Different types of sexual offenders

There are different types of sexual offenders, and each type varies in the victim of choice, the offenses and what the offender psychological gains from the offenses. Some of the different types of sexual offenders include rapists, pedophiles, child molesters and incest offenders. According to Bartol & Bartol (2008) rapists and child molesters are the two most frequently discussed sexual offenders and the two groups of sexual offenders that are incarcerated and treating them can be challenging (p. 439). Understanding the differences among these types of offenders assist the psychologist with assessing the offender prior to treatment; the type of treatment that will be most effective for them as well as if the offenders are likely to re-offend once they are released. The latter is what appears to be the biggest problem with these offenders as well as what society fears.

Society has deemed sex offenders as undesirable and there are controversies as to why money is spent on treatment programs for these offenders as well as to why they are released into communities when they are most likely to reoffend. Jeglic, Moster, Schaffer & Wnuk (2010) discuss in their article society's strong desire to have sexual offenders confined away from society, however interesting enough, these offenders spend the majority of their lives in the communities. The statistics for sexual offenders are alarming. Hanson & Morton-Bourgon (2005) discuss in their article that " 1%-2% of the adult male population will eventually be convicted of a sexual crime and community surveys have found that 5% to 20% of men admit to a least one instance of sexual aggression" (p. 1154). Sex offender recidivism rates are high and one of the reasons for this could be the types of treatment programs that are available for sex offenders and how they lack

effectiveness. Research has found that the recidivism rates after five years of being released is 10%-15% and the rates can be higher depending on the offender (Hanson & Morton-Bourgon, 2005).

There are several different treatment programs that are used in the treatment of sexual offenders. Some of the common treatments are psychotherapy, pharmacology and the controversial surgical castration. Psychotherapeutic treatments involve cognitive behavioral and behavioral therapy while pharmacological treatment involves the use of medications that are intended to reduce sexual urges and thus behavior (Klugman, Stone & Winslade, 2000). Surgical castration which is not often used involves removing the testicles thus removing the production of male hormones and reducing sexual urges (Klugman, Stone & Winslade, 2000). Research has found however, that surgical castration is not completely effective at reducing sexual urges and that if testosterone is taken, sexual urges will resume (Klugman, Stone & Winslade, 2000). The use of medications can also be problematic in that there are side effects that can occur as well as if the person discontinues their use, their sexual urges will also resume (Klugman, Stone & Winslade, 2000). It appears, however that cognitive behavioral therapy is a common choice for treatment programs and has been somewhat successful, despite the high recidivism rates (Bradford, 1994).

Cognitive behavioral therapy (CBT) works through examining the “ factors that are associated with the sex offender’s deviancy and the cognitive distortions are systematically broken down, with the intentions of enabling the offender to recognize the wrongfulness of his behavior, conform his behavior accordingly, and to reinforce behavior change” (Klugman, Stone &

Winslade, 2000, p. 94). Jeglic, Moster, Schaffer & Wnuk (2010) discuss two different CBT approaches that have been used in treatment programs in their article on CBT for sexual offenders. The first approach is Risk-Need-Responsivity (RNR) which looks at each of the three components as it relates to the offender. This program is more suited for the offenders who are deemed a higher risk of recidivism and therefore the treatment is more intensive than programs for those of a lower risk (Jeglic, Moster, Schaffer & Wnuk, 2010). The first component looks at the offender's risks for re-offending and structures the treatment around these risks. The second component looks at the offender's " behavioral deficits and dynamic risk factors that relate to the offender's behavior" (Jeglic, Moster, Schaffer & Wnuk, 2010). The last component, which in this author's opinion is one of significant importance for the rehabilitation of sexual offenders, looks at " matching the offender's learning style, level of motivation, and cultural background" in the treatment (Jeglic, Moster, Schaffer & Wnuk, 2010). Despite the tailoring effect of the treatment program to the offenders, this approach has had criticism specifically on the program's focus. The main criticism has been that fact that the focus is on criminogenic risk factors, and other factors and characteristics of the offender are ignored, thus causing treatment to be potentially ineffective (Jeglic, Moster, Schaffer & Wnuk, 2010).

The second approach mentioned in Jeglic, Moster, Schaffer & Wnuk's (2010) article is the Good Lives Model (GLM). This is an interesting approach because it " looks not only at the criminogenic factors that contribute to sexual offending, but also looks to understand each offender's unique values,

life position, and goals when conceptualizing management strategies and/or treatment" (Jeglic, Moster, Schaffer & Wnuk, 2010). Basically, this approach allows the offender's goals and how they want to lives their lives surface and if this occurs, the offensive behaviors should cease due to the offender's motivation to change. Research has shown that the GLM approach has had " higher levels of program completion, motivation, engagement, and within-treatment changes as well as lower attrition rates" (Jeglic, Moster, Schaffer & Wnuk, 2010).

CBT looks at different deficits that can contribute the risks of reoffending in offenders. Some of these deficits include cognitive distortions and schemas, emotion dysregulation, interpersonal skills deficits, deviant sexual behavior and empathy deficits (Jeglic, Moster, Schaffer & Wnuk, 2010). Cognitive distortions are the thoughts the offender has surrounding their offensive behaviors and the schemas are the beliefs the offender has supporting these distortions (Jeglic, Moster, Schaffer & Wnuk, 2010). One technique used in treatment programs is to have offenders look at these thoughts and beliefs on a daily basis and understand why they have these thoughts and how they can work to control acting upon these thoughts and beliefs (Jeglic, Moster, Schaffer & Wnuk, 2010). This can also be used when working with emotion dysregulation which is when offenders have problems regulating their emotions especially after offensive behaviors as well as understanding their emotions. This is important during the treatment of offenders because they can have an array of emotions that occur during their offenses as well as emotions that can trigger an offense.

Interpersonal skill deficits appear to be at the heart of sexual offenses. Some of these skill deficits include problems with intimate relations, social support and other interpersonal relationships (Jeglic, Moster, Schaffer & Wnuk, 2010). These deficits can be a result of the offender's childhood and development which continue throughout adulthood if intervention and treatment are not sought. Research has shown that these deficits can contribute to sexual offenses especially the problem with intimacy and relationships. In treatment, relearning social and relationship skills can assist in correcting these deficits.

Deviant sexual behavior is one of the main factors that contribute to sexual offensives. This includes " deviant sexual preoccupations, preferences, and arousal…and it has been found that the offenders that exhibit more deviant patterns are at higher risk for sexual reoffending" (Jeglic, Moster, Schaffer & Wnuk, 2010). CBT looks at these factors and tries to correct them through different techniques of covert sensitization and masturbatory and verbal satiation. (Jeglic, Moster, Schaffer & Wnuk, 2010).

One of the major problems that offenders have is that of empathy. Empathy is being able to put oneself in someone else's place and understand their emotions and feelings. In regards to offenders, they do not comprehend empathy and cannot understand how their victims felt or feel about the offense. It is thought that when an offender can have empathy, their chances of reoffending will be reduced. In treatment, offenders work towards putting themselves in the shoes of their victims and can also be required to write a letter to their victim discussing their remorse for their actions (Jeglic, Moster, Schaffer & Wnuk, 2010).

Despite the numerous treatment programs used for sexual offending, the recidivism rate for these offenders continue to be high. There could be several reasons for this current problem. Much research has been conducted on recidivism rates of sexual offenders and some thoughts are that certain dynamic factors are the cause of reoffending. As it is seem, many treatment programs are aimed at looking at these factors and working with the offender either individually or in a group setting to correct them. The next thought is, if these programs are aimed at correcting these factors and deficits, why are they not completely effective at reducing reoffending? Digianantonio & Durkin (2007) discuss in their article how research conducted on CBT has shown that it is effective in reducing recidivism in child molesters however, these programs only work when " subjects understand that their sexual urges involving children are not appropriate" (p. 253).

One would also be lead to believe that the problem of recidivism lies in the adequacy of the programs. Treatment programs in the correctional setting are the first to be affected when budget reductions occur thus causing a decrease in the resources necessary to run these programs effectively. It could be that the treatments are not intensive or long enough for the offenders to completely learn and implement new behaviors. Digianantonio & Durkin (2007) discuss this concept by stating that treatment programs that are short-term are not effective and that it is necessary for long term programs in order to reduce recidivism.

Another issue with treatment programs not being effective at reducing recidivism is when the relationship between the offender and the therapist is

not adequate. Brunet, Drapeau & Korner (2004) conducted a study on the motivation of offenders to treatment as well as what they think about the treatment programs that are participating in. One issue that they found is that the offender lacks motivation to continue treatment when their ideas of treatment goals are different than those of the therapist. This issue, as well as the lack of a good therapeutic relationship, results in conflicts between the therapist and offender, as well as inadequate treatment. The authors conclude in their article that " despite the fact that empirical research has demonstrated over and over again that most therapeutic techniques are equal in effectiveness, most researchers desperately insist on demonstrating not the effectiveness of their interventions, but their superiority on other interventions" (Brunet, Drapeau & Korner, 2004, p. 77).

Despite the fact that there has been a considerable amount of research conducted on treatment programs for sexual offenders as well as recidivism rates, there appears to be no change in improving treatment programs and therefore reducing recidivism. Further research needs to be conducted on combining the techniques that have been found useful for the treatment of these offenders and how this can effectively reduce recidivism. An example of this would be combining the RNR and GLM cognitive behavioral approaches in a treatment program since both approaches look at different aspects of the offender and combining them would allow for a well rounded program.

Another area for future research is looking at what offenders want to achieve from treatment as well as their motivations for continuing the program to completion. Society looks negatively on these offenders as worthless

individuals that need to be locked up and away from society. However, everyone deserves a chance to change and start over. If more time was devoted to talking with these offenders on their needs and motivations for change and programs are tailored to meet the individualistic needs of these offenders, it is possible that treatments could be more effective at lowering recidivism. Obviously, this would take more time and money than the system is willing to provide, but if research can show that these techniques are effective, it is possible that in the future the legal system might take the chance to implement them.