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Sincerely,

Maia Christopher

William Murphy

Co-Chair, Professional Issues Committee

Professional Issues Committee Members
James Haaven
Ron Kokish
Robert McGrath
Jerry Thomas
THE ASSOCIATION FOR THE TREATMENT OF SEXUAL ABUSERS PRACTICE STANDARDS AND GUIDELINES FOR THE EVALUATION, TREATMENT, AND MANAGEMENT OF ADULT MALE SEXUAL ABUSERS

(Short title: “ATSA Adult Male Standards and Guidelines”)

Introduction

This document is provided to members of the Association for the Treatment of Sexual Abusers (ATSA), a voluntary professional association, in order to assist members in performing their professional duties. ATSA members are committed to protecting their clients\(^1\) and the public against unethical, incompetent, or unprofessional practices.

The ATSA Adult Male Practice Standards and Guidelines is intended to provide standards of professional conduct to aid ATSA members in the process of making decisions regarding their professional behavior. For the purpose of this document, standards are practices that must be followed and guidelines are recommended best practices. The Clinical Membership Requirement section of this document

\(^1\) The terms client or clients are used to refer to individuals who have committed sexual offenses. Other terms that can be used and that may be preferred by some ATSA members, based on their disciplines and practice settings, include consumer, patient, or service recipient. Individuals who have committed sexual offenses are defined in this document as individuals who have engaged in sexual behavior that involves others without their consent and may cause harm to them; such behavior is usually, but not always, illegal. This definition includes, but is not limited to, individuals who have forced or threatened someone to have sex, engaged in sexual acts with a child under the legal age of consent, use the internet to secure child pornography, had sexual contact with someone without their consent, had sexual contact with an individual in violation of a special trust, or exposed their genitals to an unsuspecting stranger.
includes criteria established in the ATSA by-laws and therefore these practices are considered standards. Other sections of the document include referenced items\(^2\) adapted from the ATSA Code of Ethics (2001) and therefore these practices are also considered standards. The remaining practices in this document are considered guidelines.

The guidelines in this document are written broadly to apply to the varied roles of ATSA members. However, characteristics of individual cases may cause a member not to adhere strictly to a particular practice guideline. In these circumstances, members should document their reasons or rationale for deviating from the guideline.

The ATSA Adult Male Practice Standards and Guidelines are based primarily on what we know about adult males who engage in sexual offending behavior and are intended for this population. ATSA recognizes that juveniles and adult females who have committed sexual offenses are in many ways distinct populations with distinct needs. Practitioners are urged to use caution and professional discretion if applying these standards to populations other than adult males\(^3\).

\(^2\) Items adapted from the ATSA Code of Ethics (2001) are listed by statement number, and identified in bold.

\(^3\) Although many of these standards may be applicable to juveniles, they are written for adults. For further information regarding the management of juveniles who have committed sexual offenses please refer to ATSA publications on the evaluation, treatment and management of juvenile sexual offenders.
The ATSA Adult Male Practice Standards and Guidelines are designed to describe clinical practices that reflect the best available clinical and research knowledge, and are interpreted with reference to the major goals of ATSA, which are:

- The dissemination of current information on clinical practice and research in order to promote best practices for the field,
- To provide quality care to individuals who have engaged in sexual offending behavior to assist them to manage their risk of sexually reoffending, and to facilitate them living a safe, healthy and satisfying life,
- The prevention of sexual assault through effective management of individuals who commit sexual offenses,
- The development of a public health approach to the prevention of sexual abuse,
- The protection of our communities through responsible and ethical treatment of individuals who sexually offend, effective risk management strategies, public education and awareness, and the use of evaluation, treatment and management strategies that reflect the best available clinical and research knowledge and,
- The maintenance of high standards of professionalism and integrity within the membership.

Members therefore agree to abide by the ATSA Adult Male Practice Standards and Guidelines, and integrate these into clinical and programmatic decision making in order to achieve these goals.

The following principles were applied to the development of this document. These principles distinguish the evaluation, treatment, and management of individuals who sexually offend from many other areas of clinical practice.

**Guiding Principles for this Document**

- Most individuals who sexually offend will benefit from treatment oriented to reduce the risk of recidivism by using the treatment interventions shown to offer the greatest promise, which are outlined in these Standards and Guidelines.
• Inadequate, inappropriate, or unethical treatment is harmful to the client, damages the credibility of all treatment providers, and presents an unnecessary risk to the community.

• Management of the factors that contribute to sexually abusive behavior is a life-long task for many adults who sexually offend.

• Internal motivation may improve an individual’s participation in treatment. Although not always the case, many individuals who sexually offend will not request or comply with treatment or supervision requirements without external motivation such as being legally mandated to participate.

• Criminal investigation, prosecution, a court order, or a similar directive requiring specialized sexual abuser treatment may be important components of effective intervention and management and may provide impetus for treatment.

• It is advisable to provide a specialized evaluation to determine treatment and/or supervision needs before releasing individuals who have sexually offended to the community without treatment.

• Effective management of sexual abusers is enhanced by working collaboratively with probation/parole officers, child welfare workers, clients’ support persons, community members, victim advocates, and therapists who work with victims to increase community safety.

**Important Note to Readers:**

Some of the statements made in this document may conflict with state, provincial or federal statutes and/or professional regulations that pertain to a member’s practice. If such a situation occurs, statutory and professional obligations should take precedence over the statements made in this document.
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The ATSA Adult Male Standards and Guidelines have been organized as follows. The letters A, B, C, D, E, and F refer to the six domains in which the Standards and Guidelines are grouped.

Within each lettered domain, numbered statements (e.g., Statement 1) indicate major practice issues, while statements with subordinate numbers (e.g., Statement 1.01) indicate more specific recommendations related to these major practice issues. Where applicable and appropriate, brief explanations or discussions are provided in the main text.

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A. ATSA Clinical Membership Requirements

The educational and professional backgrounds of ATSA members are diverse and members have different sets of skills and knowledge from their courses of study and work experiences. A multi-disciplinary approach can enhance our ability to provide services to individuals who sexually offend.

1. ATSA does not certify or license practitioners to practice in any discipline and Clinical Membership does not confer the privileges of either certification or licensure to practice in any field. Members are responsible for complying with statutory and regulatory requirements within their respective jurisdictions, including any licensure or certification requirements.

2. Clinical members of ATSA possess a graduate degree in the behavioral, health, or social sciences or a health-related professional degree from a fully accredited college or university. This does not preclude appropriately qualified students working under the supervision of a clinical ATSA member.

3. Clinical members of ATSA have engaged in direct behavioral research and/or clinical assessment and treatment of sexual abusers for a minimum of 2000 hours.
B. General Training and Qualification

4. Members providing clinical service who do not have graduate or professional degrees, have had specific training and experience in working with individuals who sexually offend and are under the direct supervision of a qualified mental health professional.

5. Members providing clinical services participate in a minimum of 2000 supervised hours of face-to-face clinical contact with individuals who sexually offend before providing unsupervised clinical services.

6. Members obtain and document annual continuing education in the field of sexual abuse. Continuing education includes courses, seminars, conferences, workshops, and other training experiences. Ethics 4a

7. Members have education, training, and experience in the evaluation, treatment, and management of individuals who sexually offend. Members working with a specialized population, have education, training, and experience specific to that population (for example, clients with developmental disabilities, or clients with mental illness).

7.01 Members complete courses, training, and/or gain experience in order to become knowledgeable about the following areas (the order does not indicate priority):

- Assessment and diagnosis,
- Cognitive therapy,
- Counseling and psychotherapy,
- Cultural/ethnic issues,
- Ethics as apply to working with a forensic population,
• Human development with special attention to sexual development,
• Interviewing skills,
• Knowledge of family dynamics as related to sex offending,
• Psychometric and psychophysiological testing,
• Psychopathology,
• Relapse prevention,
• Relationship and social skills training,
• Risk assessment,
• Sexual arousal control,
• Social support networks,
• Victim awareness and empathy.

Additional training and knowledge is necessary when engaging in the following areas:

• Assessment and treatment of mental illness including neuropsychological disorders,
• Couples and family therapy,
• Family reunification,
• Pharmacological therapy and,
• Substance abuse treatment.

7.02 Members, regardless of degree and years in the sexual abuse field, continue to supplement their educational and professional experience through consultation with other professionals who have relevant expertise in the field. Ethics 4a
7.03 Members are encouraged to affiliate with other professional organizations, agencies, or groups involved in the assessment, treatment and management of individuals who sexually offend, victim therapists, and prevention of sexual abuse.

7.04 Members stay informed of all professional confidentiality rules as well as applicable statutory and regulatory requirements to warn, report, and notify the appropriate persons or entities of information learned during the course of providing clinical services. Clients are made aware of all limits to confidentiality before services are rendered. **Ethics 9d**

8. Members respond only to referral questions that fall within their areas of training and expertise. **Ethics 4b**

8.01 Members refrain from diagnosing, using assessment methods, treating, or consulting on clinical problems that are outside their areas of competence. **Ethics 4b**

8.02 Members refuse referrals for evaluations to determine if someone has or has not committed a specific sexual act.
C. Professional Conduct

As in other areas of forensic practice, members need to be sensitive to potential conflicts and problems of providing clinical services to clients who are involved with third-parties such as courts, attorneys, correctional authorities, or child protection services. Of particular relevance is the potential conflict between client rights, community safety, and the member’s ethical and professional responsibilities. In particular, members recognize the right of clients to refuse to consent for specific services, even when there is significant social or legal pressure to participate, and shall respect client confidentiality as defined by law and professional codes of conduct.

9. Members use reasonable security precautions (and comply with institutional security procedures, when applicable) in their contacts with clients in order to provide a safe environment for themselves, the community, other clients, and other staff.

10. Members recognize that there may be potential conflicts of interest when they provide both evaluation and treatment services to the same person. When it is necessary to fulfill both functions, (for example, in rural settings or institutions) members take reasonable steps to manage and resolve any conflict in the best interests of the client and the community. **Ethics 8aiii**

Clients

11. Members obtain written informed consent from the client and/or their guardian when providing direct clinical services. The document outlines the details of the informed consent and is signed and dated by the client and the member. It is important to realize there are many elements to informed consent. (See definition in Appendix E).

11.01 Members proceed with evaluation or treatment only after obtaining proper informed consent. **Ethics 8c**
11.02 Members obtain renewed informed consent if there are major changes in procedure during the course of providing services, for example, the addition or deletion of a major evaluation or treatment component.

11.03 Members recognize that clients have the right to obtain legal representation prior to beginning an evaluation conducted for legal purposes.

11.04 Members’ arrangements for payment are settled at the beginning of assessment or treatment. **Ethics 7bii**

11.05 Members take prompt action to inform clients and, where appropriate, their guardians if there are any significant changes in fees.

12. **Members maintain client confidentiality consistent with relevant professional and legal requirements and governmental statutes. Ethic 9d**

The ATSA Code of Ethics (2001) requires members to obtain a client’s written permission before disclosing confidential information to someone other than program staff, unless otherwise authorized or required by law. **Ethics 9i** This includes communicating with individuals who can be important participants in the client’s treatment or management plans, such as probation/parole officers, other treatment providers, child welfare workers, victim therapists, social support persons, and adult chaperones for contact with children (see Risk Management in the Community).

12.01 Members abide by all applicable legal statutes that pertain to client confidentiality in their practice. **Ethics 9d**

12.02 Members abide by applicable laws that mandate reporting abuse to appropriate authorities (e.g., mandatory reporting laws regarding child abuse or neglect). **Ethics 9j**
12.03 Members inform clients that disclosure of potentially incriminating information to mandated reporters can lead to future prosecution.

12.04 Members inform clients and/or their guardians of professionally or legally mandated limits of confidentiality prior to rendering services and remind clients of such limits periodically and as needed. **Ethics 9a ii**

12.05 Members obtain explicit permission from clients or their authorized representatives before divulging any information to a third party other than that required or allowed by applicable federal, provincial, or state reporting laws, or under the circumstances described in statement 12.08. **Ethics 9j**

12.06 Members store all client records in such a way as to ensure their security and confidentiality. Client records are kept for a minimum five years.

12.07 In circumstances where test data is to be released to a third-party who is not qualified to interpret test data, members urge the third-party to consult with a qualified professional in order to obtain a valid interpretation of those data.

12.08 Members follow professional and legal obligations regarding a duty to protect or warn that apply to their profession. Depending on the member’s jurisdiction, there may be a duty to protect if a client has communicated a credible, specific, and immediate threat of serious bodily injury against a specifically identified or readily identifiable person. The discharge of this duty may require members to warn the intended victim, notify the police, or to take other steps that would be deemed reasonable and necessary under the circumstances. **Ethics 9j**
13. Members take reasonable steps to provide continuity of care for their clients.

13.01 Members who anticipate the disruption or termination of their services inform their clients promptly and, when applicable, arrange for transfer or referral to another qualified service provider and inform the appropriate authorities. **Ethics 7h**

13.02 Members who provide services to clients of a colleague during a temporary absence or emergency serve those clients with the same consideration they provide to their own clients. **Ethics 7i**

13.03 Members make a referral to another qualified service provider if they do not have the resources to provide the necessary evaluation or treatment services for a client.

Other Professionals

14. Members maintain appropriate boundaries in their interactions with other professionals.

14.01 Members do not engage in the harassment of co-workers, students or other trainees, or other professionals or personnel. **Ethics 2d**

14.02 Members do not offer gifts or gratuities of more than token value to an actual or potential referral source. **Ethics 10f**

14.03 Members do not offer or accept payments for making or receiving referrals. **Ethics 10f**

14.04 Members work collaboratively with other community members involved in the treatment of individuals who sexually offend and the prevention of sexual abuse.
15. Members will not knowingly offer services to a client who is currently involved in treatment with another professional without attempting to consult with that professional and determine whether this arrangement is in the best interests of the client and the community. **Ethics 10a**

15.01 Members ask clients to provide information about their involvement with other clinicians at the time of the initial appointment. Members obtain a release of information in order to consult with that clinician. If the client refuses to comply, members consider whether it is appropriate to continue a professional relationship with a client who will not provide this release. Members also inform the client of possible consequences should they choose not to sign release forms. **Ethics 10b**

15.02 If a member discovers that a client previously received mental health services from another service provider, members obtain a release of information from the client and attempt to obtain information from the other service providers in a timely fashion. **Ethics 10c**

15.03 Members receiving requests for information about clients or former clients require a release of information signed by the client and forward the information in a timely fashion.

15.04 Members recognize that clients have the right to change therapists.
16. Members strive to be balanced, fair, and honest in their professional communications. **Ethics 2b**

16.01 Members take reasonable steps to correct the misuse or misrepresentation of their professional credentials, reports, and other professional communications.

16.02 Members recognize, and when providing expert testimony, acknowledge, that there is no known psychological or physiological test, profile, evaluation procedure, or combination of such tools that prove or disprove whether an individual has committed a specific sexual act.

16.03 Members do not provide expert testimony during the guilt phase of a criminal trial from which a reasonable person would draw inferences about whether an individual did or did not commit a specific sexual act.

17. Members securely retain treatment progress notes, assessment materials and copies of reports for a minimum of five years after treatment of a client ends (i.e., after treatment completion, dropout, termination, or the end of a treatment program).
D. Evaluation

Members conduct psychosexual evaluations to determine a client's risk to reoffend, identify dynamic risk factors, and develop appropriate treatment and supervision plans. As well, psychosexual evaluations provide useful guidance to others, such as the courts, in making decisions affecting a client's future and whether the client's risk can be managed in a community setting. The purpose of the evaluation is clearly stated to clients and to any recipients of the evaluation. Clients may refuse to consent to participate in all or any specific aspects of the evaluation even when there is significant social or legal pressure to participate.

The psychosexual evaluation should provide clear statements regarding client's dynamic risk factors, risk for reoffending, specific treatment needs, strengths, amenability to treatment, recommendations regarding the intensity and type of intervention that is required, and risk management strategies. Evaluations specifically include a comprehensive description of the client's abusive and nonabusive sexual behavior. Evaluations also address issues that could affect a client's response (responsivity) to treatment such as culture, ethnicity, age, IQ, learning style, neuropsychological disorders, personality style, mental and physical disabilities, medication, and motivation. Evaluators do not offer conclusions regarding whether an individual has or has not committed a specific act of sexual abuse.
General Considerations

18. **Members strive to produce objective, fair, and impartial evaluations.**

18.01 Members clearly identify the nature and purpose of an evaluation and provide the client an opportunity to participate or refuse participation in the evaluation.

18.02 Members who do not believe they can be objective, fair, and impartial in conducting an evaluation refer the potential client to another clinician or agency for these services.

18.03 Members inform clients of the reasons for the evaluation, how the information obtained is to be used, and the potential consequences of the evaluation.

18.04 Members identify who requested the evaluation, the purpose of the evaluation, and who will be directly informed of the results of the evaluation in an evaluation report.

18.05 Members try to be aware of the client's current legal status and how that status may influence the evaluation.

18.06 Members use appropriate evaluation procedures and instruments to address the referral questions.

18.07 Members conducting risk assessments use an actuarial risk assessment instrument that is appropriate for the client population being evaluated.

18.08 Members are familiar with the psychometric properties of the assessment measures they use including reliability and validity as well as acceptable administration protocols for the assessment measures.

18.09 Members are aware of the relative strengths and limitations of the assessment measures used and avoid making statements that exceed the capability of these measures.
**Types and Sources of Information**

19. **Members attempt to obtain the following information when completing psychosexual evaluations (listed alphabetically):**

- Availability of appropriate community supports,
- Access to potential victims,
- Criminal and other antisocial behavior and values,
- Developmental history and family background,
- Deviant sexual interests and arousal,
- Education and employment histories,
- History of aggression or violence,
- History of sexually abusive behavior, including details about victims, tactics used in the commission of the offense, and the circumstances in which the sexual abuse occurred,
- Insight into offense precursors and risk,
- Level of cognitive functioning and other responsivity factors,
- Level of self-disclosure and accountability,
- Medical and mental health history,
- Official and unreported history of sexual and nonsexual crimes,
- Peer and romantic relationship history,
- Relevant personality traits such as, but not limited to suspiciousness, hostility, risk-taking, impulsivity, and psychopathy,
• Sexual history, including sexual fantasies, urges, and behavior, early sexual experiences; number and duration of sexual relationships; gender identity and sexual orientation; masturbation and intercourse frequency; sexual functioning; and unusual sexual interests or behavior that are not sexually deviant (as defined in this document) or illegal, such as cross-gender dressing,

• Substance use and,

• Use of sexually arousing materials (e.g., magazines, computer pornography, books, videos, Internet sites, telephone sex services).

20. Members use multiple sources of information when conducting evaluations. These may include (not listed in order of priority):

• Client interviews,

• Interviews with collateral informants as applicable (family members, romantic partner/spouse, employer, previous service providers, probation/parole officer),

• Measures of sexual preference,

• Relevant psychometric testing,

• Review of official documents including criminal justice records, witness statements, previous assessment and treatment reports, polygraph reports (see Appendix C), medical records, victim impact statements,

• Risk assessment.

20.01 Members note significant discrepancies between client self-report and collateral information in the evaluation report.
20.02 Members seek an interview with the client during evaluations. If such an interview is denied or is not possible, members indicate this fact in their reports and in any subsequent testimony. Further, members note in reports and testimony the limitations of their conclusions based upon the failure to be afforded such an interview.

Corroboration of Self-Report

21. Members are aware of the limitations of client self-report and use collateral information in conducting evaluations so that conclusions and recommendations are not based solely on client self-report (i.e., interviews and/or computerized paper-and-pencil tests).

21.01 Members describe the sources of information used in the evaluation report.

21.02 Members identify significant limitations in their evaluation reports and identify relevant information or collateral sources that are unavailable to the evaluator. Members explain the potential impact such omissions may have upon the conclusions and recommendations contained in the report.

21.03 Members use extreme caution if interviewing victims during a sexual abuser evaluation because of the potential risk of additional harm to the victim. However, members recognize that some victims may have an interest in participating in the evaluation process. If considering a victim interview, members are to be knowledgeable of ethical guidelines surrounding informed consent and limitations of confidentiality. Members recognize that at times, victims and/or their legal guardians may not be able to give truly informed consent.

21.04 Members use caution if evaluating both the offender and victim because of the potential for conflict of interest.
Psychophysiological Assessments

22. Psychophysiological assessments such as phallometry, viewing time, and polygraphy are commonly used in corroborating client self-report and/or monitoring treatment compliance and progress. Phallometry is discussed in greater detail in Appendix A; viewing time is discussed in greater detail in Appendix B; and polygraphy is discussed in greater detail in Appendix C.

22.01 Members obtain informed consent from clients and/or their guardian before using specialized behavioral assessments.

22.02 Members do not use the results of psychophysiological assessments as the sole criterion for estimating client risk of engaging in sexually abusive behavior, making recommendations to release (or not release) clients to the community, or deciding that clients have completed a treatment program.

22.03 Members attempt to obtain assurances that examiners are appropriately trained in the use of their psychophysiological assessments and adhere to the applicable standards or guidelines of their profession.

Special Considerations

23. Members are aware that less is known about the risk factors and prognosis for special populations such as clients with developmental disabilities and clients with major mental illnesses.

23.01 Members who work with special populations have additional training working with these populations.

23.02 Members acknowledge and attempt to address any biases or assumptions based on age, cultural differences, socioeconomic differences, education, language, level of intellectual functioning, and mental or physical disability.
23.03 Members who are unable to communicate fluently with a client refer the client to another professional who is able to communicate fluently with that client. A professional interpreter may be used with the client’s permission. Members note within their evaluations if an interpreter is used. The interpreter should be professionally qualified and not related to the client or the case.

23.04 Members select the most reliable and valid evaluation instruments and procedures that are appropriate to the client’s culture, socioeconomic status, education, language, and level of intellectual functioning.

23.05 Members note any limitations if using instruments or procedures that were not developed for a client’s age, cultural background, socioeconomic status, education, language, or level of intellectual functioning.

23.06 Members meet the special needs of clients with mental or physical disabilities during evaluations (e.g., using taped versions of questionnaires for vision-impaired or illiterate clients).

23.07 Members are aware that if using alternative methods of administering tests (for example, using taped versions or reading tests aloud), the test reliability and validity may be different from published data. Reasons and the rationale for using alternative testing methods are documented in the report.

23.08 Members screen clients for mental or physical disabilities, major psychiatric disorders, substance abuse, and suicide potential. These conditions may have to be dealt with before assessment or treatment for sexually abusive behavior is initiated.

23.09 Members recognize that treatment for a concurrent disorder or condition is, in most cases, not a substitute for treatment specifically addressing sexually abusive behavior.
24. **Members clearly articulate their reasons for making recommendations with regard to treatment, case management, or supervision requirements.**

24.01 Members state their recommendations in clear and specific language.

24.02 Members attempt to inform clients of the results, conclusions, and recommendations contained in the evaluation and, the basis for any conclusions and recommendations that are made when appropriate.

24.03 Members consider community safety and the degree to which the client is capable of, and willing to manage their sexual behavior when making recommendations.

24.04 Members recommend services appropriate to the needs of the client and the maintenance of community safety. When such services are unavailable due to limitations of existing resources, members clearly note this in their report.

25. **Members release evaluation results to others only with written consent from their clients, unless they are legally obligated to do so.**

26. **Members securely retain notes, raw test scores, and other documentation (including a copy of the evaluation report) for a minimum of five years after completing an evaluation.**
E. Intervention

Interventions are designed to assist the client to effectively manage thoughts, feelings, attitudes, and behaviors associated with their risk to reoffend. Structured, cognitive-behavioral and skills-oriented treatment programs that target specific criminogenic needs appear to be the most effective approaches in reducing rates of reoffending in adult male offenders. Other treatments, for example, the use of certain prescribed medications (see Appendix D), can play a valuable adjunctive role. It is important to assess the efficacy of specific treatment techniques and client progress in achieving treatment goals. Unstructured, insight-oriented treatment programs are less likely to be effective in reducing sexual reoffending and do not constitute primary interventions in the treatment of men who sexually offend.

Treatment is designed to address risk factors that can change over time (i.e., dynamic risk factors or criminogenic needs). Criminogenic needs may include but are not limited to access to potential victims, insufficient or inappropriate employment, inappropriate living circumstances, inappropriate use of leisure time, substance misuse, intimacy deficits, emotional management deficits, sexual preoccupation, deviant sexual interests, deviant sexual arousal, attitudes supportive of offending, antisocial lifestyle and associates, and lack of cooperation with supervision.

Treatment is most likely to be effective when the intensity of services is matched to the client’s risk of recidivism. Providing an inappropriate intensity of services may negatively affect a client’s risk and the community’s perception of treatment.

Members strive to deliver treatment in a manner to which clients can be receptive and responsive. This includes matching services to the client’s IQ, learning style, personality characteristics, culture, mental and physical disabilities, and motivation. Members also identify and build upon client strengths. These include but are not necessarily limited to motivation, willingness to comply with supervision requirements, ability to read and write, lifestyle stability, and prosocial support systems.

Members may deliver services to clients using a variety of modalities, including individual, family, and group therapy. Group therapy is the most common treatment format used with individuals who sexually
offend. It is important to note that treatment will likely be most effective when the modalities are matched to clients individual needs and circumstances, and when delivered in conjunction with other interventions such as community supervision, prosocial community support, and appropriate housing.

27. **Members only offer treatment that is appropriate for a client’s level of risk and needs and when they have the resources needed to provide an adequate and appropriate level of intervention and risk management.**

27.01 Members only offer treatment to individuals who have sexually offended once an evaluation of their risks and clinical needs has been completed.

27.02 Members identify and target those criminogenic needs most directly linked to the client’s offending behavior.

27.03 Members refer a potential client to other clinicians or agencies when they cannot provide an adequate and appropriate level of intervention. This may involve a full transfer or sharing of clinical responsibility.

28. **Members are aware that a majority of clients present with varying degrees of denial related to sexually abusive behavior. This denial may be an obstacle to treatment progress and compliance with treatment or supervision conditions.**

28.01 Members are aware that presenting with some degree of denial does not preclude potential clients from entering treatment.

28.02 Members are aware that treatment should support clients in being honest about all aspects of their history and functioning. It is not the role of the therapist to coerce confessions.

28.03 Clients who completely deny their offenses should not be represented as having successfully completed a sexual abuser treatment program.
28.04 Members are aware of the ethical implications of treating individuals for a problem they persistently deny having.

29. Members develop and implement a written treatment plan for each client outlining clear and specific treatment goals consistent with the results of a recent evaluation.

29.01 Members update evaluations before initiating treatment or other interventions if one year or more has elapsed since an evaluation was completed, if the original evaluation was not comprehensive, or if changing circumstances so dictate.

29.02 Members have treatment contracts (e.g., treatment consent forms) with clients specifying the nature of treatment, program rules, the consequence of noncompliance with these rules, and the expected frequency and duration of treatment involvement.

29.03 Members, whenever possible, rely on other sources in addition to client self-report to assess treatment compliance and progress.

29.04 Members clearly identify and document specific and observable changes in factors associated with a client's risk for reoffense, or the lack of such changes, in treatment records and progress reports.

29.05 Members discuss the treatment plan with clients and provide regular feedback to clients on their treatment compliance and progress, or lack thereof.

29.06 Members prepare their clients for treatment completion, which may include a gradual reduction in frequency of contacts over time as treatment gains are made, booster sessions to reinforce and assess maintenance of treatment gains, and consultation to any future service providers.

29.07 Members hold voluntary clients to the same treatment expectations as court-ordered clients.
29.08 Members cooperate with other professionals who are involved in the management of clients, including judges, probation/parole officers, child welfare workers, and victim therapists. Such cooperation is consistent with and limited to activities and behavior appropriate to member’s professional roles.

29.09 Members immediately notify appropriate authorities if a legally mandated client discontinues treatment or violates a legally mandated condition of parole, probation, or treatment.

29.10 Members providing community treatment recommend more intensive treatment and/or supervision if a client experiences significant difficulties managing their risk for sexual abuse in a way that jeopardizes community safety.

30. **Members provide the client and the appropriate authorities with written information that includes follow up recommendations for maintaining treatment gains.**

30.01 Members do not make statements asserting that a client is no longer at any risk to reoffend.

30.02 Members are clear when communicating with clients, other professionals, and the public that many but not all clients require ongoing management of their risks and needs.

31. **Members periodically evaluate their client’s progress using multiple methods such as client self-report, collateral reports, paper and pencil tests and inventories or, specialized behavioral assessments. Members are aware of the strengths and limitations of each of these methods.**

31.01 Members are aware that it is important that the skills learned in treatment are practiced and generalized to various settings.
32. Members are aware that treatment for individuals who sexually offend is an evolving science. Research continues to search for new and more effective treatment methods. Similarly, some current techniques, with continued research, may be found to be ineffective. Practitioners, to the extent possible, engage in evidence-based practice as it emerges. Currently recommended treatment methods include:

Relapse Prevention Knowledge and Skills

32.01 Members teach clients how to analyze the typical pathway of events-including external circumstances, thoughts and feelings, and behavioral responses preceding their sexual offenses.

32.02 Members use cognitive-behavioral techniques to help clients develop and rehearse strategies to escape or avoid risky situations as early as possible.

32.03 Members assist clients in developing individualized plans for avoiding relapse. These plans include specific strategies for recognizing and coping with risk factors and developing social supports to assist the clients in adhering to their relapse prevention plan.

32.04 Members recognize the value of working with clients on goals which clients strive to achieve (i.e. approach goals) as opposed to strictly working to avoid inappropriate behaviors and situations (i.e., avoidance goals).

Cognitive Restructuring

32.05 Members target perceptions, attitudes, beliefs, and values that are supportive of abusive behavior using established cognitive therapy techniques as part of a comprehensive treatment program.
32.06 Members recognize that client attitudes, beliefs, and values that are unconventional or different from those espoused by members, but are not related to risk for sexually abusive or criminal behavior, are inappropriate treatment targets.

Empathy Enhancement

32.07 Members are aware that it is more common for clients to lack empathy for their specific victim as opposed to having general empathy deficits. Therefore, assessment and treatment should be tailored to identify whether specific empathy deficits exist and, if so, to address these on an individual level.

32.08 Members recognize that empathy is comprised of both cognitive and emotional aspects and both components may need to be addressed.

32.09 Members do not target victim awareness or empathy solely in order to elicit expressions of guilt, shame, or remorse from clients.

32.10 Members recognize that awareness of another’s distress does not necessarily prevent reoffending.

32.11 Members are aware that empathy enhancement may be contraindicated for certain populations including clients with high levels of psychopathy, and those that find victim suffering sexually arousing.

Interpersonal Skill Training

32.12 Members target a client’s interpersonal skills through education, modeling of appropriate behavior, and rehearsal of specific skills in order to help clients develop and maintain stable, prosocial relationships with partners, family members, friends, and co-workers (see Social Support Networks).
Emotional Management

32.13 Members assist clients in managing and learning to self-manage emotional states that support or contribute to their sexual offending.

Sexual Arousal Control

32.14 Members use cognitive-behavioral and/or pharmacological techniques that are effective at reducing deviant sexual interest and arousal, increasing appropriate sexual interest and arousal, and improving management and control of sexual impulses.

32.15 Members target cognitions that support deviant sexual arousal and behavior as part of the sexual arousal control strategies.

32.16 Members teach their clients to minimize contact with persons or situations that evoke or increase the client's deviant interests and deviant arousal.

Family and Other Social Support Networks

32.17 Members encourage partners, family members, and other support persons to actively participate in the treatment process and address issues related to risk.

32.18 Members encourage and assist clients to identify appropriate, prosocial individuals who can act as support persons.

32.19 Members recognize that developing a support team may be contraindicated with clients who have a history of violence towards support people and have not been violence-free for a significant amount of time [see Working with Social Support in Risk Management in the Community].

Generalization

32.20 Members assist the client to generalize skills learned in treatment to the community.
F. Risk Management in the Community

Effective management of clients in the community requires a team approach that may be referred to as a risk management team. Depending on each client's risk and needs, the risk management team may include some combination of the following individuals: family members, treatment providers, institutional staff, polygraphers, probation and parole officers, child welfare workers, victim advocates, law enforcement, and other support persons. Key elements of this team approach to risk management include a clear delineation of roles within the team, regular communication among professional team members, the clients, the client's family and other support persons.

In cases where a client is released from an institutional setting, risk management may be more effective when members of the risk management team identify appropriate transition services to prepare the client for release into the community before release actually occurs.

To be most effective, community-based treatment and supervision are matched to a client's risk of reoffending, and criminogenic needs (see section D). Therefore, a comprehensive, up-to-date sexual abuser evaluation is a critical component of effective risk management in the community. Whereas higher risk clients may profit from treatment and supervision that is more intensive, lower risk clients may be adequately managed with less intensive treatment or supervision.

Effective risk management is enhanced when progress that clients make in institutional settings is documented, reinforced, and strengthened with follow-up services in the community. Relevant post-release services include correctional supervision, community aftercare treatment, and involvement of family members and/or other appropriate support persons. When possible, members working in institutional settings provide community service providers and support persons with information that can be used for informing appropriate treatment, supervision, and risk management in the community.
33. Members facilitate the provision of follow-up services for clients who transition from one program or one jurisdiction to another. This may include moving from institution to community treatment, community treatment to institutional treatment, or the transfer of a supervision order.

33.01 Members prepare written discharge summaries for clients who change programs or transition from an institution to the community, or from the community to an institution. These summaries usually include (not listed in order of priority):

- Assessment of risk, including individualized risk factors, and indicators of imminent risk,
- Description of offending pattern,
- Description of sexual and non-sexual criminal history,
- Identification of client strengths and deficits,
- Identification of relevant problems and continuing treatment needs (including medication),
- Identification of support people,
- Level of participation in programming and,
- Recommendations for community supervision, treatment, and support services.

33.02 Members recognize the importance of the client beginning community treatment services in a timely manner after release from an institution.
34. **Members cooperate and collaborate with other professionals and support persons who are involved with clients as part of treatment and supervision in the community within the bounds imposed by rules of confidentiality.**

34.01 Members identify other professionals and support persons in their client’s lives in order to develop a risk management team.

34.02 Members recognize that a risk management team is more effective at increasing community safety when team members are appropriately trained and knowledgeable about working with individuals who have committed sexual offenses. Therefore, members promote education and training of all professionals and non-professionals (e.g., family members) working with these clients.

34.03 Members, to the degree possible, include the client, institutional case worker, institutional treatment staff, community supervision staff, community treatment staff, family members, and support persons in release planning meetings. When this is not possible, electronic alternatives such as teleconferencing or video conferencing may be used.

35. **Members explain their expectations to clients who are under community supervision. These expectations usually include (not listed in order of priority):**

- Abstinence from alcohol when alcohol use is a risk factor,
- Abstinence from illegal drug use,
- Appropriate plans for work, social, and leisure activities to enhance quality of life and reduce the possible exposure of clients to cues or situations associated with risk of reoffending,
- Appropriate sexual behavior,
• Compliance with all other conditions of supervision,

• Disclosure of offense history among involved professionals and significant others, when appropriate,

• Participation in treatment, compliance with program rules and individual treatment plans,

• Restrictions on contact with potential victims.

36. **Members regularly update their expectations of clients in treatment as circumstances change or new information becomes available.**

**Working with Probation/Parole Officers**

Close cooperation between therapists and probation/parole officers can increase the effectiveness of community risk management strategies. A close working relationship recognizes that sexual abuse is criminal behavior and that legal sanctions apply.

37. **Members regularly exchange information with probation/parole officers regarding clients who are under supervision. This is done with the client’s knowledge and consent unless otherwise specified by law.**

37.01 Members report client participation and progress in treatment, any violations of the client’s conditions of supervision, and significant changes in dynamic risk factors to the client’s probation/parole officers in a timely manner.

37.02 Members obtain supervision-related information from a client’s probation or parole officers, which minimally includes copies of pre-sentence or pre-release reports, the conditions of probation/parole, and involvement with other service providers.
38. **Members exercise caution if allowing probation/parole officers to observe treatment sessions.**

Many therapists allow probation/parole officers to attend treatment sessions as observers. This can help educate probation/parole officers about individuals who sexually offend, appropriate treatment, and enhance the ability of probation/parole officers to supervise their clients. Allowing observers to attend treatment sessions can also cause difficulties, such as eliminating client confidentiality and inhibiting treatment participation.

When probation/parole officers attend treatment sessions as observers, members ensure that the following issues are addressed:

- Appropriate informed consent is obtained from each client in a group when anyone other than the treatment provider and clients attend a group treatment session. Election not to participate in such a group should not impact the treatment a client receives.

- The role of probation/parole officers as agents of the criminal justice system is made clear to clients.

- Members address the purpose and possible impact of having probation/parole officers present in group.

39. **Members recognize that ethical concerns related to dual relationships arise when a probation/parole officer acts as both therapist and supervisor for the same individual.**

39.01 Members attempt to ensure that probation/parole officers providing co-therapy treatment services are clinically qualified to do so.

39.02 Members actively discourage having community probation/parole officers provide treatment to clients they supervise.
Working with Child Welfare Workers

Child welfare workers may become involved with clients who have abused their own children and wish to have contact with them, or who begin relationships with individuals who have children. In such situations, members work collaboratively with child welfare workers to protect children from potential abuse. In particular, members may be asked for their recommendations regarding an acceptable level of contact with children, ranging from no contact at all to unsupervised contact. The safety and well-being of the children is the top priority of these considerations.

40. Members regularly exchange information with child welfare workers involved in a client’s case with the client’s knowledge and consent unless otherwise specified by law.

40.01 Members report on a client’s treatment progress and any significant changes in dynamic risk factors to child welfare workers involved in monitoring the safety of children with whom the client is having or considering contact.

40.02 Members obtain relevant information from child welfare workers involved in monitoring children when the client is having contact or where there may be plans for contact.

40.03 Members work cooperatively with child welfare workers in designing safety plans when child welfare workers are involved in a client’s case.

Working with Support Persons

Promoting the involvement of appropriate support persons (individuals who know the client and can help him live successfully in the community) can increase significantly the effectiveness of community risk management strategies (see Social Support Networks). Support persons can help monitor the client’s attempts at self-regulation, and can promote prosocial behavior and meaningful participation in treatment when they are included as part of the community risk management team.
41. Members are aware that bringing appropriate support persons onto the risk management team as soon as possible can increase the effectiveness of managing the client’s risk in the community.

41.01 Members obtain the client’s consent and inform support persons (or ensure that they are informed) about the client’s history of sexually abusive behavior, including its antecedents and tactics for effectively managing the client’s risk factors.

41.02 Members encourage support persons to have regular contact with clients.

41.03 Members strongly encourage support persons to have regular contact with other members of the risk management team.

41.04 Members encourage support persons to monitor clients for potentially risk-related behavior and inform them of intervention strategies when needed.

41.05 Members encourage support persons to involve clients in prosocial relationships and activities.

41.06 Members remove support persons from the risk management team if they prove themselves unable or unwilling to effectively monitor or manage a client’s risk-related behavior.

Contact with Children

Upon reintegration into the community, clients may have planned or unplanned contact with children in their own family, the children of new romantic partners, friends, co-workers, or neighbors. In this section, the definition of contact is not limited to the client’s close physical proximity with a child, but also includes one-on-one interactions such as telephone calls, email, written notes, and communications through third parties. It does not necessarily include incidental contact such as walking by children on the street. Members should determine if incidental contact is a concern based on legal restrictions, the client’s level of risk, response to treatment and/or supervision, and other relevant considerations.
If a client is permitted to have contact with children under the terms of a legal disposition (e.g., court order or probation/parole order), members assess the risk that the client may pose to the child to help determine whether and what type of contact should be permitted. Contact with children is addressed as part of a comprehensive community risk management plan and should be linked to the client’s reoffense risk and his progress in treatment and/or supervision. Contact with the client’s children, their current romantic partner’s children, or children of family members is also discussed in Family Reunification.

If contact between the client and child is deemed important to the child’s well-being or the client’s reintegration into the community, members discuss this issue with the appropriate authorities and obtain written authorization from them before approving or facilitating any such contact. Members recommend contact only when the child’s emotional and physical safety can be effectively protected.

42. **Members give top priority to the rights, well-being, and safety of children when making decisions about contact between clients and children.**

   42.01 Members attempt to restrict clients from having contact with a child if the child does not want contact or if contact would not be in the best interests of the child.

   42.02 Members obtain informed consent from a child’s non-offending parent or legal guardian before approving a clients contact with that child.

   42.03 Members consult risk management team members including child advocates, support persons, and other professionals involved with the client before making recommendations about contact with children.

   42.04 Members base their assessment regarding appropriate level of contact with children on a careful evaluation of the client’s risk for reoffending and dynamic risk factors.
42.05 Members may approve or support structured contact with children when the client is making acceptable progress in treatment and/or supervision, is managing dynamic risk, when safety precautions are in place, and when contact is assessed to be in the best interest of the child.

42.06 Members ensure that a child has access to a responsible adult chaperone and/or therapist trusted by that child before recommending their client be allowed to have contact with that child.

42.07 Members assist in the selection and education of responsible adult chaperones for contacts between clients and children.

42.08 Members recommend as potential chaperones only adults who accept and understand the client’s past sexual offending, the potential for sexual reoffense, and the role and responsibilities of being a chaperone.

42.09 Members ensure that clients educate potential chaperones about the client’s sexual history, treatment and/or supervision conditions, and antecedents to sexual offending. Members ensure that chaperones fully understand the safety plans for the child and appropriate reporting procedures for violations of the safety plan.

42.10 Members monitor authorized contacts between the client and children through interviews with the client, interviews with the chaperone, the child’s therapist/support person, and other supervision options.

42.11 Members document all decisions about a client’s contact with children including whether contact is permitted or not, the type of contact that is permitted, the preparations made with children and chaperones, and information obtained during the ongoing monitoring.
42.12 Members only approve unsupervised contact between a client and a child after a thorough assessment of the client’s risk, the child’s safety plan, and consultation with other members of the community risk management team.

Family Reunification and Visitation

43. Members are aware that family reunification is one of many ways that families may resolve issues generated by the offender’s abusive behavior.

44. Members, if necessary, recommend that the clients be removed from residences with victim(s) or potential victims rather than removing the victim(s) or potential victim(s).

45. Members attempt to consult with other professionals involved with the client, the victim(s) or potential victim(s), and when applicable members of the victim(s) or potential victim(s) family before making recommendations regarding family reunification.

46. Members recommend contact with familial victim(s) and other family members under 18 (or otherwise vulnerable persons) only when a non-offending parent or another responsible adult is adequately prepared to supervise the contact; the victim or minor is judged to be ready for such contact by a professional who can monitor their safety; and clients have made acceptable progress in their treatment.

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4 A child safety plan is defined as a detailed plan reviewed with the child's non-offending parent or legal guardian that describes the appropriate levels of supervision for contact between clients and family members at risk for sexual abuse including privacy, discipline practices, sexual education, appropriate dress, hygiene, bedtime routines with children, how any contact will be made between a client and child, the conditions or limits that may apply, and how contact will be terminated if it is no longer appropriate for the child.
47. Members do not recommend the involvement of victim(s) or potential victim(s) in family reunification efforts unless such involvement is likely to benefit the victim(s) or potential victim(s) and unlikely to cause them inordinate levels of distress.

48. Members consider the wishes of victim(s) or potential victim(s) with regard to family reunification, taking into account their ability to understand the ramifications of their decisions.

49. Members ensure that appropriate safety plans are developed and monitored during the family reunification process.
Appendix A: Phallometry

Phallometry is a specialized form of assessment used in treatment with individuals who have committed sexual offenses. Responsible use of phallometry results requires at least a rudimentary understanding of how phallometry works, and its advantages and limitations. As with any instrument or procedure, members are familiar with current literature and obtain appropriate training before using or interpreting phallometric testing results. Examiners receive training in phallometric testing in order to become knowledgeable about the technical aspects of the equipment and the appropriate protocols for conducting phallometric testing specific to the equipment being used. Examiners are also familiar with the research evidence on the reliability and validity of phallometric testing.

Phallometric testing using penile plethysmography involves measuring changes in penile circumference or volume in response to sexual and nonsexual stimuli. Circumferential measures (measuring changes in penile circumference) are much more common than volumetric measures (measuring changes in penile volume), which are used in only a few laboratories worldwide. However, there is good agreement between circumferential and volumetric measures once a minimal response threshold is reached. Therefore, circumferential measures are the focus of this Appendix.

Phallometric testing provides objective information about male sexual arousal and is therefore useful for identifying deviant sexual interests during an evaluation, increasing client disclosure, and measuring changes in sexual arousal patterns over the course of treatment.

As noted in the main body of this document, phallometric test results are not used as the sole criterion determining deviant sexual interests, for estimating risk for engaging in sexually abusive behavior, recommendations to release clients to the community, or decisions that clients have completed a treatment program. Phallometric test results are interpreted in conjunction with other relevant information (for example, the individual’s offending behavior, use of fantasy, and pattern of masturbation) to determine risk and treatment needs. Phallometric test results are not to be used to draw
conclusions about whether an individual has or has not committed a specific sexual crime. As well, there are limited data available regarding the use of the plethysmograph with clients with developmental disabilities and clients with an acute major mental illness. Therefore, one needs to exercise caution in using phallometry with these populations and in the interpretation and reporting of phallometric results.

Prior to testing, examiners screen clients for potentially confounding factors such as medical conditions, prescription and illegal drug use, recent sexual activity, and sexual dysfunction. Clients with an active, communicable disease, particularly sexually transmittable diseases, are not to be tested until their symptoms are in remission.

Specific informed consent for the testing procedure and release forms for reporting test results are obtained at the beginning of the initial appointment. Laboratories have a standard protocol for fitting gauges, stimulus presentation, data recording, and scoring.

Examiners use the appropriate stimulus set to assess sexual interests that are the subject of clinical concern. For example, examiners use a stimulus set with depictions of children and adults to test clients who have child victims or who are suspected of having a sexual interest in children. At a minimum, examiners have at least two examples of each stimulus category. Stimuli that are more explicit appear to produce better discrimination between individuals who sexually offend and control subjects than less explicit stimuli. It is important to ensure that the stimuli are good quality and avoid any distracting elements.

Members are aware of the applicable legislation in their jurisdiction regarding the possession of sexually explicit materials. If permitted to use visual stimuli for testing of sexual interest in children, examiners use a set of pictures depicting males and females at different stages of physical development, ranging from very young, pre-pubertal children to physically mature adults. The use of neutral stimuli, such as pictures of landscapes without people present may increase the validity of the assessment. The inclusion of neutral stimuli serves as a validity check because responses to sexual stimuli that are lower than responses to neutral stimuli might indicate faking attempts. Faking tactics include looking away from or not listening
to stimuli. Audio-taped stimuli may also be used to assess sexual interest in children; if used, these stimuli clearly specify the age and sex of the depicted individuals.

For testing of sexual arousal to non-consenting sex and violence, examiners using audio tapes include stimuli describing consenting sex, rape, and sadistic violence. Stimuli depicting neutral, nonsexual interactions are also included. Stimuli can depict males or females, children or adults.

The phallometric testing report includes a description of the method used for collecting data, the types of stimuli used, an account of the client’s cooperation and behavior during testing, and a summary and description of the client’s profile of responses. Client efforts to fake or other potential problems for the validity of the data or the interpretation of results are also reported.

The three most common means of scoring plethysmograph data are: standardized scores, percentage of full erection and millimeter of circumference change. Those using phallometric assessment are aware of the advantages and disadvantages of each scoring method. Research has found that standardized scores (e.g., z scores) increase discrimination between groups. Transforming raw scores to standardized scores for subjects who show little discrimination between stimuli can, however, magnify the size of small differences between stimuli. Raw scores, millimeter of circumference change or scores converted to percentage of full erection may be clinically useful in the interpretation of results.

Deviance indices can be calculated by subtracting the mean peak response to non-deviant stimuli from the mean peak response to deviant stimuli. For example, a pedophilic index could be calculated by subtracting the mean peak response to stimuli depicting adults from the mean peak response to stimuli depicting prepubescent children. Thus, greater scores indicate greater sexual arousal to child stimuli.

Because the sensitivity of phallometric testing is lower than its specificity, the presence of deviant sexual arousal is more informative than its absence. Results indicating no deviant sexual arousal may be a correct assessment or may indicate that a client’s deviant sexual interests were not detected during testing.
Research indicates that initial phallometric assessment results are linked with recidivism. Repeated assessments can be helpful to monitor treatment progress, and to provide information for risk management purposes.
Appendix B: Viewing Time

Viewing Time is a specialized form of assessment used in the treatment of individuals who have committed sexual offenses. Using the results of viewing time measures responsibly requires ATSA members to have at least a rudimentary understanding of how viewing time measures work, its advantages and limitations. As with any instrument or procedure, members should be familiar with current literature and obtain appropriate training before using or interpreting viewing time testing results.

Unobtrusively measured viewing time is used as a measure of sexual interest. The relative amount of time clients spend looking at pictures of children (who can be clothed, semi-clothed, or nude) is compared to the time that the same adult spends looking at pictures of adults. This is because research suggests that as a group, individuals who have offended against children look relatively longer at stimuli depicting children than adults. Unobtrusively measured viewing time correlates significantly with self-reported sexual interests and congruent patterns of phallometric responding among non-offending subjects. Little is known, however, about the value of re-testing using viewing time as a measure of treatment progress.

As with any test, specific informed consent for the test procedure and release forms for reporting results are obtained prior to beginning testing. Examiners have a standardized protocol for presenting the stimuli, recording, and scoring. Examiners are familiar with the reliability and validity of the test. In particular, it is important that examiners know the degree to which the viewing time measure being used has been validated for the client population being assessed. Currently this technology has primarily been used to identify sexual interest in gender and age. As well, there is limited information specific to the use of viewing time with clients with developmental disabilities.

For testing sexual interest in children, examiners have a set of pictures depicting males and females at different stages of development, ranging from very young children to physically mature adults. It is important that stimuli are of good quality and avoid any
distracting elements. Members who use sexually explicit stimuli are aware of applicable legislation in their jurisdiction about possession of such material.

The test report includes a description of the method used for collecting data, the types of stimuli used, an account of the client’s cooperation and behavior during testing, and a summary and description of the client’s responses. Client efforts to fake or other potential problems for the validity of the data or the interpretation of results are also included.

As noted in the main body of this document, viewing time is not to be used as the sole criterion for determining deviant sexual interests, estimating a client’s risk for engaging in sexually abusive behavior, recommendations to release clients to the community, or decisions that clients have completed a treatment program. Viewing time test results are interpreted in conjunction with other relevant information (for example, the individual’s offending behavior, use of fantasy, and pattern of masturbation) and are never to be used to make inferences about whether an individual has or has not committed a specific sexual crime.
Appendix C: Polygraphy

Polygraph testing involves a structured interview during which trained examiners record several of an examinee's physiological processes. Following this interview, examiners review the charted record and form opinions about whether the examinee was non-deceptive or attempting deception when answering each of the relevant questions.

Post Conviction Sex Offender Polygraph Testing is a specialized form of general polygraph testing that has come into widespread use in the United States. Although all principles applicable to general polygraph testing also apply to post conviction sex offender testing, its unique circumstances generate additional challenges. Using post conviction sex offender testing responsibly requires ATSA members to have at least a rudimentary understanding of how the polygraph works, its advantages and limitations, and special considerations related to its integration into sex offender work. This appendix serves as a brief introduction to these issues. As with any instrument or procedure, members should be familiar with current literature and obtain appropriate training before using or interpreting polygraph results.

Post conviction sex offender testing is intended to serve two objectives. These are to:

1. Generate information beyond what can be obtained from other self-report measures;
2. Increase compliance with supervision conditions and treatment rules and procedures.

Research indicates that the polygraph exam does lead to clients providing increased information regarding their offending. However, test validity and reliability vary widely across studies. Therefore, it is important for providers to become informed about types of tests that produce the most accurate findings. As well, it is possible that some of the information obtained through post conviction sex offender testing may yield false positive data and represent an accommodation to pressure for disclosures.
The second objective of post conviction sex offender testing, increased supervision and treatment compliance, has received only limited empirical attention.

The American Polygraph Association, The National Association of Polygraph Examiners, and other polygraph associations have developed standards for certifying polygraph examiners who work in sex offender management and treatment and standards for administering sex-offender tests. Some states also regulate post conviction sex offender testing standards and procedures. Members are familiar with laws, state regulations and association guidelines governing post conviction sex offender testing where they practice. Members work with examiners who meet certificate requirements and adhere to procedures recommended by a relevant polygraphists’ organization.

Four types of post-conviction polygraph exams are commonly performed with sex offenders.

1. **Sexual History Disclosure Tests** inquire whether examinees have fully disclosed their sexual history to their treatment providers.

2. **Maintenance Tests** inquire into the degree to which the examinee has been complying with treatment and supervision requirements.

3. **Monitoring Tests** inquire whether the examinee has been free of new sex offenses during supervision and treatment.

4. **Specific Issue Tests** are conducted to examine issues of fact such as whether an offender attempted to make unauthorized contact with a victim at a particular time or to clarify discrepancies between the offender’s and the victim’s descriptions of the conviction offense.

Examiners reduce the risk of errors when they focus on highly specified (i.e., single issue, narrow, and concrete) questions. Members cooperate with examiners in structuring tests that are responsive to program needs without unnecessarily compromising accuracy considerations.
Limits of confidentiality are fully disclosed to clients prior to polygraph testing. Clients are informed in writing about how the results of polygraph exams will be used and who will receive the results. Clients are informed about the possible consequences to them as a result of the polygraph examination.

There is very limited empirical research on the use of polygraph with clients with developmental disabilities and clients with low/ borderline IQs. Therefore, additional caution is advised if members use polygraph in the management and treatment of these clients.

Polygraph charts are not the only means of monitoring offenders’ behavior and are not to be the sole basis for significant case decisions. Examiner and examinee characteristics, treatment milieu, instrumentation, procedures, examination type, base rates of attempted deception in the population being tested, and other idiosyncratic factors can affect accuracy and usefulness. Likewise, there is reason for concern regarding the results of polygraph testing for monitoring purposes, when questions are not highly specific.

Members primary purpose for collecting sexual history information is increased ability to design clinical interventions and other management strategies. The usefulness of post conviction sex offender testing as a clinical tool derives from its ability to elicit historical information, allowing psychosexual behavioral patterns to be more fully revealed, better understood, and therefore more effectively managed and changed. Client disclosures of potentially incriminating information to mandated reporters can, however, lead to future prosecution. Members inform clients in writing, of this potential dilemma and how it is addressed in their jurisdiction and program.

As noted in the main body of this document, polygraphy is not used as the sole criterion for determining deviant sexual interests, for estimating a client’s risk for engaging in sexually abusive behavior, recommendations to release clients to the community, or decisions that clients have or have not completed a treatment program. Polygraph results are interpreted in conjunction with other relevant information to make these decisions. Members do not automatically change a client’s status in treatment solely due to failed polygraph examinations.
Appendix D: Medications for Managing Sexual Arousal

The use of medications may be helpful for some individuals who have sexually offended, but is not the sole intervention provided. Anti-androgens have been used to reduce the sex drive of paraphilic adults who have been unable to control their deviant sexual arousal or behavior (see ATSA position paper on “Anti-androgen Therapy and Surgical Castration”).

In the United States, the most commonly prescribed anti-androgens are medroxyprogesterone acetate (Provera) and leuprolide acetate (Lupron). In Canada and Europe, cyproterone acetate (Androcur) is also used. Anti-androgens can markedly reduce serum testosterone and this effect lowers sexual motivation and arousal in males. The current scientific evidence supporting a role for these medications in the treatment of sexual abusers includes small placebo-controlled trials as well as other studies with larger samples. Anti-androgen medications have some potentially serious side-effects, and are often administered in a more invasive manner than other medications because they are usually delivered via injection (although delivery by injection ensures medication compliance). There are case reports suggesting that oral medroxyprogesterone and cyproterone can effectively reduce sexual motivation including deviant sexual behavior but the usual prescription is for the longer duration injectable preparations.

Selective serotonin reuptake inhibitors (SSRIs), a class of anti-depressant medication, have been used to reduce impulsive, obsessive, and compulsive behavior, and can also ameliorate mood disorders (i.e., anxiety or depression) that may play a role in the sexual offense behavior of some patients. A common side effect of SSRIs is sexual dysfunction in terms of difficulty in achieving an erection, reduction of libido, and/or delay of orgasm. Some authors have suggested that SSRIs may have a more specific effect in helping reduce deviant sexual behavior.

This appendix incorporates text from the ATSA position paper on “Anti-androgen Therapy and Surgical Castration” and text with permission from documents written by Bradley Johnson, M.D., Stephen Hucker M.D., and Martin Kafka, M.D.
sexual arousal independent of their anti-depressant or anti-anxiety effects. The use of anti-depressants has been supported by multiple case reports, open clinical trials, and retrospective chart reviews. Large placebo-controlled studies to evaluate the effectiveness of these medications in reducing recidivism among individuals who have sexually offended are still needed.

Neither anti-androgens or anti-depressants are formally approved by legislative authorities (such as the Food and Drug Administration in the United States or Health Canada) for the treatment of sexual paraphilias. However, off-label use of these medications has become a recognized standard of care in the treatment of individuals who have sexually offended. In all cases it is important to weight the relative risk and potential benefits of a medication when recommending a specific drug treatment.

Besides anti-androgens and anti-depressants, other psychotropic medications have also been tried with individuals who sexually offend, including anti-psychotics and mood stabilizers such as anti-convulsants and lithium carbonate. The literature supports the notion that sexual offenders more frequently suffer from co-morbid psychiatric disorders than the general public, and may need general psychiatric treatment including the use of appropriate medication.

Non-physician members do not make specific recommendations about what medications should be prescribed. It is appropriate for members to refer clients to physicians who have experience working with individuals who sexually offend as possible candidates for pharmacological therapy. They can provide information about the role of pharmacological therapy in sexual deviancy treatment to the consulting doctor. Non-physician members should consider referring clients to a physician for possible pharmacological therapy if these clients have relatively high levels of deviant sexual arousal, are considered to be at moderate to high risk for reoffending, or have not been able to achieve control over their deviant sexual arousal using sexual arousal conditioning procedures. Clients who repeatedly engage in impulsive or compulsive behavior, or who report a persistent inability to control deviant sexual fantasies, arousal, or behavior may also be good candidates for pharmacological therapy. Motivated and informed clients are often the best candidates for pharmacological therapy.
A physician prescribes medications only after a comprehensive sexual abuser evaluation has been completed. It is important to individualize medical treatment for the patient based on their particular need, response, medical history, and personal agreement with the treatment offered. Pharmacological therapy is linked to appropriate treatment and supervision, and is medically monitored as needed based on the treatment chosen. As with any treatment, appropriate informed consent is obtained when pharmacological therapy is implemented. Informed consent includes a discussion of medication options, targeted symptoms, potential side effects, and the expected course of pharmacological therapy.

Medications can only be taken on a voluntary basis. Although criminal justice officials such as correctional staff, or probation/parole officers can encourage a client to comply with pharmacological therapy if it is recommended, they cannot compel clients to take medication. In some cases, however, judges may compel repeat sexual offenders who have been determined as “sexually dangerous” to take medication, including injectable anti-androgens. Medical doctors should be the only ones to make the final determination based on reasonable medical necessity whether a particular patient should be prescribed medication, and what specific type should be prescribed.

As with other treatments discussed in this document, the use of medication may help clients manage their risk for sexually abusive behavior, but medications do not “cure” deviant sexual interests or eliminate the risk for reoffending.
Appendix E: Glossary of Terms

This glossary was designed to assist members and other readers of the ATSA Standards and Guidelines in understanding terms that are in this document and have a special or technical meaning in sex offender assessment, treatment, and management.

Actuarial Risk Assessment
An objective, algorithmic, mechanical method of estimating risk for reoffending based on empirically identified risk factors. Actuarial risk assessment methods are generally more accurate than clinical judgment alone in predicting the likelihood of sexual reoffending over a long-term period.

Alford or “nolo contendre” plea
From the United States Supreme Court decision determining that defendants have a constitutional right to be sentenced without an admission of guilt. This form of plea can be counter-therapeutic if it affects a client’s acceptance of responsibility, motivation for treatment, or amenability to supervision.

Anti-androgens
Anti-androgens reduce endogenous levels of testosterone and thereby can reduce sex drive. This may help some sexual abusers to control their deviant sexual arousal. Among the most commonly prescribed anti-androgens are medroxyprogesterone acetate, leuprolide acetate, cyproterone acetate.

Aversive Conditioning
Aversive conditioning is a behavioral technique that reduces deviant sexual arousal by pairing it with a noxious stimulus, in order to reduce deviant sexual arousal.
Community Supervision
Refers to monitoring individuals who have sexually offended living in the community, in order to maximize compliance with treatment and other requirements and to assess changes in dynamic risk. Community supervision is usually provided by probation/parole officers to individuals who are under legal sanction. Community supervisors can also include managers of work release programs, other therapists, and employers.

Covert Sensitization
Covert sensitization is a behavioral technique that reduces deviant sexual arousal by pairing it with uncomfortable or aversive thoughts.

Criminogenic Needs
Also referred to as dynamic risk factors, criminogenic needs are factors that can change over time and relate to risk for reoffending. Criminogenic needs are therefore important targets for treatment and supervision of individuals who have sexually offended. Examples of criminogenic needs include association with antisocial peers, deviant sexual fantasizing, and substance use.

Denial
Denial is usually interpreted as the failure of an individual to admit to and accept responsibility for their offenses. Some clients deny committing any type of sexual crime, some admit to past acts but deny that these constitute sexual offenses (e.g., claiming that the victim had consented). Others admit they have committed sexual offenses but minimize their responsibility in some way (e.g., blaming their alcohol intoxication, minimizing the duration or intrusiveness of the sexual offenses).

Developmentally Disabled
For the purpose of this document, developmental disability is defined as the severe, chronic disability of an individual with subnormal intellectual functioning (IQ below 70) and deficits in adaptive functioning.
Deviance Index

A deviance index is a means of reporting relative arousal to deviant stimuli, for example, sexual arousal to depictions of prepubescent children compared to depictions of adults. A deviance index can be calculated by subtracting the mean peak response to nondeviant stimuli from the mean peak response to deviant stimuli. Deviance indices are most informative when they can be reported as a percentile rank, relative to a reference group of other sexual abusers or a reference group of nonabusers.

Deviant Sexual Interests/Deviant Sexual Arousal

Deviant sexual interests are defined as sexual interests that: (a) are rarely observed among individuals who have not engaged in criminal sexual behavior, and (b) in some manifestations would infringe upon the rights of others if acted upon. Deviant sexual interests that would meet this definition are described in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Deviant sexual arousal is the most obvious manifestation of deviant sexual interests.

Dynamic Risk Factors

See criminogenic needs.

External Motivation

External motivation pertains to incentives outside the self (often legal in nature) that encourage individuals who have sexually offended to participate in treatment and comply with other mandated requirements. For example, treatment participation may be a condition of probation or may be necessary in order to become eligible for parole. The relevance of external motivation distinguishes individuals who have sexually offended and other offenders from more traditional mental health clients who often seek treatment on their own without any external pressures (i.e., these traditional clients are thought to have internal motivation for treatment).
Family Reunification
In cases where the client has victimized a family member, family reunification is the process whereby the individual who has sexually offended re-establishes relationships with family members, including the victim(s). Initially, most individuals who have sexually offended are prohibited from having contact with past victims and/or potential victims. After becoming involved in treatment and/or community supervision, family reunification may be considered. The decision to support reunification should be based on the abuser’s risk to reoffend, the wishes of the victim and other family members, and the implementation of an appropriate supervision plan.

Guilt Phase of Trial
The guilt phase of a criminal trial occurs when the court (judge, magistrate, or jury) determines the guilt or innocence of the accused regarding a specific crime.

Index Offense
See Instant Offense.

Informed Consent
Informed consent provides clients with information about the purpose, goals, techniques, procedures, limitations, consequences of not consenting, the limits of confidentiality, alternatives to the services offered, potential risks and benefits of services to be performed. Providers ascertain the client’s ability to understand and utilize the information. When providing services to persons unable to give informed consent, providers obtain consent from the client’s guardian.

Instant Offense/Index Offense
The specific sexual offense(s) that has (have) brought an individual to the notice of the authorities.
**Internal Motivation**

Many traditional mental health clients seek treatment on their own, that is, they have internal motivation for treatment. Individuals who have sexually offended often do not want to participate in treatment focusing on their sexual offenses, and may require externally imposed incentives (external motivation) to participate and comply with treatment and supervision requirements.

**Masturbatory Satiation**

Masturbatory satiation is a behavioral technique designed to reduce sexual arousal to a particular deviant fantasy. The client masturbates to non-deviant fantasies, if possible until orgasm. Following orgasm, the client continues masturbating for some period of time to deviant fantasies. It is believed that deviant sexual arousal will diminish over time if this technique is consistently applied.

**Odor Aversion**

Odor aversion is a behavioral technique used to aid in the reduction of deviant sexual arousal. It involves pairing a noxious odor, such as ammonia, with deviant sexual thoughts or arousal.

**Offense Chain/Offense Cycle**

The typical sequence(s) of thoughts, feelings, behaviors, and events that preceded an individual's past sexual offenses. Elements of a client's offense chain or offense cycle are thought to be precursors of sexual offending and are therefore, important targets for relapse prevention efforts. Treatment is designed to develop strategies for coping with these precursors.
**Paraphilic Interests**

Paraphilic interests are described in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), published by the American Psychiatric Association. Paraphilic interests are defined in DSM-IV as “recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors” pertaining to a particular class of objects or activities. Whereas some paraphilic interests are illegal if acted upon, such as pedophilia (a paraphilic interest in prepubescent children), other paraphilic interests are not necessarily illegal but can cause serious problems, such as fetishism (a paraphilic interest in inanimate objects -- some individuals go into financial debt because of the amount of money they spend on purchasing their fetish objects).

**Phallometry**

Phallometry is a measure of penile erection in response to presentations of sexual stimuli. Whereas circumferential methods measure changes in penile circumference volumetric methods measure changes in penile volume. These changes reflect physiological sexual arousal and provide useful information about deviant sexual interests for the assessment, treatment, and management of sexual abusers.

**Polygraphy**

Polygraphy measures physiological responses such as heart rate, galvanic skin response, breathing, and blood pressure that are used to form inferences about the veracity of client statements. Polygraph examinations involve posing different kinds of questions while these physiological measurements are taken.

**Prosocial**

Viewed as the opposite of “antisocial” this term describes attitudes, beliefs, values, and behavior that are associated with compliance with important societal norms and criminal laws. In contrast, antisocial individuals have little regard for the feelings of others, focus on their own needs, and are willing to engage in behavior that causes harm to others.
Psychometric Testing
These are generally described as measures of psychological factors. They are typically, but not always, paper-and-pencil questionnaires. These include measures of intelligence, academic achievement, personality traits, attitudes and beliefs, and mood. Measures may not be specific to individuals who have sexually offended, but may nonetheless provide useful information for the assessment, treatment, or management of sexual abusers.

Psychopathy
Psychopathy represents an extreme manifestation of antisocial personality traits, including callousness, glibness, need for stimulation, impulsivity, irresponsibility, and grandiosity. Individuals who are high in psychopathy are very likely to have serious criminal histories, likely to engage in violence, and likely to reoffend. Psychopathy overlaps with antisocial personality disorder but the two clinical diagnoses are not synonymous.

Recidivism
Recidivism is another term for reoffending. A distinction can be made between different forms of recidivism, ranging from any recidivism (a new offense of any kind) to specifically sexual recidivism (a new sexual offense). Recidivism rates will vary according to the sample of sexual abusers being followed (e.g., rapists are more likely to commit new offenses of any kind or new sexual offenses than offenders against only related children), the length of follow-up (longer follow-up periods are associated with higher recidivism rates), and the outcome measure being used (e.g., self-reported offenses versus new charges versus new convictions).

Relapse Prevention
Adapted from the addictions literature, relapse prevention constructs are used to assist clients in developing strategies to cope with the precursors (e.g., thoughts, feelings, behaviors, and events) that have typically preceded their sexual offenses, as identified in the client’s offense chain. For example, clients may learn to cope with dysphoria by talking with their spouse or engaging in prosocial activities rather than deviant sexual fantasizing.
Responsivity

The term responsivity was first used by Dr. Don Andrews and his colleagues as one of their three principles of effective correctional treatment. The term responsivity refers to changing and matching the mode of treatment delivery depending on the learning style and personality of the offender.

Risk Management Team

The risk management team refers to the client’s professional and personal support who aid in the client’s transition to the community and/or ongoing monitoring and managing of the client’s behavior in the community.

Selective Serotonin Reuptake Inhibitors/SSRIs

The SSRI’s constitute a category of drugs that increase active levels of serotonin in the brain by blocking serotonin reabsorption by neurons. These drugs have been used to reduce anxiety, depression, as well as impulsive and compulsive behavior. A common side-effect of SSRIs is sexual dysfunction involving reduced libido and/or delayed orgasm. Some authors have suggested that SSRIs have a more specific effect on deviant sexual arousal.

Social Support Network

A social support network comprises individuals who communicate with each other and can help clients refrain from reoffending while they are living in the community. Members of the social support network (support persons) can help clients cope with risky situations and can help monitor their compliance with treatment or community supervision requirements. Support persons can include family members, church officials, employers, probation or parole officers, and treatment professionals.

Static Risk Factors

Static risk factors are historical in nature or are very unlikely to change over time. These can be contrasted with dynamic risk factors that can change over time and are, therefore, important targets for treatment and community supervision.
Test Data
For the purpose of this document, the American Psychological Association’s definition of test data is used. Test data include raw and scaled scores, client responses to test questions or stimuli, notes and recordings concerning client statements and behavior during an evaluation.

Verbal Satiation
Verbal Satiation is a behavioral technique that requires clients to repeatedly describe their deviant sexual fantasies in detail without positive reinforcement (orgasm). This frequent repetition is supposed to diminish the sexual arousal and enjoyment of the specific fantasy.

Victim Impact Statements
Due to greater awareness of crime victim rights, many courts allow victims to submit statements regarding the impact of the offenses on their lives and their opinions regarding the disposition of the offender.

Viewing Time Measures
Viewing Time measures are based on the relative amount of time an individual spends looking at visual stimuli. There is some evidence that the relative amount of time spent looking at pictures of clothed or semi-clothed children, compared to pictures of adults, can distinguish sexual abusers with child victims from men who have not sexually abused children.