

Association for the Treatment of Sexual Abusers

ATSA

Practice Guidelines

for the Assessment, Treatment,
and Management of Male Adult
Sexual Abusers

2014

**ASSOCIATION
FOR THE TREATMENT
OF SEXUAL ABUSERS**

**PRACTICE GUIDELINES
FOR THE ASSESSMENT,
TREATMENT, AND MANAGEMENT
OF MALE ADULT SEXUAL ABUSERS**

2014

(Short title: ATSA Adult Practice Guidelines)

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Dear ATSA Members,

In keeping with the tradition and commitment of ATSA to provide its members with contemporary resources to inform their practices, the Professional Issues Committee is pleased to present the Practice Guidelines for the Assessment, Treatment, and Management of Male Adult Sexual Abusers (short title: *ATSA Adult Practice Guidelines*).

The ATSA bylaws provide for periodic review, and revisions if deemed necessary, of existing practice standards and guidelines for its membership. In 2009, our Committee, comprised of the members listed below, completed a thorough review of the *ATSA Practice Standards and Guidelines for the Evaluation, Treatment, and Management of Male Adult Sexual Abusers (2005)* within the context of contemporary research and practice in the field. We subsequently recommended to the ATSA Executive Board of Directors that revisions were warranted to reflect advances that had occurred since the most recent publication. With the endorsement of the Executive Board of Directors, we subsequently embarked upon the revision process, ultimately culminating in the current *ATSA Adult Practice Guidelines* resource document.

We extend our appreciation to the international, discipline-diverse membership of ATSA for the thoughtful insights and feedback on the initial draft of this document, and to the ATSA Executive Board of Directors for the careful review, critique, and ultimate approval of the final document. It is our hope that the *ATSA Adult Practice Guidelines* continue to remain instructive and beneficial for ATSA members and non-members alike.

Sincerely, the ATSA Professional Issues Committee,

Kurt Bumby, Ph.D., Co-Chair

Robert McGrath, M.A., Co-Chair

Sandy Jung, Ph.D. | Geneviève Martin, M.A.

Julia McLawsen, Ph.D. | Jill Stinson, Ph.D.

Maia Christopher, Executive Director (ex-officio member)

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ATSA 2014

PRACTICE GUIDELINES

FOR THE ASSESSMENT, TREATMENT, AND MANAGEMENT OF MALE ADULT SEXUAL ABUSERS

A. INTRODUCTION AND GENERAL EXPECTATIONS

The Association for the Treatment of Sexual Abusers (ATSA) is an international, multidisciplinary organization that is committed to playing a vital role in the prevention of sexual abuse by promoting sound research, informed policy, and effective practice with respect to individuals who have engaged in sexually abusive behavior.¹ To that end, the Practice Guidelines for the Assessment, Treatment, and Management of Male Adult Sexual Abusers (short title: *ATSA Adult Practice Guidelines*) provides current “best practice” guidance to members and non-members alike regarding assessment, treatment, and other interventions with male adult² sexual abusers.

¹ For ease of readability and economy of presentation, the terms “client” and “sexual abusers” are used throughout this document to refer to individuals who have engaged in sexually abusive behavior and/or have been convicted or adjudicated in a court of law for sex offenses, as defined in the respective statutes or codes in a given jurisdiction. 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.”

The term “sexual abuse” as used in this document refers to sexual or sexually motivated behavior that involves others 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 another person to have sexual contact; engaged in sexual or sexually motivated acts involving a person under the legal age of consent or who is otherwise unable to provide consent; or used the Internet or other technology to produce or secure sexual images involving minors or others who have neither provided nor are able to provide consent, or solicitation of or communication with a minor for sexual purposes.

² In this document, “adult” refers to persons 18 years of age or older.

The ATSA Adult Practice Guidelines are to be interpreted within the context of the goals and objectives of ATSA, which include, but are not limited to, the following:³

- Disseminating current research and information pertaining to clinical and other interventions with sexual abusers in order to promote “best practices” in the field;
- Promoting empirically-informed assessment, treatment, and other interventions to individuals who have sexually abused or are at risk to sexually abuse,
- Reducing sexual abusers’ risk to engage in sexually abusive or other harmful behaviors and increasing their ability to live healthy, non-abusive, and satisfying lives, with the ultimate goal of making communities safer;
- Preventing sexual abuse through a collaborative, multidisciplinary, public health approach; and
- Maintaining high standards of professionalism and integrity within the membership.

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

³ Readers are referred to the ATSA Professional Code of Ethics (available through www.atsa.com) for further information regarding these goals.

Intended Scope, Applicability, and Use

Historically, the predecessors to the *ATSA Adult Practice Guidelines* were developed primarily for ATSA members who provide assessment, treatment, or complementary risk reduction or risk management interventions involving male adult sexual abusers in correctional facilities, inpatient mental health settings, other residential or facility-based placements, and the community. Indeed, these guidelines are consistently reported by ATSA members as one of the most significant benefits of ATSA membership. In addition, these guidelines can also provide clarity and direction for other professionals including non-ATSA members with roles and responsibilities pertaining to risk reduction and risk management with male adult sexual abusers. As such, when implemented appropriately, these guidelines can offer a measure of protection for clients, practitioners, and the public against unethical, non-informed, or unprofessional practices with this population.

The ATSA Adult Practice Guidelines can also be instructive for policy makers and other stakeholders across organizations, agencies, and disciplines. More specifically, these guidelines may support broader efforts to reduce and prevent sexual abuse through educating and engaging the public and others regarding generally accepted principles and practices specific to reducing and managing risk among male adult sexual abusers. Finally, these guidelines may serve as a catalyst for additional empirical research to further inform practices and policies regarding male adult sexual abusers.

The ATSA Adult Practice Guidelines are designed to complement, not supplant or replace, any local, state, provincial, or federal statutes, provisions, mandates, promulgated ethical codes, or practice requirements/parameters established for regulated professions. Where conflicts exist, statutory and other promulgated regulations take precedence. It should be noted that ATSA does not certify, credential, or license individuals to practice

in any given discipline or specialization. ATSA membership is not a designation of formal certification, credentialing, or licensure specific to professionals providing assessment, treatment, or other services to individuals who have engaged in sexually abusive behavior.

The information and guidelines detailed in this document are based on contemporary theories, empirical research, and promising practices regarding male adults who engage in sexually abusive behaviors, and are therefore intended to be used to inform practices specifically involving male adult sexual abusers. ATSA recognizes that children with sexual behavior problems, adolescents who have engaged in sexually abusive behaviors, and female adults who have engaged in sexually abusive behaviors are distinct subpopulations with etiological influences, risk and protective factors, and intervention needs that do not necessarily parallel those of male adult sexual abusers. Members are encouraged to remain aware of developments in research and practice with these and other subpopulations of individuals who have engaged in sexually abusive behaviors and of any accompanying resources to guide such practices.⁴

⁴ For additional information regarding children with sexual behavior problems, adolescents who have engaged in sexually abusive behavior, and other subpopulations, please refer to ATSA documents, fact sheets, policy statements, other resources, and links at www.atsa.com. Indeed, “special populations” resources are among the objectives outlined in ATSA’s Strategic Plan. At the time of the publication of the current practice guidelines for male adult sexual abusers, an initial set of practice guidelines regarding adolescents was under development by the ATSA Adolescent Guidelines Committee.

Underlying Tenets and Guiding Principles

Assessment and treatment interventions for male adult sexual abusers are similar in some ways to those for other clients, including other criminal justice-involved individuals, although further guidance and direction is warranted for practices specifically involving sexual abusers. Therefore, the *ATSA Adult Practice Guidelines* are built on multiple tenets that are particularly salient for policies and practices specific to men who have sexually abused and the overall prevention of sexual abuse. These tenets, many of which are reflected in ATSA's Vision Statement, Mission Statement, and Strategic Plan, include the following:

- I. The reduction, management, and prevention of sexually abusive behaviors are a complex public health issue that requires a multifaceted, multidisciplinary, and collaborative approach.
- II. Community safety and the rights and interests of victims and their families are of paramount consideration when developing and implementing assessment, treatment, and other strategies designed to reduce the risk posed by sexual abusers.
- III. Outcomes and resource utilization for communities, victims, their families, and sexual abusers and can be markedly enhanced when policies and practices are grounded in empirical research.
- IV. Providing empirically-informed assessment, treatment, and management services to individuals who have sexually abused or who are at risk to sexually abuse, increases their ability to live adaptive, non-abusive lives with the ultimate goal of making communities safer.
- V. Risk reduction and risk management efforts can be enhanced by working collaboratively with correctional and other facility staff, probation/parole officers, child welfare officials, clients'

support persons, community members, victim services providers and advocates, and other professionals.

- VI. Establishing and maintaining stable and prosocial lifestyles, and effectively managing the factors that contribute to sexually abusive behaviors, often reflect an ongoing process, not simply a series of tasks to be completed for many individuals who have committed or who are at risk of committing sexually abusive behaviors.
- VII. Although external motivators often provide necessary catalysts to promote participation in and compliance with sexual abuser-specific interventions with many nonvoluntary clients, internal motivation is critical for supporting risk reduction and long-term change.
- VIII. Policies and practices should address the heterogeneity of individuals who sexually abuse, taking into account individual differences, such as age, gender, culture, mental health functioning, developmental and cognitive functioning, intervention needs, and recidivism risk.
- IX. Research-informed practice guidelines are an important mechanism for promoting quality and consistency, but the effectiveness of interventions is contingent on the fidelity of implementation through knowledge and skills-based training, ongoing supervision, and quality assurance.
- X. Expanding the knowledge base of the field through empirical investigation, theoretical development, and clinical initiatives strengthens professionals' ability to effectively respond to matters of sexual abuse.
- XI. Clinical practitioners and other professionals play an important role in collaborating with researchers to support empirical examinations of current practices with sexual

abusers and to identify areas that warrant additional research to inform future practices.

- XII. Resources should extend beyond responding to known sexual abusers, and also include prioritizing primary prevention of sexual abuse and the development of public health policies that promote public education, community engagement, early intervention, and sexual health, and that prevent the development of sexually abusive behaviors.

Empirical Framework

The guidelines herein reflect accepted, promising practices that are, to the extent possible, supported by current research.⁵ The presentation of these statements as guidelines rather than standards reflects the recognition among researchers and practitioners that ongoing research is necessary to support definitive standards or mandates. As such, the guidelines are offered as recommended “best practices.” The *ATSA Adult Practice Guidelines* are designed as a companion resource to the *ATSA Professional Code of Ethics (2001)*,⁶ a compilation of standards to which members are required to adhere.

The *ATSA Adult Practice Guidelines* are presented within the evidence-based framework for effective interventions with criminal justice involved populations, including male adult sexual abusers. This research indicates that interventions are most effective and resources are maximized when guided by the principles of risk, need, and responsivity (RNR), as follows:

⁵ Readers are referred to www.atsa.com for supporting reference materials and resources.

⁶ The principles and procedures that guide ATSA members in resolving ethical and professional dilemmas are detailed in the *ATSA Professional Code of Ethics (2001)*. The Code of Ethics also outlines the procedures for filing ethical complaints regarding ATSA members.

- Risk: Providing a level of service that is commensurate with the client's assessed level of recidivism risk (i.e., greater intensity and dosage for higher risk clients);
- Need: Focusing interventions primarily on research-supported dynamic risk factors that are linked to recidivism (i.e., criminogenic needs including procriminal attitudes, offense-related sexual interests, sexual preoccupations, negative social influences, lifestyle impulsivity, problems with intimacy, and resistance to supervision) over targets of intervention that are not demonstrated by research to be linked to recidivism; and
- Responsivity: Using intervention models with empirical support for promoting behavioral change (i.e., general responsivity) and delivering services in a manner that appropriately takes into account individual factors such as age, level of functioning, learning style, culture, motivation, and denial (i.e., individual/specific responsivity), in order to increase the potential for the client to benefit from interventions.

The current *ATSA Adult Practice Guidelines* is a fluid document that should be reviewed and adjusted periodically to align with contemporary research findings and other advances in the field.

Structure of the Document

The primary topic-specific sections of the *ATSA Adult Practice Guidelines* – Assessment, Treatment Interventions, and Risk Reduction and Risk Management in the Community – each begin with an introductory narrative to provide a contemporary overview that frames the respective area of practice. This overview is followed by subsections, within which specific statements offer further clarity and direction regarding the broad guideline statements. The guidelines are numbered consecutively from the beginning to the end of the document for ease of reference. Appendices are included

to provide users with supplementary information regarding special topic areas, including qualifications and ATSA Clinical Membership requirements, psychophysiological assessment tools, and pharmacological interventions.

General Guidelines

- 1. Members provide and support ethically sound and empirically-informed assessment, treatment, and other interventions to male adult sexual abusers in a manner that facilitates successful outcomes for sexual abusers, reflects sensitivity to the needs and interests of victims and communities, and maintains the integrity of the field.**
 - 1.01 Members commit to carefully reviewing, understanding, and adhering to the *ATSA Adult Practice Guidelines* whenever possible.
 - 1.02 Members adhere to the ethical standards as detailed in the *ATSA Professional Code of Ethics* and other applicable ethical standards and guidelines for their respective professions.
 - 1.03 Members demonstrate transparent decision making and practices that align with the *ATSA Adult Practice Guidelines* and the *ATSA Professional Code of Ethics* when providing services and interventions to male adult sexual abusers.
 - 1.04 Members providing clinical services have education, training, and supervision that are congruent with the guidelines outlined in Appendix A: Recommended Qualifications and ATSA Clinically-Focused Membership Requirements.

- 1.05 Members provide services to and interact with sexually abusive individuals, victims, and their families in a humane and respectful manner, focusing on a positive therapeutic relationship by demonstrating research-supported therapist characteristics (e.g., respectfulness, warmth, openness, empathy, a firm but fair style, and the use of reinforcers).
- 1.06 Members remain informed of the contemporary research and practice literature and the associated implications for assessment, treatment, and other management strategies with respect to these *ATSA Adult Practice Guidelines*.
- 1.07 Clinical members providing assessment, treatment, and other interventions to sexual abusers strive to further the field by collaborating whenever possible with researchers. Similarly, research members strive to collaborate with clinicians to identify appropriate research questions and to explore the effectiveness of interventions outlined in the *ATSA Adult Practice Guidelines* and elsewhere.
- 1.08 Members acknowledge and respect the roles, responsibilities, and interests of all stakeholders involved in sexual abuse prevention and management efforts.
- 1.09 Members strive to raise awareness among stakeholders about the *ATSA Adult Practice Guidelines* as a means of advancing the mission and vision of ATSA.

B. ASSESSMENTS

Recognizing the heterogeneity of male adult sexual abusers, members conduct sexual abuser-specific assessments to promote informed decision making among stakeholders who share responsibility for treatment, risk management, and other domains of intervention. Empirically-informed and reliable sexual abuser-specific assessments can be used, for example, to inform:

- Sentencing and other legal decisions;
- Treatment planning and progress;
- Release decision making;
- Transition and reentry planning; and
- Supervision and other case management planning.

Sexual abuser-specific assessments are most reliable and beneficial when evaluators adhere to ethical practices, incorporate multiple sources of information, use research-supported methodologies, and strive to engage clients in the assessment process. Furthermore, such assessments are most effective for guiding decision making, maximizing public safety, and promoting successful client outcomes when conducted within the evidence-based risk, need, and responsivity framework, as outlined in Section A: Introduction and General Expectations.⁷

Because risk, needs, and other circumstances change over time, assessments of sexual abusers are ongoing processes, not a single event. Research-informed tools that include dynamic risk factors specific to male adult sexual abusers are important

⁷ For ease of presentation of the specific types, elements, and strategies pertaining to assessments of sexual abusers, many of the guidelines in this section are outlined within the categories of Psychosexual Evaluations, Risk Assessment, and Psychophysiological Assessment. This is not, however, intended to suggest that these are mutually exclusive categories. For example, risk assessments and psychophysiological assessments are key components of psychosexual evaluations and, as such, are generally conducted concurrently and within the context of psychosexual evaluations. However, risk assessments or psychophysiological assessments may be requested and conducted independently for a prescribed purpose at a given point in time in which a psychosexual evaluation is not prudent, practical, or necessary.

for obtaining a more accurate understanding of the current risk and intervention needs of a given individual and for informing adjustments to interventions accordingly.

Overarching Assessment Guidelines

2. Members conduct objective, impartial, and reliable sexual abuser-specific assessments that support well-informed decision making and maintain the credibility and integrity of the profession.

2.01 Members conduct sexual abuser-specific assessments in accordance with the ATSA Professional Code of Ethics and any additional ethical standards, codes, laws, or other expectations for the respective profession or discipline of practice.⁸ This includes ethical standards pertaining to, but not limited to, the following:

- Informed consent;
- Specialized training, knowledge, expertise, and scope of practice;
- Documentation and retention of records;
- Currency of research;
- Confidentiality;
- Professional relationships; and
- Conduct.

2.02 Members explore and disclose any conflicts of interest or other issues that may interfere with their ability to provide an objective, fair, and impartial assessment, and refer the potential client to another clinician or agency if the assessment process and findings will be compromised by such factors.

⁸ The ATSA Professional Code of Ethics is provided to members, and all members agree to adhere to such standards. The ATSA Professional Code of Ethics is publicly accessible at www.atsa.com.

- 2.03 Members conducting sexual abuser-specific assessments acknowledge and attempt to address any personal biases or assumptions they may have based on age, cultural differences, socioeconomic differences, education, language, level of intellectual functioning, and mental or physical disability, and refer the potential client to another clinician or agency if the assessment process and findings will be compromised by such factors.
- 2.04 Members take into account the client's current legal status (e.g., no legal status, pre-adjudication, pre-trial psychiatric hold, pre-sentencing, civil commitment referral, parole hearing, revocation) and the ways in which that status may influence the nature or scope of the sexual abuser-specific assessment.
- 2.05 Members take reasonable steps to afford the client who is the subject of the assessment (and/or legal guardian) the opportunity to make an informed decision about participating in the assessment process (even when a court-ordered report will be produced regardless of the provision of informed consent) and to decline participation if he so chooses, and document such efforts in the report accordingly. These steps include, but are not limited to, the following:
- Explaining the nature and purposes of the assessment;
 - Outlining potential benefits, risks, and limitations of the assessment procedures that will be used;
 - Highlighting the potential implications of participating or declining to participate;
 - Specifying limits on confidentiality, such as persons or entities to whom the findings will be provided and the circumstances under which information may otherwise be released; and
 - Responding to questions that are posed by the client regarding the assessment process.

- 2.06 Members inform clients of the evaluator's responsibilities vis-à-vis the client and the requesters of the evaluation. Members also ensure that clients understand that aspects of the evaluation may still proceed with or without their consent.
- 2.07 Members recognize the potential for disclosures of previously undetected sexually abusive behaviors, work closely with other system stakeholders to establish protocols for the fair, ethical, and responsible handling of such disclosures, and ensure the client understands the ways in which such information may be used.
- 2.08 Members take reasonable steps to ensure that the assessments of sexual abusers are current when such information will be used to inform case management decisions, such as sentencing, civil commitment, release, treatment, and supervision.
- 2.09 Members take reasonable steps to clearly articulate the specific rationale for all conclusions and recommendations provided in a given assessment, using language that is readily understandable to the consumers of the assessment, including the client.
- 2.10 Members consider community safety and the degree to which the client is capable of and willing to manage his sexual behavior when making recommendations in the assessment(s).

3. Members clarify with the requestor and client the specific purpose(s) for which an assessment is being conducted, and document accordingly.

3.01 Members conduct sexual abuser-specific assessments primarily for the following purposes:

- Understanding the nature and extent of a client's sexually abusive behavior;
- Exploring the criminogenic and other needs that should be the focus of treatment and other interventions;
- Estimating short and long-term recidivism risk, both sexual and non-sexual;
- Identifying specific responsivity factors; and/or
- Obtaining baseline information regarding a client against which progress and other changes can be gauged.

3.02 Members recognize that sexual abuser-specific assessments are not designed or reliable for, and should not be conducted for the following purposes:

- Substantiating or refuting allegations that are the focus of a criminal, civil, child custody, or other investigation;
- Exploring the veracity or motivations of an alleged victim's statements;
- Guiding law enforcement, prosecutorial, or charging determinations;⁹
- Suggesting the existence of a predetermined profile of a sexual abuser against which an individual can be compared to determine fact; or
- Addressing or alluding to a client's potential guilt or innocence, or otherwise speaking to issues that are within the purview of a trier-of-fact.

⁹ It is recognized that in some circumstances, such as plea negotiations, some clients who acknowledge the sexually abusive behaviors that are the subject of the court proceeding agree to such assessments on the advice of counsel.

- 3.03 Members collaborate with other stakeholders involved in risk reduction, risk management, and prevention efforts to promote the appropriate and effective use of assessment data to inform case management decisions with sexual abusers.
- 3.04 Members take steps to educate stakeholders, including the public regarding the appropriate purposes, potential misuses, strengths, and limitations pertaining to the assessment of sexual abusers.
- 4. **Members utilize assessment measures, instruments, and procedures that are appropriate for addressing the specific goals of the assessment, the purposes for which the tools were designed, and for the client being assessed.**
- 4.01 Members are familiar with the psychometric properties of the assessment measures to be used, including reliability and validity, and favor well-accepted instruments that are supported by empirical research.
- 4.02 Members use instruments and methods for which they are appropriately trained, follow recommended administration protocols for all assessment measures utilized, and offer statements of findings that are limited to the capabilities of these methodologies.
- 4.03 Members recognize that the assessment instruments developed for and used with male adult sexual abusers may not be appropriately normed, valid, or reliable for use with other subpopulations of sexually abusive clients.

- 4.04 Members select the most reliable, valid, appropriate assessment instruments and procedures given the client's age, gender, culture, language, developmental intellectual functioning, and other unique characteristics.
- 4.05 Members who are unable to communicate fluently with a client refer the client to another qualified professional who is able to communicate fluently with that client. A professional interpreter may be used with the client's permission, provided that confidentiality agreements are in place. Members note within their assessments if an interpreter is used.
- 4.06 Members who conduct assessments on subpopulations of sexually abusive clients possess specialized knowledge, and experience obtained through focused training and clinical supervision, regarding these subpopulations.
- 4.07 Members assess/screen clients for acute mental or behavioral health needs that may require intervention prior to initiating assessments or interventions specific to sexually abusive behavior and, if necessary, refer clients to other professionals who are qualified to provide these services. The impact of such mental health or behavioral needs on the assessment procedures or findings should be noted in the evaluator's report.
- 4.08 Members strive to meet the special needs of clients with developmental, learning, or physical impairments during assessments (e.g., using taped versions of questionnaires, modifying terminology/language on self-report instruments). Reasons and the rationale for using alternative testing methods should be documented in the report. As well, it should be noted, that these special accommodations may have an impact on the reliability and validity of instruments that are typically self-administered.

Psychosexual Evaluations

5. Members recognize that conducting psychosexual evaluations provides a critical opportunity to (a) gain a comprehensive understanding of the client's circumstances, risk, intervention needs, and responsivity factors; (b) engage the client in the assessment and overall intervention process; and (c) offer reliable data to inform decision making.

5.01 Members rely on multiple sources of information when conducting a psychosexual evaluation, ideally including the following:

- Client interviews;
- Interviews with collateral informants, as applicable (e.g., family members, intimate partner/spouse);
- Thorough review of official documents (e.g., police reports, victim impact statements, criminal justice records, previous assessment and treatment records, pre-sentence or social services investigations);
- Empirically grounded general psychometric testing (e.g., intellectual, diagnostic);
- Empirically grounded instruments designed to measure broad sexual, as well as offense related, attitudes and interests;
- Empirically grounded, objective psychophysiological measures of sexual arousal, interests, and/or preferences; and
- Empirically grounded strategies to estimate the risk of sexual and/or non sexual-recidivism.

5.02 Members identify, document, and explain the implications of specific responsivity factors, which include but are not limited to the following:

- Age;
- Culture;
- Psychosocial and emotional development;
- Level of adaptive functioning;
- Neuropsychological, cognitive, and learning impairments;
- Language or communication barriers;
- Acute psychiatric symptoms;
- Denial; and
- Level of motivation.

Client interview process

5.03 Members interact with clients in ways that are designed to promote engagement, decrease resistance, and foster internal motivation throughout the assessment process.

5.04 Members explore and incorporate the client's own perspectives, interests, and goals when interviewing and assessing the client.

5.05 Members take reasonable steps to employ communication strategies that take into account specific responsivity factors such as age, culture, developmental level, and intellectual functioning.

5.06 Members recognize that the varying reasons for which a client is referred for a psychosexual evaluation may impact the client's demeanor during the interview.

Domains of assessment

5.07 Members seek to obtain a range of general background information about the client, including but not limited to the following:

- Developmental history (e.g., family dynamics, exposure to violence, maltreatment);
- Nature and quality of past and current relationships (e.g., family, peers, intimate partners);
- Medical and mental health history (i.e., client and family);
- Intelligence, cognitive functioning, and level of maturity and
- Education and employment history.

5.08 Members collect information regarding sexual history and sexually abusive/offending behavior that includes but is not limited to the following:

- Psychosexual development, early sexual experiences, and history of age appropriate, consensual sexual relationships;
- Nature and frequency of sexual practices (e.g., masturbation, non abusive and appropriate sexual behaviors, unconventional or risky sexual activities);
- Paraphilic interests, fantasies, and behaviors that may not be sexually abusive (e.g., fetishes, masochism);
- Use of sexually oriented services or outlets (e.g., magazines, hiring prostitutes internet, telephone sex lines, adult establishments);
- Abusive or offense related sexual arousal, interests, and preferences;
- History of sexually abusive behaviors, both officially documented and unreported (if identified through credible records or sources);
- Information about current and/or previous victim(s) (e.g., age, gender, relationship to client);

- Contextual elements of sexually abusive behaviors (e.g., dynamics, motivators, patterns, circumstances); and
- Level of insight, self disclosure, and denial (e.g., of the behaviors, motivations or intent, level of violence and coercion) relative to various aspects of the sexually abusive behavior.

5.09 Members explore and document a client's strengths, assets, and protective factors which may include but are not limited to the following areas:

- Prosocial community supports and influences, and others involved in care and treatment;
- Structure and support that promote maintaining success (e.g., limited access to potential victims);
- Healthy, age appropriate, normative, long term intimate and sexual relationships;
- Motivation to change;
- Insight, understanding, and management of risk factors;
- Appropriate problem solving and emotional management skills; and
- Employment, financial, and residential stability.

Potential involvement of victims in the evaluation process

5.10 Members recognize that some victims may have an interest in having their perspectives represented by actively participating in the evaluation process of the sexual abuser. In such instances, members:

- Carefully consider and appropriately respond to the potential for conflict of interest that may arise by involving the sexual abuser and victims;

- Are knowledgeable of ethical guidelines surrounding informed consent and limitations of confidentiality and recognize that, at times, victims may not be able to provide informed consent;
- Interview victims only when possessing the requisite knowledge, experience, skills, and training to work with sexual abuse victims;
- Exercise caution if interviewing victims because of the potential risk of unintended impact on the victims; and
- Consult with victim advocates, when they are involved, and consider alternate methods of incorporating the perspectives of the victims (e.g., written victim impact statements).

The written report

- 5.11 Members outline the full range of information sources used to conduct the psychosexual evaluation, note any relevant information sources that were unavailable at the time of the evaluation, and highlight the potential implications of any data limitations on the conclusions and recommendations contained therein.
- 5.12 Members provide an addendum to the psychosexual evaluation report when additional key information is received about the client that significantly impacts the initial findings, conclusions, and recommendations.

- 5.13 Members document areas of convergence and/or divergence between self-report, collateral information, and other sources of assessment data, including objective behavioral or psychophysiological assessment measures.
- 5.14 Members clearly articulate conclusions and recommendations based on supporting evidence documented in the body of the report, and that generally address the following (as relevant to the purpose of the assessment):
- Recidivism risk (sexual and non-sexual);
 - General and offense-related criminogenic needs;
 - Responsivity factors;
 - Other intervention needs;
 - Current stressors;
 - Client-identified goals and interests;
 - Implications of the client's strengths and assets;
 - Potential risk management strategies that may be important for other stakeholders to consider (e.g., potential targets for community supervision); and
 - Recommended interventions that support the application of the risk, need, and responsivity principles for the client and that sufficiently take into account victim and community safety.
- 5.15 Members note in the psychosexual evaluation report any recommended interventions or services that are unavailable due to limitations of existing resources, while recognizing that the absence of such resources does not lessen the evaluator's responsibility for providing assessment-driven recommendations.

- 5.16 Members recognize that communicating the results of the evaluation to the client may be beneficial (e.g., for clarity, to facilitate client engagement, to gauge the subject's response to feedback) and take reasonable steps – using language at a level that is accessible to the individual being assessed – to inform the client of the basis of the conclusions and recommendations contained in the evaluation report and provide clarification when warranted, practical, and appropriate.

Risk Assessment

- 6. Members appreciate the potential weight of general and sexual abuser-specific risk assessments across various criminal justice-related and civil contexts. These include implications not only for community safety, but also for the client's civil liberties. Accordingly, members recognize the critical need to ensure reliable and valid findings.**
- 6.01 Members clarify the specific purpose for conducting a risk assessment on a given client and the way in which such information will be used, and articulate this in communications regarding the findings.
- 6.02 Members conducting risk assessments on sexual abusers are well versed in the contemporary research regarding static and dynamic factors linked to recidivism among sexual abusers. At present, these variables fall into the following categories:
- Criminal history (e.g., prior arrests, convictions);
 - Victim-related variables (e.g., stranger, non-related, young male);
 - Sexual deviancy (e.g., offense-related sexual arousal, interests, and/or preferences; sexual preoccupation);

- Antisocial orientation (e.g., criminal attitudes, values, and behaviors; lifestyle instability);
 - Intimacy and relationship difficulties (e.g., unstable relationships, conflictual intimate relationships, deficits in social support, restricted social interaction and involvement; and
 - Self-regulation difficulties (e.g., hostility, substance abuse, impulsivity, access to victims).
- 6.03 Members conducting risk assessments of sexual abusers use empirically-supported instruments and methods (i.e., validated actuarial risk assessment tools and structured, empirically guided risk assessment protocols) over unstructured clinical judgment.
- 6.04 Members conducting risk assessments of sexual abusers are appropriately trained in scoring, interpreting, effectively and accurately reporting, and applying the findings of the risk assessment instruments/protocols employed.
- 6.05 Members recognize the potential for both sexual and non-sexual recidivism among sexual abusers and clarify the type of recidivism risk assessed in the report or other statements of findings.
- 6.06 Members are aware of the relative strengths and limitations of the risk assessment measures/methods employed, reference these issues when communicating risk assessment findings, and ensure that statements about the findings remain within the scope/capability of these measures (e.g., refraining from making absolutes about whether a given sexual abuser will or will not recidivate).
- 6.07 Members ensure that any communications about a given client's recidivism risk are based on current and reliable assessment data about that individual.

- 6.08 Members appreciate that recidivism risk is not static and may change as a result of interventions, client actions, or other circumstances and, therefore, members conducting risk assessments employ research-supported methods of assessing dynamic risk factors as warranted over time.

The Use of Phallometry, Viewing Time, and Polygraphy to Support Information-Gathering for Assessments

- 7. Members recognize that research-supported assessment methods such as phallometry and viewing time may be useful for (a) obtaining objective behavioral data about the client that may not be readily established through other assessment means; (b) exploring the reliability of client self-report; and (c) exploring potential changes, progress relative to treatment and other case management goals and objectives. Members appreciate that the polygraph for which reliability and validity questions remain may have utility in facilitating disclosure about sexual history, offense-specific behaviors, and/or compliance with treatment and other expectations.**
- 7.01 Members obtain specific informed consent from clients prior to using phallometric, viewing time, and/or polygraph methods.
- 7.02 Members are familiar with the strengths and limitations of phallometric, viewing time, and polygraph methods (see Appendix B) and note these issues when interpreting and communicating the findings from these methods.
- 7.03 Members take reasonable steps to obtain assurances that examiners utilizing phallometric, viewing time, and polygraph methods are appropriately trained in the use of such methods, use accepted methods, and adhere to

applicable professional/discipline-specific standards or guidelines.

- 7.04 Members recognize that the findings from phallometric, viewing time, and polygraph methods are to be used in conjunction with other sources of assessment information, not as the single source of data for any assessment.
- 7.05 Members recognize that the results of phallometric, viewing time, and polygraph methods are not to be used as the sole criterion for the following:
- Estimating level of risk for recidivism;
 - Making recommendations for release to the community from a correctional, institutional, or other non-community placement;
 - Determining treatment completion; or
 - Drawing conclusions regarding compliance with or violations of conditions of release or community placement.
- 7.06 Members appropriately limit phallometry to the following purposes:
- Assessing the client's relative sexual arousal and preferences regarding age and gender;
 - Evaluating the client's arousal responses to various levels of sexually intrusive or aggressive/coercive behaviors;
 - Exploring the potential role of offense-related sexual arousal in the client's sexually abusive or at-risk behavior and developing accompanying treatment goals; and
 - Monitoring the effectiveness of interventions involving the modification, management, and expression of both healthy and offense-related sexual arousal.

7.07 Members appropriately limit the use of viewing time measures to the following purposes:

- Assessing the client's sexual interests with respect to age and gender;
- Exploring the potential role of offense-related sexual interests in the client's sexually abusive or at-risk behavior and developing accompanying treatment goals; and
- Monitoring the effectiveness of interventions involving the modification, management, and expression of both normative and offense-related sexual interests.

7.08 Members appropriately limit use of the polygraph to the following purposes:

- Facilitating a client's disclosure of sexual history information, which may include sexually abusive or offense-related behaviors (generally disclosed in the interview portion of the examination);
- Eliciting from the client clarifying information regarding the instant/index offense;
- Exploring potential changes, progress, and/or compliance relative to treatment and other case management goals and objectives (through yes/no questions about adherence to specific treatment and other case management expectations); and/or
- Making collaborative case management decisions about a client with other partners and stakeholders based on the information gleaned from the examination and interview.

C. TREATMENT INTERVENTIONS

Sexual abuser-specific treatment is designed to assist clients with effectively managing thoughts, fantasies, feelings, attitudes, and behaviors associated with their potential to sexually abuse. In addition to reducing risk for sexual and/or non-sexual recidivism, treatment is designed to assist clients with developing a prosocial lifestyle that is inconsistent with offending. As noted elsewhere in these ATSA Practice Guidelines for Adults, men who sexually abuse are a heterogeneous population, with risk levels and treatment needs that can differ markedly. Therefore, sexual abuser-specific treatment services are best offered and provided along a continuum of care – from correctional, institutional, inpatient, or residential facilities to community settings – and are matched to the assessed recidivism risk and treatment needs of a given client.

Research indicates that treatment for criminal justice-involved populations, including male adult sexual abusers, is most effective when it is delivered in accordance with the evidence-based principles of correctional intervention – risk, need, and responsivity – as outlined in Section A: Introduction and General Expectations. As applied to treatment interventions for sexual abusers, this translates into the following:

- **Risk:** Sexual abusers presenting a higher risk of reoffending receive a greater intensity and dosage of treatment services, while lower risk sexual abusers receive less. Providing an inappropriate intensity of services may negatively affect treatment effectiveness and recidivism risk.
- **Need:** Treatment primarily targets research-supported dynamic risk factors that are linked to recidivism (i.e., criminogenic needs) over targets of intervention that are not empirically linked to recidivism.

- **Responsivity:** To address general responsivity factors, evidence-based intervention models are broadly structured, cognitive-behavioral, and skills-oriented. Unstructured, insight-oriented models typically are less effective in reducing sexual recidivism and do not constitute primary interventions in the treatment of male adults who sexually abuse. To address specific responsivity factors, services are delivered in a manner that accommodates client characteristics, such as level of intellectual functioning, learning style, personality characteristics, culture, mental and physical disabilities, and motivation level. Services also build upon client strengths, which may include motivation, ability to read and write, lifestyle stability, and prosocial support systems.

Treatment effectiveness for sexual abusers is also enhanced when providers engage clients in the treatment process and interact with clients in a respectful, directive, and empathic manner.

For some male adult sexual abusers, other complementary interventions, such as psychiatric or mental health care; couples or family therapy; education, housing, or employment services; and risk-reducing or risk management strategies, such as community supervision, may contribute to public safety efforts and promote the overall stability and success of clients. As such, treatment providers often collaborate with other professionals who have various roles and responsibilities with a given client, such as correctional or other institutional staff, probation and parole officers or agents, victim advocates, and other treatment providers, as well as positive community supports (which may include trained volunteers) (see also Section D: Risk Reduction and Risk Management in the Community).

Researchers continue to explore the effectiveness of treatment methods and, as such, treatment providers should remain abreast of current research and align practices accordingly. Currently,

recommended methods include structured, cognitive-behavioral, and skills-oriented treatment approaches that target dynamic risk factors. These methods have the greatest potential for reducing rates of sexual and other types of criminal reoffending in male adult sexual abusers.

Overarching Treatment Guidelines

8. Members provide sexual abuser-specific treatment that is guided by ethical principles and current empirical research in order to maximize treatment effectiveness, promote public safety, facilitate prosocial goals for clients, and maintain the integrity of the profession.

8.01 Members provide sexual abuser-specific treatment in accordance with the ATSA Professional Code of Ethics and any additional ethical standards, codes, laws, or other expectations for the respective profession or discipline of practice. This includes ethical standards including but not limited to the following:

- Informed consent;
- Specialized training, knowledge, expertise, and scope of practice;
- Documentation and retention of records;
- Currency of research;
- Confidentiality;
- Professional relationships; and
- Conduct.

8.02 Members appreciate that treatment for individuals who have sexually abused or are at risk for sexually abusing others is an evolving science.

8.03 Members remain apprised of contemporary research and engage in professional development activities to ground their provision of research-supported and evidence-based interventions for sexual abusers accordingly.

- 8.04 Members encourage, support, and participate in ongoing empirical research efforts designed to identify and refine effective interventions for sexual abusers and those at risk to sexually abuse others.
- 8.05 Members providing treatment for sexual abusers collaborate – when warranted and appropriate – with other professionals who are involved in the management of clients, including judges, probation/parole officers, correctional and other facility staff, child welfare workers, and victim therapists, in order to facilitate information sharing and further the goals of treatment. Such collaboration/cooperation is consistent with and limited to activities and behavior appropriate to members' professional roles (see also Section D: Risk Reduction and Risk Management in the Community).
- 8.06 Members recognize that correctional staff and community supervision practitioners who are well trained and skilled in using evidence-based behavioral techniques (e.g., prosocial modeling, skill practice, rehearsal, redirection, positive reinforcement) can complement treatment activities in correctional and other facilities and post-release.

Assessment-Driven Treatment

- 9. Members recognize the importance of individualized, assessment-driven treatment services and deliver treatment accordingly.**
- 9.01 Members ensure that, prior to initiating treatment services for individuals who have sexually abused or are at risk of sexually abusing others, a psychosexual evaluation of a client's recidivism risk and intervention needs has been conducted, is current, and is comprehensive (see also Section B: Assessments).

- 9.02 Members rely on research-supported assessment methods that are designed to identify dynamic risk factors present for a given client.
- 9.03 Members develop and implement an individualized, written treatment plan for each client, outlining clear and specific treatment goals and objectives that are consistent with the results of a current psychosexual evaluation.
- 9.04 Members routinely review and update treatment plans based on multiple methods of assessment.
- 9.05 Members offer treatment that is appropriate for a client's assessed level of risk and intervention needs.
- 9.06 Members offer treatment services only when they have the resources necessary to provide an adequate and appropriate level of intervention for a client's risk and needs.
- 9.07 Members refer a potential client to other treatment providers or agencies when they cannot provide an adequate and appropriate level of intervention. This may involve a full transfer or sharing of clinical responsibility.
- 9.08 Members recognize the importance of primary and secondary prevention by making treatment services available to – or making appropriate referrals for – individuals who may be at risk for engaging in sexually abusive behaviors and are seeking non-mandated assistance.
- 9.09 Members recognize that some individuals may present for sexual abuser treatment in the absence of legal or other mandates and that appropriate services should be made accessible to such individuals.

Treatment Methods

- 10. Members providing treatment to sexual abusers utilize empirically supported methods of intervention. Recommended methods include structured, cognitive-behavioral, and skills-oriented treatment approaches that target dynamic risk factors.**
- 10.01 Members deliver services to clients using a variety of modalities, including individual, family, and group therapy, that are matched to each client's individual intervention needs and responsivity factors.
- 10.02 Members assist clients with identifying and analyzing the individual factors (e.g., environmental, cognitive, affective, and relational) that increase their vulnerability to engage in sexually abusive behaviors.
- 10.03 Members use cognitive-behavioral techniques, at the earliest opportunity, to help clients develop and rehearse strategies to effectively manage (i.e., avoid, escape, or use adequate coping skills) situations that may increase their risk of sexually abusing or otherwise reoffending.
- 10.04 Members use behavioral methods such as education, prosocial modeling, skill practice, rehearsal, redirection, and positive reinforcement to teach or enhance skills that will help clients achieve prosocial goals.
- 10.05 Members encourage clients to practice the skills they learned in treatment in order to support generalization of these skills to the clients' environments.

- 10.06 Members assist clients in developing individualized strategies and plans for effectively managing their risk of sexual abuse or other harmful or illegal behaviors. These plans include specific strategies for avoiding or limiting access to potential victims, recognizing and coping with risk factors, and building social support systems.
- 10.07 Members assist clients with identifying and enhancing prosocial interests, skills, and behaviors that the clients themselves seek to enhance or attain (i.e., approach goals that are oriented toward a non-offending lifestyle), as opposed to strictly focusing on managing inappropriate thoughts, interests, behaviors, and risky situations (i.e., avoidance goals).

Primary Treatment Targets: Dynamic Risk Factors

- 11. Members focus treatment interventions primarily on research-supported dynamic risk factors that are linked to sexual and non-sexual recidivism (i.e., criminogenic needs) over factors that have not been shown to be associated with recidivism, as outlined below.**

General self-regulation

- 11.01 Members assist clients in learning to self-manage emotional states that support or contribute to their potential to sexually abuse.
- 11.02 Members assist clients in learning and practicing problem-solving and impulse control skills.
- 11.03 Members assist clients in obtaining appropriate services for evident problems related to the clients' mental health and substance use patterns.

Sexual self-regulation

- 11.04 Members use cognitive-behavioral, behavioral, and/or pharmacological techniques to promote healthier sexual interests and arousal, fantasies, and behaviors oriented toward age-appropriate and consensual partners.
- 11.05 Members use cognitive-behavioral, behavioral, and/or pharmacological techniques known to be associated with reductions in sexual preoccupation (paraphilic and non-paraphilic) and atypical sexual interests and arousal, and with improvements in the management and control of sexual impulses.
- 11.06 Members target cognitions that support age-inappropriate and non-consensual sexual interest, arousal, and behavior in order to assist clients in enhancing their sexual self-regulation.
- 11.07 Members help clients find effective ways to minimize contact with persons or situations that evoke or increase clients' atypical sexual interests and arousal.

Attitudes supportive of sexual abuse

- 11.08 Members recognize that client attitudes and beliefs that are tolerant of sexual abuse (e.g., women enjoy being raped, children should be able to make up their own mind about having sex with adults) are important treatment targets.
- 11.09 Members use established cognitive therapy techniques to strengthen attitudes, beliefs, and values that support prosocial sexual behaviors, and help clients manage or decrease those that support sexually abusive behavior.

- 11.10 Members are aware that clients may hold attitudes, beliefs, and values that are unconventional but unrelated to their risk for sexually abusive or criminal behaviors; these unconventional attitudes, beliefs, and values are not deemed appropriate primary treatment targets.

Intimate relationships

- 11.11 Members assist clients in the development of skills that can enable the experience of prosocial intimate relationships with adults. Members orient their interventions so that they build on strengths in the client's existing relationships, when appropriate.
- 11.12 Members aim, when possible and appropriate, to include adult romantic partners in treatment in order to maximize treatment gains and enhance prosocial lifestyles.

Social and community supports

- 11.13 Members encourage and assist clients in identifying appropriate, prosocial individuals who can act as positive support persons.
- 11.14 Members encourage family members and other support persons to actively participate in the treatment process and to help clients achieve and maintain prosocial lifestyles.
- 11.15 Members assist clients who are transitioning to the community or are already in the community to develop and maintain stable, prosocial lifestyles, which are characterized by stable and appropriate housing, employment, and leisure activities.
- 11.16 Members recognize that the development of a support network may be gradual for clients who have a history of violence toward support persons and have not been

violence-free for a significant amount of time. Hence, members encourage clients to make small and gradual changes, and members closely monitor these changes, to ensure clients are receiving or have received interventions to address these issues and reduce the risk for violence.

- 12. Members may, as warranted for a given client based on a comprehensive assessment, also include treatment targets that are not clearly established by research to be dynamic risk factors (e.g., denial and minimization, low self-esteem) but that, when addressed, enhance therapeutic alliance, treatment engagement, and treatment responsiveness.**

Treatment Engagement and Goal Setting

- 13. Members strive to foster clients' engagement and internal motivation at the onset, and throughout the course of, sexual abuser-specific treatment, recognizing that these process-related variables enhance treatment responsiveness and outcomes.**

13.01 Members recognize that, although many clients present for sexual abuser-specific treatment as a direct result of legal or other mandates, external motivators alone are generally insufficient for producing long-term change among clients.

13.02 Members provide services in a respectful, directive, and humane manner, and facilitate a therapeutic climate that is conducive to trust and candor.

13.03 Members recognize that client engagement may increase, and resistance may decrease, when the treatment provider and client are in relative agreement about treatment goals

and objectives. As such, to the extent possible, members involve clients in the development of their treatment plans and in the identification of realistic goals and objectives.

- 13.04 Members clarify, at the onset of sexual abuser-specific treatment, the client's understanding of the problem(s) for which he has been referred to treatment and that primary treatment objectives often include modifying attitudes, sexual arousal and interests, and offense-related behaviors.
- 13.05 Members are aware that clients present with differing levels of internal motivation to change and have varied types and levels of denial and minimization related to sexually abusive behaviors, interests, arousal, attitudes and beliefs. However, such characteristics need not preclude access to treatment.
- 13.06 Members recognize that denial and minimization may impact the client's engagement in treatment, but that the influence of denial and minimization on sexual recidivism risk has not yet been clearly established and may vary among client groups.
- 13.07 Members support the client in being honest in discussing his history and functioning but acknowledge that it is not the role of treatment providers to attempt to determine or verify a client's legal guilt or innocence, or to coerce confessions of unreported or undetected sexually abusive behaviors.
- 13.08 Members are aware that attempting to provide treatment for problems that a client persistently denies having may result in limitations in making reliable clinical recommendations about the individual's treatment progress and reoffense risk, and that this has ethical implications.

- 13.09 Members routinely seek and explore the client's perspectives and offer feedback on his engagement, motivation, and progress in treatment, or lack thereof.

Treatment Progress and Completion

14. Members recognize and communicate that “successful completion” of a sexual abuser-specific treatment program/regimen indicates that a client has demonstrated sufficient progress in meeting the goals and objectives of an individualized treatment plan. Such a plan is designed to reduce the individual's risk to reoffend and increase stability and prosocial behaviors. Members recognize that treatment completion does not indicate that the individual's risk to reoffend has been eliminated completely.

- 14.01 Members ensure clarity and agreement between the provider and clients. Such agreement addresses, at a minimum, the following:

- The nature, goals, and objectives of treatment;
- The expected frequency and duration of treatment;
- Rules and expectations of treatment program participants;
- Rewards and incentives for participation and progress;
- Consequences of non-compliance with program rules and expectations; and
- Criteria used for assessing progress and determining program completion.

- 14.02 Members routinely utilize multiple methods in an effort to objectively and reliably gauge treatment progress, particularly with respect to dynamic risk factors. These methods include:

- Structured, research-supported tools and inventories;
- Specialized behavioral/psychophysiological tools;

- Client self-report; and
 - Collateral reports.
- 14.03 Members routinely review the client's individual treatment plan and clearly document in treatment records the specific and observable changes in factors associated with the client's risk to recidivate, or the lack of such changes.
- 14.04 Members recognize that a client who has completed treatment has generally:
- Acknowledged treatment needs for which he was referred in sufficient detail for treatment staff to have developed a treatment plan that, if implemented properly, could be reasonably expected to reduce his risk to reoffend;
 - Demonstrated an understanding of the thoughts, attitudes, emotions, behaviors, and sexual interests linked to his sexually abusive behavior and can identify these when they occur in his present functioning; and
 - Demonstrated sufficiently sustained changes in managing these thoughts, attitudes, emotions, behaviors, and sexual interests and developed/enhanced prosocial attitudes and skills such that it is reasonable to conclude that he has reduced his risk to reoffend.
- 14.05 Members evaluate a client's treatment progress within the context of a thorough understanding of the client's individual capacities, abilities, vulnerabilities, and limitations. Associated recommendations should reference these factors and aim to stay within the bounds of what is likely or possible for the individual client.
- 14.06 Members providing community-based treatment recommend more intensive treatment and/or supervision if a client experiences significant difficulties managing his

risk for sexual abuse in a way that jeopardizes community safety and, conversely, recommend gradual reduction to the intensity and/or dosage of services as the client consistently demonstrates stability and positive gains.

- 14.07 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.
- 14.08 Members are clear when communicating with clients, other professionals, and the public that some clients may require ongoing management of their risk and treatment needs.
- 14.09 Members provide the client, support persons, and appropriate professionals involved in ongoing case management with written information that includes follow-up recommendations for maintaining treatment gains.
- 14.10 Members, within the parameters of any applicable provisions, regulations, or statutes, notify appropriate authorities if a legally mandated client discontinues treatment or violates a mandated condition of parole, probation, or treatment.
- 14.11 Members hold non-mandated clients to the same treatment expectations as mandated clients.

Specific Responsivity Factors, Special Populations

- 15. **Members acknowledge the diversity among individuals who sexually abuse others, and that responsiveness to sexual abuser-specific treatment can vary as a function of client characteristics such as demographics, language, development, capabilities, functioning, and motivation to change.**

- 15.01 Members recognize that not all treatments have been developed or evaluated with various subpopulations of sexual abusers (e.g., individuals with intellectual and developmental disabilities, clients with serious mental illness, those with varied cultural backgrounds and other demographics). The limitations of such treatments with these populations should be identified prior to initiating treatment services.
- 15.02 Members appreciate that treatment for sexual abusers is more effective when responsivity factors are addressed, and recognize the potential for unintended collateral consequences when services fail to take into account responsivity factors.
- 15.03 Members assess and identify responsivity factors, such as comprehension, cognitive capabilities, adaptive functional level, psychiatric stability, and other factors that may impact a client's ability to maximally benefit from sexual abuser-specific treatment.
- 15.04 Members strive to adjust approaches to interventions and match clients to appropriate services based on identified responsivity factors in order to facilitate clients' maximum benefit from services. This includes, but is not limited to, the provision of language interpreters, services for persons who deny offending, services for clients with cognitive or developmental limitations, and culturally competent programming.
- 15.05 Members strive to equip themselves with the knowledge and skills necessary to adequately address clients' responsivity factors and/or special needs by consulting with knowledgeable others, accessing specialized training, and participating in other professional development activities.

- 15.06 Members recognize their own strengths and limitations with respect to their ability to provide adequately responsive services to clients, and refer clients to qualified providers skilled in addressing specific responsivity factors when necessary.
- 15.07 Members understand that for some subpopulations of sexual abusers, sexual abuser-specific treatment services are best provided subsequent to or in concert with other psychiatric, behavioral, or responsivity-oriented interventions. Members offering sexual abuser-specific treatment collaborate with the providers of such services to ensure that sexual abuser-specific services are complementary and not contraindicated.
- 15.08 Members providing sexual abuser-specific treatment work closely with a client's partner, family members, and other community support persons who can facilitate successful treatment outcomes because of their abilities to attend to a given client's specific responsivity factors.

D. RISK REDUCTION AND RISK MANAGEMENT IN THE COMMUNITY

Many male adult sexual abusers residing in the community are supervised under the jurisdiction of the courts, correctional departments, probation or parole divisions, or mental health agencies. Approaches to reducing and managing risk in the community for a range of practitioners outside of treatment services may involve imposing various supervision conditions, expectations, and requirements; monitoring and tracking; linking clients to appropriate programs and services; facilitating successful reentry to and stability in the community following release from correctional or other facility custody; promoting continuity of care within and across facility-based programs and services and community-based services; educating and engaging the public and communities; using and encouraging other system partners to use empirically informed assessment information to guide interventions and strategies; and engaging positive community support networks, which may include trained volunteers. Some strategies are explicitly designed to reduce the recidivism risk of sexual abusers by assisting them with developing and enhancing prosocial attitudes, skills, and behaviors; increasing healthy and appropriate interests, effectively managing risk factors; developing positive and prosocial community supports; and enhancing other protective factors. Other strategies are primarily designed to promote accountability, deterrence, and risk management.

Research indicates that focusing supervision activities primarily or exclusively on risk management is not effective in reducing recidivism. Using risk-reducing interventions, such as treatment and other skill-building approaches, generally complements risk management-based supervision strategies and leads to better outcomes. To support a balance of risk reduction and risk management efforts, contemporary trends involving sexual abusers in the community, trends supported by the extant literature, often

emphasize multidisciplinary and multi-agency collaborations. Such collaborative efforts may include communication and partnerships among professionals, such as sexual abuser-specific treatment providers and other treatment providers (e.g., substance abuse, mental health, marital and family therapists), probation or parole officers, case managers, child welfare professionals, victim advocates, and others.

In many jurisdictions, collaboration occurs through multidisciplinary case management teams, the composition of which may vary depending on the risk, needs, and circumstances of a given client. Key elements of effective collaboration include a clear delineation of roles and responsibilities, complementary policies and procedures, mutual and ethically sound communication and information-sharing mechanisms, and a shared community safety goal. Through effective partnerships, early intervention can be exercised to reduce the risk posed by sexual abusers prior to behaviors that are criminal in nature and occur to facilitate the exchange of information to develop appropriate treatment plans, inform risk management decisions, make recommendations regarding victim contact, and increase the overall stability and success of clients in the community.

In cases where a client will be released from a correctional, inpatient, or other institutional setting, the transition to the community is likely to be more successful when collaboration exists among professionals with case management responsibilities in the facility and in the community. Transition and reentry planning should be initiated well in advance of the client's release in order to identify any current and ongoing intervention needs, promote continuity of care, explore and begin to address potential barriers to reentry in the community (e.g., housing or employment challenges), clarify any post-release conditions and expectations, and facilitate access to community resources and services, which may include community-based sexual abuser-specific treatment.

As mentioned in earlier sections, research on correctional populations, including sexual abusers, demonstrates that interventions are most

effective when guided by evidence-based principles of correctional intervention (i.e., risk, need, and responsiveness). Therefore, community-based risk reduction and risk management strategies involving sexual abusers are ideally matched accordingly and may change over time, based on current and empirically-informed assessment information. Although higher risk/higher need clients may require supervision, monitoring, and treatment of greater intensity and dosage, less intensive supervision and other risk management and risk reduction strategies may be more effective and sufficiently adequate for sexual abusers with lower recidivism risk, fewer intervention needs, and greater protective factors.

Overarching Risk Reduction and Risk Management Considerations

- 16. Members recognize that the community management of sexual abusers generally involves a variety of interventions, strategies, and mechanisms.**
 - 16.01 Members appreciate that sexual abuser-specific public policies and practices have varied goals (e.g., deterrence, retribution, risk management, risk reduction, prevention) and may reflect the different interests and priorities for stakeholders. Some may complement sexual abuser-specific treatment, other risk-reducing interventions, and prevention strategies, whereas others may not.
 - 16.02 Members recognize that some interventions and strategies used to promote risk management and risk reduction with clients have more empirical support than others.
 - 16.03 Members remain apprised of the current research pertaining to the impact and effectiveness of various risk management and risk reduction policies and strategies utilized with clients in the community.

- 16.04 Members work with researchers to assess the impact and effectiveness of community-based risk management and risk reduction strategies utilized with clients.
- 16.05 Members play a role in educating stakeholders regarding the current empirical support for various strategies and encourage the use of research-supported principles and practices to promote effective risk reduction and risk management with clients in the community.
- 16.06 Members appreciate that the application of empirically-informed assessments of risk and need can enhance the potential effectiveness of risk management and risk reduction strategies for sexual abusers in the community and support the use of such assessments system-wide.
- 16.07 Members strive to ensure that collaborative partners and other stakeholders have access to current, empirically-informed assessments to guide decision making regarding risk management and risk reduction of sexual abusers in the community.

Multidisciplinary Collaboration

- 17. Members recognize that effectively reducing and managing risk among sexual abusers in the community often involves collaboration across multiple agencies, entities, and disciplines.**
- 17.01 Members appreciate that their respective roles and responsibilities with clients are part of a broader system of community management.
- 17.02 Members value and respect the roles, responsibilities, and perspectives of the full range of stakeholders invested in the management of sexual abusers in the community.

- 17.03 Members strive to engage stakeholders, such as the judiciary, treatment providers, probation and parole officers, correctional staff, victim advocates, law enforcement agents, employers, landlords and housing officials, civic organizations, mentors, the faith community, and other community supports in contributing to risk reduction, risk management, and prevention activities.
- 17.04 Members recognize that collaborative partnerships are more effective at increasing community safety when the various stakeholders are appropriately trained and knowledgeable about working with sexual abusers. Therefore, members promote education and training of the involved professionals and non-professionals (e.g., family members, community supports).
- 17.05 Members ensure that information-sharing and collaboration occur within the parameters of confidentiality provisions, informed consent, and other ethical standards.

Collaborating with Probation/Parole or Other Community Supervision Professionals

- 18. Members providing treatment to sexual abusers collaborate with probation and parole officers, correctional and other facility staff, case managers, and post-release aftercare professionals to support successful public safety and client outcomes.**
- 18.01 Members appreciate that some probation/parole officers and other correctional staff are appropriately trained, skilled, and supervised to use research-supported general cognitive skills interventions and evidence-based behavioral techniques (e.g., prosocial modeling, skill practice, rehearsal, redirection and positive reinforcement).

Collaborating on the use of such strategies may complement sexual abuser-specific interventions.

- 18.02 For clients who are under court-mandated or other formal supervision in the community (e.g., probation, parole, aftercare/stepdown from an inpatient treatment facility), members strive to obtain supervision and treatment-related information from the appropriate authorities. This minimally includes copies of pre-sentence investigations, pre-release reports, previous sexual abuser-specific evaluations, and treatment summaries, and conditions of probation or post-release placement in the community.
- 18.03 Members providing treatment to sexual abusers review with the probation/parole officers and other case managers the specific conditions that are designed for risk reduction and management purposes, and discuss the rationale with the clients. Such conditions often include, but are not limited to, the following (not listed in order of priority):
- Abstaining from alcohol and/or illegal drugs, when substance use is a risk factor;
 - Adhering to treatment expectations (e.g., participation, compliance with program rules and individual ongoing treatment plans);
 - Practicing healthy sexual attitudes and behaviors;
 - Disclosing offense history, risk factors, and effective coping strategies to professionals who are involved with the client and the client's significant others, when appropriate;
 - Making plans for work, social, and leisure activities to enhance quality of life and reduce possible exposure to cues or situations associated with the client's risk of reoffending;

- Complying with other conditions of supervision, such as restricted Internet access, polygraph examinations, and electronic monitoring; and
- Complying with restrictions on contact with children or other vulnerable parties (e.g., adults with developmental limitations) as deemed necessary for a given individual.

18.04 Members providing clinical services to sexual abusers establish and clarify the appropriate parameters (e.g., timing, type of content) and mechanisms (e.g., written, verbal, face-to-face) for reciprocal information-sharing with the probation/parole officer or other relevant case management professionals in order to promote well-informed decision making. Information to be shared minimally includes the following:

- Attendance in treatment;
- Overall participation in treatment;
- Specific changes in dynamic risk factors and protective factors;
- Progress toward specific goals in treatment;
- Engagement and compliance with supervision;
- Referrals to and/or participation in additional programs and services; and
- Adjustments to level of supervision or supervision strategies.

18.05 Members report, in a timely manner, any violations of their clients' conditions of supervision and significant adverse changes in dynamic risk factors to the appropriate professionals with the authority and responsibility for supervision.

19. Members recognize the distinct but potentially complementary roles and responsibilities of treatment providers and supervision officers, clarify these roles and responsibilities to clients and other professionals, and actively strive to maintain these professional boundaries.

19.01 Members are aware of the ethical concerns related to dual relationships and adhere to any licensing, discipline-specific, ethical, or other credentialing standards and guidelines regarding dual relationships and conflict of interest.

19.02 While supporting complementary risk reduction and risk management efforts with clients, members strive to ensure that:

- Sexual abuser-specific treatment providers limit their role to that of clinicians and do not attempt to assume the roles of supervision officers or law enforcement agents or represent themselves as such;
- Probation/parole officers do not represent themselves as specialized sexual abuser-specific treatment providers unless they possess the requisite education, training, supervision, licensure, and continuing education;
- Probation/parole officers who deliver “general” cognitive and/or behavioral interventions to promote skill-building and behavior change among clients are well-trained and appropriately supervised to deliver such interventions with fidelity; and
- Probation/parole officers do not assume specialized clinical responsibilities within treatment programs for sexual abusers with clients for whom they have supervision responsibility.

19.03 Members exercise caution if allowing probation/parole officers to observe clinical treatment sessions in programs for sexual abusers.

- 19.04 Members recognize that such observation can help educate officers about individuals who sexually abuse and the nature and approach to treatment for sexual abusers, and obtain information that may enhance their supervision of a given client.
- 19.05 Members recognize that such observations can also impact the client's confidentiality, inhibiting client participation and disclosure; disrupt continuity of the treatment process; and blur clients' perceptions of officers' roles.
- 19.06 If allowing such observations, members:
- Ensure that officers clarify their roles and responsibilities as supervision officers;
 - Review and clarify the purpose and possible impact of having officers present;
 - Obtain appropriate informed and voluntary consent from clients; and
 - Ensure that officers are aware of and adhere to professional ethics, including but not limited to confidentiality limits and boundaries.

Engaging Community Supports

- 20. Members recognize that appropriate support persons can assist professionals and clients with risk reduction, risk management, and other successful outcomes for clients, victims, and communities (see also "Social and Community Supports" in Section C: Treatment Interventions).**

- 20.01 Members collaborate with clients and other professionals to identify and engage community support persons in the supervision and treatment processes, when appropriate and feasible.
- 20.02 Members acknowledge that appropriate support persons ideally are able and willing to:
- Appreciate that clients are responsible for having engaged in sexually abusive behavior;
 - Recognize that recidivism risk can increase and decrease over time;
 - Maintain routine contact with the individual who has engaged in sexually abusive behavior;
 - Understand, recognize, and intervene when risk factors are present;
 - Maintain, model, and assist clients with practicing prosocial attitudes and behaviors;
 - Support adherence to supervision, treatment, and other expectations pertaining to risk reduction and risk management;
 - Participate in the development and implementation of safety plans for victims and other vulnerable persons, as applicable; and
 - Communicate effectively with the professionals responsible for assessing, supervising, and providing treatment to sexual abusers.
- 20.03 Members establish and clarify appropriate parameters (e.g., timing, nature, limits, methods) of reciprocal information-sharing with support persons.
- 20.04 Members take appropriate steps to ensure that support persons are equipped with knowledge and skills regarding risk factors for reoffending, strategies for effectively reducing and managing clients' risk for recidivism, and the strengths and limitations of strategies in place.

- 20.05 Members educate clients and identified support persons regarding the roles, responsibilities, expectations, and risks and benefits associated with serving as part of a collaborative support network, and elicit informed consent accordingly.

Engaging Chaperones

21. Members exercise prudence and caution when involved with the selection and education of responsible adult chaperones for contacts between clients and children or other vulnerable parties who may be unable to give consent.

- 21.01 Members recommend as potential chaperones only adults who:

- Accept and understand the client's history of sexually abusive behavior;
- Appreciate that the client is solely responsible for his decisions to act in a sexually abusive manner (i.e., chaperones do not place responsibility on victims or external circumstances);
- Recognize the potential for risk factors and intervention needs to change over time, either increasing or diminishing;
- Appreciate the need for the client to have prosocial supports; and
- Accept the role and responsibilities of being an effective chaperone.

- 21.02 Members ensure that clients educate potential chaperones candidly about the clients' sexually abusive behaviors, antecedent and ongoing risk factors, and treatment and/or supervision conditions.

- 21.03 Members ensure that chaperones fully understand the safety plan for the child(ren) and other vulnerable parties and appropriate reporting procedures for violations of the safety plan.
- 21.04 Members monitor authorized contacts between the client and child(ren) and other vulnerable parties through interviews with the client, interviews with the chaperone, the child's/children's therapist/support person, and other supervision options.

Collaborating with Child Protective/Child Welfare Professionals

This section pertains to clients whose sexually abusive behaviors, interests, preferences, or arousal involve children¹⁰ and the potential for these clients to have planned or unplanned contact with children (e.g., children in their own families, the children of new romantic partners, friends, co-workers, or neighbors). It is important to note that contact is not limited to the client's close physical proximity with a child or adolescent, but also includes one-to-one interactions such as telephone calls, electronically facilitated communication, written notes, and communications through third parties¹¹

22. Members prioritize the rights, well-being, and safety of children when making decisions about client contact with minors.

¹⁰For the purpose of this section, the term "children" refers to minors under the legal age of consent.

¹¹For the purpose of these guidelines, "contact" generally does not necessarily include incidental proximal contact such as walking by children on the street or in another public location. However, as part of a comprehensive evaluation of risk, 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.

- 22.01 Members take reasonable steps to support a client's adherence to any no contact orders or other restrictions that have been imposed by the courts or other entities statutorily authorized to impose such restrictions for that client.
- 22.02 When contact with children is at issue under the terms of any legal disposition (e.g., court order, probation/parole order), members may provide written assessment-driven recommendations regarding an individual client's acceptable level of contact with children that range from no contact to supervised or unsupervised contact.
- 22.03 Members' recommendations regarding contact with minors should be minimally informed by the following:
- Empirically-informed assessments of recidivism risk and protective factors;
 - The client's history of atypical sexual interests, fantasies, and behaviors involving children;
 - The nature, extent, and duration of the offending behaviors of the client;
 - The client's engagement and progress in sexual abuser treatment, particularly with respect to general and sexual self-regulation, sexual preoccupations, and the extent of sexual deviance variables; the abuser-victim relationship; and offense-related motivations, grooming patterns, attitudes, and offense-specific variables;
 - The presence of positive prosocial supports who can serve as chaperones for the client;
 - The client's level of engagement and compliance with supervision expectations and conditions;
 - The ability, skills, and willingness of non-offending parents or guardians to provide an environment that is appropriately conducive to maintaining the child's emotional and physical safety;

- The availability and professional opinions of a qualified child advocate, a mental health professional, or a child welfare professional to whom the child and family are therapeutically engaged, and the confidence that the child will be able to articulate interests and concerns regarding the potential for contact with the client;
 - The child's reported interests for contact or no contact, or if contact would or would not be in the best interests of the child; and
 - The extent to which community strategies are currently in place to provide adequate mechanisms and resources to ensure adequate child safety plans for victims and other minors.
- 22.04 Members collaborate with the proper authorities or professionals to support restrictions that prohibit 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.
- 22.05 Members consider the impact that a client having contact with a victim's siblings may have on the victim or the non-abused siblings and approve only contact that minimizes distress to the victim.
- 22.06 Members work collaboratively with child welfare/child protection agencies, victim advocates, and others (e.g., treatment providers, probation/parole officers) to develop safety plans for victims and other vulnerable children.
- 22.07 Members obtain informed consent from a child's non-offending parent or legal guardian before approving a client's contact with that child, while adhering to the parameters of any legal or other restrictions.
- 22.08 Members may support structured and/or supervised contact with the child when the client is making acceptable progress in treatment and/or supervision,

when he is effectively managing dynamic risk, when appropriate safety precautions are in place, and when contact is assessed to be in the best interest of the child by the appropriate/designated professional(s) working with or responsible for child welfare decisions.

- 22.09 Within the bounds of confidentiality, members regularly exchange information in a timely manner with child welfare workers involved in a client's case and with child welfare workers involved in monitoring the safety of children with whom the client is having or considering having contact, unless otherwise specified by law. Information may include, but is not limited to, the following:
- Client's treatment progress;
 - Significant changes in dynamic risk factors; and
 - Significant safeguards and social services agreements in place with goals and objectives that have to be met by all in order to promote contact or reunification.
- 22.10 Members familiarize themselves with restrictions related to client-victim contact and abide by those restrictions in a therapeutic manner.
- 22.11 Members ensure that, as warranted for a given client, contact with children is addressed as part of a comprehensive community risk management plan and should be linked to the client's reoffense risk, progress in treatment, and/or compliance with supervision, as applicable.
- 22.12 Members document all decisions about a client's contact with children, including whether contact is recommended or not, the nature of the contact that is recommended, the preparations made with children and chaperones, and information obtained during the ongoing monitoring process.

Addressing Family Reunification and Visitation

23. Members collaborate with child welfare workers to address family reunification efforts when clients have abused children in their own families and wish to have contact with them, or when they seek to begin relationships with individuals who have children.

23.01 Members recognize that family reunification may not necessarily be an advisable goal because of the risk and potential for harm that may be unmanageable (e.g., high risk, lack of appropriate caregiver supervision, nature of the victimization, impact on family and victim). However, family reunification may be one of many ways that victims and families attempt to resolve issues generated by the abuse and may be beneficial for other reasons in some circumstances.

23.02 Members are aware that reunification is a gradual and well-supervised process in which a sexual abuser is allowed to reintegrate into his familial network where a victim or potential victims is present.

23.03 Before providing recommendations regarding family reunification, members collaborate with professionals from a range of disciplines who have different agency missions and mandates, which may include child welfare professionals, family therapists, victim services providers or advocates, treatment providers, supervision officers, and other community supports.

23.04 Members ensure that any child contact decisions within the context of family reunification efforts should be informed by a thorough assessment of the client's risk, a plan to protect the child's safety, and consultation with other members of the community risk management team, such as collaborative partners and stakeholders.

- 23.05 Members ensure that, as appropriate and indicated, any contact with the client's children, his current partner's children, or children of family members are also discussed as part of the reunification process.
- 23.06 Members do not recommend the involvement of the 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.
- 23.07 Members, if necessary, recommend that the client be removed from the residence of the victim or potential victim rather than removing the victim or potential victim.
- 23.08 Members consider the wishes of the victim or potential victim with regard to family reunification, taking into account their ability to understand the ramifications of their decisions.
- 23.09 Members ensure that a child has access to a responsible adult chaperone trusted by that child before recommending their client be allowed to have contact with that child.
- 23.10 Members may make recommendations for a client to have contact with an intrafamilial victim and other family members who are minors only when the following are present:
- 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
 - The client has made acceptable progress in his treatment.

- 23.11 Members ensure that appropriate safety plans are developed and monitored during the family reunification process. Safety plans should include explicit and non-negotiable rules and boundaries.

Continuity of Care

24. Members recognize that continuity of care is necessary to support effective risk management and risk reduction of sexual abusers in the community.

- 24.01 Members facilitate, in a timely manner, the seamless access to and provision of follow-up services for clients who transition from one program to another. This may include transition from:

- Institutional to community-based treatment;
- Community-based treatment to treatment in a correctional, inpatient, or other institutional setting;
- Programming within a facility/institution or within the community, at a lateral level of transfer; or
- The current jurisdiction/place of residence to a new jurisdiction/place of residence, due to relocation or transfer of supervision.

- 24.02 Members seek information, through appropriate releases of information, regarding treatment progress and take this into consideration when initiating treatment services for a client who has been receiving services elsewhere or in another setting in order to prevent duplication of efforts and promote timely, assessment-driven, well-informed treatment planning.

- 24.03 Members providing clinical services to sexual abusers in institutional settings ensure that progress in such programs is documented and, ideally, reinforced and

strengthened with appropriate and relevant follow-up services in the community.

24.04 Members, to the greatest 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 an in person meeting is not possible, electronic alternatives, such as teleconferencing or video conferencing, may be used.

24.05 Members providing services to clients prepare written treatment/discharge summaries for clients who change programs, transition from an institution to the community, or transition from the community to an institution (i.e., lesser level of care or increased level of care/security). These summaries usually include the following elements (not listed in order of priority):

- Assessment of risk to sexually harm others, including individualized risk factors and indicators of imminent risk;
- Assessment of dynamic risk factors and protective factors/client strengths (e.g., prosocial support systems);
- Description of offending pattern;
- Description of sexual and non-sexual criminal history;
- Identification of relevant problems and continuing intervention needs (including medication);
- Level of participation in programming; and
- Recommendations for community supervision, treatment, and support services to guide post-release case management decisions.

24.06 When appropriate and within ethical parameters, bounds of confidentiality, and other information-sharing statutes or professional regulations, members working in correctional facilities or inpatient/other institutional settings provide community-based providers, supervision officers/case managers, aftercare workers, and other appropriate support persons with information that can be used to inform appropriate post-release or transitional treatment, supervision, and management in the community.

Appendix A: Recommended Qualifications and ATSA Clinically Focused Membership Requirements

ATSA members have diverse educational backgrounds, training and employment experiences, and roles and responsibilities, which result in varied types and levels of knowledge, skills, and expertise. As noted in Part A: Introduction and General Expectations, the guidelines outlined in this document are designed to promote ethically sound and empirically-informed assessment, treatment, and other interventions to male adult sexual abusers in a manner that facilitates successful outcomes for sexual abusers, victims, and communities and that maintains the integrity of the field. To that end, ATSA recognizes the need for its members to possess formal educational, training, and practical experiences that can support the delivery of such services to this client population.

I. Recommended Qualifications

A. Members who provide or intend to provide clinical services to male adult sexual abusers possess education, training, and experience that promote well-informed and effective practices.

1. General/Foundational. Members who provide or intend to provide clinical services to male adult sexual abusers are expected to complete coursework and training, and gain practical experience, in order to develop knowledge and/or skills in the following areas (not listed in order of priority):

- Assessment and evaluation, including interviewing and psychometric testing;
- Client engagement and motivating clients to change;
- Cognitive, behavioral, and cognitive-behavioral therapy;
- Counseling;
- Cultural/ethnic issues;
- Diagnosis;

- Family dynamics;
- Group therapy and group dynamics;
- Human development, including human sexuality;
- Performance and outcomes measurement;
- Professional ethics;
- Psychometric testing;
- Psychopathology;
- Research design and methodology; and
- Treatment planning and documentation.

2. Advanced/Specialized. Members who provide or intend to provide clinical services to male adult sexual abusers are expected to complete coursework and training, gain practical experience, and/or conduct research to enhance knowledge and/or skills in the following areas (not listed in order of priority):

- Atypical sexual interests, arousal, and preferences;
- Empirically-informed psychometric and psychophysiological testing specific to sexual abusers;
- Empirically-informed risk assessment specific to sexual abusers;
- Empirically-informed treatment interventions for sexual abusers;
- Ethical principles and practices with forensic client populations;
- Etiological theories pertaining to sexually abusive behavior;
- Evidence-based correctional principles and practices; and
- Victimology, specifically with respect to victims of sexual abuse.

3. Members providing clinical services to male adult sexual abusers possess additional knowledge, training, and experience – and collaborate with relevant professionals – when working with clients for whom the following are issues:
 - Severe and persistent mental health difficulties, neuropsychological disorders, developmental delays, and other responsivity factors, as (outlined in Part B: Assessments and Part C: Treatment Interventions of this document);
 - Family reunification;
 - Couples and family therapy;
 - Substance abuse treatment; and
 - Pharmacological therapy.
- B. Members providing clinical services to male adult sexual abusers obtain and document annual continuing education in the field of sexual abuse.
- C. Members, regardless of educational attainment and years of practice in the sexual abuser-specific field, continue to supplement their educational and professional experiences through continuing education and consultation with other professionals with relevant expertise in the field.

II. ATSA Clinically Focused Membership Categories and Requirements

The ATSA by-laws establish the minimum educational and experience criteria required for designation in the various membership categories. With respect to providing clinical services specifically, the by-laws outline the specific requirements for Clinical Members, Clinical and Research Members, Clinical Associate Members, Professional Members, and Student Members. These criteria are requisite standards – not general guidelines – that must be met for individuals seeking designation in a given membership category

specifically for the purpose of providing clinical services to male adult sexual abusers. The ATSA by-laws related to the clinical practice membership categories are as follows:

- A. Clinical Members must possess a graduate degree (Master's Degree or above) in the behavioral or social sciences, or in a healthcare/medical field, from a fully accredited college or university, and must have engaged in a minimum of 2000 hours providing direct clinical services, such as assessment or individual or group treatment, to individuals who have engaged in sexually abusive behaviors.
- B. Clinical and Research Members must possess a graduate degree (Master's Degree or above) in the behavioral or social sciences, or in a healthcare/medical field, from a fully accredited college or university, and have engaged in a minimum of 2000 hours of conducting research specific to issues related to sexually abusive behaviors, and 2000 hours of providing direct clinical services, such as assessment or individual or group treatment, to individuals who have engaged in sexually abusive behaviors.
- C. Clinical Associate Members are professionals who either (a) possess a Master's Degree or above in the behavioral or social sciences, or in a healthcare/medical field, from a fully accredited college or university, and have engaged in less than 2000 hours of direct clinical services to individuals who have engaged in sexually abusive behaviors; (b) possess a Bachelor's Degree or equivalent in the behavioral or social sciences and have engaged in direct research of and/or provided direct clinical services to individuals who have engaged in sexually abusive behaviors; or (c) are employed on a full-time basis for at least 40 hours per week in a position that provides direct clinical services to individuals who have engaged in sexually abusive behaviors.

- D. Research Associate Members are professionals who hold graduate level degrees and who have engaged in research on sexual abuse for less than 2000 hours.
- E. Professional Members are professionals who have engaged in a minimum of 2000 hours of work specifically related to sexual abuse prevention or the management of individuals who have engaged in sexually abusive behaviors.
- F. Student Members are students who are registered at least half time in programs at an accredited college or university, pursuing an advanced degree or its equivalent related to the study or treatment of sexually abusive behaviors.
- G. Members who do not have graduate or professional degrees, but are providing or intend to provide clinical services to male adult sexual abusers, are expected to receive specific training and experience in working with this client population and to remain under the direct supervision of a qualified mental health professional.
- H. Members who are providing or intend to provide clinical services to male adult sexual abusers are expected to receive a minimum of 2000 supervised hours of face-to-face clinical contact with this client population before providing unsupervised clinical services, with such supervision conducted by a qualified mental health professional.

Appendix B: Phallometry, Viewing Time, and Polygraphy

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 non-sexual 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 circumference 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 atypical sexual interests, increasing client disclosure, and measuring changes in sexual arousal patterns over the course of treatment.

Phallometric test results are not used as the sole criterion for determining atypical sexual interests, estimating risk for engaging in sexually abusive behavior, recommending that clients be released to the community, or deciding that clients have completed treatment programs. Phallometric test results are interpreted in conjunction

with other relevant information (such as, 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 who have developmental disabilities and clients with an acute major mental illness. Therefore, members need to exercise caution in using phallometry with these populations and in interpreting and reporting 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 active, communicable diseases, 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, presenting stimuli, recording data, 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 abuse 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. Audiotaped 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 audiotapes include stimuli describing consenting sex, rape, and sadistic violence. Stimuli depicting neutral, non-sexual 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 phallogometric testing is lower than its specificity, the presence of atypical/deviant sexual arousal is more informative than its absence. Results indicating no atypical/deviant sexual arousal may be a correct assessment or may indicate that a client's atypical/deviant sexual interests were not detected during testing.

Research indicates that initial phallogometric assessment results are linked with recidivism. Repeated assessments can be helpful to monitor treatment progress and to provide information for risk management purposes.

Viewing Time Measures

Viewing time measures are a specialized form of assessment used with individuals who have engaged in sexually abusive behaviors. Using the results of viewing time measures responsibly requires members to have at least a rudimentary understanding of how viewing time measures work, as well as their 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.

Currently, unobtrusively measured viewing time is primarily used to identify sexual interest in children. For instance, to test 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. The relative amount of time clients spend looking at pictures of children (who

are clothed, semi-clothed or nude, depending on the jurisdiction,) is compared to the time that the same adult spends looking at pictures of adults. Research suggests that, as a group, individuals who have engaged in sexually abusive behaviors 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 phallogometric responding among non-sexually abusive subjects. Little is known, however, about the value of retesting 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. Note that there is limited information specific to the use of viewing time with clients who have developmental disabilities. 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.

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, recommending whether a client be released to the community, or deciding whether a client has 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.

Polygraphy

Polygraph testing involves a structured interview during which a trained examiner records several physiological responses of the examinee. Following this interview, the examiner reviews the charted record and forms opinions about whether the examinee was non-deceptive or attempting deception when answering each of the relevant questions. Many regions and jurisdictions do not utilize polygraphy for a variety of reasons, including empirical questions about its reliability and validity, yet in many other jurisdictions it is a widespread practice.

Post-conviction sex offender polygraph testing is a specialized form of general polygraph testing. 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 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 work with individuals who have engaged in sexually abusive behaviors. 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 the following objectives:

1. Facilitate a client's disclosure of sexual history information, which may include sexually abusive or offense-related behaviors (generally disclosed in the interview portion of the examination);

2. Eliciting from the client clarifying information regarding the instant/index offense
3. Exploring potential changes, progress and/or compliance relative to treatment and other case management goals and objectives (through yes/no questions about adherence to specific treatment and other case management expectations); and/or
4. Making collaborative case management decisions about a client with other partners and stakeholders based on the information gleaned from the examination interview.

Some research indicates that the polygraph examination can lead to clients providing increased information regarding their sexually abusive behaviors; however, as has been mentioned, test validity and reliability often vary widely across studies. 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 also affect reliability and validity. 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 might be fictitious, representing an accommodation to pressure for disclosures. The third objective of post-conviction sex offender testing –to gauge enhanced supervision and treatment compliance – has received only limited empirical attention.

Members' primary purpose for collecting sexual history information is to further inform, as a complement to other assessment data, clinical interventions and other management strategies. The usefulness of post-conviction sex offender polygraph testing as a "clinical" tool is based on its potential to elicit historical information, thus arguably allowing psychosexual behavioral patterns to be more fully revealed, better understood, and therefore more effectively managed and changed.

The American Polygraph Association, The National Association of Polygraph Examiners, and other polygraph associations have developed standards for certifying polygraph examiners who work in the management and treatment of sexual abusers, as well as standards for administering sexual abuser 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 individuals who have engaged in sexually abusive behavior:

1. **Instant/Index Offense Tests** are designed to explore and clarify discrepancies between the client's and the official descriptions of the conviction offense(s).
2. **Sexual History Disclosure Tests** are designed to facilitate a client's disclosure of sexual history information, which may include sexually abusive or offense-related behaviors, to their treatment provider prior or subsequent to the polygraph examination itself.
3. **Maintenance/Monitoring Tests** are designed to explore potential changes, progress, and/or compliance relative to treatment, supervision, and other case management goals, objectives, and expectations, based on specific yes/no questions pertaining to very specific and narrow expectations and goals that have been established.
4. **Specific Issue Tests** are generally designed using a yes/no format to explore a client's potential involvement in a specific prohibited behavior, such as unauthorized contact with a victim at a particular time.

Polygraph test accuracy is believed to be greatest when examiners 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.

Members must ensure that limits of confidentiality are fully disclosed to clients prior to polygraph testing, and that clients are afforded the opportunity for informed consent, specifically with respect to the ways in which the findings will be used and to whom the findings will be provided. Client disclosures of potentially incriminating information to mandated reporters can lead to future prosecution. Members inform clients, in writing, of this potential dilemma and how it is addressed in their jurisdiction and program.

There is very limited empirical research on the use of polygraph with clients who have developmental disabilities and clients with low/borderline IQs. Therefore, further caution is advised if members use polygraphy for assessment, treatment, and management processes with these clients.

As noted in the main body of this document, polygraphy is not used as the sole criterion for determining deviant sexual interests, estimating a client's risk for engaging in sexually abusive behavior, recommending whether a client be released to the community, or deciding whether a client has completed a treatment program or to change a client's treatment status. When the polygraph is utilized, findings are to be interpreted in conjunction with other relevant information to inform decision making.

Appendix C: Pharmacological Interventions¹²

Research examining the effectiveness of various treatment interventions for adult sexual abusers indicates that, when used in combination with other treatment approaches, medical interventions such as testosterone–lowering hormonal treatments may be linked to greater reductions in recidivism for some clients than the use of psychosocial treatments alone. Other data, described below, suggest that non–hormonal psychotropic medications can also be effective supplements to standard therapeutic interventions for sexual abusers. It should be noted that pharmacological interventions are not typically used for all sexual abusers, but are often applied to those with paraphilias or offense–specific patterns of sexual arousal that could be altered through the use of such interventions. Further, such interventions should be integrated into a comprehensive treatment program that addresses other static and dynamic risk factors that contribute to sexual abuse.

Hormonal agents for managing sexually abusive and paraphilic behaviors

- A number of hormonal agents have been introduced as pharmacological treatments for reducing testosterone and sexual drive in individuals with paraphilias and/or who have engaged in sexually abusive behaviors. Primary examples include medroxyprogesterone acetate, leuprolide acetate, cyproterone acetate, and gonadotropin–releasing hormone analog. These hormonal agents, sometimes referred to as “anti–androgens,” act in numerous ways to decrease the production and increase the elimination of testosterone. Because testosterone is associated with sexual arousal,

¹² The majority of the content in this appendix is from the 2012 ATSA fact sheet entitled “Pharmacological Interventions with Adult Male Sexual Abusers,” available at www.atsa.com

the use of these agents generally results in a reduction of sexual arousal. This reduction in sexual arousal is assumed to also reduce the motivation for sexual abuse in individuals predisposed to such behaviors.

- Some research suggests that clients treated with hormonal agents, when compared with those who have not received such treatment, have lower rates of detected sexual recidivism as well as decreased sexual arousal in response to offense-specific stimuli by self-report and physiological evidence. However, there is also evidence that clients treated with hormonal agents alone show similar rates of sexual recidivism following a standard course of pharmacotherapy and follow-up than their non-hormonally treated counterparts. In all, well-designed control studies are lacking, and more empirically rigorous research is needed in this area.
- The use of hormonal treatments sometimes carries negative and punitive connotations (i.e., referred to as “chemical castration”), and testosterone-lowering agents have significant medical side effects (e.g. breast enlargement or swelling, weight gain, blood clots, depression, gallstones, diabetes mellitus, osteoporosis, hot flashes). As a result, individuals may be prone to decline such treatments, or to demonstrate later non-compliance after initially agreeing to a treatment regimen.
- The limited outcome data on all testosterone-lowering agents make definitive treatment recommendations premature. Because of significant side effects, the prescription of such medications should be restricted to paraphilic patients and individuals with an at least moderate or high risk for hands-on sexual offenses. Additionally, because other etiologies and risk factors

are present, the use of hormonal agents should be combined with empirically supported psychotherapy practices.

Non-hormonal agents for managing sexually abusive and paraphilic behaviors

- Studies of sexual abusers, men with paraphilias, and those with non-paraphilic expressions of “hypersexuality” suggest that mood disorders (dysthymic disorder, major depression, and bipolar spectrum disorders), certain anxiety disorders (especially social anxiety disorder and childhood-onset post-traumatic stress disorder), psychoactive substance abuse disorders (especially alcohol abuse), Attention-deficit/hyperactivity disorder (ADHD), and neuropsychological conditions (e.g., schizophrenia, autism spectrum disorder, and head injury) may occur more frequently than expected in sexually impulsive men, including those who sexually abuse.
- Empirically established effective pharmacological treatments for mood disorders, ADHD, and impulsivity are well documented. These conditions affect prefrontal/orbital frontal executive functioning and are associated with impulsivity; therefore, amelioration of such conditions could certainly affect, if not markedly ameliorate, the propensity to be sexually impulsive.
- Though much evidence exists demonstrating the efficacy of these treatments for other Axis I disorders, few empirical studies have examined the role of such interventions in the reduction of sexual arousal or sexual aggression. One retrospective study reported significant reduction in paraphilic activity among participants, all of whom had received Selective Serotonin Reuptake Inhibitor (SSRI) medications and psychotherapy.

- Literature supporting the prescriptive use of mood stabilizers, such as limbic anticonvulsants and atypical neuroleptics, for sexual abusers is lacking. There have also been sporadic case reports of the prescriptive use of naltrexone for adults with “compulsive sexual behavior.”
- Despite there being no double-blind placebo-controlled treatments of the efficacy of SSRIs for the treatment of sexual abusers, such medications have been reported to be the most commonly prescribed agents for clients, at least in the United States and Canada
- As is the case with hormonal agents, the prescriptive use of non-hormonal pharmacological agents to treat individuals who have engaged in sexually abusive behaviors will not address all etiologies and risk factors and should therefore be combined with psychotherapy specific to sexual abusers.

Ethical Considerations

- Research support for the effectiveness of pharmacological treatments such as testosterone reducing agents is mixed. Without clear data regarding the efficacy of such treatments, providers should be sure to balance the risks of such interventions with the potential benefits of treatment.
- Available medications for hormonal therapy often cause significant negative side effects for the men taking them, including metabolic changes, fatigue, gastrointestinal problems, cardiovascular problems, bone loss, and headaches. In addition to these systemic effects which may compromise a client’s health, these medications may additionally contribute to increased depression and mood instability, which have been identified as potential dynamic risk factors for actually increasing risk of sexual recidivism. Similarly, the reduction of

sexual drive may contribute to difficulties in forming healthy intimate relationships, and these support systems may be necessary to improve quality of life and reduce the risk of continued sexual violence. While the use of other, non-hormonal agents may produce less aversive side effects than those associated with hormonal agents, side effects are still a concern and may impact the decision to use such interventions.

- Access to these specific forms of treatment may be limited for some clients, either due to cost or the availability of qualified medical providers with expertise in the use of such medications, particularly with individuals with paraphilias or problem sexual behaviors. Whenever possible, medical providers should be included as a part of the treatment team.
- As noted above, due to unpleasant side effects and other complaints, there are often compliance problems with those who are prescribed hormonal agents. Not only must providers consider medication refusal but also the potential use of illegally obtained anabolic steroids or other hormonal agents to counteract the reduction of androgens, or the use of sildenafil citrate, tadalafil , or other comparable medications to increase sexual response. Further, providers may be pressured to administer such medications involuntarily, adding legal and ethical conflicts for prescribing physicians and their clients.
- In the United States, there are no current medications that have received approval from the U.S. Federal Drug Administration (FDA) for the use in treating individuals with paraphilias or other sexual disorders. Therefore, the use of any of the medications described are considered “off-label.” Thus, the immediate and long-term impact of these medications on adult male sexual abusers

has not been thoroughly tested and remains unknown. In some jurisdictions or agencies, the off-label usage of pharmacological interventions is strongly discouraged. Insurance companies may be less likely to reimburse for off-label medication usage as well, thus increasing the cost of treatment compliance. A medical provider should obtain informed consent when prescribing such medications.

- The use of hormonal agents to reduce sexual drive and consequently sexual behavior could be classified as a form of chemical restraint, a practice that is generally used to describe efforts to sedate or restrict freedoms of psychiatric patients. However, this definition could be expanded to include use of specific hormonal agents to restrict sexual freedoms and behaviors. The use of such chemical interventions – particularly involuntarily – as forms of restraint carry a negative ethical connotation and may be illegal in some jurisdictions. Further, in some agencies involving individuals with intellectual and developmental disabilities, policies exist that prohibit the limitation of sexual behaviors and freedoms of these persons (resulting as a reaction to prior efforts to sterilize or otherwise control the reproductive behaviors of such individuals), and the use of such medications may in fact violate these policies.

Practice Guidelines

Members who are not medical professionals do not make specific recommendations about what medications should be prescribed. It is appropriate for members to refer clients to medical providers who have experience working with individuals who have sexually abused as possible candidates for pharmacological therapy. They can provide information about the role of pharmacological interventions to the consulting medical provider. Members who are not medical providers could consider referring clients to a medical provider 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 reasonable candidates for pharmacological therapy. Motivated and informed clients are often the best candidates for pharmacological therapy.

A medical professional 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 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 by the client 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 a client to take medication. Medical providers 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. Patients have the right to discontinue medication treatments at any time.

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, eradicate deviant arousal, or fully eliminate the risk for reoffending.

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