

1



2

# What do we mean when we say “sexual offense”

3

- Sexual offenses means any sexual act directed against another person, without the consent of that person, including instances when the person is unable to give consent. This can include child sexual abuse images.

4



## Not all people who commit a sexual offense are the same

- The majority of sexual offenses are committed by males, but NOT all.
- Sexual offenders can be of any gender, race, age, socioeconomic status, ability, etc.
- A person who has offended differs in risk level, offense behavior and treatment needed.
- Stranger danger is a myth and only accounts for 7% of sexual violence against children-most victims know their abuser
- Assumptions about a SO
  - [Fighting the "Stranger Danger" Myth | Psychology Today](#)

5

## Challenges of Working with the Sex Offender Population

Working with the criminal legal system and other referral sources	Court ordered treatment
Clients are in denial in many cases	Clients themselves are shutdown

6

Challenges  
of Working  
with the  
Sex  
Offender  
Population

Hierarchy of needs

Re-integration from  
prison

Clinical bias

7

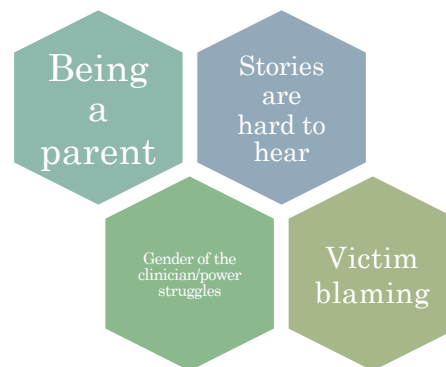
Challenges  
of Working  
with the  
Sex  
Offender  
Population

Always keeping the  
experience of victims as part  
of the framework

Challenges morals, ethics  
and the dialectic of a “good  
person who does something  
bad”

8

## Challenges of Working with the Sex Offender Population



9

## Barriers to Treatment



10

## Why is it important to work with this population

Everyone deserves treatment

Recovery is possible

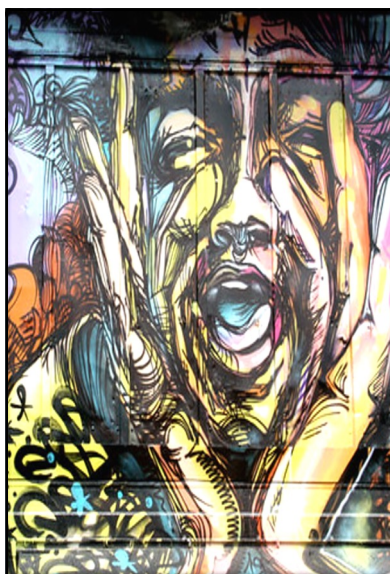
Clients have served prison sentences and are being punished by the criminal legal system

11

## Treatment provides SO clients with:

- An opportunity for positive socialization and peer relationships
- A space to get support for past childhood trauma
- A space to create new life goals as they come out of prison
- Provide support and guidance on how to keep others safe as well as themselves and help them to understand probation conditions and conditions of the registry

12



## Treatment provides SO clients with:

- Address substance use/abuse as well as sexual and pornography addiction
- Provide space for managing stress
- Gaining leads for employment and housing
- Providing support where many people have lost their community
- Provide a space to understand their sexually abusive behavior and take responsibility
- A place to address shame

13

NOT providing  
treatment puts  
people at a  
higher risk for  
recidivist  
behavior



14

## Best Practices in treatment and assessment

- a. Intake
- b. Assessment
- c. Treatment
- d. Treatment completion

Assessment begins with:

- i. SOSE/psychosexual assessment
- ii. Static/dynamic risk
- iii. Self reporting questionnaires on sexual history
- iv. CCA-who the person is at a glance/diagnosis/substance use/abuse assessment

15

## Best Practices in treatment and assessment

- Age
- Culture;
- Psychosocial and emotional development;
- Level of adaptive functioning;
- Neuropsychological, cognitive, and learning impairments;

16



## Best Practices in treatment and assessment

- Language or communication barriers;
- Acute psychiatric symptoms;
- Denial; and
- Level of motivation.

17

## SOSE/psychosexual assessment

• Psychosexual development, early sexual experiences, and history of age appropriate, consensual sexual relationships;

• Nature and frequency of sexual practices (e.g., masturbation, non-abusive and appropriate sexual behaviors, unconventional or risky sexual activities);

• Paraphilic interests, fantasies, and behaviors that may not be sexually abusive (e.g., fetishes, masochism); • Use of sexually oriented services or outlets (e.g., magazines, hiring sex workers, internet, telephone sex lines, adult establishments);

18

## SOSE/psychosexual assessment

- Abusive or offense-related sexual arousal, interests, and preferences;
- History of sexually abusive behaviors, both officially documented and unreported (if identified through credible records or sources)
- Information about current and/or previous victim(s) (e.g., age, gender, relationship to client)
- Contextual elements of sexually abusive behaviors (e.g., dynamics, motivators, patterns, circumstances)
- Level of insight, self-disclosure, and denial (e.g., of the behaviors, motivations or intent, level of violence and coercion) relative to various aspects of the sexually abusive behavior.

• ATSA Practice Guidelines for Assessment and Treatment

19

Other methods of assessment include:  
Phallometry, Viewing Time, and  
Polygraphy to Support Information-  
Gathering for Assessments

20

MSI-Multiphasic Sexual Inventory -Nichols & Molinder Assessments, Inc. - MSI II  
[nicholsandmolinder.com](http://nicholsandmolinder.com)

1. The MSI II Adult Male Form is designed to measure the sexual characteristics of an adult male alleged to have committed a sex offense or sexual misconduct and can be used both to do a sex deviance evaluation and also to measure treatment progress. It can be useful in evaluation a client who has been alleged to have engaged in sexual misconduct but who denies any such behavior.

## Multiphasic Sexual Inventory/MSI

21

## Assessing for strengths and protective factors

- Social support
- Employment
- Family/community support
- Faith/religion/spiritual practices
- Culture
- Hobbies/interests
- Emotional health
- Access to support



22

# Risk/Needs/Responsivity

Best Practice in working with the sexual offending population

23

## Static risk vs Dynamic Risk

### Examples of Static Risk Factors for Sex Offenders

Prior sex offenses  
Prior non-sex offenses  
Unrelated victims  
Stranger victims  
Young male victims  
Deviant sexual  
arousal, interests,  
preferences

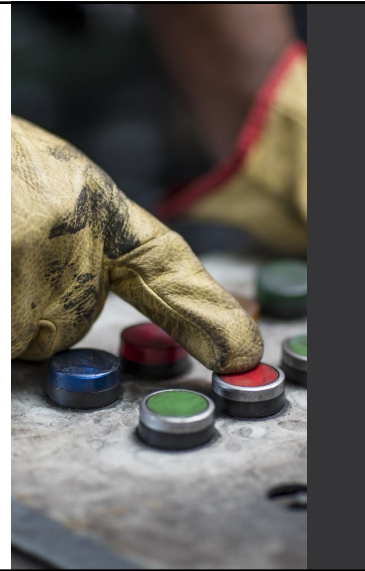
### Examples of Dynamic Risk Factors for Sex Offenders

Sexual preoccupations  
Access to victims  
Intimacy deficits, conflicts  
in relationships  
Pro-offending attitudes  
Hostility  
Non-compliance with  
supervision, treatment  
Lifestyle instability

24

## Risk

- Matching the level of service to the individual's risk to reoffend. (i.e., greater intensity and dosage for higher risk clients)




25

## Need

- Focusing interventions primarily on research– supported dynamic risk factors that are linked to recidivism (i.e., criminogenic needs including procriminal attitudes, offense–related sexual interests, sexual preoccupations, negative social influences, lifestyle impulsivity, problems with intimacy, and resistance to supervision) over targets of intervention that are not demonstrated by research to be linked to recidivism




26



## Responsivity

- Using intervention models with empirical support for promoting behavioral change (i.e., general responsivity) and delivering services in a manner that appropriately takes into account individual factors such as age, level of functioning, learning style, culture, motivation, and denial (i.e., individual/specific responsivity), in order to increase the potential for the client to benefit from interventions

27



## Examples of RNR treatment modalities

- Good Lives Model
- Pathways
- DBT
- CBT
- EMDR
- Facing the Shadows; Patrick Carnes
- Positive Psychology

28



## Treatment goals will always include;

- Self regulation
- Sexual self regulation and awareness
- Attitudes that support sexual beliefs
- Relationship skills
- Community support
- Addressing trauma
- Address addictive patterns of behavior
- Treatment and goal setting
- Relapse management and prevention

29

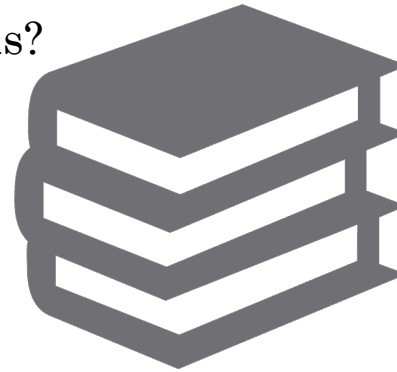
## Self care and recognizing clinical bias



30

## What is clinical Bias?

- The National Library of Medicine says that “bias is a predisposition to form premature or undue impressions that are not based on actual data. This all-too-common human trait may result in cognitive errors with serious consequences.”



31

## Clinical bias is normal!

- We expect to have clinical bias in our work, and address it proactively as an expectation, not as a negative result of being “bad therapists”
- Its not IF its WHEN
- We can not expect to do work that involves violence and trauma and not have feelings, beliefs, judgement and experiences that come up in us

32



## Things that impact clinical bias

Transference/countertransference

Overidentification with the victim

Overidentification with the sexual  
abuser

Trauma triggers/Clinicians'  
experience/exposure to sexual violence

Our individual vulnerabilities

33

“The expectation that we can be  
immersed in suffering and loss  
daily and not be touched by it is  
as unrealistic as expecting to be  
able to walk through water  
without getting wet.”

Dr. Naomi Rachel Remen

34

## Understand and recognize secondary Trauma

indirect exposure to **trauma** through a firsthand account or narrative (*details*) of a **traumatic** event. It is sometimes called compassion fatigue.



35

## Common symptoms of Secondary Trauma

- Increased anxiety and concern about safety
- Intrusive negative thoughts and images related to client's sexual abuse behavior or experiences of trauma
- Fatigue and physical complaints
- Feelings of numbness or detachment from students and peers
- Diminished concentration and difficulty with decision making
- Desire to physically or emotionally withdraw from others
- Feelings of professional inadequacy\*\*\*



36

Cumulative transformational effect upon a direct care professional who is working with survivors of traumatic life events

## Vicarious Trauma

37

## Planning for Clinical Bias and the impact of the work

- Utilize supervision to process distressing content/cases and challenging clients
- Stay up to date on research, conferences and ATSA information
- Acknowledge when content is distressing, sometimes even to the client
- Be honest about this work to friends, family and community
- Have your own support systems in place

38

## Planning for Clinical Bias and the impact of the work

- Work in teams when possible
- Collaborate, Collaborate, Collaborate
- Be a part of a Coordinated Community Response
- Set time for communicating with collateral partners and referral sources; probation, parole, Sheriff's office, etc.
- Talk about the work to help lessen the stigma of SO specific treatment

39

Stay present in the  
work and utilize your  
self care plan

40

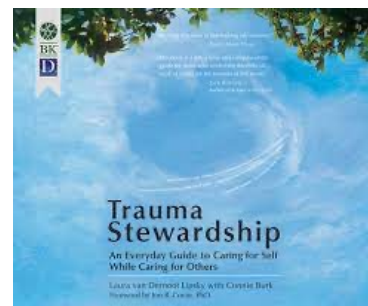
## — laura van dernoot lipsky/connie burk, trauma stewardship

Staying present

Paying attention to your  
mind/body response

Slow down/take inventory

Focus on yourself (its okay)



41

In closing....

"I believe that each person is more than the worst thing they've ever done," **Bryan Stevenson**, a lawyer and the founder and Executive Director of the Equal Justice Initiative.


42



43

## Resources

- [Fighting the "Stranger Danger" Myth | Psychology Today](#)
- [ATSA 2014 Adult Practice Guidelines.pdf](#)
- <https://www.bing.com/search?pglt=41&q=safet+society+press&vid=346348c7ceac4d418b01b8054b005dd2&aq=s=edge.0.0j69i57i0l7.7559i0j1&FORM=ANNTA1&PC=DCTS> Safer Society Press
- [The Good Lives Model of Offender Rehabilitation – Information](#)
- [HOME | drpatrickcarnes](#)
- [Nichols & Molinder Assessments, Inc. - MSI II \(nicholsandmolinder.com\)](#)
- [Bryan Stevenson: We need to talk about an injustice | TED Talk](#)
- [Home - The Trauma Stewardship Institute](#)



44

Marie Romeo, MSW, LCSW  
Inspire Counseling Services, PLLC

Asheville, NC

[Marie.Romeo@ncinspire.com](mailto:Marie.Romeo@ncinspire.com)

631-889-3817