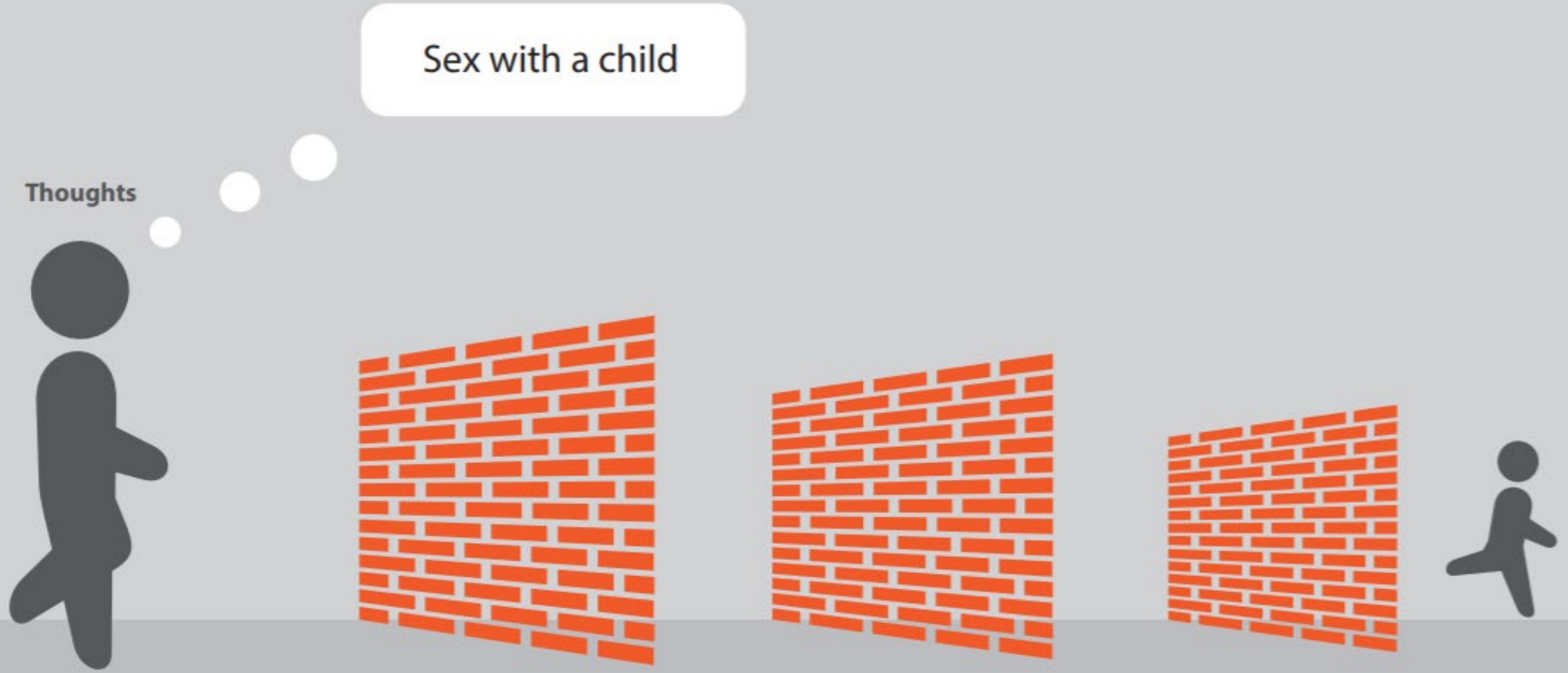
  - Child sexual abusers (contact offenders or fixated offenders who are compulsively attracted to children.

  - Opportunistic or situational offenders / Regressed offenders

  - No Contact Offenses such as Human Trafficking, Child Pornography, Voyeurism, Exhibitionism

Four Pre-conditions to child sexual abuse

Adapted from: D. Finkelhor, *Child Sexual Abuse: New Theory & Research* 1986



1st Precondition: Motivation

The journey of the offender towards sexual abuse of a child starts with the development of an interest to engage in sexual contact with a child.

Factors that influence this motivation include:
- sexual arousal to children,
- emotional congruence with children and
- a blockage to adult relationships.

The backgrounds of offenders often include childhood adversity (correlation not causation) – including experiencing child sexual abuse as a victim; but also the absence or inadequacy (neglect) of their parents or caregiver, perhaps due to drugs, alcohol misuse or domestic violence.

2nd Precondition: Internal Barriers

Overcoming one's internal barriers or conscience is the ability overcome any internal inhibitions against acting on that predisposition or motivation.

"Cognitive distortions in sex offenders are specific or general beliefs/attitudes that violate commonly accepted norms of rationality that have been shown to be associated with the onset and maintenance of sexual offending." (Ciardha & Ward, 2013)

Cognitive distortions arise long before an offense is committed but serve to influence an individual's life-course and goals in a way that brings them closer eventually sexually offending. Some account for distortions that arise in the lead up to or immediately before a sexual offense, providing a justification for committing an offense. And others accounts for distortions that are formed post-offense as a result of the adversarial context of the individual's social environment.

Ex: "She looked / acted more mature for her age." (Justification)

Denial & Resistance

Tx Goal: Taking Complete Responsibility with Full Disclosure of Offending Behavior

Resistance is avoidance of responsibility and serves to protect one's ego. AKA "Pretend Normal"

Build rapport (autobiography, help w/ current problem, self disclosure, etc)

Explain their road to completing treatment (specific risks, g

Use of collateral information in group (PSE, polygraph)

Limit Grievance Thinking discussion in group.

Denial is not a cause for discharge.

Discuss these cases in peer supervision.

Remember: You have time with these clients!

"Before we begin, I'd like to say a few words about the concept of 'defence mechanisms'."

Types of Denial

- Denial of Offense
- Denial of Victim Impact
- Denial of Extent
- Denial of Responsibility
- Denial of Planning
- Denial of Sexual Deviancy
- Denial of Relapse Potential
- Denial of Need for Help or Social Sanction

Treatment Resistance Examples

- Attempts to confuse
- Points out others' faults
- Builds self up by putting others down
- Makes a big scene about minor issues
- Accuses others of misunderstanding
- Uses anger as a weapon to control others
- Argues over "words" to avoid the real issue
- Introduces irrelevant material
- Puts others on the defense
- Deliberately vague
- Avoids duties/obligations
- "I forgot," "I'm stupid," "I don't know."
- Tells others what they want to hear not the truth
- Omits facts, distorts truth, and reveals only what pleases self
- Agrees without commitment (says "yes" without meaning it)
- Does not pay attention
- Chooses only what is self gratifying
- Refuses to communicate or participate—silence
- Minimizes behavior ("I just did it once")
- Claims to be changed after doing the right thing once
- Pouting
- Splitting (divide and conquer)
- Gossiping/Talking about others behind their back
- Triangulation

Effective Treatment Techniques

Have them tell their story often.

Use psychoeducation strategically (Finkelhor Model, healthy sexuality materials, videos).

Get everyone speaking in group.

Make connections between members, highlight similarities.

Explain why you do what you do.

Highlight progress as it is made.

Directive / skilled use of confrontation

Use of Polygraph

When stuck, consult with a peer.

TN Sex Offender Treatment Board

The Sex Offender Treatment Board is administratively housed at the Tennessee Department of Correction. The Board consists of 13 appointed individuals dedicated to the mission of reducing the likelihood of sexually based offenders.

In 1995, the Tennessee General Assembly created the Sex Offender Treatment Board in the Department of Correction. The General Assembly declared, *reference* TCA 39-13-702 (a), that the "…comprehensive evaluation, identification, treatment, and continued monitoring of sex offenders who are subject to the supervision of the criminal justice system are necessary in order to work toward the elimination of recidivism by the offenders."

The General Assembly charged the Board with the following activities:

- Developing and prescribing a standardized procedure for the evaluation and identification of sex offenders

- Developing and implementing methods of intervention

- Development of guidelines and standards for a system of programs for the treatment of sex offenders placed on probation, parole, community corrections, or incarcerated in the Department of Correction.

Website: https://www.tn.gov/correction/tennessee-sex-offender-treatment-board.html

The Ethics of S.O. Practice

The Tennessee Sex Offender Treatment Board was charged with developing standards for the treatment and monitoring of sexual abusers…the Board elected to review existing treatment and monitoring standards. The Board recognizes the Association for the Treatment and Prevention of Sexual Abusers (ATSA). The Board endorses ATSA Practice Standards and Guidelines for the evaluation, treatment, and management of adult male sexual abusers (2014 revised). The Board also endorses ATSA Professional Code of Ethics. Both sets of documents can be obtained from ATSA.

All you need to know: https://www.tn.gov/correction/tennesseesex-offender-treatment-board/tsotb-policies-–forms.html

Treatment Provider Qualifications

- Must hold professional license.

- The Provider shall have at least 50 hours of specialized sex offender training.

- The Provider shall have 2,000 hours of supervised clinical experience in the field of sex offender treatment. Clinical experience is defined as participation in professional training, work, research, writings, etc. related to the field of sex offender treatment. The supervisor for those hours must also have relevant experience and background in the treatment of sex offenders.

- Experience can be obtained as part of your pre-licensure or post licensure. *Hours received pre-licensure while working with a TSOTB Approved Provider may be used to satisfy the 2,000-hour requirement as long as the Board has approved such arrangement

- The Provider/Evaluator shall have a minimum of 100 hours of face-to-face supervision, from a qualified clinical supervisor, within the prerequisite 2000 hours of clinical experience. Group or peer supervision time dedicated to case presentations may constitute up to 50 hours of face to face-to-face supervision.

- Sign an agreement with the State of Tennessee / The Sex Offender Treatment Board, attend annual training conference, and any ongoing training (peer supervision, quarterly regional training, monthly lunch & learns) required to maintain status.

https://www.tn.gov/content/dam/tn/correction/documents/TSOTBApprovedTreatmentProviderQualifications.pdf

https://www.tn.gov/content/dam/tn/correction/documents/TSOTBProviderAgreement.pdf

Individual Therapy

"The Sex Offender Treatment Board recognizes the importance of individual therapy in addition to group therapy during sex offender treatment. Individual therapy, if utilized, should be a part of the offender's treatment plan and the offender's risk management. While this is considered sometimes necessary during treatment, the Sex Offender Treatment Board has adopted a weekly group model of sex offender treatment…"

Q: "What do I do if asked to do therapy with such a client but they are not or have not completed S.O. Treatment?" (Presentence vs post sentence)

What issues can I treat ethically? When do I refer?

When can I accept?

How do I handle denial in a client convicted of an S.O?

Where can I refer? (Presentence vs post sentence)
https://www.tn.gov/content/dam/tn/correction/documents/TSOTBProviderDirectory.pdf

#2 Setting Up Groups

Homogenous vs heterogenous groups

- Gender,
- Age,
- Type of offense
- Victimization

Structure and elements that make for effective group therapy

- Number
- Location/space
- Levels of tx
- Communication with TDOC (Monthly reports/Waivers/High risk situations)
- Treatment Contract (Attendance, expectations, etc)
- Running a business

Treatment Planning

- Identify and develop goals from the Psychosexual Evaluation
- Target Dynamic Risks
- Use of Objective Testing to identify risks (VASI & Polygraph)
- Assess regularly to measure progress (SOTIPS, STABLE)
- Communicating their progress in group
- Updating Treatment Plan regularly
- Have a solid understanding of what Tx Completion looks like for the client.

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THE END!

Q&A

FEEDBACK ...

SHARE IDEAS!