# Current Practices in the Treatment of Adult Male Sexual Abusers: The Safer Society 2009 North American Survey

**Reprinted from: Association for the Treatment of Sexual Abusers Forum. (Spring 2010). pp. 11-20**

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For over two decades, the Safer Society Foundation[1] (SSF) has tracked and reported on the development of specialized sexual abuser treatment program models and methods. In its ninth and most recent report on practices in the field, SSF examined data collected from programs throughout the United States, and for the first time, from Canadian programs (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010).

In this article, we summarize the results of this newest survey for programs serving adult male sexual abusers. To examine these results in more detail or to examine survey results about sexual abuser programs treating other populations - adult females, and male and female adolescents and children - the reader can view and download the full report at no cost at www.safersociety.org.

## Method

North American programs that treat sexual abusers were identified through the e-mail lists of several professional organizations. Potential respondents were invited to complete the survey on the Internet during a 45 day period in spring of 2009. Survey questions remained largely unchanged from recent SSF surveys. Current survey questions are reprinted in the full report.

Returned usable surveys contained information on 1,379 programs. Although calculating a response rate was difficult for reasons detailed in the full report, programs from each of the 50 United States, the District of Columbia, and nine Canadian provinces provided information on their programs. A program was defined as treating only one age group (i.e., adult, adolescent, or child) and one gender, and was classified as either a community or a residential program.

The present article only examines programs that treat adult males. Of the 415 United States programs for adult males analyzed in the survey, 330 were located in the community and 85 in residential settings. Of the 27 Canadian programs, 19 were located in the community and eight in residential settings. All together, these programs treated over 40,000 sexual abusers in 2008. Almost three-quarters (73%) of community programs were located in private practices and the remainder in settings such as mental health centers, court clinics and hospitals. About half (51%) of residential programs were located in prisons and the remainder in settings such as civil commitment centers, hospitals, half-way houses and group homes.

## Results and Discussion

The full report and this article are organized around best practices that guide the delivery of services to sexual abusers (Association for the Treatment of Sexual Abusers, 2005; Hanson, Bourgon, Helmus, & Hodgson, 2009). Programs following best practices utilize evidence-based models of change. They adhere to the risk, need, and responsivity (RNR) principles. In other words, programs match the intensity of services to the client's risk level (risk principle). They focus treatment on problems directly linked to

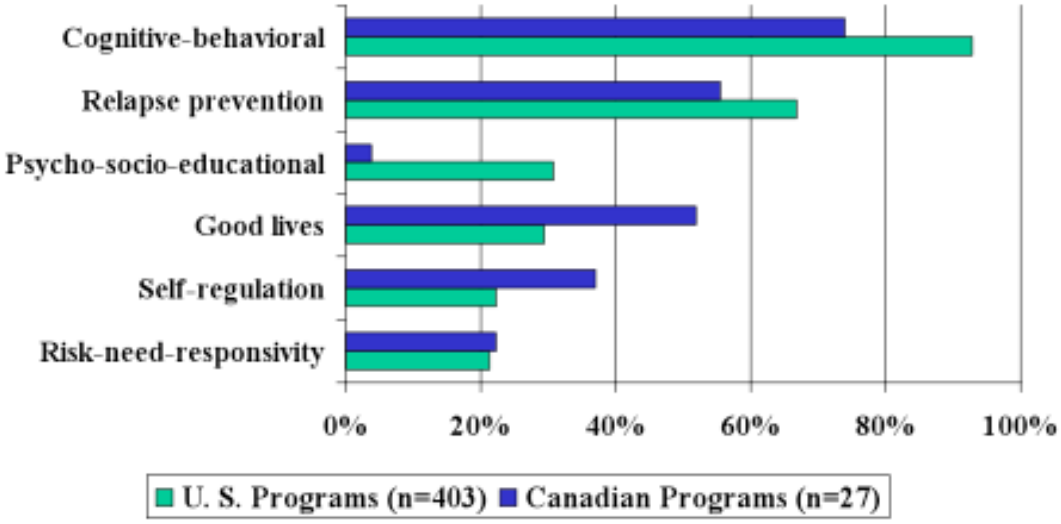
offending behavior (need principle). Programs use effective methods, typically cognitive-behavioral and skills-based interventions, matched to the learning style of the individual (responsivity principle). Programs provide aftercare services. They use trained staff, and these staff collaborate with other professionals, such as probation and parole officers, to coordinate services. Finally, programs monitor and evaluate their effectiveness and are committed to continuous quality improvement.

**Program Models**

To indentify programs' primary treatment model, respondents were asked to rank, from a list of thirteen theories, the three theories that best describe their approach. As shown in Figure 1, the cognitive-behavioral model was selected most often by programs, typically by a wide margin. In the United States, 93 percent of programs selected the cognitive-behavior model as a top-three choice as did 74 percent of Canadian programs. The cognitive-behavioral model is arguably the most empirically supported approach for working with this population (Hanson et al., 2009; Schmucker & Losel, 2008).

**Figure 1. Primary Theory**

**What three theories best describe your program?**




Relapse prevention was the second most endorsed model in both countries. In the United States, 67 percent of programs listed it as a top-three choice in the current survey. This is considerably lower than the 80 percent of programs that endorsed it as a top-three model in the 2002 survey. This statistically significant decrease likely reflects the considerable criticism leveled by practitioners and researchers against relapse prevention in recent years (e.g., Ward, Polaschek, & Beech, 2006). Criticisms of relapse prevention include that it describes only one pathway to offending, overemphasizes avoidance as opposed to approach goals and has little support in the treatment outcome literature. In Canada, 56 percent of programs listed relapse prevention as a top three choice in the current survey.

Two models, self-regulation and good lives, attempt to address the perceived failings of the relapse prevention model. The self-regulation model identifies four pathways to offending and recommends treatment approaches relevant for each. The good lives model focuses on helping individuals obtain the primary human goods sought by all humans in socially acceptable ways. The goal is to help the individual

develop a good life that is inconsistent with offending. These two models were included for the first time in the 2009 survey. About one-third (30%) of United States programs selected the good lives model as a top-three choice and almost one-quarter (22%) selected the self-regulation model. One-half (52%) of the Canadian programs listed the good lives model among their top-three choices, and almost two-fifths (37%) listed the self-regulation model.

This also is the first survey in which the risk, need, and responsivity (RNR) model was listed as a theory choice. The RNR model has considerable empirical support (Andrews & Bonta, 2006; Hanson et al., 2009) and it forms the cornerstone of national adult sex offender treatment programs in several countries around the world, including Canada. Despite this, only slightly more than one-fifth of the programs in both the United States (21%) and Canada (22%) selected it as a top three theory choice.

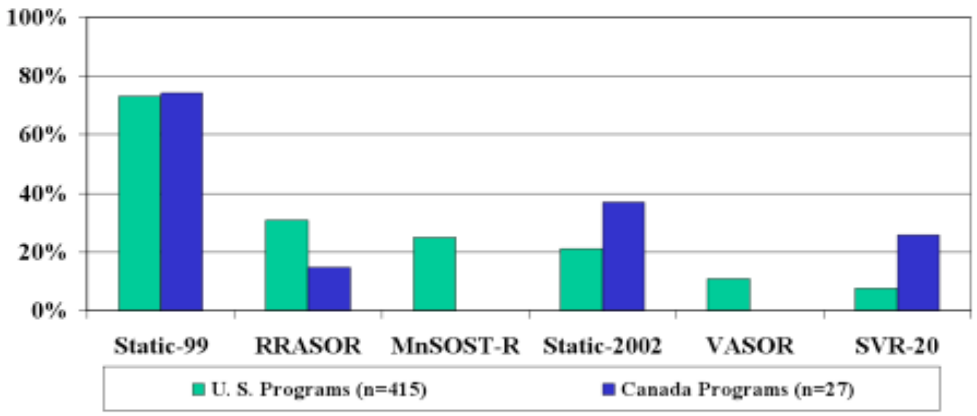
**Assessment Methods**

Assessment-driven decision making is a best practice in the field, and it forms the foundation for effective sexual abuser services. Assessments illuminate case-by-case differences among sexual abusers so that programs can make placement, treatment, supervision and other service delivery decisions based on individuals' risk level, treatment needs, and responsivity factors (Andrews & Bonta, 2006; Hanson, Bourgon, et al., 2009; Harland, 1996).

The percentage of programs using actuarial risk assessment methods continues to increase. Actuarial risk instruments assess an abuser's risk by determining how similar he is to other groups of abusers for whom the reoffense risk is known. The actuarial instruments listed in Figure 2 are comprised primarily or entirely of static (unchangeable) risk factors and are valuable in assessing the long-term reoffense risk of abusers. United States programs using one or more of these risk instruments has shown a statistically significant increase from three-fifths (62%) of the programs in 2002 to almost nine-tenths (89%) in the current survey.

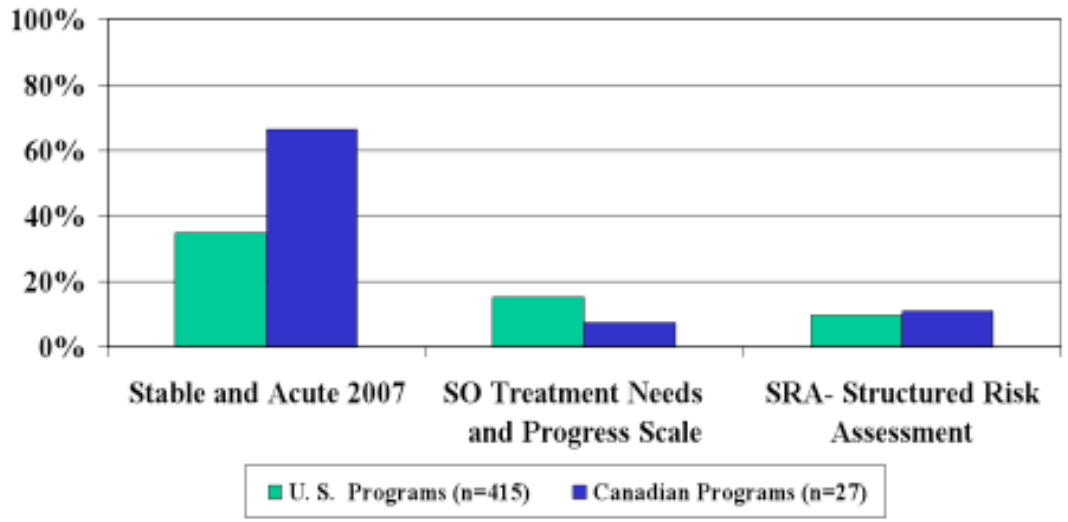
All but one Canadian program reported using a sex offender specific actuarial risk instrument listed in Figure 2. Throughout North America, the Static-99 is the most commonly used actuarial instrument by a large margin. Use of the Static-99 and Static-2002 will likely decrease as programs begin to use the recently revised versions of these two instruments (see www.static99.org).

**Figure 2. Risk Instruments**



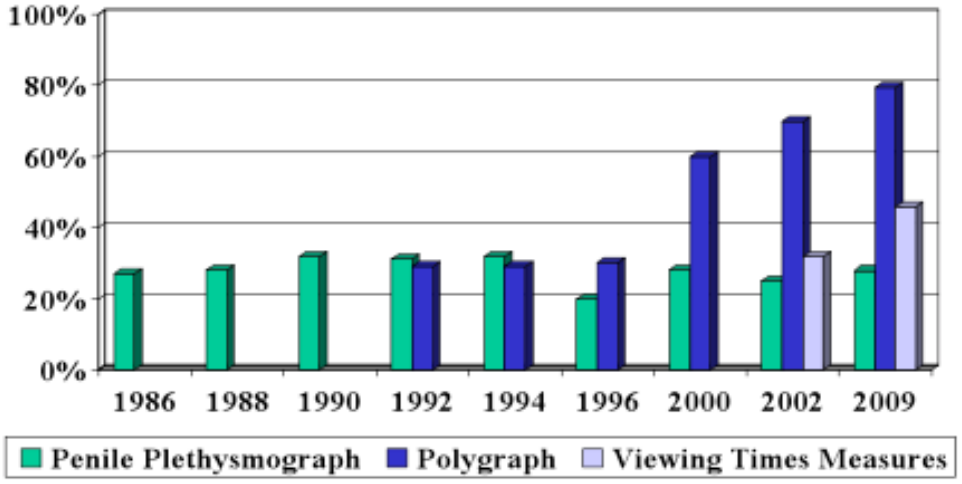
Almost half (48%) of United States programs and seventy percent of Canadian programs also use one or more of three dynamic risk assessment measures listed in the survey (see Figure 3). Dynamic risk assessment measures assess potentially changeable offending-related aspects of an individual's functioning or their situations that should be targets in treatment and supervision. These instruments also are valuable in assessing the moderate and short-term reoffense risk of abusers. As shown in Figure 3, the most commonly used are the Stable 2007 and the Acute 2007.

**Figure 3. Dynamic Risk Instruments**




The survey also examined programs' use of the penile plethysmograph, viewing time measures, and polygraph. Using results from the present study and available data from prior SSF surveys, Figure 4 shows trends in the use of these psychophysiological assessment instruments in community programs in the United States. Trend data for Canadian programs was not available because this was the first SSF survey to include Canadian programs.

**Figure 4. Psychophysiological Assessment Methods in U. S. Community Programs**




The penile plethysmograph is a measure of sexual arousal for males. It measures penile tumescence, typically with a strain gage, as an individual attends to slides, audio-tapes, or video-tapes depicting various appropriate and inappropriate sexual stimuli. The percentage of United States programs reporting use of the penile plethysmograph has remained relatively constant over the last two decades. In the present survey, 28 percent of community programs and 37 percent of residential programs use it. Canadian practice patterns differ between residential programs, where seven out of eight programs (88%) report using the penile plethysmograph, and community programs, where 37 percent use the penile plethysmograph.

Viewing-time measures compute the length of time an individual views slides of males and females of different ages during a structured assessment process. Response times reflect an individual's sexual interests. In United States community programs, the use of viewing-time measures shows a statistically significant increase between the 2002 and 2009 surveys, going from 32 to 46 percent of programs. Viewing-time measures are now used more often than the penile plethysmograph in United States community programs. Overall, 15 percent of Canadian programs report using a viewing-time measure.

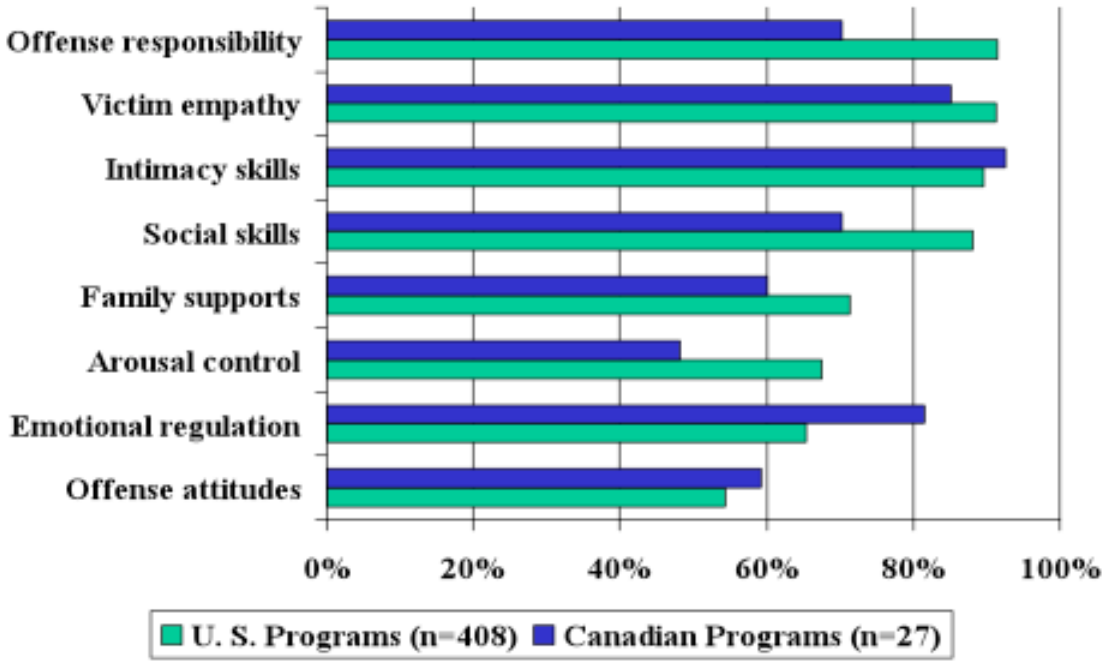
Many programs employ the polygraph post-conviction to verify treatment and supervision compliance. Polygraph use continues to increase in the United States. In community programs, its use increased from 30 percent of programs in 1996, to 63 percent in 2000, to 70 percent in 2002 and to 79 percent in the current survey. Less than 10 percent of programs in Canada use the polygraph. The dramatic and statistically significant increases in the United States are particularly noteworthy given that polygraph use has not been associated with reductions in sexual reoffending rates (McGrath, Cumming, Hoke, & Bonn-Miller, 2007).

**Treatment Targets**

Over the past decade a series of meta-analyses have identified the types of problems abusers have that are linked to their sexual offending (e.g., Hanson & Morton-Bourgon, 2005). These problems, commonly referred to as criminogenic needs, are believed to be the most important treatment targets for reducing sexual reoffending. Survey respondents' reported treatment targets, however, are often at odds with this

research. Offense responsibility and victim empathy, for example, are targeted in almost all programs (see Figure 5). Yet little evidence exists that focusing on these issues in treatment results in reduced reoffending rates. In contrast, sexual abusers who show evidence of offense-supportive attitudes and who display problems controlling their sexual arousal (e.g., sexual obsessiveness and deviant sexual interests) have increased rates of sexual reoffending. A comparatively smaller percentage of programs, however, report targeting these issues in treatment. Some caution in the interpretation of these findings is needed since survey respondents were asked whether they targeted a particular issue, not how much emphasis they placed on it.

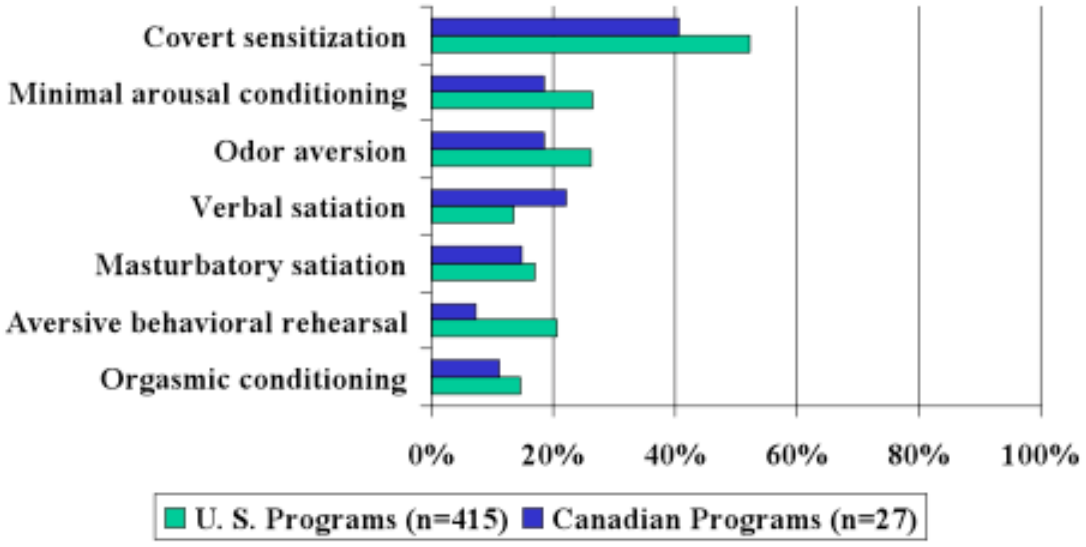
**Figure 5. Core Treatment Targets**




In addition to asking if programs targeted offense responsibility, respondents were asked more detailed questions about providers' expectations for offense disclosure. In the United States, about one-third (34%) of adult programs require clients to make near complete disclosure of their sexual offending behavior for successful program completion. Few (6%) require no offense disclosure to complete the program. In contrast, no Canadian programs responding to the survey require abusers to fully admit their sexual offending behavior in order to successfully complete treatment. In fact, about one-third (30%) of Canadian programs do not require any offense disclosure for program completion.

Behavioral techniques designed to help individuals control sexual interests and arousal are commonly used by programs. Figure 5 shows that in the United States, two-thirds (67%) of programs use behavioral arousal control techniques, as do about half (48%) of Canadian programs. Figure 6 shows the percent of programs that use each of seven techniques that were included in the survey. Covert sensitization, a procedure in which an individual imagines successfully dealing with situations linked to reoffending, is the most common technique.

**Figure 6. Sexual Arousal Control Treatments**

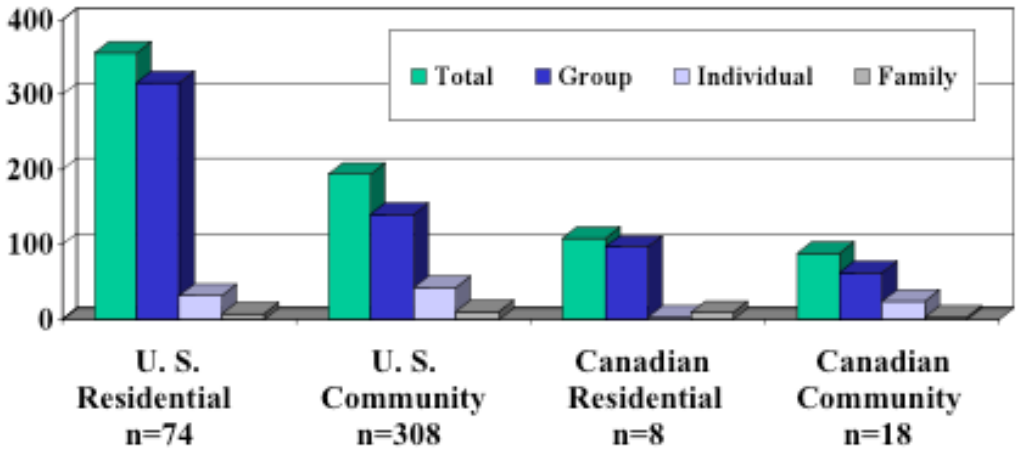



Programs sometimes use medications to treat abusers' sexual arousal control problems and reduce their sexually obsessive thoughts. For these purposes, the most commonly used medications are Selective Serotonin Reuptake Inhibitors (SSRI's), a class of antidepressants. Physicians prescribed them to at least some abusers in slightly over half of programs in both the United States (51%) and Canada (56%). Antiandrogens, testosterone-lowering medications, are used much less. Their use appears to be declining in the United States. Between 2000 and 2009, the use of the antiandrogen Provera in community programs dropped from 31 to 17 percent and, in residential programs, from 41 to 18 percent. Antiandrogen medications are very expensive, and the decline in usage may be attributable to decreased program funding.

**Treatment Dosage**

Treatment dose refers to the type, amount, frequency, and duration of treatment services. Programs typically use multiple treatment modalities. Group and individual treatments are the most common treatment modalities in both community and residential programs in the United States and Canada. Collectively, 89 percent of programs use group treatment and 83 percent use individual treatment. However, as shown in Figure 7, the vast majority of treatment hours delivered in programs are in group sessions, and comparatively few treatment hours are delivered in individual treatment sessions. Almost three-fifths (57%) of programs provide some family or couples therapy sessions.

**Figure 7. Median Hours of Core Treatment**




The amount and duration of treatment services in United States programs typically is much greater than that for Canadian programs (see Figure 7). For example, in United States residential programs, median core treatment consists of 348 hours over 18 months. In Canadian residential programs, the median dose is 100 hours over five months. The survey did not address whether abusers were enrolled in other treatments, such as cognitive skills and substance-abuse programs. Whether treatment programs took these additional methodologies into consideration when calculating treatment dose is not known. Since excessive or inappropriate psychological and medical treatments can be ineffective or have adverse effects, the appropriate treatment dosage for various abuser risk and need levels is an important research agenda.

**Aftercare and Support Services**

Overall, about three-quarters of United States (79%) and Canadian (74%) programs report providing aftercare or step-down services to their clients. Fewer residential programs report providing aftercare services than do their community-based counterparts. How often other organizations provide aftercare services to clients released from residential programs is unclear. Clients returning to the community from a residential facility often need considerable transitional support services, so this is an area where further research is indicated.

In the United States, 77 percent of community programs involve family members in treatment but only 47 percent of adult residential programs do so. None of the Canadian residential programs responding to these questions report providing these types of supports but half of community programs did.

**Funding**

The survey data do not provide information on the stability of programs' funding streams but do provide information on the nature and diversity of profit status and funding sources. In the United States, private

organizations operate about 91 percent of community programs, whereas in Canada, public organizations operate 75 percent of the community programs. Community programs typically have diverse funding sources. In the United States, the most common funding source is client self-pay (90%); in Canada it is provincial and federal funding (88%).

**Staff Training**

Although having an advanced degree does not ensure competence as a treatment provider, it does indicate a minimum level of advanced professional training. Survey results reveal that Canadian treatment staff typically have a higher level of formal education than their counterparts in the United States. Forty percent of Canadian providers have doctorate degrees and an additional 34 percent have a masters degree. In the United States, 11 percent of providers hold doctorate degrees and 63 percent hold masters degrees.

**Collaboration among Service Providers**

Almost all community programs report exchanging information with probation and parole officers and caseworkers. The practice of probation and parole officers and caseworkers periodically visiting treatment groups occurs in about half (53%) of United States community programs. This practice is much less common in Canadian community programs (17%). Co-therapy teams of treatment providers and probation and parole officers or caseworkers are relatively rare (9%) in United States community programs but more common (28%) in Canada.

**Monitoring and Evaluation**

Programs should monitor and evaluate their services and work to continually improve their quality. In the United States, 32 percent of residential programs and 14 percent of community programs report that they utilize external consultants to review their programs. In Canada, 11 percent of residential programs and no community programs report use of external reviews.

Respondents also were asked to estimate the percentage of clients who successfully complete their program. In the United States, residential programs report an average completion rate of 71 percent while community programs report a completion rate of 76 percent. In Canada, residential programs report an average completion rate of 94 percent with community programs reporting an 89 percent completion rate.

**Provider Opinions about Sex Offender Legislation**

For the first time, the survey examined providers' views about the impact of recent sex offender legislation, namely, registration, community notification and residency restrictions for both adolescents and adults. Overall, respondents report they have little confidence that these laws enhance community safety and many providers report they believe the laws actually reduce community safety. The only exception is that 51 percent of United States providers report they believe adult registration laws enhance community safety.

## Conclusions

Considerable research evidence now exists about the types of treatment programs that are most effective in reducing reoffending among sexual abusers. The results of this report suggest a large percentage of programs in the United States and Canada are following these evidence-based practices.

The current survey, of course, has limitations. It is not known, for example, to what extent programs responding to this or previous surveys are representative of programs in the United States and Canada. Further, the survey has been conducted in a variety of ways over the years and this variation may have affected the nature of programs' responses. Definitions were not provided for the various program models

and methods that formed the basis for many questions in this as well as previous surveys. It would be naïve to assume that every provider who filled out the survey defined terms in the same way.

It is encouraging, nonetheless, that a large number of geographically diverse programs collectively providing services to thousands of sexual abusers responded to the survey. Taken together, the findings from the current survey and those from SSF's eight previous national surveys provide an important and interesting chronicle of how the field of sexual abuser assessment, treatment, and management has changed and improved over the past two decades.

We express our appreciation to all the sexual abuser treatment providers who took the time to complete the survey. We also look forward to Safer Society Foundation having the opportunity to periodically update the survey in order to document changes in methods and models used by programs throughout North America. Readers are invited to recommend further areas of inquiry and to make suggestions for future Safer Society surveys.

## Footnote

[1] The Safer Society Foundation, Inc., a non-profit agency, is a national research, advocacy, and referral center for the prevention and treatment of sexual abuse. It was founded in 1985 by Fay Honey Knopp and is located in Brandon, Vermont.

## Acknowledgements

Funding for the Safer Society 2009 North American Survey was provided by the Association for the Treatment of Sexual Abusers, Public Safety Canada, and the Safer Society Foundation.

## References

For complete reference list, see full report:

McGrath, R. J., Cumming, G. F., Burchard, B. L., Zeoli, S. & Ellerby, L. (2010). *Current practices and trends in sexual abuser management: The Safer Society 2009 North American Survey.* Brandon, VT: Safer Society Press. (Available at no cost at: www.safersociety.org.)