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MANAGEMENT OF SEX OFFENDERS

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ABSTRACT

Sex offender is a broad term used for all individuals convicted of crimes which involve sex, including rape, molestation, sexual harassment and pornography production or distribution. There has been considerable research in recent times on the role of psychological and social factors that can lead to rape. Many factors have been identified such as disinhibition, coercive sexual fantasies, childhood environments that are physically violent, emotionally unsupportive and characterized by competition for limited resources. Societal norms around the use of violence as a means to achieve objectives have been strongly associated with the prevalence of rape. Apart from discussing about factors related to sexual offences, the present article also discuss about various management for sexual offenders such as cognitive/Behavioral group and individual therapy, schema-focused therapy, and biomedical interventions. Tough current treatments are found to be effective, more longitudinal studies are required to assess the long term effects of different therapeutic techniques.

Key words: Sex offender, treatment for offenders, causes of sexual offences, schema-focused therapy, Biomedical interventions

Sex offender is a broad term used for all individuals convicted of crimes which involve sex, including rape, molestation, sex trafficking or possession of child pornography(Merriam-Webster's Collegiate Dictionary, 2005).What constitutes a sex crime differs by culture and legal jurisdiction. The majority of convicted sex offenders have convictions for crimes of a sexual

nature however; some sex offenders have simply violated a law contained in a sexual category (Wikipedia, 2011).

Kinds of sexual offenses

Sexual assault

Sexual assault is a crime of power and control. It refers to sexual contact or behavior that occurs without explicit consent of the victim. Some forms of sexual assault include: Penetration of the victim's body, also known as rape, attempted rape,forcing a victim to perform sexual acts, such as oral sex or penetrating the perpetrator's body and fondling or unwanted sexual touching.However, force doesn't always refer to physical pressure. Perpetrators may use emotional coercion, psychological force, or manipulation, threats and/or other intimidation tactics to coerce a victim into non-consensual sex. (RAINN, 2016)

Sexual harassment

Sexual harassment includes unwelcome sexually determined behavior (whether directly or by implication) such as: physical contact and advances, a demand and request for sexual favours, sexually coloured remarks, showing pornography and any other unwelcome physical, verbal or non-verbal conduct of sexual nature.

Where any of these acts is committed in circumstances where-under the victim of such conduct has a reasonable apprehension that in relation to the victim's employment or work whether she is drawing salary, or honorarium or voluntary, whether in government, public or private enterprise such conduct can be humiliating and may constitute a health and safety problem (Vishakha guidelines against sexual harassment, 1997).

Child sexual abuse

Child sexual abuse is a form of child abuse that includes sexual activity with a minor. Some forms of child sexual abuse include: Obscene phone calls, text messages, or digital interaction, fondling, exhibitionism, or exposing oneself to a minor, masturbation in the presence of a minor or forcing the minor to masturbate, Intercourse, sex of any kind with a minor, including vaginal, oral, or anal, producing, owning, or sharing pornographic images or movies of children, Sex trafficking, and any other sexual conduct that is harmful to a child's mental, emotional, or physical welfare. (RAINN, 2016)

Incest

The term incest refers to sexual contact between family members. Laws vary from state to state regarding what constitutes crimes of incest. Regardless of state laws, unwanted sexual contact from a family member can have a lasting effect on the survivor. (RAINN, 2016)

What leads them to commit the act?

Psychological factors

There has been considerable research in recent times on the role of cognitive variables among the set of factors that can lead to rape. Sexually violent men have been shown to be more likely to consider victims responsible for the rape and are less knowledgeable about the impact of rape on victims. Such men may misread cues given out by women in social situations and may lack the inhibitions that act to suppress associations between sex and aggression (Denhere, n.d.). They may have coercive sexual fantasies (Dean &Malamuth, 1997) and overall are more hostile towards women than are men who are not sexually violent (Quimette& Riggs, 1998; Koss &Dinero, 1989; Malamuth, 1998).

In addition to these factors, sexually violent men are believed to differ from other men in terms of impulsivity and antisocial tendencies (Crowell &Burgese, 1996). They do tend to have an exaggerated sense of masculinity. Sexual violence is also associated with a preference for impersonal sexual relationships as opposed to emotional bonding with having many sexual partners and with the inclination to assert personal interests at the expense of others (Malamuth, 1998; Malamuth et al., 1991). A further association is with combative attitudes on gender that hold that women are opponents who are to be challenged and conquered (Lisak et al., 1990).

Early Childhood Experiences

There is evidence to suggest that sexual violence is also a learnt behavior in some adults, particularly as regards child sexual abuse. Studies on sexually abused boys have shown that around one in five continue in later life to molest children themselves (Watkins &Bentovin, 1992). Such experiences may lead to a pattern of behavior where the man regularly justifies being violent, denies doing wrong, and has false and unhealthy notions about sexuality.

Childhood environments that are physically violent, emotionally unsupportive and characterized by competition for limited resources have been associated with sexual violence. (Borowsky et al., 1997; Crowell &Burgese, 1996; Dobash&Dobash, 1992). Sexually aggressive behavior in young men has been linked to witnessing family violence, and having emotionally distant and

uncaring fathers (Quimette& Riggs, 1998; Borowsky et al., 1997). Men raised in families with strongly patriarchal structures are also more likely to become violent, to rape and use sexual coercion against women, as well as to abuse their intimate partners, than men raised in homes that are more egalitarian (Crowell &Burgese, 1996).

Social norms

Sexual violence committed by men is to a large extent rooted in ideologies of male sexual entitlement. These belief systems grant women extremely few legitimate options to refuse sexual advances (Wood &Jewkes, 2001; Ariffin, 1997; Bennettet al., 2000). Some men thus simply exclude the possibility that their sexual advances towards a woman might be rejected or that a woman has the right to make an independent decision about participating in sex. In some cultures, women as well as men, regard marriage as entailing the obligation on women to be sexually available virtually without limit (Jewkes& Abrahams, 2002; Sen, 1999) although sex may be culturally prohibited at certain times, such as after childbirth or during menstruation (Buckley & Gottlieb, 1998).

Societal norms around the use of violence as a means to achieve objectives have been strongly associated with the prevalence of rape. In societies where the ideologies of male superiority are embedded in strength, emphasizing dominance, physical strength and male honor, rape is found to be more common (Sanday, 1981). Countries with a culture of violence, or where violent conflict is taking place, experience an increase in almost all forms of violence, including sexual violence (Sanday, 1981; Smutt et al., 1998)

Feminist theories of male-female rape

This is summarized by Susan Brownmiller's statement: "rape is nothing more or less than a conscious process of intimidation by which all men keep all women in a state of fear" (Brownmiller, 1993). Some feminists assert that male domination of women in socio-political and economic domains is the ultimate cause of most rapes, and consider male-female rape to be a crime of power that has little or nothing to do with sex itself (Ellis, 1989).

Therefore, we see the role of psychological factors in a sexual offense committed by a sex offender. Like any other psychological problem, this is too has been attempted to be treated.

MANAGEMENT OF SEX OFFENDERS

Difference between Sex Offender Treatment and Traditional Psychotherapy

In sex offender treatment, the primary client is the community and the goal is, no more victims.

Sex offender treatment is mandated, confrontational, structured, victim centered, and the treatment provider imposes values and limits. Providers cannot remain neutral because of the risk of colluding with, adding to, and/or contributing to the offender's denial. In sex offender treatment, confidentiality is not maintained due to the enormous public safety issues. Treatment providers must not solely rely on self-report because sex offenders see trust as abuse-able. Treatment providers rely on polygraphs to verify information given by the offender. Sex offender treatment is offense specific and focused on the deviant behavior.(Council on Sex Offender Treatment, 2005).

In traditional psychotherapy the client voluntarily seeks therapy and is motivated. Goal setting is a joint responsibility with the client having the final say. Therapists remain neutral and do not impose their values and limits. Confidentiality and trust are maintained and are essential to the therapeutic process. Psychological treatment of sex offenders can be categorized into building insight, identifying and remove maintaining factors for offending pattern and prevent relapse. (Perkins et al., 1998).

Ward & Hudson (1998), gave overview of sex offenders' criminogenic needs, meaning, factors that if present and untreated are likely to contribute to reoffending. Such factors are as follows: deviant sexual arousal/sexual pre-occupation, weak commitment to avoiding re-offending, cognitive distortions which support offending , limited/inappropriate reactions to victim distress, impulsive, antisocial lifestyle, difficulty recognizing personal risk factors, difficulty generating/enacting coping strategies for personal risk factors, deficits in (personal/interpersonal) problem solving skills for risk factors, social support for sex offending, poor emotional control, emotional loneliness, limited/inappropriate intimacy skills (e.g. dealing with disclosure, jealousy etc), dysfunctional schemas, linked to early attachment experiences (e.g. suspiciousness), history of drug and/or alcohol abuse.

Approaches to treatment of sex offenders may include: Skill-based interventions (e.g. role-play, anger management, sex education), behavioural Modification (e.g. aversion/ covert sensitization, orgasmic reconditioning, masturbatory satiation), Insight Orientated interventions. Approaches to the psychological treatment of sex offenders have changed over time. The focus has shifted from treatment aimed at offenders gaining insight into why they perpetrate sexual crimes. A more structured cognitive behavioural approach (Salter, 1988; Marshall et al., 1990; Maletsky, 1991) focusing on a range of risk factors for future offending was established. The cognitive behavioural model has also adopted relapse prevention techniques from drug and alcohol

research and applied it to sex offender intervention through the development of individually tailored programmes (Laws, 1989).

Offense specific sex offender treatment

Offense specific sex offender treatment is effective in reducing recidivism. A multifaceted treatment program includes the following:

Cognitive/Behavioral group and individual sessions- Cognitive-behavioural treatment programmes have tended to draw from both, empirical research on criminogenic factors associated with sex offending (Thornton & Hogue, 1993) which identifies what treatments are likely to be relevant and effective and the multi-modal functional analyses of individual offenders' contemporary patterns of offending (Perkins, 1991; Perkins, 1993), which helps tailor treatments to the specific patterns of offending of individual offenders. Cognitive distortions allow the adult sex offender and juveniles with sexual behavior problems to overcome prohibitions, progress from fantasy to behavior and reduce guilt and responsibility. The treatment literature describes interventions directed towards the modification of offenders' denial and minimisation of the acts committed, sexual motivation, harm to victims and need for treatment, which has been handled variously by the use of official documents (victim statements), reinforcement of offenders' disclosure, group discussion and challenge and polygraph "lie detectors" (Salter, 1988; Barbaree, 1991; Perkins, 1993; Marshall, 1996; Maletsky, 1998).Cognitive-behavioural training in anger management, social skills and assertiveness training have also all been used with varying degrees of success with sex offenders who lack these capacities and in whom these have contributed to their offending. More recently, relationship therapy, training in intimacy skills and the enhancement of self-esteem have also been identified as appropriate treatment targets (Marshall & Barrett, 1990; Marshall, 1996; Solicitor General Canada, 1990; Sampson, 1994; Marshall &Eccles, 1998).

Schema-Focused therapy-Recent work has suggested the relevance of schema-focused therapy for sex offenders but this is in its early stages of development. This approach stems from findings that sex offenders have schemas, or ways of viewing the world, which stem from early attachment experiences and contribute to offending behaviour. (Malamuth& Brown, 1994) found a sample of rapists to have "suspicious schemas" in which women's hostile behaviour was misinterpreted as seductive and seductive behaviour was viewed with suspicion.

Arousal control- Control of deviant arousal, fantasies, and urges is a priority with most adult sex offenders and juveniles with sexual behavior problems. Fantasy and sexual arousal to fantasy are precursors to deviant sexual behavior. It should be assumed that most adult sex offenders and juveniles with sexual behavior problems have gained sexual pleasure from their specific form of deviance. In an early study on satiation therapy with sex offenders, (Abel & Blanchard, 1974) subjected patients to 20 hours of masturbatory satiation and reported success in reducing deviant arousal patterns.

Victim empathy- Empathy is a quality which helps an individual to understand what another person is going through in their life. Although there is no clear evidence to suggest that all sex offenders can gain true empathy for victims of abuse, a universal goal of treatment is to learn to understand and value others. The importance of a lack of general or victim empathy in sexual offending has led to the development of interventions designed to address this issue. (Pithers, 1994; Marshall &Eccles, 1998) have developed awareness-raising and skills-developing programmes. These involve components aimed at offenders' understanding the effects of sexual offending on victims/survivors (through discussion of evidence, videotape material), offenders addressing the effects of their own offending (through discussion, preparation of written material and role-playing).Highlighting the consequences of victimization helps sensitize the offender to the harm he or she has done. Empathy is comprised of cognitive and emotional aspects and both components may need to be addressed. The use of analogous experiences has been shown to be effective especially with juveniles.

Biomedical interventions- Physical or chemical castration should be utilized only as an adjunct to treatment and not in lieu of treatment. Anti-androgens such as depo-provera or Lupron act by reducing testosterone levels. These agents may be helpful in controlling arousal and libido when these factors are undermining progress in treatment or increasing the risk of re-offending before significant progress can be made in the cognitive aspects of therapy. (Council on Sex Offender Treatment, 2005).

Offense Cycle and Relapse Prevention- (Pithers et al., 1988; Laws, 1989) imported the concept of relapse prevention into the area of sex offender treatment from work with drug and alcohol addiction. Current knowledge of deviant sexual behavior suggests that there is a cycle of behaviors, emotions, and cognitions that is identifiable and which precede deviant sexual behavior in a predictable manner. The ability to accurately identify these maladaptive behaviors is a primary goal for every adult sex offender and juvenile with sexual behavior problems in

treatment. Autobiographies, sexual history polygraphs, offense reports, interviews and cognitive-behavioral chains are used to identify antecedents to offending. It is essential to examine the sex offender's deviant sexual arousal and behavior and not just the offense of conviction. Research and clinical reports have begun to demonstrate that a number of treatment methods are effective in modifying some forms of sexual deviance. It is known that very specific thoughts occur prior to the sexually deviant act. This is what is commonly referred to as an offense cycle.

IMPULSE ⟶ FANTASY ⟶ PLAN ⟶ ACT ⟶ CONSEQUENCE

Impulses are normal and natural. Everyone has impulses and impulses are automatic. An impulse is when a person recognizes an individual in terms of their sexual attractiveness. A fantasy is a mental picture of what it would be like to engage in deviant sexual behavior. The setup is the plan for victimization. The consequence for deviant sexual acts should be legal actions but unfortunately not all deviant sexual acts are followed by such consequences.

Sex offenders must recognize their deviant impulses and stop those impulses from developing into deviant fantasies. It is essential to examine the sex offender's deviant thought, sexual arousal, and behavior.

Polygraphs and sexual offenders- Because secrecy and dishonesty is the major component in sexual offending, polygraphs may be utilized. Polygraphs measure the emotional arousal that is caused by fear and anxiety. The autonomic nervous system responds to arousal with physiological reactions such as increased heart rate, depth of respiration, and sweat gland activity. There are four types of polygraphs that are used on sex offenders: (1) Disclosure Polygraph- addresses the offense of conviction in conjunction with the official version. (2) Sexual History Polygraph- addresses the complete sexual history of the client up to the instant offense.(3) Maintenance Polygraph- addresses compliance with conditions of supervision and treatment.(4) Monitoring Polygraph- addresses if the client has committed a "new" sexual offense (Council on Sex Offender Treatment, 2005).

There are enough signs and symptoms in some adult sex offenders and juveniles with sexual behavior problems to merit an additional diagnosis by DSM IV-TR criteria. These diagnoses can be anywhere in the entire spectrum of psychiatric disorder. The co-morbid diagnoses should be treated with the appropriate therapies parallel with the treatment for sex offending behavior except in the case of psychosiswhere the anti-psychotic treatment would take the lead.

After-care treatment should involve periodic follow up sessions to reinforce and assess maintenance of positive gains made during treatment.

The Effectiveness of Sex Offender Treatment

Decades of research across a broad spectrum of issues show that punishment merely suppresses deviant behavior and does not eradicate it (Cole et al., 1997). The purpose of treatment is to modify both cognitive distortions and deviant sexual behavior to reduce the risk of re-offending. Research and clinical reports have begun to demonstrate that a number of treatment methods are effective in modifying some forms of sexual deviance. The following are studies that show the effectiveness of treatment:

In a 2004 study of 31,216 sex offenders, Hanson observed on average that the sexual recidivism rate was 13%, violent non-sexual recidivism at 14%, and general recidivism at 36.9%. In 2000 Hanson found that the overall effect of treatment demonstrated reductions in both sexual recidivism (10% of the treated subjects to 17% of untreated) and general recidivism (32% for treated subjects to 51% of untreated subjects).

In the December 2002 publication of Psychiatry News, an article titled "Sex Offender Recidivism Rates Below Expectations: A 15 Year Prospective Study" concluded that more than eighty percent (80%) of sex offenders who have undergone treatment do not re-offend within fifteen (15) years. The study of 626 individuals was reported at the American Academy of Psychiatry and Law. The study found that sex offenders who were compliant with treatment were less likely to re-offend. Approximately forty percent (40%) of these individuals received anti-androgenic drugs in order to lessen their sex drive.

Child molesters who participated in a cognitive behavioral treatment program had fewer sexual re-arrests than the sex offenders who did not receive any treatment (13.2% vs. 57.1%, respectively). Both groups were followed for 11 years. The recidivism data was obtained by official sources and self-reports. Treated exhibitionist were reconvicted or charged with a sexual offense less than the untreated exhibitionist (23.6% v. 57.1%, respectively) (Lane, Council, 2003).

A meta-analytic study showed that treated sex offenders recidivated at a rate of 19% (Hall, 1995). Treated offenders are more likely to make emotional and psychological restitution for the offender's deviant behavior and be available to contribute to the victim's treatment process. When treatment programs are compared with criminal justice sanctions, the findings show treatment is more likely to reduce recidivism. Even detailed analyses of types of sanctions show no one particular sanction as significantly effective in reducing recidivism. If the community

safety is to be enhanced, offender rehabilitation programs that follow the principles of effective treatment are most likely to meet with success (Bonta, 1997-2001).

McGrath et al. (2003) demonstrated a significantly lower rate of sexual re-offending in offenders who completed a prison-based treatment programme compared with offenders who completed some of the programme and none of the programme respectively (5.4% vs. 30.6% and 30%).

Conclusion

Sexual offense, being a delicate as well as critical issue, has received serious attention to its various aspects including legal, social as well as psychological aspects. However attempts to provide therapeutic treatment to these offenders despite various limitations indeed provide a comprehensive and complete picture. Various researchers have focused their intervention mainly on helping the offender gain insight into their behavious, helping them understand others' emotions, teaching techniques to control their behaviours and help them prevent similar future acts. Few available literatures have also shown positive results using therapeutic intervention.

Future direction

Many studies have tried to investigate root causes of sexual offending however few studies are available about the therapeutic management of these offenders. More longitudinal studies are required to assess the long term effects of different therapeutic techniques.

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