

**Obtaining Treatment Compliance With  
Juvenile And Youthful Sexual Offenders  
Via  
Addressing Specific Psychosocial  
Deficits Identified With This Population**

By

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To my loving mother Mrs. Lana Bednar  
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## **ABSTRACT**

This paper briefly reviews the growth and decline of sexual offender treatment programs in the United States. Some suggestions as to the cause of the reduction in the number of programs are given. Psychological and social skills deficits identified with juvenile and youthful sexual offenders are identified and discussed. The fact that for decades now the need for social skills training has been seen in the available literature is pointed out. A criticism of authors in the field by researchers and reviewers has been that their programs are not clearly and concretely described nor do they actually provide enough details about how they do specific interventions. This has created problems when others want to study and replicate their work. In this paper the process of dealing with social problems and social skill training is covered in more depth with specific forms, strategies and verbatim techniques that could easily be repeated by other therapists or researchers. It is hoped that other clinician's will also take up this cause and leave a clear trail for researchers wanting to study the efficacy of therapeutic interventions for juvenile and youthful sexual offenders which may ultimately elevate our scientific understanding of the process and justify our continued existence.

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## INTRODUCTION

Treatment of sex offenders and sexual offender treatment programs have proliferated over the past fifty years (Becker, 1990; Hanson, Steffy, & Garithier, 1993; & Alexander, 1999). A national survey reported that the number of sexual offender treatment programs increased from six hundred forty-three in 1986 to seventeen hundred eighty-four in 1994 (Freeman-Longo, Bird, Stevenson, & Fiske, 1995). By 1996 the number of programs decreased to thirteen hundred eighty and by the year 2000 to eight hundred eighteen (Burton & Darden 2001) indicating a steady decline in the total number of programs. This reduction is likely based on declining funding and the belief by some that sex offender therapy programs have not proven effective. Yet there has been a consistent increase in violent crimes and sexual offenses for which juveniles have been arrested during the same period of time (Hunter & Figueredo, 1999).

It has long been assumed and more recently demonstrated that completion of a community-based treatment program can reduce the risk of subsequent sexual reoffending behavior as well as nonsexual criminal offense behaviors (Becker, Harris & Sales, 1993; Bench, Kramer & Erickson, 1997; Hunter & Figueredo, 1999). Despite these findings a pessimistic climate presently surrounds the effectiveness of sex offender treatment. Public funding has declined steadily over the past ten years. Lack of research funds has hampered improving treatment through better understanding the efficacy of various interventions which may lead some to conclude that there is no effective treatment (Alexander, 1999). Findings suggest that some effective strategies have been identified (Maletzky, 1999).

While those in the field seek confirmation of their work optimistic in the hope that time will tell and turn the tide of doubt other point to problems with research design, ethical issues and methodological concerns (Alexander 1999). Those who treat offenders should develop and standardize curricula so that others can follow them. Research could then enhance efficacy.

There is a promise of hope for the future as the fields of clinical sexology and subfield of sex offender therapy have recently emerged as separate clinical specialty areas with their own training programs and doctoral candidates (Walker 2000). Some of whom despite their present positions as treatment providers and therapists with scarce resources will go on to collect, analyze and publish their work adding to our knowledge, expanding available resources and shedding light on the enigmatic sometimes murky field of sex offender treatment. It is from this positive view that this clinician will present information accumulated from 1988 to 2000.

A common finding is that attrition rates are high for juvenile and adult offenders (Miner & Crimmins,1997). The most likely reasons for non-completion is noncompliance with program rules, violation of probation or new criminal offense. Which is often as simple as not attending therapy sessions. The etiology of negative attitudes toward therapy and strategies for increasing positive client participation is needed (Hunter & Figueredo 1999).

Most boys and men reported on in recidivison studies do not represent the most likely to be dangerous offenders those who will not enter treatment (despite compulsion by the courts or others sources). These who do are preselected for some measure of compliance. Yet boys and young men considered appropriate for outpatient treatment interventions fail to complete at alarmingly high rates exposing the community to increased risk of reoffending both for sexual and non sexual offending behavior (Alexander, 1999, Hunter & Figueredo, 1999).

The author who has worked with juvenile youthful and adult sexual offender will focus on the social deficits of juvenile and youthful offenders as one causative factor in unsuccessful completion of outpatient treatment.

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## THE SELECTION PROCESS

From 1988 to 1994 psychosocial and psychological data was gathered with Juvenile offenders in Greensboro, North Carolina and from 1996 to 2000 psychosocial data was gathered on juvenile and youthful offenders in Stuart, Florida. The information gathered and assessments were made on boys age ten and up and young adult offenders from age eighteen to twenty-six (hereafter referred to as Juvenile Sex Offender's and Youthful Sex Offender's ).

The identified psychological deficits and liabilities for Juvenile Sex Offender's as compared to non patients according to Ginsburg were:

- 1) Fewer total resources
- 2) More vulnerability to impulsive behavior
- 3) Less emotional expression
- 4) Emotional balance in favor of uncontrolled responses
- 5) Much more defensive
- 6) Make fewer conventional responses
- 7) Perception is poor. More idiosyncratic and distorted
- 8) Low self-esteem
- 9) Have lost their connection to people
- 10) Less empathic ability

(Ginsburg 1988-1994)

All Juvenile Sex Offenders and Youthful Sex Offender's assessed by the author from 1988 to 2000 were given a comprehensive and separate psychosocial assessment whereas the Juvenile Sex Offender's and Youthful Sex Offender's seen from 1996 to 2000 did not have the additional resource of psychological testing due to the previously mentioned funding problems. Although the author may have been biased by the previous testing results of Ginsburg the psychosocial findings were similar. Youthful Sex Offender's accepted for outpatient treatment from 1997 to 2000 did have polygraph testing. Which will be discussed in more depth below.

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Ron Ginsburg was a staff psychologist at the Greensboro Mental Health Center and a member of the N.C. State Task Force Developing and Implementing Treatment for the Sexual Offender. His area of expertise is in psychological evaluation of sex offenders. He consistently confirmed his findings from June 1988 to December 1994.

## RISK ASSESSMENT

In addition to the psychosocial assessment the Juvenile Sex Offender's and Youthful Sex Offender's were given risk assessments which were initially based on the following 37-point checklist of clinical risk criteria compiled by Wenet & Clark. Which relates to risks involved in nonresidential versus residential treatment for these clients. The authors emphasize the list is not validated by research and thus should be used only as a guide. For our present purpose the reader should closely examine the list and see what this reveals about the Juvenile Sex Offenders or Youthful Sex Offender's social deficits and liabilities. The higher risk clients deficits are highly correlated with social deficits also referred to as pathology, deviance and dysfunction. Thereby increasing the likelihood of criminal nonsexual offenses as well as expulsion from treatment.

### LOW RISK

1. \_\_\_\_\_ first documented offense, with no indication it is a pattern (i.e., not a compulsive fantasizer about the offense)
2. \_\_\_\_\_ evidence of peer support group, adequate social adjustment
3. \_\_\_\_\_ supportive family
4. \_\_\_\_\_ adequate school adjustment
5. \_\_\_\_\_ willingness to discuss the offense
6. \_\_\_\_\_ expresses concern for the victim
7. \_\_\_\_\_ positive attitude about sexuality
8. \_\_\_\_\_ understands what society views as wrong about his offense
9. \_\_\_\_\_ able to identify strengths about himself
10. \_\_\_\_\_ no indications of significant depression
11. \_\_\_\_\_ family supportive of treatment

### MODERATE RISK

12. \_\_\_\_\_ two or more documented offenses
13. \_\_\_\_\_ evidence of social isolation
14. \_\_\_\_\_ evidence of school difficulties
15. \_\_\_\_\_ negative family relationships
16. \_\_\_\_\_ minimizes victim's hurt
17. \_\_\_\_\_ resistant to discussing offense
18. \_\_\_\_\_ cannot describe why society views his behavior as wrong
19. \_\_\_\_\_ blames others for what happened

- 20. \_\_\_\_\_ unable to identify strengths about himself
- 21. \_\_\_\_\_ rigid attitude about sexuality
- 22. \_\_\_\_\_ offense associated with use of drugs or alcohol
- 23. \_\_\_\_\_ evidence of significant depression
- 24. \_\_\_\_\_ history of physical or sexual abuse
- 25. \_\_\_\_\_ masturbatory fantasies associated with the offense
- 26. \_\_\_\_\_ history of aggressive behavior

HIGH RISK (these individuals may share characteristics in common with the moderate group but will be differentiated by the following)

- 27. \_\_\_\_\_ offense involved violence, physical force, use of weapon, or threat to use weapon
- 28. \_\_\_\_\_ continued offense behavior in spite of victim expressing hurt or fear
- 29. \_\_\_\_\_ repeated offense for which he already received treatment
- 30. \_\_\_\_\_ evidence of progressive increase in the force used to commit repeated offense
- 31. \_\_\_\_\_ complete denial of a documented offense
- 32. \_\_\_\_\_ refuses to discuss sexuality
- 33. \_\_\_\_\_ refuses to participate in the evaluation
- 34. \_\_\_\_\_ parents denying that their youngster has any problems or evidence of parents overprotecting
- 35. \_\_\_\_\_ any history of chronic substance abuse
- 36. \_\_\_\_\_ any evidence of thought disorder
- 37. \_\_\_\_\_ significant intellectual deficits limiting ability to learn from the consequence of one's behavior

Groth and Loredó identified the following risk criteria:

1. *What is the age relationship between the persons involved?*
2. *What is the social relationship between the persons involved?*
3. *What type of sexual activity is being exhibited?*
4. *How does the sexual contact take place?*
5. *How persistent is the sexual activity?*
6. *Is there any evidence of progression in regard to the nature or frequency in the sexual activity?*
7. *What is the nature of the fantasies that precede or accompany the adolescent's abusive behavior?*
8. *Are there any distinguishing characteristics about the persons who are targets of the adolescent's assaults?*

In addition Growth & Loredó suggest three general queries:

1. *What critical developmental events or experiences may have combined to predispose the adolescent to act out his problem?*
2. *What current life tensions or stresses, particularly family dynamics, are operating on him that serve to trigger the offense?*
3. *To what extent are the adolescent sex offender's offender's problems compounded by other serious disorders such as retardation, mental illness, (psychosis), drug or alcohol dependency, organicity, and so forth?*

The risk assessment checklist was expanded upon by Wallace & Moore (1990) to encompass corollary behaviors and other factors considered relevant by those in the field. This was/is included in the assessment for Juvenile Sex Offender's (also used with Youthful Sex Offender's) accepted for outpatient treatment. It was consistently used after its development. The reader is again advised that there is no research validation for this checklist. The information was used as a guide to address more deeply specific individual deficits of referred Juvenile Sex Offender's and Youthful Sex Offender's. Identified issues were more deeply addressed as needed through the collection of additional data as clinically indicated. By requesting educational records, law enforcement reports, history of problems, psychological testing and polygraph testing with Youthful Sex Offender's seen after 1996.

### LOW RISK

1. \_\_\_\_\_ First documented offense with no indication it is a pattern
2. \_\_\_\_\_ Evidence of peer support group, adequate social adjustment
3. \_\_\_\_\_ Supportive family
4. \_\_\_\_\_ Adequate school adjustment
5. \_\_\_\_\_ Willingness to discuss the offense
6. \_\_\_\_\_ Expresses concern for the victim
7. \_\_\_\_\_ Positive attitude about sexuality
8. \_\_\_\_\_ Positive attitude toward women
9. \_\_\_\_\_ Understands what society views as wrong about his offense
10. \_\_\_\_\_ Able to identify strengths about himself
11. \_\_\_\_\_ No indications of significant depression
12. \_\_\_\_\_ Family participates in treatment sessions
13. \_\_\_\_\_ Family agrees to supervise the client and not allow access to children
14. \_\_\_\_\_ Parent is a reliable reporter
15. \_\_\_\_\_ Client's age is five years or less in difference from the offender

- 16.\_\_\_\_\_ There is a presence of social relationships and in friendships which are appropriate for developmental stage
- 17.\_\_\_\_\_ The sexual activity was of conventional nature
- 18.\_\_\_\_\_ Client exhibits a variety of mild acting out behaviors not requiring treatment
- 19.\_\_\_\_\_ Client exhibits heterosexual relationships consistent with developmental level
- 20.\_\_\_\_\_ Client is under 15 years of age

### MODERATE RISK

- 21.\_\_\_\_\_ Two or more documented offenses
- 22.\_\_\_\_\_ Evidence of social isolation
- 23.\_\_\_\_\_ Evidence of school difficulties; learning disabilities
- 24.\_\_\_\_\_ Evidence of negative family relationships; dysfunctional family which is either enmeshed or disengaged
- 25.\_\_\_\_\_ Minimization of victim's hurt
- 26.\_\_\_\_\_ Resistance to discussing offense
- 27.\_\_\_\_\_ Inability to describe why society views behaviors wrong
- 28.\_\_\_\_\_ Blames others for what happened without accepting responsibility for the offense
- 29.\_\_\_\_\_ Unable to identify strengths about self
- 30.\_\_\_\_\_ Rigid attitude about sexuality
- 31.\_\_\_\_\_ Ambivalent attitude toward women
- 32.\_\_\_\_\_ Offense associated with use of drugs or alcohol
- 33.\_\_\_\_\_ Evidence of moderate to significant depression
- 34.\_\_\_\_\_ History of physical or sexual abuse
- 35.\_\_\_\_\_ Family is willing for client to be involved in treatment but does not participate in treatment
- 36.\_\_\_\_\_ Masturbatory fantasies associated with the offense
- 37.\_\_\_\_\_ History of aggressive behavior for which treatment has been indicated
- 38.\_\_\_\_\_ Placement problems
- 39.\_\_\_\_\_ Coercion without the use of threat or weapon
- 40.\_\_\_\_\_ Victim is six years or more in age difference
- 41.\_\_\_\_\_ Client has impaired social relationships without any close friends
- 42.\_\_\_\_\_ Sexual activity is unconventional or age inappropriate
- 43.\_\_\_\_\_ No history of other serious acting out behaviors
- 44.\_\_\_\_\_ Limited access to children
- 45.\_\_\_\_\_ Inconsistent supervision
- 46.\_\_\_\_\_ Client boast of heterosexual exploits (beware of compensation for feelings of inadequacy)
- 47.\_\_\_\_\_ Client is 15 plus in age

### HIGH RISK

- 48.\_\_\_\_\_ The offense involved violence, physical force, use of weapon or threat to use weapon
- 49.\_\_\_\_\_ Offense secret is maintained by threat of physical harm
- 50.\_\_\_\_\_ Continued offense behavior in spite of victim expressing hurt or fear
- 51.\_\_\_\_\_ Repeated offense for which client has already received treatment

- 52.\_\_\_\_\_ Evidence of progressive increase in the force used to commit repeated offense
- 53.\_\_\_\_\_ History of highly corollary behaviors such as fire setting, cruelty to animals, or bedwetting without overt acknowledgment of sexual victimization
- 54.\_\_\_\_\_ Complete denial of documented offense
- 55.\_\_\_\_\_ Refusal to discuss sexuality
- 56.\_\_\_\_\_ Refusal to participate in evaluation
- 57.\_\_\_\_\_ Parents deny that their youngster has any problems or evidence of parental over protectiveness
- 58.\_\_\_\_\_ Negative attitude toward women
- 59.\_\_\_\_\_ Any history of chronic substance abuse
- 60.\_\_\_\_\_ Any evidence of thought disorder
- 61.\_\_\_\_\_ Any significant intellectual deficits limiting ability to learn from the consequences of one's behavior
- 62.\_\_\_\_\_ Seven years plus age difference
- 63.\_\_\_\_\_ Absence of social relationships or one characterized by anger, revenge in conflict
- 64.\_\_\_\_\_ Sexual activity is ritualistic, compulsive, driven
- 65.\_\_\_\_\_ Borderline or sociopathic features present in perpetrator
- 66.\_\_\_\_\_ Evidence of persistence, preoccupation with sexual behavior
- 67.\_\_\_\_\_ Progression over time in frequency, intensity, aggression and number of different sexual activities
- 68.\_\_\_\_\_ Compulsive masturbation accompanied by violent fantasies associated with offense
- 69.\_\_\_\_\_ Characteristic victims are under age five, infants, severely mentally or physically handicapped or are elderly
- 70.\_\_\_\_\_ preference for interpersonal relationships with substantially younger or older individuals with the absence of mutually satisfying relationships with the opposite sex
- 71.\_\_\_\_\_ Involvement with delinquent or deviant groups or cults
- 72.\_\_\_\_\_ Marked disturbance in functioning at school or work
- 73.\_\_\_\_\_ Sexualized family environment
- 74.\_\_\_\_\_ Evidence of severe psychosocial or environmental stressors
- 75.\_\_\_\_\_ Access to children or opportunity for offending; quality of supervision is poor
- 76.\_\_\_\_\_ Severe empathy deficit
- 77.\_\_\_\_\_ No effective legal control

This additional data was utilized in the assessment process for Juvenile Sex Offender's and Youthful Sex Offender's which ultimately was utilized in all court ordered assessment reports. The following report form is printed exactly as shown in work by Steen (1989).

## INITIAL ASSESSMENT REPORT FORM

\_\_\_\_\_ was evaluated on \_\_\_\_\_  
(name of adolescent) (date)

by Community Treatment Center Staff, following three personal interviews with the minor and his parent(s) or guardian(s), completion by the minor and his parent(s) or guardian(s) of various assessment instruments, standardized testing, and review of reports on the minor prepared by the criminal justice agencies. Based on this data, we believe that this minor is/is not an appropriate candidate for outpatient community treatment. We have made this determination by weighing the elements of risk of harm to the community with the amenability of the adolescent offender to treatment after a careful review of offense, offender and situational factors.

The following is a summary of our findings:

**OFFENSE FACTORS:** (Summarize nature of offense, level of aggression, victim harm frequency of sex offense(s), duration of the deviant activity(ies), victim selection factors, and whether the offense(s) was (were) committed while the offender was under the influence of drugs or alcohol).

**OFFENDER FACTORS:** (Summarize age and sophistication of offender, how honest and open he is, whether or not he takes responsibility for the offense, his empathy for the victim(s), how motivated he is for treatment, the extent of his prior criminal activities, his treatment history, any substance abuse problems, psychosis or other mental impairment, his school, social and/or work adjustment, the compulsivity of his actions, and the extent of his own sexual or physical abuse. In addition, the results of standardized testing is summarized here).

**SITUATIONAL FACTORS:** (Summarize family elements, such as deviance or pathology, acknowledgment or denial of offense, degree of supportiveness and cooperation of parent(s) or guardian(s), support of significant persons outside of the family which impacts the adolescent offender, and the stressors affecting the offender).

Based on our analysis of these factors, we believe that \_\_\_\_\_  
(name of offender)  
is amenable to treatment and that his presence in the community, preferable placed  
\_\_\_\_\_, would not present an unreasonable risk to  
(at home, in a foster home, etc.)  
the safety of the community.

-or-

Based on our analysis of these factors, we believe that \_\_\_\_\_  
(name of offender)  
is not amenable to treatment and that his presence in the community would present an  
unreasonable risk to the safety of the community. We recommend instead that he be  
placed in a \_\_\_\_\_, such as \_\_\_\_\_.  
(custodial or residential treatment program) (name of recommended program)

If you have any further questions or concerns, please do not hesitate to contact us.

Respectfully submitted by

\_\_\_\_\_

The risk assessments and report form format shown above are by no means exhaustive regarding available literature on assessing risk. The author is describing the process utilized to determine who was selected for admission to the programs where Juvenile Sex Offender's and Youthful Sex Offender's included in this article were treated for their sexually offending behavior. As well as why those clients tended to be considered lower risk for continued acting out sexually. The report form above was extremely helpful in summarizing clients individual issues and explaining why some referrals were recommended for residential placement. It also served to identify individualized treatment objectives and the social deficits that require intervention in order for the client to have reasonable relationship skills .

The previously mentioned preselection bias is clearly evident as those offenders identified as "high risk" were not accepted into outpatient treatment. Nonetheless dropout and noncompletion was/is very high with this age group. This was clearly evident as the author continuously work with Juvenile Sex Offender's, Youthful Sex Offender's and adult offenders over the age of twenty-six. Adults were much more compliant with treatment and probation increasing the likely hood that they would successfully complete.

Obviously measures are needed to increase compliance. It is apparent from the data gathered that most Juvenile Sex Offender's and Youthful Sex Offender's referred for community based outpatient treatment had social (skills) deficits. This was clear from their psychological testing, risk assessment reports and psychosocial assessment.

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Vicki Wallace, was Senior Psychologist at the Greensboro Mental Health Center where she was the children and youth team leader and coordinator in the Juvenile Sexual Offender Program. Ms. Wallace is an Approved Supervisor of the American Association of Marriage and Family Therapists. She is the senior author of the risk assessment checklist shown above consistently used under her direction from June 1988 to January 1995.

## PSYCHOSOCIAL ASSESSMENT OF OFFENDERS

The raw data was/is collected via a psychosocial assessment and the areas to be addressed in same was developed by the author and used from 1996 on. The actual psychosocial form provides space to write or type in the information being collected on offenders as shown below.

### PSYCHOSOCIAL EVALUATION

Date of Evaluation:\_\_\_\_\_

Client Name:\_\_\_\_\_

Identifying Information (Race \_\_\_\_\_ Sex \_\_\_\_\_):\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DOB:\_\_\_\_\_ SS#\_\_\_\_\_ Height \_\_\_\_\_ Weight\_\_\_\_\_

Hair & Eye Color\_\_\_\_\_

Identifying marks or anything else  
remarkable\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Individuals Present:\_\_\_\_\_

Chief Complaint ( in the client's own words):\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What prompted the client to seek treatment now?\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Referral Source:\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

PREVIOUS TREATMENT

Psychiatric/Psychological: \_\_\_\_\_ None \_\_\_\_\_ Yes (what, where, when, results, etc.): \_\_\_\_\_

Substance Abuse: \_\_\_\_\_ None \_\_\_\_\_ Yes ( what, where, when, results, etc.): \_\_\_\_\_

FAMILY HISTORY ( include family history of substance abuse & mental health problems):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Marital Status: \_\_\_\_\_ # of children \_\_\_\_\_ Living arrangements? \_\_\_\_\_

Does the client report physical, emotional or sexual abuse? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes please explain in detail ( include if the allegations were reported to the proper authorities): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Sexual History: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does the client report violence in the family? \_\_\_\_\_ Yes \_\_\_\_\_ No (if yes, explain):

\_\_\_\_\_  
\_\_\_\_\_

Highest School Grade Completed: \_\_\_\_\_ ESE Placement? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does the client report problems with school or job performance? \_\_\_\_\_ Yes \_\_\_\_\_ No

(If yes, include if child repeated any grades, if client was ever fired from a job, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Developmental History: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medical conditions & Medications: \_\_\_\_\_  
\_\_\_\_\_

Sleep Problems? \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_  
\_\_\_\_\_

Eating Problems? \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_  
\_\_\_\_\_

Substance Use: \_\_\_\_\_ No \_\_\_\_\_ Yes \_ nicotine \_ alcohol \_ Cannabis \_ cocaine/crack \_ amphetamines \_ opiates  
\_ inhalants \_ barbiturates \_ benzodiazepines \_ hallucinogens \_ prescriptions \_ others \_\_\_\_\_  
\_\_\_\_\_ Use \_\_\_\_\_ Abuse \_\_\_\_\_ Dependence Drug(s) of Choice:

Age of first use (for each substance): \_\_\_\_\_

Date of last use (for each substance): \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the client perceive drugs as dangerous? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does the client perceive alcohol as dangerous? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does the client perceive tobacco as dangerous? \_\_\_\_\_ Yes \_\_\_\_\_ No

Juvenile Delinquency/Legal Involvement: \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Number of Arrests: \_\_\_\_\_

Mental Status Exam (current symptoms reported or observed):

**General Appearance:** \_ Appropriate \_ Inappropriate

**Orientation:** \_ Oriented \_ Disoriented

**Thought Process:** \_ Logical \_ Tangential \_ Illogical

**Speech:** \_ Normal \_ Impaired

**Motor:** \_ Normal \_ Excessive \_ Slow

**Intellect:** \_ Average \_ Above \_ Below

**Thought Content:** \_ Appropriate \_ Inappropriate

**Insight:** \_ Present \_ Minimal \_ Absent

**Judgment:** Normal\_ Excessive\_ Slow

**Memory:** Normal\_ Impaired\_ S-T\_ L-T

**Hallucination:** None Reported\_ Auditory\_ Visual **Delusions:** None Reported\_ Reported

**Mood:** Normal\_ Depressed\_ Anxious\_ Labile\_ Euphoric\_ Euthymic

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Suicidal: \_ Not Present \_ Ideation \_ Plan \_ Means \_ Prior Attempts \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Homicidal: \_ Not Present \_ Ideation \_ Plan \_ Means \_ Prior Attempts \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If clients reports Suicidality or Homicidality, identify recommendations and actions taken to ensure safety: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other Current Symptoms:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Guilt                  | <input type="checkbox"/> Crying Spells           | <input type="checkbox"/> Disorganized/Bizarre Thoughts      |
| <input type="checkbox"/> Hypochondriasis        | <input type="checkbox"/> Obsessions              | <input type="checkbox"/> Financial Indiscretion             |
| <input type="checkbox"/> Low Self Esteem        | <input type="checkbox"/> Social Withdrawal       | <input type="checkbox"/> Grandiosity                        |
| <input type="checkbox"/> Distractability        | <input type="checkbox"/> Compulsions             | <input type="checkbox"/> Spontaneous Panic Attacks          |
| <input type="checkbox"/> Avoidant Behavior      | <input type="checkbox"/> Phobias                 | <input type="checkbox"/> Generalized Anxiety                |
| <input type="checkbox"/> Self Mutilation        | <input type="checkbox"/> Acute Grief Response    | <input type="checkbox"/> Terminal of Chronic Illness        |
| <input type="checkbox"/> Excessive Behavior     | <input type="checkbox"/> Excessive Anger         | <input type="checkbox"/> Organic Factor Affecting Mood      |
| <input type="checkbox"/> Hopelessness           | <input type="checkbox"/> Victim if Violence      | <input type="checkbox"/> Self Starvation/Bulimia            |
| <input type="checkbox"/> Impaired Concentration | <input type="checkbox"/> Psychomotor Retardation | <input type="checkbox"/> Anhedonia                          |
| <input type="checkbox"/> Agoraphobia            | <input type="checkbox"/> Poor Relationships      | <input type="checkbox"/> Decreased Attention Span           |
| <input type="checkbox"/> Poor Impulse Control   | <input type="checkbox"/> Symptoms of PTSD        | <input type="checkbox"/> Sexual Problems other than Offense |

Symptoms have persisted: \_\_\_ Days \_\_\_ Weeks \_\_\_ Months \_\_\_ Years \_\_\_ Chronic

Client's Strengths: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Client's Expectations from Treatment \_\_\_\_\_  
\_\_\_\_\_

Clinical Impressions and Summary: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DSM IV Diagnostic Formulation ( ICD-9 for Insurance Clients):

Axis I: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Axis II: \_\_\_\_\_  
\_\_\_\_\_

Axis III: \_\_\_\_\_  
\_\_\_\_\_

Axis IV: \_\_\_\_\_  
\_\_\_\_\_

Axis V: Current GAF: \_\_\_\_\_ Highest GAF in Past Year \_\_\_\_\_

Initial Treatment Recommendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Risk Assessment Target Date: \_\_\_\_\_

Court / Probation Report Due Date: \_\_\_\_\_

Therapist Signature & Credentials \_\_\_\_\_ Date \_\_\_\_\_

Therapist Name (printed) \_\_\_\_\_

## REFERENCES

- Association for the Treatment of Sexual Abusers (1997). *Ethical standards and principles for the management of sexual abusers*. Beaverton, OR, USA. pp. 12-16.
- Groth, A. N. & Lored, C. M. (1981). *Juvenile sex offenders: Guidelines for assessment*. International Journal of Offender Therapy & Comparative Criminology, 25 (1).
- Knopp, F. H. (1985) *The Youthful Sex Offender: The Rationale and Goals of Early Intervention and Treatment*. Safer Society Press, Brandon, Vermont, USA.
- Moore, R. C. (1990) *WORKSHOP SERIES: EVALUATION AND TREATMENT OF JUVENILE SEX OFFENDERS*. Greensboro AREA HEALTH EDUCATION CENTER. September 14, 1990, October 9 & 10, 1990 and November 13 & 14 1990. Greensboro, North Carolina, USA
- Moore, R. C. (1993) *Sexual Abuse Intervention "Introduction to the Intervention Process with Adolescent and Adult Sex Offenders"*. Greenville, North Carolina, USA July 20-22, 1993
- Moore, R. C. (1996) *Psychosocial Assessment Form*. Counseling & Evaluation Services Stuart, FL USA.
- Salter, A. C. (1988) *Treating Child Sex Offenders and Victims*. A Practical Guide SAGE PUBLICATIONS , Newberry Park, California, USA.

\*\*\*\*\*

Ryan Moore was the Clinical Specialist at the Guilford County Area Mental Health Program. He also served as a group counselor at both Family Violence Prevention Services Program and The Family and Children's Services of Greensboro, FOCUS PROGRAM. He was the lead therapist and clinical coordinator for the STOP CHILD ABUSE NOW sex offender therapy program. Prior to entering the mental health field Mr. Moore has experience as a law enforcement officer in the criminal investigation of sexual abuse cases from . He presently operates Counseling & Evaluation Services of Stuart, FL where he is actively engaged in the evaluation and treatment of Juvenile, Youthful and Adult Sexual Offenders, Substance Abusers, Addictions and Mental Health patients from 1996.

### **Additional Current Resources:**

- Carich, M. S., & Mussack, S. E. (2001) *Handbook for Sexual Abuser Assessment and Treatment*. Safer Society Press, Brandon, Vermont, USA.

## POLYGRAPH TESTING

Following the psychosocial and risk assessment each Youthful Sex Offender was required to complete polygraph testing after 1997. Whether the client was admitting or denying he was given a disclosure test " as suggested by Abrams (1993). All polygraph testing was administered by the same polygraph examiner. (Shaffer 1997-2000). The polygraph evaluator was approved for probationers under supervision by the Florida Department of Corrections.

The polygraph was used with Youthful Sex Offender's after 1997 as this is required by Florida law (1997) and the treatment program (Moore 1997-2000). Clients were required to obtain their own funds for this service. They are required to pass a denial test also known as the disclosure test. Clients were motivated to successfully complete polygraph testing in order to not have to continue paying fees. As a side note we have found the polygraph to be quite useful in obtaining treatment and probation compliance in various stages of the offender's treatment. Clients were required to complete information similar to the SEX OFFENDER DISCLOSURE QUESTIONNAIRE developed by Salter & Holden (2000) for the Wisconsin Department of Corrections.

### PROBLEM LIST

Community Corrections and your treatment program requires you to fill out this problem list because it is not possible to effectively supervise and/or treat a sex offender without knowing the nature and extent of the offending behavior. A doctor would not set a bone without seeing an x-ray. Today, many knowledgeable people will not supervise or treat sex offenders without having the information on this problem list. The problem list is not a complete sexual history. It does not ask you about consenting, non-violent sexual experiences with other adults. This problem list focuses on deviant sexual behavior, e.g., on sex with children, violent sex or sexual practices that violate another person's boundaries or their privacy. You will be asked to list **every** deviant sexual act that you have ever committed during the time periods defined in each section. You will be given a polygraph on the truthfulness of this information and results will be shared with your agent and your treatment provider in order to enhance your supervision and the effectiveness of your treatment. You are **not** being asked to provide **identifying** information about victims.

Because you are **required** to complete this problem list, you will not be asked to give information specific enough to be used to prosecute you. You can accurately fill out this form and pass your polygraph without giving any identifying information about your victims. You are required, however, to fill out information about the sex and age of victims, degree of force, and so forth because that information is crucial to successful monitoring and treatment of sex offenders. Research suggests that sex offenders who fill out disclosure questionnaires and take polygraphs are more likely to succeed on supervision than those who do not. If you have questions about this form, or the uses to which it will be put, please ask your therapist or community corrections agent.

## **POLYGRAPH DISCLOSURE QUESTIONNAIRE**

Anna C. Salter and Eric J. Holden

**ALL QUESTIONS RELATE ONLY TO BEHAVIOR THAT OCCURRED BEFORE THE DATE OF YOUR LAST CONVICTION FOR A SEXUAL OFFENSE. ALL QUESTIONS EXCLUDE THIS LAST OFFENSE OR ANY OFFENSES THAT OCCURRED SINCE YOUR LAST CONVICTION.**

**IN SHORT, THIS QUESTIONNAIRE IS ABOUT YOUR HISTORY PRIOR TO THE DATE OF YOUR LAST CONVICTION FOR A SEXUAL OFFENSE.**

**YOU WILL BE ASKED TO TAKE A POLYGRAPH EXAMINATION TO VERIFY THE COMPLETE TRUTHFULNESS OF YOUR ANSWERS ON THIS FORM. YOU SHOULD BE VERY CAREFUL NOT TO WITH-HOLD OR FALSIFY ANYTHING ABOUT YOUR SEXUAL HISTORY. YOU WILL NOT BE CONSIDERED TO HAVE SUCCESSFULLY COMPLETED YOUR SEXUAL HISTORY UNTIL YOU HAVE PASSED THE POLYGRAPH.**

**YOU WILL BE ASKED QUESTIONS ABOUT VICTIMS OF SEXUAL OFFENSES THAT YOU HAVE COMMITTED. YOU WILL NOT BE ASKED TO GIVE IDENTIFYING INFORMATION ABOUT THESE VICTIMS. SHOULD YOU REPORT IDENTIFYING INFORMATION ABOUT THESE VICTIMS ANYWAY. THIS INFORMATION WILL BE REPORTED TO CHILD PROTECTIVE SERVICES AS REQUIRED BY STATE LAW.**

## SEXUAL CONTACT WITH CHILDREN

All questions relate to behavior that occurred prior to the date of conviction for your last offense and do not include that offense or subsequent offenses.

How many children did you have some form of sexual contact with **prior to the date of conviction for your last offense?** \_\_\_\_\_ (A child is someone under the age of 18 who was also at least three years younger than you at the time of the sexual contact.)

Please fill in the following information about these child victims.

*Use additional sheets whenever necessary.*

*\*\*Use "F" for family (Family would include children of live-in girlfriends or boyfriends).*

*"A" for acquaintance, or "S" for stranger. Complete a "Victim Form" on each victim.*

Victim's age at First Sexual Contact \_\_\_\_\_

Victim's Gender \_\_\_\_\_

Your Age at First Sexual Contact Mo. / Yr. of First Sexual Contact \_\_\_\_\_

Mo. / Yr. Of Last Sexual Contact \_\_\_\_\_

Frequency per Week \_\_\_\_\_

Relationship to Victim\*\* \_\_\_\_\_

Type of Sex Acts Type of Force Used \_\_\_\_\_

Victim's Age at First Sexual Contact \_\_\_\_\_

Victim's Gender \_\_\_\_\_

Your age at First Sexual Contact Mo. Yr. Of First Sexual Contact \_\_\_\_\_

Mo. / Yr. Of Last Sexual Contact \_\_\_\_\_

Frequency per Week \_\_\_\_\_

Relationship to Victim\*\* \_\_\_\_\_

Type of Sex Acts Type of Force Used \_\_\_\_\_

Prior to the date of your last conviction, how many children did you groom for sexual activities, (e.g. entice, persuade or manipulate)? \_\_\_\_\_

Describe what you said or did and include a description of any rewards or gifts you gave to victims.

Prior to the date of your last conviction, how many children did you threaten in order to get them to agree to sexual activities? \_\_\_\_\_

**CLINICAL POLYGRAPH EXAMINATION REPORT**

<b>DATE OF REPORT</b> 15 August 2000	<b>DATE OF EXAMINATION</b> 10 August 2000	<b>FILE NUMBER</b> SAMPLEYO
<b>EXAMINEE NAME (LAST, FIRST, MI)</b> SAMPLE, Youthful Sex Offender		<b>SSAN</b> 000-00-0000
<b>DATE OF BIRTH</b> 20 August 1980	<b>PLACE OF BIRTH</b> Palm City, FL	<b>PROBATION OFFICER</b> John Doe, FL DOC.

**ORGANIZATION REQUESTING THE REPORT:**

Counseling & Evaluation Services  
2440 South Federal Highway  
Stuart, FL 34994 ATTN: Ryan Moore, M.Ed., P.A.

**PURPOSE OF EXAMINATION:** Sex Offender Screening:  
( ) Maintenance      (  ) Monitoring      ( ) Denial      ( ) History

**INVESTIGATIVE SUMMARY:**  
**CHECK APPROPRIATE PARAGRAPH:**

(  ) EXAMINEE was advised that this screening examination is a mandatory treatment requirement and failure to complete this examination will be reported to the proper authorities. ( ) This examination is being conducted at the request of a Florida Probation Officer or an evaluating therapist.

( ) EXAMINEE was advised that this examinations in support of HIS/HER statement of denial or confirmation of all or any part of the original offenses(s) or at the request of an evaluation therapist.

( ) EXAMINEE was advised this examination was to verify all sexual activity prior to the last conviction and all victims have been fully disclosed in accordance with treatment standards.

( ) EXAMINEE was provided a detailed explanation of the polygraph instrument, the polygraph examination, examination chronology and physiology as it pertains to polygraph. All relevant issues were discussed with HIM/HER and all questions were formulated and reviewed to insure a complete and accurate understanding of the question meanings and to avoid possible difficulties with semantics.

( ) This examination is a continuation of an examination conducted on: \_\_\_\_\_

**LOCATION OF EXAMINATION:** Vero Beach, FL

**SYNOPSIS OF RESULTS**

( <input checked="" type="checkbox"/> ) No Significant Response/ NSR	( ) Inconclusive/INC
( ) Significant Response/ SR	( ) No Opinion/NO
( <input checked="" type="checkbox"/> ) Pretest Admission	( ) Post-Test Admissions

( ) PENDING SATISFACTORY RESULTS OF QUALITY CONTROL (QC) REVIEW (NSR/Denial on only)

Unusual physiological responses were not observed. EXAMINEE was cooperative.  
ALL parts of this examination were completed.

**POLYGRAPH INSTRUMENT DATA:**  
**Manufacturer:** AXCITON / Packard Bell      **Function Test:** 10 August 2000  
**Model:** AXCEL 3510 Serial No. NO68008996      **Date Last Calibrated:** 10 August 2000

**NOTE: The information provided in this report designed to assist the TRIAD with Treatment, Supervision and to act as a deterrence factor. Authority (F/SS 948.001 (7))**

## **CONCLUSION:**

**1. TREATMENT; PRETEST ADMISSIONS/CLARIFICATIONS: EXAMINEE executed the standard Questionnaire, which was reviewed prior to the examination. This questionnaire consisted of 88 questions, covered the time period since EXAMINEE'S last Clinical Polygraph Examination (SYLP) , 10 August 2000. The following information was provided by the EXAMINEE during the review: EXAMINEE denied any sexual contact with anyone under the age of 18, SYLP. EXAMINEE stated HIS sexual activity SYLP, has been with two (2) adult females, ages 19 and 20. HE said this activity occurred in HIS home. EXAMINEE said HE borrowed a videotape which could be considered pornographic. HE said HE still has the video at home. EXAMINEE denied any other personal involvement with pornographic materials, SYLP. EXAMINEE related HIS girlfriend likes to play and at times grabbed HIS penis through HIS clothing while in public. EXAMINEE denied any contact with HIS victim(s), SYLP. EXAMINEE denied any unauthorized/unsupervised contact with any one under 18 years of age, SYLP. EXAMINEE said HE masturbated approximately sixty (60) times SYLP and denied masturbation fantasies about minors under the age of 18, SYLP. EXAMINEE said HIS reoccurring sexual fantasies involving sexual activity with older women in their 30's and 40's. EXAMINEE admitted to alcohol and cannabis abuse. He estimated cannabis abuse 6 times or less due to the random urine testing required by probation. Alcohol abuse 30 times or less to the point of intoxication. EXAMINEE admitted to operating a motor vehicle while under the influence of alcohol and/or cannabis at least 10 times SYLP. EXAMINEE admitted to a "fist -fight" with an acquaintance who was rude to him. He related losing his temper shouting at his girlfriend, mother and friends 20 times or less with and without illegal drugs SYLP. EXAMINEE said that he had missed treatment 4 times or less without a valid reason and that he'd been dishonest with his therapist as to the reason for HIS failure to attend sessions, SYLP.**

**2. MONITORING; PRETEST ADMISSIONS/ CLARIFICATIONS: EXAMINEE said twice HE was at a friends home watching television and fell asleep and stayed the night. HE said HE left for work from HIS friend's house. HE denied being absent any other time from HIS residence over 24 hours for any reason unknown to the Probation Officer, SYLP. EXAMINEE admitted to operating a motor vehicle while under the influence of alcohol and/or cannabis at least 10 times, SYLP. EXAMINEE said that he had missed treatment 4 times or less without a valid reason and that he'd been dishonest with his probation officer as to the reason for HIS failure to attend sessions, SYLP. EXAMINEE said HE and HIS girlfriend left the county without probation officers approval, SYLP. EXAMINEE admitted to use of illegal drugs "cannabis" but denied any other drug use or contact with drug dealers, SYLP.**

**(Continuation)**

**NAME OF CLIENT AND SS#**

**DPOB:**

**CONCLUSION SECTION (CONTINUED)**

**3. EVALUATION: The following relevant questions were asked, answered in the negative and evaluated as NO SIGNIFICANT RESPONSE (NSR) observed:**

a. Did you lie during the review about sexual contact with someone under 18 since your last polygraph?

b. Did you lie during the review about being alone with a minor when it was prohibited?

c. Did you lie during the review about any of your activities that violate the conditions of your probation?

d. Did you do anything to defeat this test?

**4. TREATMENT; POST-TEST ADMISSIONS/CLARIFICATIONS:** Examinee admitted that he had smoked cannabis on several occasions, abused alcohol numerous times engaged in a fist fight with an acquaintance. Viewed pornography with age mates several times and purchased pornography.

**5. MONITORING; POST-TEST ADMISSIONS/CLARIFICATIONS:** Examinee admitted that he had minimized his alcohol and drug use and temper problems. He stated that his therapist was aware of some of these issues but that he has not fully disclosed relevant material to the therapist. He fears the reaction of his probation officer and will discuss all related issues with therapist at the next session.

**EXAMINER'S NOTE: CAUTION:**

Numerical scoring and grading consistent with nationally standardized procedures evaluated the examination. Additionally, the test data was reviewed using the computerized Algorithms of Johns Hopkins University Applied Physics Laboratory POLYSCORE, AXCITON Chart Analysis and IDENTIFI or any appropriate language for the computer based algorithm being used.

\_\_\_\_\_  
Typed Name of Witness, Monitor, or Interpreter

\_\_\_\_\_  
EXAMINEE'S Native Language

\_\_\_\_\_  
EXAMINER (Typed Name and License Number) Language Conducted In  
MICHAEL H. SHAFFER, CE/APA, CFLEPE (NAPS #67)

\_\_\_\_\_  
ORGANIZATION OF EXAMINER  
SHAFFER & ASSOCIATES  
FORENSIC TECHNOLOGIES.  
P.O. BOX # 1972 Cape Canaveral, FL 32920

\_\_\_\_\_  
Signature of Examiner



## REFERENCES

- Abrams, S. & Abrams J. B. (1993) *Polygraph testing of the pedophile*. Portland, OR: Ryan Gwinner Press.
- Association For The Treatment Of Sexual Abusers (1997) *Ethical standards and principles for the management of sexual abusers*. Appendix C: Polygraph Examination pp. 52-57.  
Beaverton, OR, USA
- Salter, A. C. (1988) *Treating Child Sex Offenders and Victims*. A Practical Guide SAGE PUBLICATIONS, Newberry Park, California, USA
- Salter, A. & Holden, E. J. (2000) *Sex Offender Disclosure Questionnaire*. Developed for Wisconsin Department of Corrections. *Polygraph*, 29 pp. 11-12.
- Shaffer, M. (1997-2001) President/CEO, Shaffer & Associates Forensic Technologies.  
Cape Canaveral, FL, USA.

## FLORIDA GUIDELINES FOR POLYGRAPH TESTING

Starting in 1995 their sweeping changes in probation psychotherapy and polygraph requirements for probationers convicted of sexual offenses in the state of Florida. (Champion, Jewell, Parrish & Criss 1995).

For probationers or for community controllees whose crime was committed on or after October 1, 1995, and who are placed under supervision for violations of chapter 794 or s. 800.04, s. 827.071, or s. 847.0145, the following conditions in addition to all other standard and special conditions imposed:

A mandatory curfew from 10 p.m. to 6 a.m. The court may designate another 8-hour period if the offender's employment precludes the above-specified time, and such alternative is recommended by the Department of Corrections. If the court determines that imposing a curfew would endanger the victim, the court may consider alternative sanctions.

If the victim was under the age of 18, a prohibition on living within 1,000 feet of a school, day care center, park, playground, or other place where children regularly congregate, as prescribed by the court.

Active participation in and successful completion of a sex offender treatment program with therapists specifically trained to treat sex offenders, at the probationer's or community controllee's own expense. If a specially trained therapist is not available within a 50-mile radius of the probationer's or community controllee's residence, the offender shall participate in other appropriate therapy.

A prohibition on any contact with the victim, directly or indirectly, including through a third person, unless approved by the victim, the offender's therapist, and the sentencing court.

If the victim was under the age of 18, a prohibition, until successful completion of a sex offender treatment program, on contact with a child under the age of 18 without another adult present who is responsible for the child's welfare, has been advised of the crime, and is approved by the sentencing court, unless authorized by the sentencing court.

If the victim was under age 18, a prohibition on working for pay or as a volunteer at any school, day care center, park, playground, or other place where children regularly congregate.

Unless otherwise indicated in the treatment plan provided by the sexual offender treatment program, a prohibition on viewing, owning, or possessing any obscene, pornographic, or sexually stimulating visual or auditory material, including telephone, electronic media, computer programs, or computer services that are relevant to the offender's deviant behavior pattern.

A requirement that the probationer or community controlle must submit two specimens of blood to the Florida Department of Law Enforcement to be registered with the DNA data bank.

A requirement that the probationer or community controllee make restitution to the victim, as ordered by the court under s. 775.089, for all necessary medical and related professional services relating to physical, psychiatric, and psychological care.

Submission to a warrantless search by the community control or probation officer of the probationer's or community controllee's person, residence, or vehicle.

Effective for a probationer or community controllee whose crime was committed on or after October 1, 1997, and who is placed on sex offender probation for a violation of chapter 794, s. 800.04, s. 827.071, or s. 847.0145, in addition to any other provision, the following condition of probation or community control:

As part of a treatment program, participation at least annually in polygraph examinations to obtain information necessary for risk management and treatment and to reduce the sex offender's denial mechanisms. A polygraph examination must be conducted by a polygrapher trained specifically in the use of the polygraph for the monitoring of sex offenders, where available, and shall be paid by the sex offender. The results of the polygraph examination shall not be used as evidence in court to prove that a violation of community supervision has occurred.

Maintenance of a driving log and a prohibition against driving a motor vehicle alone without the prior approval of the supervising officer.

A prohibition against obtaining or using a post office box without the prior approval of the supervising officer.

If there was sexual contact, a submission to, at the probationer's or community controllee's expense, an HIV test with the results to be released to the victim and/or the victim's parent or guardian.

Electronic monitoring when deemed necessary by the community control or probation officer and his or her supervisor, and ordered by the court at the recommendation of the Department of Corrections. (Florida statutes)

## REFERENCES

- Champion, K., Jewell, E., Parrish, D., & Criss, S. *Guidelines for Sex Offender Testing*. Florida Department of Corrections Probation and Parole December 20, 1995.
- Florida Statutes (1995-1999) Courtesy of Legislative Data Center, a division of the Joint Legislative Management Committee of the Florida Legislature.  
webmaster@leg.state.fl.us

## THE TRIAD

### PSYCHOTHERAPY-PROBATION-POLYGRAPH

*There has to be some "penalty" for not successfully "passing" the polygraph examination. The examinee must have a meaningful stake in the examination results. Without penalty for unsuccessfully passing the polygraph examination, the examinee has no general fear of being detected. As we are all aware, there is a general battle between "them" and "us". The examinees' communication system is probable as good as it can get. We in the polygraph end of the triad sometimes actually believe that each examinee has a "mission" to test or find something to defeat the examination. If "we" are going to maintain a winning course of action, we must pull together and be consistent in treatment and enact penalties when warranted. We are not recommending outright revocation, as that is not the intent of the program. However, the examinees must know that they have to play by the rules and the rules are ours. If the examinees continue in their cause of not abiding by the rules, revocation of probation status should be considered, but only as a last resort. Again, our aim is for an effective and consistent treatment of the sex offenders.*

*There are many things that we can do to enhance each other's position. We have to compliment each other's fields of expertise. We have been told by some of the sex offenders that the therapist instructed them, not to tell the polygraph examiner anything. Should these instructions be credible, it puts the examinee in a quandary as to how to act in the polygraph environment. Sex offenders show up at the polygraph facility with Xerox copies of media articles about the inaccuracy or inadmissibility of polygraph results. These articles are usually incomplete, specific in nature and not general in coverage or out of some grocery store weekly tabloid. Actions of this type can only be interpreted as an indication of just how far the sex offenders will go to eliminate the polygraph segment of the triad. The examinee's dedication for disqualifying the polygraph segment can only be construed as their fear of us finding out the truth.*

*As we exchange ideas on the subject and develop a united front we will be in a better position to afford an excellent and successful treatment for the sex offenders, with less stress to the program providers.*

**OBJECTIVES OF THE POLYGRAPH EXAMINER  
IN THE ADMINISTRATIONS OF  
SEX OFFENDER CLINICAL POLYGRAPH EXAMINATIONS**

1. *To establish current situational truthfulness of the examinee.*
2. *To advise the therapist and/ or probation specialist of any weak or danger points noted of the examinee in order to allow for any remedial action determined by the therapist and/or probation specialist.*
3. *To serve as a threat to the sex offender that is not following proper therapeutic and probational guidelines.*
4. *To give positive feedback to the sex offender that they are within the proper therapeutic and probational guidelines.*
5. *To deter the sex offender from considering violation of their therapeutic and probational guidelines.*

\*\*\*\*

*The polygraph procedure works basically on the individual examinee's personal fear of detection. The more the examinee has to lose, theoretically, the greater the examinee's response to deceptive areas. In order for the polygraph examiner to make such a determination of deception, the examination and the examination questions must be developed in such a fashion that noted deception could only be caused by concern for the particular question. In the case of a bank robber that is being questioned about today's bank robbery, which he did not do but he did one last week, when the question " Did you rob that bank today?" is posed, the examinee will probably reflect back to the robbery he did last week. Such a reflection will cause their fears about being caught, for the prior bank robbery; to indicate a positive response of deception to the question about today's bank robbery. It is of great importance to develop a question that does not allow for any other response than that of the target (Towell, Hill & Patrick 2000; Shaffer 2001).*

## **WHY POLYGRAPH SUGGEST THE FOLLOWING TEST SEQUENCE**

1. We suggest that if applicable, the Denial test be administered first. If the Denial test indicates deception and the examinee does not come out of denial, then the examinee should be instructed that they have ninety (90) days in which they will be given a polygraph examination every thirty (30) days until they come out of denial. If at the end of ninety (90) days the examinee does not come out of denial, then the probation specialist will take them back to Court and advise the Court that the examinee is not successfully participating in the therapy program. This will also be an added financial expense and inconvenience to the examinee.

2. The second test application should be the History test. The reason for the History test is to identify if the sex offender has other victims (prior to conviction). The examinee will probably reflect back to their prior victim(s) and show deception when asked about having sex with anyone under the age of eighteen (18) since being on probation. We have experienced some cases where the examinee has displayed deceptive results on the question about having sex with anyone under the age of eighteen (18) with no deception on the question about violating the conditions of their probation - which is in direct conflict (remember the bank robber).

3. The third test application should be the Maintenance test. The reason for this is to insure therapy procedures and probation rule compliance. Then if the test displays criteria indication deception, we can be reasonable assured that he has been sexually involved with a person under the age of eighteen (18) or whatever the situation. It would even be possible for the polygraph examiner to develop a specific issue examination to further explore any questionable area(s).

## REFERENCES

- Association For The Treatment Of Sexual Abusers (1997) *Ethical standards and principles for the management of sexual abusers*. Beaverton, OR, USA
- Shaffer, M. (2001) *Shaffer & Associates Forensic Technologies* Personal communication. December 12, 2001
- Towell, S., Hill, D. P., & Patrick, D. (2000) *Polygraph 2000*, 29(1)

## INDIVIDUAL NEEDS OF OFFENDERS

The implications for obtaining compliance and achieving overall better adjustment is to increase social skills while addressing other deficits and liabilities. Since the primary therapy modality is group treatment (Burton & Darden 2001) this could be achieved simultaneously but must meet the individual needs of each offender as described by Knopp (1985).

1. *Each adolescent sex offender needs a complete, individualized assessment and treatment plan.*
2. *Each sex offender needs to (a) accept responsibility for the offenses in which he has been involved and (b) have an understanding of the sequence of thoughts, feelings, events, circumstances, and arousal stimuli that make up his "offense syndrome" that precedes his involvement in sexually aggressive behaviors.*
3. *Each sex offender needs to learn how to (a) intervene in or break into his offense pattern at its very first sign and (b) call upon the appropriate methods, tools, or procedures he has learned in order to suppress, control, manage, and stop the behavior.*
4. *Each sex offender needs to engage in a reeducation and resocialization process in order to (a) replace antisocial thoughts and behaviors with prosocial ones, (b) acquire a positive self-concept and new attitudes and expectations for himself, and (c) learn new social and sexual skills to help cultivate positive, satisfying, pleasurable, and non-threatening relationships with others.*
5. *Each high-risk, residential sex offender needs a prolonged period during his treatment when he can begin to test safely his newly acquired insights and control mechanisms in the community, without the potential for affronting or harming members of the wider community.*
6. *Each sex offender needs access to a post-treatment group for assistance in maintaining a safe lifestyle.*

## REFERENCES

- Burton, D. L., & Smith-Darden, J. (2001) *North American Survey of Sexual Abuser Treatment and Models Summary Data 2000*. Brandon, VT: Safer Society Press.
- Knopp, F. H. (1985) *The Youthful Sex Offender: The Rationale and Goals of Early Intervention and Treatment*. Safer Society Press. Brandon, Vermont, USA.

## COUNSELING & EVALUATION SERVICES

### SEXUAL OFFENDER PROGRAM

We offer multi-level sexual offender treatment program geared toward the placement of offenders in appropriate classes or groups depending on their treatment needs. Treatment is individualized and can include classes, groups, individual and family treatment. The following is an explanation of the different levels:

**LEVEL I-** psycho educational class for offenders that are in denial.

**LEVEL II-** psycho educational class for offenders that admit their offenses.

**LEVEL III-** process group psychotherapy for offenders that have completed the psycho educational program and admit their offenses.

**LEVEL IV-** advanced process group or individual psychotherapy for offenders that have completed the psycho educational program, the process group and admit their offenses.

**LEVEL V-** maintenance phase of treatment and recovery comprised of individual and family therapy, as infrequently as once every other month but is usually monthly.

Clients are evaluated and placed in the appropriate level of care program. As treatment goals are met at each level, clients move to the next level.

We also have groups for the following:

**Juvenile Sexual Offenders-** a multi-level psycho educational class and process group psychotherapy specifically geared toward offenders under the age of 18.

**Youthful Sexual Offenders-** a multi-level psycho educational class and process group psychotherapy specifically geared toward offenders between the ages of 18 and 25.

**Special Needs Sexual Offenders-** a multi-level psycho educational class and process group psychotherapy specifically geared toward offenders under the age of 18.

All of our treatment programs require the client's input and cooperation. Clients are expected to be objective, honest and to have a desire to make their lives better by the choices they make. Clients examine their crimes and motivations. They are made aware of the consequences their actions have on victims. Clients must be aware of their triggers to offending and formulate a plan to avoid re-offense. Our program has demonstrated a high success rate for those that successfully complete treatment requirements.

## REFERENCES

Moore, R. C., (1997) *Counseling & Evaluation Services*. Stuart, Florida, USA.

# **COUNSELING & EVALUATION SERVICES**

## **SEX OFFENDER PROGRAM RULES**

### **PARTICIPATION AGREEMENT**

1. I agree to be honest and law abiding and will not engage in the exploitation or manipulation of others. I will not become involved in inappropriate sexual relations, extra marital affairs or sexual harassment. I will discuss my sexual behavior with my therapist for the purpose of determining if I am engaged in inappropriate relations, which could be detrimental to my recovery.
2. I agree to refrain from possession or use of pornography, erotica and/or adult sexually oriented novels, magazines, periodicals, photographs, films or videotapes. I will discuss my masturbatory fantasies in order to determine if they are harmful to my recovery.
3. I agree to be open to attendance at 12 step support groups or other support programs, which may be helpful in achieving objectives in my recovery. I also agree to remain open to the possibility of a referral to a physician for the purpose of evaluation, medication and/or treatment planning as clinically indicated for my recovery.
4. I agree to assist my counselor in the development and implementation of my individualized treatment plan and to regularly (at least once every 6 months) review and revise my plan as necessary or appropriate for my recovery.
5. I acknowledge and agree that I must successfully complete polygraph testing as required by Florida State Law and this program.
6. I agree to attend treatment regularly as scheduled and give 24-hour notice of cancellation except in an emergency situation. I understand that missed appointments must be made up preferably prior to my next regular session. Cancellation of less than 24 hours in advance for an individual session will be considered a "no show" appointment and billed at my regular fee unless I bring in a valid written excuse that has been approved by the program director, by my next scheduled appointment. Cancellation of less than 24 hours in advance for a group session will be considered a "no show" appointment and billed at my regular fee unless I make up that group session prior to my next regular group. Any missed appointments will be reported to my probation officer and two (2) consecutive "no show" will be regarded as non-compliance that may result in termination from treatment. I agree to pay for my treatment in advance or at each appointment. If I am asked to leave a session due to disruptive behavior as determined by my therapist, it will be considered a "no show" appointment and I will be charged full fee. I agree that my account balance will not get past due or it will be regarded as non-compliance and will be reported to my probation officer and may result in termination from treatment.
7. I agree not to use alcohol and/or drugs 24 hours prior to treatment. **If I am court ordered not to use or if I've ever had a history of substance abuse problems, I will not use at anytime and agree to sign the substance abuse program rules.** At the time of my session, I will inform the counselor of any medication I am taking or changes in the medication including over the counter non-prescription drugs.
8. I agree and consent to an on-site urinalysis for the presence of illegal drugs and/or on-site breath testing for alcohol. I understand that I may be tested as part of my initial evaluation and randomly at any time while in treatment. I further understand that if I dispute the results of any on-site testing, I will be referred to a licensed laboratory at my own expense for a second opinion and any results will be reported to my probation officer.

**By signing this document I am agreeing that I have read and understand these program rules and that I am giving my full consent and agreement to comply with same as evidence by my signature below.**

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian/Authorized Rep. \_\_\_\_\_ Date: \_\_\_\_\_

Witness/Counselor who explained the rules \_\_\_\_\_ Date: \_\_\_\_\_

## REFERENCES

- Association For The Treatment Of Sexual Abusers (1997) *Ethical standards and principles for the management of sexual abusers*. Beaverton, OR, USA
- Moore, R. C. (1997) *Counseling & Evaluation Services*, Stuart, Florida, USA

# COUNSELING & EVALUATION SERVICES

## DETAILED PROGRESS REPORT

### SEXUAL OFFENDER TREATMENT PROGRAM

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Person Completing Report: \_\_\_\_\_

**Scoring: 1-10 (1 is the lowest and 10 is the highest score possible)**

1. Ability to talk about and deal with sexual abuse. \_\_\_\_\_
2. Conflict/control (Does not need to be center of attention). \_\_\_\_\_
3. Ability to confront other group members as means of helping them work toward change. \_\_\_\_\_
4. Shows respect for the therapist. \_\_\_\_\_
5. Maintenance of prosocial behavior. \_\_\_\_\_
6. Shows respect for other group members. \_\_\_\_\_
7. Emotional and behavior awareness. \_\_\_\_\_
8. Ability to be vulnerable (open...). \_\_\_\_\_
9. Ability to share feelings (loneliness, worthlessness and low self-esteem). \_\_\_\_\_
10. Improved ability to handle stress. \_\_\_\_\_
11. Self control. \_\_\_\_\_
12. Awareness of own needs. \_\_\_\_\_
13. Improved ability to get own needs met without exploiting others. \_\_\_\_\_
14. Willingness to explore issues which led to the sexual abuse (anger, rejection, alcohol or drugs). \_\_\_\_\_
15. Appropriate sexual knowledge and activities. \_\_\_\_\_
16. Ability to abstain from drugs and/or alcohol. \_\_\_\_\_
17. Positive goals and expectations. \_\_\_\_\_
18. Healthy self-esteem and self-concept. \_\_\_\_\_
19. Ability to trust others. \_\_\_\_\_
20. Positive social interactions, casual and close. \_\_\_\_\_

- 21. Empathy for the victim (responsibility for offenses). \_\_\_\_\_
- 22. Group leadership role (ability to initiate uncomfortable conversation). \_\_\_\_\_
- 23. Assertiveness. \_\_\_\_\_
- 24. Responsibility (attendance, promptness and payments). \_\_\_\_\_
- 25. Employment (unemployment, temporary and permanent). \_\_\_\_\_

Comments: \_\_\_\_\_  
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\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

**COUNSELING & EVALUATION SERVICES**  
Licensed Mental Health, Addictions and Sex Therapy Provider

Department of Corrections  
1865 South Kanner Highway  
Stuart, Florida 34994

**MONTHLY PROGRESS REPORT**

Dear Officer Skidmore;

RE: John Doe

Case# 99-0113CFA

DOB: 9/24/80

SS# 000-20-0013

The above referenced client was seen for an evaluation in my office on **12/7/99**.

**Began initial treatment on 12/8/99.**

Is presently in treatment and is complying with therapy.

Polygraph taken on **April 2, 2001**

Needs to schedule polygraph by **April 2002**.

Mr. Doe is always on time, pays his fees and participates well in group. Model client!

Please feel free to contact me at **561-220-0611** if you have any questions.

Sincerely,

Ryan Moore, M. Ed., P.A., LMHC, Diplomate of ABS.  
Licensed Psychotherapist, Licensed Substance Abuse Treatment  
Provider and American Board Certified Clinical Sexologist.

Mental Health License # 0004846  
American Board of Sexology Certification # 2555  
Specialized Mental Health Facility # F650722233001-D15  
Outpatient Substance Abuse Treatment License # 15-43-AD-2233-00

## **SUBSTANCE ABUSE AND SEX OFFENDERS**

Sex offenders are usually more willing to discuss their substance abuse history than their sexual history ( Carich & Mussack 2001). Alcohol and other drugs are often used by the offender during their offenses and many provide them to their victims. The offender is so likely to have a history of substance abuse that to ignore this fact would be to neglect a major cause of reoffense and treatment failure.

Alcohol abuse is shown to highly correlate with sexual offenses (Salters, 1998), Virkkunen (1974) found that alcohol abuse rates of fifty to eighty percent were present in his review of sex offenders. While Peters (1976) and Rada (1976) reported that over half of their sample of sex offenders had been drinking at the time they committed their offenses. Child molesters said that drinking alcohol increased their attraction to children and rapists stated that alcohol increased their desire to rape (Able, Mittelman, & Becker 1985). In conclusion Abel and his colleagues said "alcohol appears to be a particularly dangerous drug for paraphiliaes to use " (Abel, Mittelman & Becker 1985).

It is important to get specific details of the offenders drug and alcohol use history. This information will lead to clinically useful data concerning impulse control problems, patterns of cognitive distortions and other addictions which will need to be addressed. The treatment provider needs to know substances used, age of first use, frequency, consequences, motivations and rationalization for substance use or abuse ( Carich & Mussack 2001). The psychosocial assessment form developed by the author and shown on pages 17-21 provides a convenient format for recording this information. Also critical to the evaluation process for the assessor is to review prescriptions medications the offender uses as some sexual abusers have been known to rely on these medications as disinhibitors rather than "street drugs" ( Carich & Mussack 2001).

Since the use of any disinhibitors can increase the risk of reoffense the following pages will briefly cover a substance abuse intervention for alcohol abuse appropriate for juvenile and youthful offenders. Alcohol abuse treatment is shown as this is the most popular drug of abuse and the most widely abused substance on the planet. It is a simple matter to individualize treatment plans that are drug of choice specific but probably a good idea to cover alcohol as a topic in the group intervention.

The offender will need to be continuously monitored throughout treatment in order to achieve a healthy non offending lifestyle. Substance abuse educational interventions may also help introduce or reinforce the concept of relapse prevention, sexual addiction (Carnes 1992) as they focus on triggers cycles and intervening with issues highly related to impulse control.

## REFERENCES

- Abel, G. G., Mittelman, M. S., & Becker, J. V. (1985) Sexual offenders: Results of assessment and recommendations for treatment. In M. H. Ben-Aron, S. J. Huckle, & C. D. Webster (Eds.), *Clinical criminology: The assessment and treatment of criminal behavior* (pp. 191-205). Toronto: M & M Graphic.
- Carich, M. S., & Mussack, S. E. (2001) *Handbook for Sexual Abuser Assessment and Treatment*. Safer Society Press, Brandon, Vermont, USA.
- Carnes, P. J. (1994) *Out of the Shadows "Understand Sexual Addiction*. Published by Hazelden Foundation, USA
- Peters, J. J. (1976). Children who are victims of sexual assault and the psychology of offenders. *American Journal of Psychotherapy*, 30, 398-421.
- Rada, R. T. (1976). Alcoholism and the child molester. *Annals of the New York Academy of Science*, 273, 492-496.
- Salter, A. C. (1988) *Treating Child Sex Offenders and Victims*. A Practical Guide SAGE PUBLICATIONS, Newberry Park, California, USA
- Virkkunen, M. (1974). Incest offenses and alcoholism. *Medicine, Science, & the Law*, 14, 124-128.

**COUNSELING & EVALUATION SERVICES**  
**SUBSTANCE ABUSE PROGRAM RULES**

**PARTICIPATION AGREEMENT**

**CLIENT NAME:** \_\_\_\_\_

1. I agree to remain abstinent from alcohol and illegal drugs and inform my counselor of any medication I am taking or changes in the medication while in treatment including over the counter drugs.
2. I agree to be open to attendance at 12 step support groups or other support programs, which may be helpful in achieving and maintaining abstinence and/or other objectives while in treatment.
3. I agree to assist my counselor in the development and implementation of my individualized treatment plan and to regularly review/revise (at least once every 60 days) as necessary or appropriate for my recovery.
4. I agree to remain open to the possibility of a referral to a physician for the purpose of evaluation, medication and/or treatment planning as necessary or indicated for my recovery.
5. I agree to give 24 hours notice to cancel any appointments and acknowledge that I will be charged full fee for any and all appointments cancelled less than 24 hours before the scheduled appointment time or any and all appointments I choose to not attend at all and that I will pay such fees prior to or at my next appointment or I will be unable to attend and will be charged the fee again. The only exception to this rule is a documented medical emergency that needs to be approved by the program director that I will bring with me to my next appointment. I am aware that any session(s) I do not attend will not count toward my goal. I agree that two (2) consecutive late cancelled or no show appointments will be regarded as non-compliance and will be reported to my probation officer or referral source and may result in termination from services or in extending my treatment.
6. I agree to pay for my treatment in advance or at each appointment. I agree that my account balance will not get past due or it will be regarded as non-compliance and will be reported to my probation officer or referral source and may result in termination from treatment. I understand that I will not receive my certificate of completion from the program until my balance is paid in full.
7. I agree and consent to an on-site urinalysis for the presence of illegal drugs and/or on-site breath testing for alcohol. I understand that I may be tested as part of my initial evaluation and randomly at any time while in treatment. I further understand that if I dispute the results of any on-site testing, I will be referred to a licensed laboratory at my own expense for a second opinion and any results will be reported to my probation officer or referral source.
8. I agree that if I argue about these rules it will be regarded as non-compliance and can result in either extended treatment or termination from treatment for non-compliance.

By signing this document, I am agreeing that I have read and understand that these program rules and that I am giving my full consent and agreement to comply with same as evidence by my signature below.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian/Authorized Rep.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness/Counselor who explained the rules

\_\_\_\_\_  
Date

# COUNSELING & EVALUATION SERVICES

## INITIAL TREATMENT PLAN

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

PROBLEM STATEMENT: \_\_\_\_\_

**GOAL: (1) Client to remain abstinent from alcohol and illegal drugs while in treatment.**

- OBJECTIVES:**
- A) Attend 18 to 24 treatment sessions and 18 to 24 AA or NA meetings. TD \_\_\_\_\_  
CD \_\_\_\_\_
  - B) Share negative consequences, costs and problems from using. TD \_\_\_\_\_  
CD \_\_\_\_\_
  - C) Learn and relate philosophy and purpose of AA or NA. TD \_\_\_\_\_  
CD \_\_\_\_\_
  - D) Learn about the "Disease Model" and how 12 step programs work. TD \_\_\_\_\_  
CD \_\_\_\_\_
  - E) Learn "Cycles of Addiction" (Carnes, PhD) and triggers to use. TD \_\_\_\_\_  
CD \_\_\_\_\_
  - F) Learn "Signs & Symptoms" and identify personal triggers. TD \_\_\_\_\_  
CD \_\_\_\_\_
  - G) Complete at least 3 inventories/evaluate behavior. TD \_\_\_\_\_  
CD \_\_\_\_\_
  - H) Learn about neural pathways and the "Hijacked Brian". TD \_\_\_\_\_  
CD \_\_\_\_\_
  - I) Develop handwritten relapse prevention plan. TD \_\_\_\_\_  
CD \_\_\_\_\_
  - J) Evaluate outcome behaviorally and develop long-term goals. TD \_\_\_\_\_  
CD \_\_\_\_\_

**SPECIFIC INTERVENTION OR TREATMENT MODALITY:** Eighteen to twenty-four sessions of substance abuse educational intervention and eighteen to twenty-four AA or NA meetings, based on client's response to treatment.

Date Goal Initiated: \_\_\_\_\_ Anticipated Completion: \_\_\_\_\_

### SIGNATURES:

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian/Authorized Rep.: \_\_\_\_\_ Date: \_\_\_\_\_

Psychiatrist/Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

The implications for obtaining compliance and achieving overall better adjustment is to increase social skills while addressing other deficits and liabilities. Since the primary therapy modality is group treatment (Burton & Darden 2001) this could be achieved simultaneously but must meet the individual needs of each offender as described by Knopp (1985).

1. Each sex offender needs to:

A) Accept responsibility for the offenses.

B) Understand the sequence of thoughts, feelings, events, circumstances, and arousal stimuli that precede involvement in sexually inappropriate/illegal behavior.

2. Each sex offender needs to learn how to:

A) Intervene in the offense pattern at its very first sign.

B) Use appropriate methods to suppress, control, manage, and stop the behavior.

3. Each sex offender needs a reeducation and resocialization process to:

A) Replace antisocial thoughts and behaviors with prosocial ones.

B) Acquire a positive self-concept and new expectations for himself.

C) Learn new social and sexual skills to cultivate positive, non-threatening relationships with others.



**SUBSTANCE ABUSE GROUP**  
**CALANDAR**

Client Name: \_\_\_\_\_

Date of Evaluation: \_\_\_\_\_

Dates of Groups Attended:

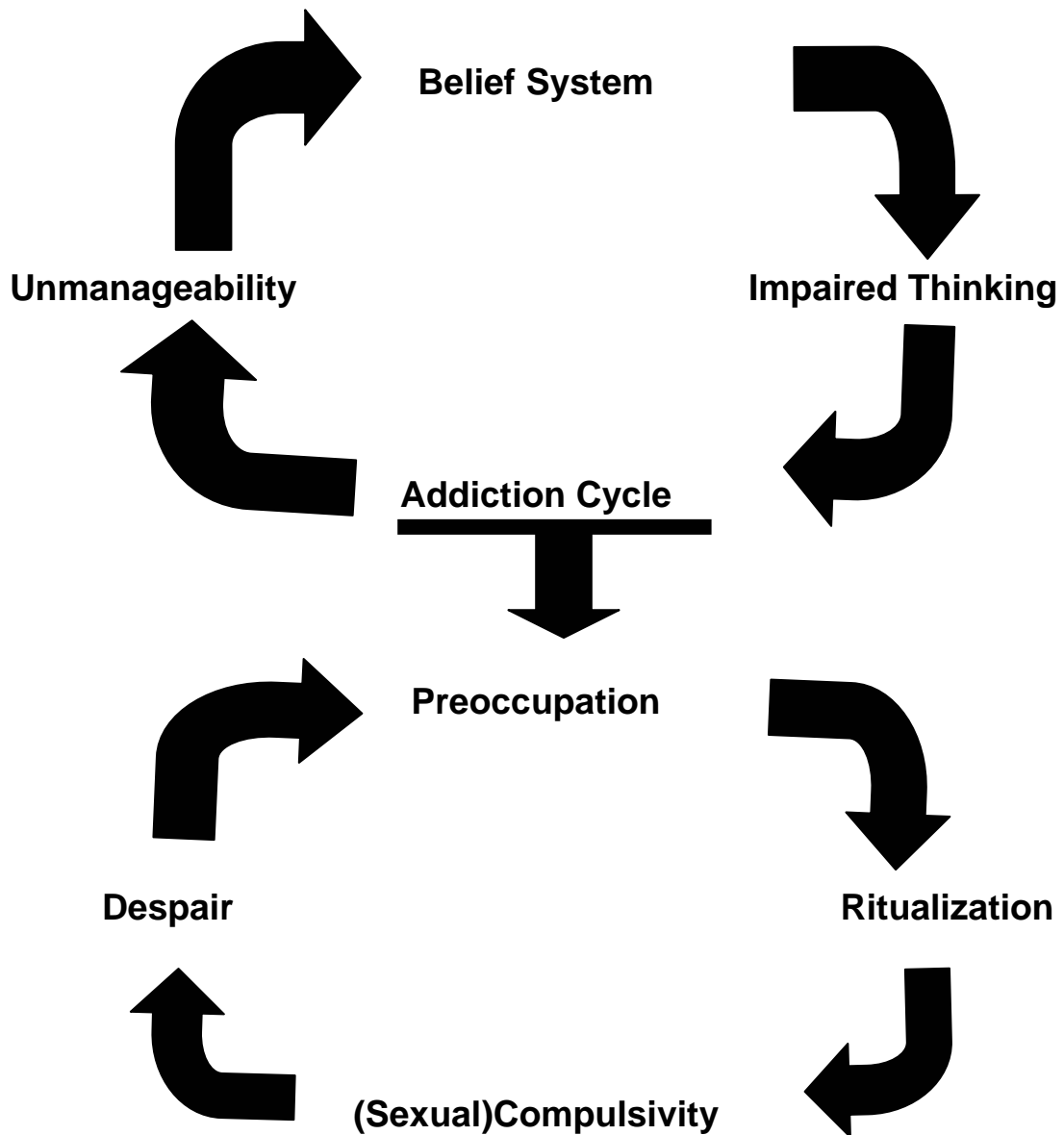
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<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>
<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>
<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>

Dates of Groups Missed:

	<b>EXCUSED</b>	<b>UNEXCUSED</b>
<b>1</b>		
<b>2</b>		
<b>3</b>		
<b>4</b>		

**TWO CONSECUTIVE “NO-SHOW” APPOINTMENTS COULD RESULT IN TERMINATION FROM PROGRAM AND WILL BE REPORTED TO YOUR PROBATION OFFICER OR REFERRAL SOURCE.**

## THE ADDICTIVE SYSTEM



The Addiction Cycle (Carens, 1994)

## **SYMPTOMS OF ALCOHOLISM**

The dictionary defines the word “symptom” as any indication of a condition. There are many indications that can point to alcoholism. No one, or even a few, are positive proof of alcoholism but, they are indications and the more there are, the more likely that the condition of alcoholism is a fact.

Following are many of the identifying symptoms of alcoholism. As alcoholism is a progressive disease, the symptoms increase in number and intensity.

1. The reaction of one to alcohol when its “magic” is discovered. It takes away discomfort, anxiety and fear. It gives a feeling of self-confidence so it becomes important-one needs it-to feel like the person one wants to be.
2. Increasing dependence on alcohol to do what others are doing without it-solve problems, shyness, boredom, lack of confidence or any other problems of living.
3. Gulping drinks-drinking and finishing faster than others.
4. Increased tolerance- the ability to outdrink others, often without the usual physical effects (thickening of speech, ‘rubber legs’, passing out) of the amounts of liquor one is able to consume.
5. A growing insistence on not going to places that don’t serve liquor and being sure drinks are available for any special event- a sports event, picnic or a social gathering.
6. Sneaking or concealing drinks.
7. Lying about the amount one consumes or minimizing it.
8. The tendency to insist that one ‘must’ drink to calm nerves, because of a hard day, because of depression or because something unusually good has happened.
9. Agreeing that one or two should be enough yet often making it three, four or five.
10. Rarely having a hangover or getting actively sick while drinking.
11. Blackouts- a form of temporary amnesia during which you walk, talk and function in an apparently normal fashion with no recollection afterward.
12. Drinking to overcome the hangover effects of prior drinking.
13. Trying new patterns of drinking as to time, place, amount and what you drink.
14. Having personality and behavior changes- even when not drinking- which effect the family situation, friendship groups, job, trouble with the law, financial problems and health.
15. **LOSS OF CONTROL**- drink more than intended, get drunk when others don’t, or when you didn’t mean to. The inability to predict what one’s condition will be when in a drinking situation.

There are many more symptoms than listed but these are the most common. As in every disease, there are exceptions to the general pattern. Not everyone will have every symptom and the extent to which each individual reacts to each symptom can be very different.

# **MICHIGAN ALCOHOLISM SCREENING TEST (MAST)**

## **Key**

(Copyright 1974, The American Psychiatric Association,  
Reprinted by permission from the American Journal of Psychiatry, 1971)

Directions: If a statement says something true about you, put a check in the nearby space under YES. If a statement says something not true about you, put a check in the nearby space under NO. Please answer all questions.

	YES	NO
1. Do you feel that you are a normal drinker?	___	<b>(2)</b>
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	<b>(2)</b>	___
3. Does your spouse/parents/other family members ever worry or complain about your drinking?	<b>(1)</b>	___
4. Can you stop drinking without a struggle after one or two drinks?	___	<b>(2)</b>
5. Do you ever feel bad about your drinking?	<b>(1)</b>	___
6. Do friends or relatives think you are a normal drinker?	___	<b>(2)</b>
7. Do you ever try to limit your drinking to certain hours of the day or to certain places?	___	<b>-0-</b>
8. Are you always able to stop drinking when you want to?	___	<b>(2)</b>
9. Have you ever attended an Alcoholics Anonymous (AA) meeting?	<b>(5)</b>	___
10. Have you gotten into fights when drinking?	<b>(1)</b>	___
11. Has drinking ever created problems with you and your spouse?	<b>(2)</b>	___
12. Has your spouse/parents/other family members ever gone to anyone for help about your drinking?	<b>(2)</b>	___
13. Have you ever lost friends because of your drinking?	<b>(2)</b>	___
14. Have you ever gotten into trouble at work because of your drinking?	<b>(2)</b>	___
15. Have you ever lost a job because of your drinking?	<b>(2)</b>	___
16. Have you ever neglected your obligations, family or work for two more days in a row because you were drinking?	<b>(2)</b>	___
17. Do you ever drink before noon?	<b>(1)</b>	___
18. Have you ever been told you have liver trouble?	<b>(2)</b>	___
19. Have you ever had delirium tremens (DT's), severe shaking, heard voices or seen things that was not there after heavy drinking?	<b>(5)</b>	___
20. Have you ever gone to anyone for help about your drinking?	<b>(5)</b>	___
21. Have you ever been to a hospital because of your drinking?	<b>(5)</b>	___
22. Have you ever been a patient in a psychiatric hospital or in a psychiatric ward of a hospital where drinking was part of the problem?	<b>(2)</b>	___
23. Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor, social worker, counselor or clergyman for help with an emotional problem in which drinking played a role?	<b>(2)</b>	___
24. Have you ever been arrested, even for a few hours, because of drunken behavior?	<b>(2)</b>	___
25. Have you ever been arrested for drunk driving or driving after drinking?	<b>(2)</b>	___

**SCORING: Total points in brackets for each question. Compare to scale.**

**SCALE:**    0 – 3                    non-problematic level  
                  4                        suggestive of alcohol problem  
                  5 or more                    indicates alcoholism

## IS DRINKING A PROBLEM?

**CLIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Ask yourself the following questions and answer them as honestly as you can.

	<b>YES</b>	<b>NO</b>
1. Do you lose time from work due to drinking?	___	___
2. Is drinking making your home life unhappy?	___	___
3. Do you drink because you are shy with other people?	___	___
4. Is drinking affecting your reputation?	___	___
5. Have you ever felt remorse after drinking?	___	___
6. Have you gotten into financial difficulties as a result of drinking?	___	___
7. Do you turn to lower companions and an inferior environment when drinking?	___	___
8. Does your drinking make you careless of your family's welfare?	___	___
9. Has your ambition decrease since drinking?	___	___
10. Do you crave a drink at a definite time daily?	___	___
11. Do you want a drink the next morning?	___	___
12. Does drinking cause you to have difficulty sleeping?	___	___
13. Has your efficiency decreased since drinking?	___	___
14. Is drinking jeopardizing your job or business?	___	___
15. Do you drink to escape from worries or trouble?	___	___
16. Do you drink alone?	___	___
17. Have you ever had a complete loss of memory as a result of drinking?___	___	___
18. Has your physician ever treated you for drinking?	___	___
19. Do you drink to build up your self-confidence?	___	___
20. Have you ever been to a hospital or institution on account of drinking?___	___	___

If you have answer YES to any one of the questions, there is a definite warning that you are an alcoholic.

If you have answered YES to any two, the chances are that you are an alcoholic.

If you have answered YES to three or more, you are definitely an alcoholic.

(The above test questions are used by Johns Hopkins University Hospital in Baltimore, MD, in deciding whether or not a patient is an alcoholic.)

## WHAT ARE THE SIGNS OF ALCOHOLISM?

**CLIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

The following questionnaire will help a person learn if he or she – or a member of the family – has some of the symptoms of alcoholism and may need help. Source: National Council on Alcoholism.

YES	NO	QUESTION	YES	NO	QUESTION
		1. Do you occasionally drink after a disappointment, a quarrel or when the boss gives you a hard time?			14. Have you tried switching brands or following different plans for controlling your drinking?
		2. When you have trouble or feel under pressure, do you always drink more heavily than usual?			15. Have you often failed to keep the promises you have made to yourself about controlling your drinking?
		3. Have you noticed that you are able to handle more liquor than you did when you were first drinking?			16. Have you ever tried controlling your drinking by making a change in jobs or moving to a new location?
		4. Did you ever wake up on the "morning after" and discover that you could not remember part of the evening before, even though your friends tell you that you did not "pass out"?			17. Do you try to avoid family or close friends while you are drinking?
		5. When drinking with other people, do you try to have a few extra drinks when others will not know it?			18. Are you having an increasing number of financial and work problems?
		6. Are there certain occasions when you feel uncomfortable if alcohol is not available?			19. Do more people seem to be treating you unfairly without good reason?
		7. Have you recently noticed that when you begin drinking you are in more of a hurry to get the first drink than you need to be?			20. Do you eat very little or irregularly when you are drinking?
		8. Do you sometimes feel a little guilty about your drinking?			21. Do you sometimes have the "shakes" in the morning and find that it helps to have a little drink?
		9. Are you secretly irritated when your family or friends discuss your drinking?			22. Have you recently noticed that you cannot drink as much as you once did?
		10. Have you recently noticed an increase in the frequency of your memory "blackouts"?			23. Do you sometimes stay drunk for several days at a time?
		11. Do you often find that you wish to continue drinking after your friends say that you have had enough?			24. Do you sometimes feel very depressed and wonder whether life is worth living?
		12. Do you usually have a reason for the occasions when you drink heavily?			25. Sometimes after periods of drinking, do you see or hear things that aren't there?
		13. When you are sober, do you often regret things you have done or said while drinking?			26. Do you get terribly frightened after you have been drinking heavily?

YES to questions 1-8: Early stage of alcoholism.

YES to questions 9-21: Middle stage of alcoholism.

YES to questions 22-26: Beginning of final stage of alcoholism.

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## ANGER MANAGEMENT

Juvenile and youthful offenders with a history of violent behavior have been seen as an especially problematic population. Typically they have been regarded as high risk and excluded from community based outpatient treatment programs and labeled as “untreatable” (Mildon & McLardy 1993).

Yet impulse control problems and a tendency toward aggressive responses is quite common in juvenile and youthful offenders accepted for outpatient treatment.

The clients psychosocial evaluation should include assessment of his violence profile. An offender’s level of aggression in nonsexual activities may indicate sadistic themes. Carich & Mussack, (2001) listed the following key factors.

*Type and frequency of violence*

*Age at which the client began using violence*

*The client’s arousal to violence*

*Age and gender of target victims*

*Any history of the client’s witnessing or experiencing violence*

The clients exposure to domestic and family violence including his own victimization must be considered as a potential treatment issue also. Juvenile and youthful offenders who are anxious or depressed may appear angry or hostile therefore the clinician should also assess for anxiety and depression. If the clients anxiety or depression is above the “mild range” (Burns 1984) and/or he does not respond to the cognitive behavioral approach employed by most sex offender therapists the client may need a referral to a physician for a medication evaluation.

The psychological profiles of offenders reveal impulse control problems and emotional balance in favor of uncontrolled responses (Ginsburg 1990). Therefore a comprehensive treatment program will address anger management issues as an important component. This also introduces negotiation, communication and problem solving skills which are all a part of the broader topic of social skills presently listed under the heading of anger management.

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**INITIAL TREATMENT PLAN**

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

PROBLEM STATEMENT: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

GOAL: (1) To eliminate violent & abusive behaviors while in treatment.

OBJECTIVES:	A) Attend 12 to 15 treatment sessions of Anger Management.	TD _____
		CD _____
	B) Identify "Signals of Rising Anger".	TD _____
		CD _____
	C) Utilize "Signals of Rising Anger" to identify when to take a time-out	TD _____
		CD _____
	D) Learn how to take a "time-out"	TD _____
		CD _____
	E) Develop or identify and personalize time-outs he/she would use.	TD _____
		CD _____
	F) Learn "Self Talk" and the use of the "I messages".	TD _____
		CD _____
	G) Learn negotiation skills, belief changes and cognitive distortions.	TD _____
		CD _____
	H) Be able to ID how to utilize above strategies in his/her life.	TD _____
		CD _____
	I) Evaluation for depression & anxiety.	TD _____
		CD _____
	J) Evaluate outcome via exit interview and written evaluation	TD _____
		CD _____

SPECIFIC INTERVENTION OR TREATMENT MODALITY: \_\_\_\_\_

Date Goal Initiated: \_\_\_\_\_ Anticipated Completion: \_\_\_\_\_

(See Formal Treatment Plan for Actual Completion Date's)

SIGNATURES:

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian/Authorized Rep.: \_\_\_\_\_ Date: \_\_\_\_\_

# ANGER MANAGEMENT

## SIGNALS OF RISING ANGER ALSO KNOWN AS SIGNS OR CUES

CLIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

RATE

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1. Swearing, abusive language.
2. Tense, shaking body: stomach, head, chest pains.
3. Clenching fists; pointing finger.
4. Becoming very quiet and still.
5. Pacing the floor.
6. Change in eyes.
7. Voice becoming louder and deeper; trying to out-shout partner.
8. Heart racing, breathing becomes faster.
9. Sweating, feeling hot.
10. Making threats, accusations.
11. To "get in some ones face".
12. Biting lip or fingernails; gritting teeth.
13. Chain smoking
14. Throwing things, breaking objects.
15. \_\_\_\_\_
16. \_\_\_\_\_
17. \_\_\_\_\_

## HOW TO TAKE A "TIME OUT"

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

***When I feel my anger rising, I will give a "T" signal for Time-Out. I will then say, "I'm starting to get mad and I'm going to take a "Time-Out". Then I will turn around and leave at once. I will not hit or kick anything. I will not slam the door.***

***I will return when I am no longer seriously angry, hopefully no longer than 30 to 60 minutes. I will take a walk or do something relaxing to use up my anger. I will try to look differently at the situation that I became angry about.***

***I will NOT drink any alcohol or use any drugs while I am gone even if I think that they might relax me. If I am very upset I will not drive.***

***If my partner gives a "T" signal and wants to leave, I will return the sign and let him/her go peacefully, no matter what is going on. I will try to look at the situation differently that I became angry about.***

***When we are back together, I will apologize for anything I said which was unfair or insensitive. I will then attempt to discuss the situation calmly.***

***Although I may not always be able to keep myself from getting angry, I CAN CONTROL how I handle it when I do get angry.***

## TIME-OUT

Time-Out is a simple procedure that anyone can learn to use. It is probably the most important and helpful tool a person can use to avoid becoming violent. And that is the purpose of taking a Time-Out, to avoid becoming abusive.

When you choose to take a Time-Out, you are showing that you care enough about your family, friends, and yourself, to take action to ensure their safety and your peace of mind.

Here are the steps for taking a Time-Out correctly:

1. As discussed in group learn what cues (thoughts, emotions and body sensations) are warning signs for you that you might become violent.
2. When you are aware of any of these cues, state out loud to yourself and to your family or friend, "I'm feeling angry and I need to take a Time-Out".
3. You must take a Time-Out for one hour – no more, no less. If you can be certain that you can be undisturbed at home, you can stay there. Most often it will be necessary to leave home.
4. During that one hour Time-Out, try to do something physical, such as walking, running or physical work if possible.
  - DO NOT spend one hour just thinking about the argument.
  - DO NOT drink or take any drugs during that hour.
  - DO NOT drive if you are very angry.
  - DO NOT have any contact with your partner during that hour.
5. Check with your partner at the end of the Time-Out period.
6. If BOTH of you want to discuss the situation, you can. If EITHER OF YOU does not want to talk about the conflict, leave it alone and don't discuss it.
7. If you find yourself getting angry again, take another Time-Out.
8. Discuss this procedure with your family so that they understand it. If they have any questions or concerns, they can call the group counselors if they want to.

When practiced and used correctly, Time-Out prevents abusive behavior EVERY TIME!

## SELF-TALK

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Both research and experience show that when people with anger problems change their self-talk, their anger de-escalates and they regain control. When you notice your cues escalating or start to feel angry, take a TIME-OUT and read these statements to yourself.

- I don't need to prove myself in this situation. I can stay calm.
- As long as I keep my cool, I'm in control of myself.
- No need to doubt myself, what other people say doesn't matter. I'm the only person who can make me mad or keep me calm.
- Time to relax and slow things down. Take a time-out if I get uptight or start to notice my cues.
- My anger is a signal. Time to talk to myself and to relax.
- I don't need to feel threatened here. I can relax and stay cool.
- Nothing says I have to be competent and strong all the time. It's okay to feel unsure or confused.
- It's impossible to control other people and situations. The ONLY thing I can control is myself and how I express my feelings.
- It's okay to be uncertain or insecure sometimes. I don't need to be in control of everything and everybody.
- If people criticize me, I can survive that. Nothing says that I have to be perfect.
- If this person wants to go off the wall, that's their thing. I don't need to respond to their anger or feel threatened.
- When I get into an argument, I can use my control plan and know what to do. I can take a time-out.
- Most things we argue about are stupid and insignificant. I can recognize that my anger comes from having my old primary feelings restimulated. It's okay to walk away from this fight.
- It's nice to have other people's love and approval, but even without it, I can still accept and like MYSELF.
- People put erasers on the ends of pencils for a reason; it's okay to make mistakes.
- People are going to act the way they want to, not the way I want.
- I feel angry, that must mean I have been hurt, scared or have some other primary feeling.

From the Duluth Abuse Intervention project: Power & Control: The Tactics of Men Who Batter.  
Manual for Education Groups.

## THE "I" MESSAGE

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

When upset it can be very useful to avoid use of the word YOU.

A more effective approach is the "I message".

I Feel \_\_\_\_\_

When \_\_\_\_\_

Because \_\_\_\_\_

This confines the conversation to feelings and behaviors and attempts to give a reason. Statements which begin with YOU are an attack on the other person. It is more helpful to look at the persons actions or behavior when attempting to resolve conflict.

Instead of arguing feelings may be expressed with "I feel statements". The method is simple. You say "I feel" and add a word that describes your feeling. As in "I feel sad" or "I feel angry". I FEEL \_\_\_\_\_.

There are many feelings that can be expressed with "I MESSAGES".

1. **Negative feelings.** Examples include "I feel angry," "I feel criticized," "I feel put down," "I feel frustrated," "I feel coerced," "I feel misunderstood." (and so forth).
2. **Vulnerable feelings.** Examples include "I feel sad," "I feel rejected," "I feel hurt," "I feel disappointed," "I feel ignored," "I feel attacked" (and so forth).

Adapted from The Feeling Good Handbook (Burns 1989)

## NEGOTIATION SKILLS

1. **Be prepared:** Before people can even begin the process of negotiation, they must first be committed to a fair process. In preparation for being fair, the parties must be ready to
  - Listen
  - Reach a mutually satisfying resolution
  - Hear things they disagree with or find painful without reacting abusively or defensively
  - Accept that something will change
2. **Setting some rules:** Begin by reviewing these rules and adding any that you mutually decide are important.
  - No yelling
  - No bringing up unrelated issues
  - No using threats or intimidation
  - No playing mind games
  - Is a time limit needed for this discussion?
  - Is a third party needed to help with this discussion?
3. **Defining the problem:** What are we negotiating? Is this negotiable?
  - How does each person experience and define the problem? (This will be different for each person.)
  - Who else is affected and how?
4. **Identifying goals:** Short and long-term goals should be identified.
  - Short-term: Name the things that need to be included in an immediate solution.
  - Long-term: Name the things that need to be included in a final solution.
5. **Finding solutions:** What would each person propose as an immediate and long-term solution that addresses the things each person has said need to be considered?
  - Is compromise necessary or can both parties be satisfied?
  - If compromise is necessary, list several fair solutions.

## CODE OF BEHAVIOR

**TRUST** – Firm reliance on the integrity, ability and character.

**SUPPORT** – Tolerate partner to keep one's spirit from failing when under stress.

From the Duluth Abuse Intervention project: Power & Control: The Tactics of Men Who Batter.  
Manual for Education Groups.

## BELIEF CHANGES

### The Belief I want to change:

*I should never get angry*

---

#### Advantages of Believing This

1. I'll avoid confrontations and conflicts with others
2. When I'm aware that I'm getting angry, I'll be able to criticize and scold myself.
3. I'll never be out of control.
4. Other people, and outside stimuli won't be able to exert influence over me.
5. I'll be able to deceive myself into thinking I have risen above average people and I'll think that I'm somehow better.
6. I'll feel like Mr. Cool.
7. It makes life simple because I'll always know what to do.
8. I can keep people at a distance.
9. I can avoid people I don't like to deal with.

#### Disadvantages of Believing This

1. The anger will come out in some other way that may be destructive.
2. I will deny myself a part of being human and not have normal feelings.
3. I'll set a bad example for others.
4. I'll set an impossible standard for myself. This will lead to further frustration and pain as I criticize myself for not being perfect.
5. I won't feel comfortable with myself.
6. I may not come across as genuine to other people
7. I may deprive myself of a source of Self-esteem and intimacy.
8. My anger could help me deal with many situations more effectively.
9. Life loses its complexity and richness.

Revised Belief: Anger may be uncomfortable but there are times when it's better for me and for the relationship to tell the other person how I feel.

Adapted from The Feeling Good Handbook (Burns 1989).

## COGNITIVE DISTORTIONS

1. *All-or-noting thinking: Things are in absolute, black-and-white, right or wrong.*
2. *Overgeneralization: A single negative event is seen as a never-ending pattern of defeat.*
3. *Mental filter: Dwelling on negatives and ignoring the positives.*
4. *Discounting the positives: Insisting that your accomplishments or positive qualities "are not real" or valuable.*
5. *Jumping to conclusions: (A) Mind reading-you assume that people are reacting negatively to you when there's not definite evidence for this; (B) Fortune-telling-you arbitrarily predict that things will turn out badly.*
6. *Magnification or minimization: Blowing things way up out of proportion or shrinking their importance inappropriately.*
7. *Emotional reasoning: Reasoning from how you feel: "I feel like an idiot, so I really must be one." Or "I don't feel like doing this, so I'll put it off."*
8. *"Should statements": Criticizing yourself or other people with "shoulds" or "shouldn'ts." "Must," "oughts," and "have tos" are similar.*
9. *Labeling: Identifying with your shortcomings. Instead of saying "I made a mistake," you tell yourself, "I'm a jerk," or "a fool," or "a loser."*
10. *Personalization and blame: Blaming yourself for something you weren't entirely responsible for, or you blame other people and overlook ways that your own attitudes and behavior might contribute to a problem.*

## THE BURNS DEPRESSION CHECKLIST

Copyright 1984 by David D. Burns, M.D., from The Feeling Good Handbook, copyright 1989

**Client Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructions:** The following is a list of symptoms that people sometimes have. Put a checkmark in the space to the right that best describes how much that symptom or problem has bothered you during the past week.

	<b>0- NOT AT ALL</b>	<b>1- SOMEWHAT</b>	<b>2- MODERATELY</b>	<b>3- A Lot</b>
1. <b>Sadness:</b> Have you been feeling sad or down in the dumps?				
2. <b>Discouragement:</b> Does the future look hopeless?				
3. <b>Low self-esteem:</b> Do you feel worthless or think of yourself as a failure?				
4. <b>Inferiority:</b> Do you feel inadequate or inferior to others?				
5. <b>Guilt:</b> Do you get self-critical and blame yourself for everything?				
6. <b>Indecisiveness:</b> Do you have trouble making up your mind about things?				
7. <b>Irritability and Frustration:</b> Have you been feeling resentful and angry a good deal of the time?				
8. <b>Loss of interest in life:</b> Have you lost interest in your career, your hobbies, your family or your friends?				
9. <b>Loss of motivation:</b> Do you feel overwhelmed and have to push yourself hard to do things?				
10. <b>Poor self-image:</b> Do you think you're looking old or unattractive?				
11. <b>Appetite changes:</b> Have you lost your appetite? Or do you overeat or binge compulsively?				
12. <b>Sleep changes:</b> Do you suffer from insomnia and find it hard to get a good night's sleep? Or are you excessively tired and sleeping too much?				
13. <b>Loss of libido:</b> Have you lost your interest in sex?				
14. <b>Hypochondriasis:</b> Do you worry a great deal About your health?				
15. <b>Suicidal impulses:</b> Do you have thoughts that life is not worth living or think that you might be better off dead?				

**ADD UP YOUR SCORE AND RECORD IT HERE:** \_\_\_\_\_

**Scale:** 0-4 not depressed, 5-10 borderline, 11-20 mild depression, 21-30 moderate depression, 31-45 severe.

## THE BURNS ANXIETY INVENTORY

Copyright 1984 by David D. Burns, M.D., from The Feeling Good Handbook, copyright 1989

**Client Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructions:** The following is a list of symptoms that people sometimes have. Put a checkmark in the space to the right that best describes how much that symptom or problem has bothered you during the past week.

	0- NOT AT ALL	1- SOMEWHAT	2- MODERATELY	3- A Lot
<b>CATEGORY I: ANXIOUS FEELINGS</b>				
1. Anxiety, nervousness, worry or fear				
2. Feeling that things around you are strange, unreal or foggy				
3. Feeling detached from all or part of your body				
4. Sudden unexpected panic spells				
5. Apprehension or a sense of impending doom				
6. Feeling tense, stressed, "uptight" or on edge				
<b>CATEGORY II: ANXIOUS THOUGHTS</b>				
7. Difficulty concentrating				
8. Racing thoughts or having your mind jump from one thing to the next.				
9. Frightening fantasies or daydreams				
10. Feeling that you're on the verge of losing control				
11. Fears of cracking up or going crazy				
12. Fears of fainting or passing out				
13. Fears of physical illnesses or heart attacks or dying				
14. Concerns about looking foolish or inadequate in front of others				
15. Fears of being alone, isolated or abandoned				
16. Fears of criticism or disapproval				
17. Fears that something terrible is about to happen				
<b>CATEGORY III: PHYSICAL SYMPTOMS</b>				
18. Skipping or racing or pounding of the hears (sometimes called "palpitations")				
19. Pain, pressure or tightness in the chest				
20. Tingling or numbness in the toes or fingers				
21. Butterflies or discomfort in the stomach				
22. Constipation or diarrhea				
23. Restlessness or jumpiness				
24. Tight, tense muscles				
25. Sweating not brought on by heartbeat				
26. A lump in the throat				
27. Trembling or shaking				
28. Rubbery or "jelly" legs				
29. Feeling dizzy, lightheaded or off balance				
30. Choking or smothering sensations or difficulty breathing				
31. Headaches or pains in the neck or back				
32. Hot flashes or cold chills				
33. Feeling tired, weak or easily exhausted				

**ADD UP YOUR SCORE AND RECORD IT HERE:** \_\_\_\_\_

**Scale:** 0-4 not anxious, 5-10 borderline, 11-20 mild, 21-30 moderate, 31-50 severe, 51-99 extreme or panic.

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## **SOCIAL SKILLS DEFICITS**

An important aspect of any juvenile or youthful sex offenders treatment should be dealing with their social skills deficits. Three decades ago Marshall (1971) suggested that therapy for sexual offenders include social skills yet we do not know any more now than we did then.

Available literature suggests that sexual offenders may hold templates of what they believe to be socially appropriate behavior that are different from the templates of non offenders (Marshall, Barbaree & Fernandez 1995). Sexual offenders have been found to be unassertive (Segal & Marshall 1985). Child molesters were found to be good at problem recognition but poor at generating quality solutions (Marshall, Barbaree & Fernandez 1995). Many may be deficient in their ability to interact appropriately because they are unskilled. Perhaps they do not know how to start and maintain conversations. If they are deficient in their ability to read social cues they will have difficulty engaging in and maintaining appropriate social relationship and may seek to avoid therapy due to the discomfort generated.

Research and theory hold that the offender with poor social and sexual skills with peers and adults have turned to children because they experience them as less threatening (Abel, Mittelman & Becker 1985). The theory is that given the social nature of human beings, an offender who is not able to meet his needs appropriately with peers or adults, will reoffend. Social and communication skills are a must if the offender is to have success in his ability to initiate and maintain appropriate peer aged relationships (Salter, 1988).

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## SOCIAL ANXIETY

Let's cover methods originally developed by Dr. David Burns (1989).

1. *Mood log: Write down the negative thoughts that create anxiety, such as: "I'm really going to lose it. "Then identify the distortions in these thoughts, such as "fortune-telling" and "all-or-nothing thinking," and substitute more positive, realistic thoughts.*
2. *Problem solving: If you think your anxiety will cause problems for you (like making your mind go blank), list these problems and think of specific solutions to them.*
3. *Script writing: Write out difficult or critical questions that people might ask. Instead of getting frazzled or defensive, "stroke" them by saying something positive about their ideas and "disarm" them by finding some truth in what they have to say. This will make them feel good, and you'll win them over to your side.*
4. *Unconditional self-esteem: if you base your self-esteem on being a success, you'll be plagued by constant anxiety and stress, because you'll always be afraid of failure. If you have unconditional self-esteem, you can learn from your failures with a spirit of compassion and self-respect.*
5. *Positive reframing: Instead of worrying about your anxiety or thinking of it as "bad," think of it as a source of energy. Use the anxiety, use the energy to come on strong and deliver your message with conviction and charisma.*

## SOCIAL SKILLS TRAINING IN GROUP

The following statements can be read in group sessions and each client would be asked to fully participate and problem solve regarding the examples listed below:

- 1. You are standing in line to get into a movie and someone walks up to the front of the line. What do you say and do?*
- 2. A friend said he'd meet you at the record store at 4 o'clock. At 4:30, he finally shows up. He did the same thing last week. What do you say and do?*
- 3. Someone in group is always making fun of you. This person really bothers you. What do you say and do?*
- 4. The therapist accuses you of doing something you did not do. The therapist is sure you did it. What do you say and do?*
- 5. Someone says something nasty or insulting about your family. What do you say and do?*

The therapist will need to encourage the juvenile and youthful sex offender to fully engage in this process by insisting that each bring up several specific situations in which they have experienced their own unique social problems wherein assertiveness could have been better used to handle their situations. Once this has been achieved the therapist will want the clients to imagine a situation that is actually one of their worst fears for processing.

## RELATIONSHIPS SKILLS FOR GROUPS

As we work toward improving our clients social skills we want to point out advantages for them. Such as keeping in mind that reducing stress that results from conflict in relationships is an important part of our well-being. They will need specific concrete examples as shown below:

### *Eleven Proven Ways To Get Along Better With Everyone*

- 1. Before you say anything to anyone, ask yourself three things: 1) is it true?, 2) is it kind?, 3) is it necessary?*
- 2. Make promises sparingly and keep them faithfully.*
- 3. Never miss the opportunity to compliment or say something encouraging to someone.*
- 4. Refuse to talk negatively about others; don't gossip and don't listen to gossip.*
- 5. Have a forgiving view of people. Believe that most people are doing the best they can.*
- 6. Keep an open mind; discuss, but don't argue. (It is possible to disagree without being disagreeable).*
- 7. Forget about counting to 10. Count to 1,000 before doing or saying anything that could make matters worse.*
- 8. Let your virtues speak for themselves.*
- 9. If someone criticizes you, see if there is any truth to what he or she is saying; if so, make changes. If there is no truth to the criticism, ignore it and live so that no one will believe the negative remark.*
- 10. Cultivate your sense of humor; laughter is the shortest distance between two people.*
- 11. "Do not seek so much to be consoled, as to **console**; do not seek so much to be understood, as to **understand**; do not seek so much to be loved, as to **love**."*

## THE COMPONENTS OF ASSERTIVE BEHAVIOR

The following material on being assertive is covered in group sessions.

Eye Contact: Looking directly at another person when you are speaking to him or her is an effective way of declaring that you are sincere about what you are saying, and that it is directed to him/her.

Body Posture: The “weight” of your messages to others will be increased if you face the person, stand or sit appropriately close, lean toward the person, and hold your head erect.

Gestures: A message accented with appropriate gestures takes on an added emphasis (over enthusiastic gesturing can be a distraction!)

Facial Expression: Ever see someone trying to express anger while smiling or laughing? It just doesn't come across. Effective assertions require an expression that agrees with the message.

Voice Tone, Inflection, Volume: A whispered monotone will seldom convince another person that you meant business, while a shouted epithet will bring his or her defenses into the path of communication. A level, well-modulated conversational statement is convincing without being intimidating.

Timing: Spontaneous expression will generally be your goal since hesitation may diminish the effect of an assertion. Judgment is necessary, however, to select an appropriate occasion, for example, such as speaking to your boss in the privacy of his or her office, rather than in front of a group of his or her subordinates where he or she may need to respond defensively.

Content: We save this obvious dimension of assertiveness for last to emphasize that, although what you say is clearly important, it is often less important than most of us generally believe. We encourage a fundamental honesty in interpersonal communication,

and spontaneity of expression. In our view, that means saying forcefully, “I’m damn mad about what you just did!” rather than “You’re and SOB!” People who have for years hesitated because they “didn’t know what to say” have found the practice of saying something, to express their feelings at the time, to be a valuable step toward greater spontaneous assertiveness.

One further word about content: We do encourage you to express your feelings and to accept responsibility for them. Note the difference in the above example between “I’m mad” and “you’re an SOB.” It is not necessary to put the other person down (aggressive) in order to express your feeling (assertive). It is most effective to use “I-messages” and least effective to use “you-messages.” Thus, “I feel . . . , I would like . . . , when you did . . . , I reacted by . . . ,” rather than “You made me feel . . . , You should . . . , You’re inconsiderate and ungrateful . . . .” It alienates others and makes them feel defensive when you label them or accuse them of being responsible for your feelings and behavior. It gives them information about you and their impact on you when you focus on describing your own feelings, reactions, needs, and wished, and gives them a sense of having the option to respond without feeling coerced. If you are not in the habit of communicating in a direct, assertive way, it will take you a while to get used to developing your own style. But it is well worth the effort to acquire this skill so that it is available to you when needed.

## **DEFINITIONS: ASSERTIVENESS, NONASSERTIVENESS & AGGRESSIVENESS**

### Assertiveness

Assertive behaviors are those verbal and nonverbal responses which enable one to act in his/her own best interests, to stand up for oneself, to express one's opinions, feelings and attitudes honestly without undue anxiety or putting others down. The assertive person exercises his/her rights without denying or violating the rights and feelings of others. Being assertive is self-enhancing, and increases one's self-esteem because it involves the statement of personal preferences in a way that causes others to take them into account. Assertiveness does not guarantee "winning" in situations, but it does facilitate self-expression and increases the likelihood that satisfactory resolution or compromise will occur, and that one's goals will be obtained.

### Nonassertiveness

Nonassertive behaviors are those which are self-denying, restrained, and inhibited. The nonassertive person is submissive in social situations and often experiences a high degree of interpersonal anxiety. The nonassertive person does not express his/her preferences, and thus allows other to make decisions or choices for him/her, and generally avoids situations involving confrontation. The nonassertive person allows his/her rights to be ignored, and humbly yield to the preferences of others. Nonassertiveness can be extremely self-depreciating and humiliating. The person feels helpless, controlled, and bitter because they rarely express what they want and thus are unlikely to achieve their goals. Feelings of self-hatred and resentment toward others are not uncommon ramifications of a lack of assertive self-expression.

## Aggressiveness

Aggressive behaviors include hostile words or actions which coerce others to give in to one's preferences. The aggressive person is interested in "winning," and attempts to achieve this goal by any means possible including putting others down, hurting or humiliating them. Although the aggressive person may not feel particularly anxious and may achieve his/her goal, the price for "winning" can be very high indeed. The reactions of others to an aggressive person who has violated their rights, is generally one of dislike, hostility, and counter-aggression which may find that others begin avoiding him/her, and react in a tense, sarcastic, or openly hostile fashion. Social isolation and chronic conflict may often be the price to pay for getting one's way at the expense of others.

## **ASSERTIVE, NON-ASSERTIVE, AND AGGRESSIVE BEHAVIOR**

Examples contrasting assertive with non-assertive and aggressive actions will help clarify these concepts. The following chart displays several feelings and consequences typical for the person (actor) whose behavior is non-assertive, assertive, or aggressive. Also shown, for each of these modes of behavior, are the likely consequences for the person toward whom the action is directed (acted upon).

It can be seen in the chart below that in the case of a non-assertive response in a given situation, the actor is typically denying himself and is inhibited from expressing his or her actual feelings. He or she often feels hurt and anxious as a result of his or her inadequate behavior. Allowing others to choose for him or her, he or she seldom achieves his or her own desired results.

The person who carries his or her desire for self-assertion to the extreme of aggressive behavior accomplishes his or her ends usually at the expense of others. Although he or she frequently find his or her behavior self-enhancing and expressive of his or her feelings in the situation, he or she usually hurts others in the process by making choices for them and minimizing their worth as persons.

**NON-ASSERTIVE  
BEHAVIOR  
As Actor**

Self-denying

Inhibited  
Hurt, anxious

Allows others to  
choose for him or her

Does not achieve  
desired goal

**As Acted Upon**

Guilty or angry

Deprecates actor

Achieves desired goal  
at actor's expense

**AGGRESSIVE  
BEHAVIOR  
As Actor**

Self-enhancing at  
expense of another

Expressive  
Depreciates others

Chooses for others

Achieves desired goal by  
hurting others

**As Acted Upon**

Self-denying

Hurt, defensive,  
humiliated

Does not achieve desired  
goal

**ASSERTIVE  
BEHAVIOR  
As Actor**

Self-enhancing

Expressive  
Feels good about self  
Chooses for self

Chooses for self

May achieve desired  
goal

**As Acted Upon**

Self-enhancing

Expressive

May achieve desired  
goal

## JOURNAL

Many clients will need assistance with getting in touch with their feelings as well as bringing in material for processing in group. A journal can help clients with this problem. Below is shown the exact instructions given to clients.

*During your treatment, we would like you to spend some time writing a journal. You should include your feelings and experiences as well as what you are learning. The following questions may help you make entries in your journal:*

1. Did I talk to someone today?
2. Did I share experiences, strengths and hopes?
3. Who are the people in my life that I trust today?
4. Who has trust in me today?
5. Have I done anything to cause harm to myself or another today?
6. Am I willing to change today?
7. Have I given of myself without expecting anything in return?
8. Was there fear in my life today?
9. Did I feel intense joy or pain today?
10. Was I happy today?

*These questions are for use to help you write in your journal. You may choose to write about other issues in your journal . . . that's okay . . . it's just important that you write in your journal every day.*

## PROBLEM SOLVING

Here are some other problems and suggestions about how you could solve each of them

(Burns, 1989).

<b>Problems</b>	<b>Solutions</b>
1. Someone might ask a question I can't answer.	1. I could tell them it's an excellent question and I don't know the answer.
2. My heart will pound and I'll feel terribly anxious before I speak.	2. I could walk or jog or do some calisthenics to work off the excess energy.
3. I might say something stupid.	3. I could acknowledge my error and correct it.
4. I might do a lousy job. People would be bored. People would not want to listen to me.	4. I could ask the group to critique me. I can learn how to make my conversations more interesting.

## REFERENCES

Reach For Health Newsletter, Fall 1990 Volume 10, Number 32

## THE CHARACTERISTICS OF BAD COMMUNICATION\*

1. **Truth** – You insisting that you are “right” and the other person is “wrong”.
2. **Blame** – You say that the problem is the other person’s fault.
3. **Martyrdom** – You claim that you’re an innocent victim.
4. **Put-down** – You imply that the other person is a loser because he or she “always” or “never” does certain things.
5. **Hopelessness** – You give up and insist there’s no point in trying.
6. **Demandingness** – You say you’re entitled to better treatment but you refuse to ask for what you want in a direct, straightforward way.
7. **Denial** – You insist that you don’t feel angry, hurt, or sad when you really do.
8. **Passive Aggression** – You pout or withdraw or say nothing. You may storm out of the room or slam doors.
9. **Self-Blame** – Instead of dealing with the problem, you act as if you’re an awful, terrible person.
10. **Helping** – Instead of hearing how depressed, hurt, or angry the other person feels, you try to “solve the problem” or “help” him or her.
11. **Sarcasm** – Your words or tone of voice convey tension or hostility which you aren’t openly acknowledging.
12. **Scapegoating** – You suggest that the other person has “a problem” and that you’re sane, happy, and uninvolved in the conflict.
13. **Defensiveness** – You refuse to admit any wrong-doing or imperfection.
14. **Counterattack** – Instead of acknowledging how the other person feels, you respond to their criticism by criticizing them.
15. **Diversion** – Instead of dealing with how you both feel in the here-and-now, you list grievances about past injustices.

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## BEFRIENDING THE SELF A GROUP EXERCISE

Objectives:

1. To clarify the role of healthy self-esteem in personal adjustment
2. To demonstrate a guided imagery exercise that promotes self-esteem
3. To provide an opportunity to discuss the applications, limitations and variations of the exercise

Outline:

### I. Background Information

### II. Self-esteem

1. Definition of self-esteem: holding oneself in high regard, a feeling of worthiness
2. Feelings of unworthiness stem from early experiences of neglect and abuse often compounded by failure experiences later in life
3. Behaviors that undermine self-esteem are often practiced by those whose self-esteem is low.
4. A change in this cycle can be facilitated by exercises aimed at changing the underlying attitudes toward self

### III. Guided Imagery

1. Preliminaries
  - a. Expectations ("seeing", faces, signaling)
  - b. Finding the Nurturing self
2. Counting down
  - a. Feet and legs – slowing down
  - b. Trunk – ease in breathe
  - c. Shoulders and arms – letting go
  - d. Face and neck – dropping guard
  - e. Mind – filling up with image of sea

3. Walk on the beach
  - a. Setting the scene
  - b. Walking in the Nurturing Self
  - c. Meeting a friend
  - d. Conversation
  - e. Message
  
4. Counting back
  - a. Feet and legs – energy
  - b. Trunk – ease of feeling
  - c. Shoulders and arms – assuming responsibility not burdens
  - d. Face and neck – congruence and ease  
Suggestion to remember the message
  - e. Mind – returning to room

#### IV. Discussion

1. Process this experience
2. Discuss applications
  - a. Adults in groups and individually
  
  - b. Juveniles in groups and individually
  
3. Discuss limitations
  
4. Variations
  - a. Letter writing
  
  - b. Affirmations

#### V. Discussion

**GOALS**

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

List ten things in your life that you would like to **HAVE**, **DO**, or **BE** and the ways you block yourself from getting them.

**DESIRES**

**BLOCKS**

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
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## THE FIVE SECRETS OF EFFECTIVE COMMUNICATION\*

### LISTENING SKILLS

1. **The Disarming Technique.** You find some truth in what the other person is saying, even if you feel convinced that what they're saying is totally wrong, unreasonable, irrational, or unfair.
2. **Empathy.** You put yourself in the other person's shoes and try to see the world through his or her eyes.
  - **Thought empathy:** You paraphrase the other person's words.
  - **Feeling empathy.** You acknowledge how they're probably feeling, given what they are saying to you.
3. **Inquiry:** You ask gentle, probing questions to learn more about what the other person is thinking and feeling.

### SELF-EXPRESSION SKILLS

1. **"I feel" statements.** You express your feelings with "I feel" statements (such as "I feel upset") rather than with "you" statements (such as "you're wrong!" or "You're making me furious!").
2. **Stroking:** You find something genuinely positive to say to the other person, even in the heat of battle. This indicates that you respect the other person, even though you may be angry with each other.

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### **LISTENING SKILL: THE DISARMING TECHNIQUE**

1. Find some truth in what the other person says. They have to be right to some extent, since no one is ever 100 percent wrong. Usually, when you agree with the other person they will then stop arguing and agree with you! This remarkable phenomenon is called the “Law of Opposites.”
2. If you feel angry or attacked, express your feelings with non-challenging “I feel: statements, such as “I fell upset that. . .” Avoid the temptation to argue or strike back. Don’t get defensive.
3. Answer in such a way that your dignity and self-esteem are maintained, even if you agree with the other person’s criticism.
4. Give up your desire to lash out or blame the other person. Try to maintain an attitude of mutual respect so that nobody has to lose face or feel put down.
5. Avoid getting into who is “right” or “wrong.” This serves no purpose!

### **LISTENING SKILL: EMPATHY**

1. Put yourself in the other person’s shoes. Listen carefully and try to understand accurately what they are thinking as they are talking. State what you think the other person is thinking by saying something like “It sounds like . . .” and then paraphrase respectfully what you understood them to say.
2. Also try to understand what the other person is feeling. Listen with your “third ear.” Notice their body language. Do they appear tense? Angry? Hurt? Acknowledge what the person is feeling, base on what they said and the manner in which they said it.
3. Ask a question to confirm how they are feeling, such as “I can imagine you must be feeling frustrated with me. Is this true?” Ask them if you have accurately understood what they are thinking and feeling.
4. Use an “I feel” statement to let them know how you would feel if you were in their shoes. You might say, “I would be feeling the same way if this had happened to me.”
5. Accept the other person’s feelings. Do not be hostile, critical, or defensive. Let them know that you are willing to hear what they have to say.

## **LISTENING SKILL: INQUIRY**

1. Most people have an intense fear of expressing their feelings openly. They are always afraid of conflict and will avoid telling you they're angry with you. They deny their feelings, and then act them out. You can prevent this if you ask the other person to tell you more about their negative feelings.
2. You can also ask the other person to tell you more about the specific problem that makes them feel upset. What are the details? How often does it happen? How do they feel about it? What did you do that turned them off?
3. Ask the person to tell you directly what you did or said that hurt their feelings. When they tell you, don't get defensive. Instead, use empathy and the disarming technique. Find some truth in what they have to say. If you feel upset or irritated or put down, express your feelings with an "I feel" statement.
4. Use a tone of voice that is respectful, not challenging, when asking what made them unhappy or angry. Do not use any form of sarcasm.
5. Don't be afraid of anger and conflict. They are healthy. Don't let the other person's unhappy feelings go unexpressed. That makes the feelings much more intense.

## **SELF-EXPRESSION SKILL: "I FEEL" STATEMENTS**

1. When expressing your feelings, use "I feel" statements, such as "I feel upset." Avoid "you" statements, such as "You're making me upset." These "you" statements sound critical and judgmental and always trigger fights and arguments! Here are some examples:

"You always" or "You never . . ."

"You are wrong."

"You shouldn't . . ."

"You've got no right."

"It's your fault."

"You're making me angry."

2. Don't act out your feelings! State them! Use "I feel" statements. Acting out emotions can take the form of:

Pouting

Stony silence

Gossiping

Door slamming

Martyr playing

Drinking too much

Being sarcastic

Being critical

Being argumentative

Frowning

Being rude

Negative body language

3. Negative feelings can be expressed by saying, "I feel . . ." with words like:

concerned	pressured
frustrated	misunderstood
angry	uncomfortable
coerced	

4. Vulnerable feelings can be expressed by saying, "I feel . . ." with words like:

sad	nervous
rejected	ignored
hurt	inadequate
unloved	intimidated
disappointed	

5. Wishes and desires can be expressed by saying something like:

"I would like to spend more time with you."  
"I really want us to work out this problem and to be closer."  
"I really want to feel close to you."  
"I want you to try to understand my point of view."

## **SELF-EXPRESSION SKILL STROKING**

1. Generally speaking, most people want to feel cared about and appreciated. The greatest fear that people have is being put down, rejected, or judged.
2. Reassure the other person by clearly letting them know that you respect them and that they are important to you, even if you are angry or disagreeing with them at the moment.
3. Let the other person know that you want to work out the problem in a mutually satisfactory way.
4. Don't criticize or condemn them as a person. Nothing is ever gained by doing this. Attacking them personally is very different from commenting negatively on something they are doing or thinking.
5. The listening and self-expression skills are only techniques. Real communication results from the spirit of genuine respect for your self and the other person. If your goal is to prove yourself right, to blame the other person, or to get back at them, any communication technique will fail. But if your goal is to resolve the problem and to understand how the other person is thinking and feeling, these powerful methods will help you resolve conflicts and enjoy greater intimacy.

## SECRETS OF EFFECTIVE COMMUNICATION\*

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## TEN ATTITUDES THAT KEEP YOU FROM EXPRESSING YOUR FEELINGS\*

1. **Conflict phobia.** You are afraid of angry feelings or conflicts with people. You may believe that people with good relationships shouldn't fight or argue. You may also believe that the people you care about would be hurt and couldn't take it if you told them how you felt or what was really on your mind. I call this the "ostrich phenomenon," because you bury your head in the sand instead of dealing with the problems in your relationship.
2. **Emotional perfectionism.** You believe that you shouldn't have irrational feelings like anger, jealousy, depression, or anxiety. You think you should always be rational and in control of your emotions. You are afraid of being exposed as weak and vulnerable. You believe that people will look down on you if they find out how you really feel.
3. **Fear of disapproval and rejection.** You are so terrified by rejection and ending up alone that you'd rather swallow your feelings and put up with some abuse than take the chance of making anyone mad at you. You feel an excessive need to please people and to meet everybody's expectations. You are afraid that people would not like you if you expressed your own ideas and feelings.
4. **Passive-aggressiveness.** You pout and hold your hurt and angry feelings inside instead of sharing them openly and honestly. You give others the silent treatment and try to make them feel guilty instead of sharing your feelings.
5. **Hopelessness.** You feel convinced that your relationship cannot improve no matter what you do, so you give up. You may feel that you've already tried everything and nothing works. You may believe that your spouse is just too stubborn and insensitive to be able to change. This acts as a self-fulfilling prophecy. Once you give up, things get stuck and you conclude that things really are hopeless.
6. **Low self-esteem.** You believe that you aren't entitled to express your feelings or to ask others for what you want. You think you should always please other people and meet their expectations.
7. **Spontaneity.** You believe that you have the right to say precisely what you think and feel when you are upset. You may feel that any change in the way you communicate will sound phony and ridiculous.
8. **Mind reading.** You believe that people should know how you feel and what you want without your having to express yourself directly. This gives you a perfect excuse to hold your feelings inside and to feel resentful because people don't seem to care about your needs.
9. **Martyrdom.** You are afraid to admit that you're angry, because you don't want to give anyone the satisfaction of knowing they've upset you. You take enormous pride in controlling your emotions and suffering silently.
10. **Need to solve problems.** When you have a conflict with someone, you go around and around in circles trying to solve the problem instead of sharing your feelings openly and hearing how the other person feels.

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## TEN ATTITUDES THAT PREVENT YOU FROM LISTENING\*

1. **Truth.** You believe that you are right and the other person is wrong. You are preoccupied with proving your point instead of expressing your angry feelings more directly or trying to grasp how the other person is thinking and feeling.
2. **Blame.** You believe that the problem is the other person's fault. You feel overwhelmingly convinced that you're completely innocent and tell yourself that you have every right to blame him or her.
3. **Need to be a victim.** You feel sorry for yourself and think that other people are treating you unfairly because of their insensitivity and selfishness. Your stubborn unwillingness to do anything assertive to make the situation better gives people the impression that you like the role of a martyr.
4. **Self-deception.** You cannot imagine that you contribute to a problem because you cannot see the impact of your behavior on others. For example, you may complain that your wife nags you, but you don't think about the fact that you repeatedly "forget" to follow through on your promise to repair the fence. You may complain that your husband is dogmatic and stubborn and unwilling to listen to your ideas, but you don't notice that you constantly contradict everything he tries to say.
5. **Defensiveness.** You are so fearful of criticism that you can't stand to hear anything negative or disagreeable. Instead of listening and trying to find some truth in the other person's point of view, you have the urge to argue and defend yourself.
6. **Coercion sensitivity.** You are afraid of giving in or being bossed around. Other people seem controlling and domineering, and you feel that you must dig in your heels and resist them.'
7. **Demandingness.** You feel entitled to better treatment from others ,and you get frustrated when they do not treat you as you expected. Instead of trying to understand what really motivates them, you insist that they are being unreasonable and have no right to feel and act the way they do.
8. **Selfishness.** You want what you want when you want it, and you throw a tantrum if you don't get it. You are not especially interested in what others may be thinking and feeling.
9. **Mistrust.** You put up a wall because you believe you will be taken advantage of if you listen and try to grasp what the other person is thinking and feeling.
10. **Help addiction.** You feel the need to help people when all they want is to be listened to. When friends and family members complain about how bad they feel, you make "helpful" suggestions and tell them what to do. Instead of being appreciative, they get annoyed and continue to complain. You both end up feeling frustrated.

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## **PROBLEMS IN PERSONAL COMMUNICATION**

Communication problems are often at the root of difficulties between two or more people. This is no simple matter to improve on. Sometimes we have problems sending messages to others or listening to problems or responding to what we hear. Some of the problems commonly seen are:

1. Not expressing your thoughts accurately
2. Not listening to all that is being said
3. Trying to say too much at once
4. Two people trying to talk about different things in the same conversation
5. Emotions which make honest communication difficult (being angry, jealous, afraid)

## **POINTS OF RESPECTFUL COMMUNICATION**

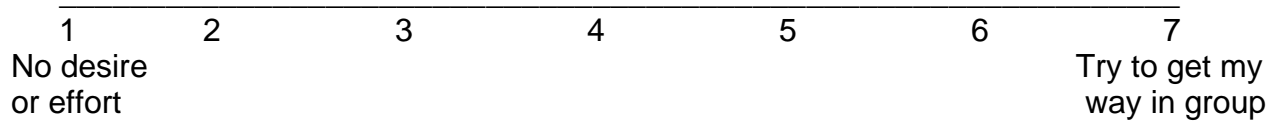
**REMEMBER THESE FOUR POINTS ABOUT RESPECTFUL COMMUNICATION AND CONFLICT RESOLUTION.**

- 1) You have the right to say what you want to say, but you cannot do it in an abusive way, using intimidating or harsh language.
- 2) In order for communication to be effective, both parties must listen to what the other person is saying and not try to merely convince the other of your position.
- 3) Good communication requires negotiation and compromise. If some-body has to win the argument, then somebody else has to lose it.
- 4) No single issue is as important as your overall goal of remaining non-abusive in your relationship.

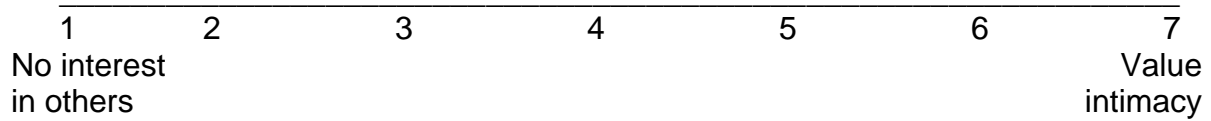
Group communication is very important. Look at the following questionnaire. Where do you think you have problems in group communication?



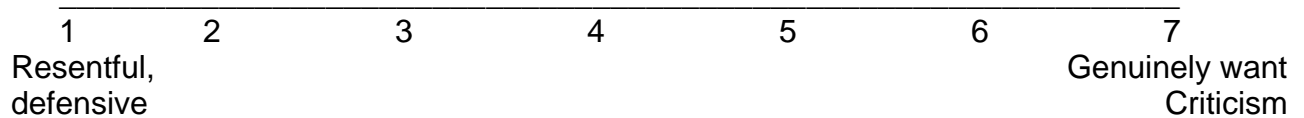
7. Tendency to run the group



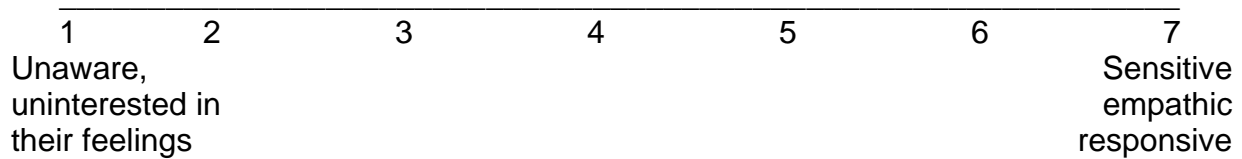
8. Tendency to seek close personal relationships with others in a group



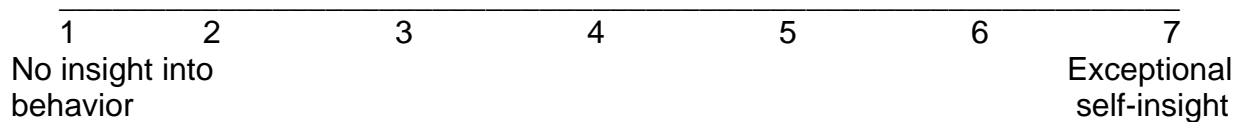
9. Reaction to critical comments about own behavior in a group



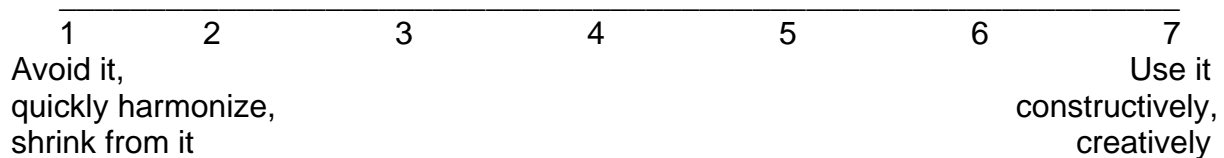
10. Awareness of the feeling of others



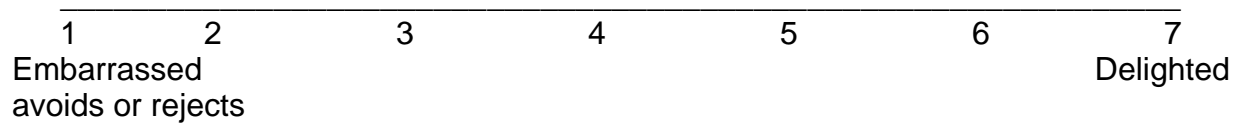
11. Degree of insight into the why of behavior – own and others



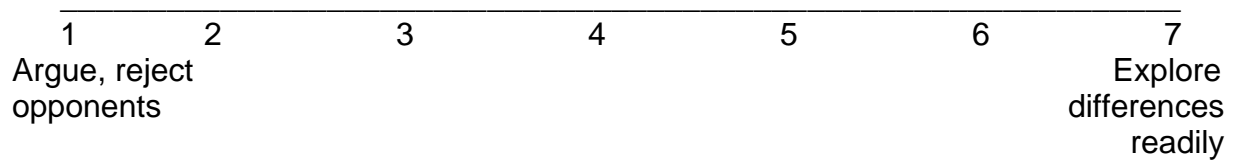
12. Reaction to conflict and antagonism in the group



13. Reaction to expressions of affection and warmth in the group



14. Reaction to opinions opposed to mine



## REFERENCES

Burns, D.D. (1984) *The Feeling Good Handbook*, William A. Morrow & Company, New York, NY, USA.

## **CONCLUSIONS**

Findings strongly suggest that sexual offenders of all ages have social skills deficit along with impulse control problems. Without intervention in these areas the offender is likely to have ongoing social and legal problems. Unless, he or she receives appropriate treatment he or she will most likely continue relationship patterns with immature or younger people. Perhaps if the therapist can show the juvenile and youthful offenders that they have something to gain from the interventions then those individual offenders will want to remain in therapy and complete the treatment program which will ultimately benefit all of society and move toward the ultimate goal of elimination of one of our major societal problems.