Over the past few decades, waves of laws and policies have been instituted to “do something” about the “threat to public safety posed by a dangerous, high risk category of offender.” It is this perception of dangerousness and high risk for recidivism that has propelled sex offenders to a major public safety concern. Despite the reality that the rates of recidivism for sex offenders are actually lower than most commonly thought, sex offenders are still perceived as a high-risk type of offender. Studies by the United States Department of Justice and the Canadian government found that sexual offense recidivism rates averaged between 14 percent and 20 percent over a five-year follow-up period.

Special laws and provisions are used to protect the public from sexual victimization, including registration, collection of DNA samples, public notification, and chemical castration. Civil commitment to facilities that provide some form of treatment may also be initiated near the end of a prison term in at least sixteen states. In addition, GPS, electronic monitoring, and restrictions prohibiting sex offenders from living and working within a certain distance from schools, parks, day care facilities, and shopping centers are other management and control strategies.

Along with these external controls on their behavior by the criminal justice system, laws and policies have also been enacted to provide more control and oversight regarding the treatment of sex offenders. Laws mandating treatment or components of treatment specific to sex offenders have been passed in at least seventeen states. For example, polygraphy is used either as a standard or discretionary clinical component in sex offender treatment in fourteen states for the assessment, disclosure, and periodic monitoring of such offenders. According to a nationwide survey of treatment programs, ten states have established boards or entities for setting standards and requirements for sex offender treatment. For instance, Texas has a multi-disciplinary team, created by state law, to review offenders eligible for civil commitment and a risk-assessment review committee, also created by state law, to assess the risk sex offenders pose at the time of their release from prison. In addition, a Council on Sex Offender Treatment establishes treatment standards in the state.

In essence, the criminal justice and the mental health systems are intermingled in the sex offender-therapist relationship. The primary interest of the criminal justice system is public safety and the prevention of further sexual victimization by sex offenders. This Article will explore the relationship between the therapeutic goals of treatment and the criminal justice objectives of offender control and management and societal protection. Issues affecting the delivery of treatment and the relationship between therapists and their sex offender clients, including coercion, constitutionality, ethics, and professional responsibility, will be discussed.

I. Involuntary or Coerced Treatment

Seventeen states require eligible sex offenders to participate in treatment, while in thirty states treatment is voluntary. Treatment may also be required as part of judicial sentencing or stipulated as a condition of community supervision. Furthermore, an argument could be made that voluntary treatment programs are indirectly coercive since refusal to attend treatment or denial of offenses on the part of the sex offender may affect parole decisions or result in negative consequences, such as denial of privileges, limits on visitation, reduction of good time credits, restriction from a lower security or custody placement, and/or referral to a denial phase of treatment.

Involuntary treatment is even less concerned with procedural justice since the offender may not be provided with the reason for the therapy, what the therapy entails, or the opportunity to choose an alternative. One rationale for required treatment is that, at the very least, the clients are exposed to the treatment process and over time their resistance may be lessened or overcome. Research on involuntary treatment indicates that involuntary clients change not because of the requirement itself, but because the policy kept them in treatment long enough to become engaged in various treatment activities to facilitate change. Dropping out or being discharged from an involuntary prison treatment may also be more difficult since there is no concern with individual choice.

II. Admission of Guilt

A belief among many clinicians is that sex offenders must acknowledge their responsibility for the offense and their problem sexual behavior before they can fully participate in...
treatment and work toward change. Their success in treatment is believed to be related to their admission of guilt and acceptance of responsibility. However, the admission of responsibility may raise fears among offenders regarding the incriminating consequences of disclosing their offenses. Additionally, it may spark concerns about contradicting previous statements the offenders made disavowing culpability for their offenses.

The issues of mandatory treatment for sex offenders and an admission of guilt as a compulsory requirement for entering treatment have been legally challenged for their constitutionality. In McKune v. Lile, the United States Supreme Court considered whether a sex offender treatment program requiring an admission of guilt violated the Fifth Amendment privilege against self-incrimination. Respondent Robert G. Lile was a convicted sex offender in the custody of the Kansas Department of Corrections. In 1994, a few years before the respondent was scheduled to be released, prison officials ordered him to participate in a Sexual Abuse Treatment Program (SATP). As part of the program, participating inmates are required to complete and sign an “Admission of Responsibility” form, in which they discuss and accept responsibility for the crime for which they have been sentenced. They also are required to complete a sexual history form detailing all prior sexual activities.

The Supreme Court upheld the admission of guilt as a requirement for participation in treatment programs and deemed loss of privileges and transfer to a higher security level not “compelling enough” to be unconstitutional. The Court emphasized the rehabilitative goals of the treatment program and opined that even if the program implicated the inmates’ Fifth Amendment rights, it reasonably advanced legitimate penological goals. Some legal scholars consider this case to be an example of the diminished constitutional and procedural protections afforded sex offenders. Amanda Graeber argued that the Supreme Court sacrificed well-established Fifth Amendment jurisprudence and completely eradicated the self-incrimination protection for sex offenders in the McKune case. She further observed that there appears to be another system of justice for sex offenders in which constitutional rights are infringed.

The premise of societal protection is what has helped many of these sex offender specific laws and policies to pass constitutional scrutiny. Because of their perceived risk to the community, legislators are more willing to remove basic civil liberties of sex offenders, and, because they are viewed by society with repugnance, few citizens are willing to oppose this trend.

III. Cognitive-Behavioral Therapy
Most sex offender treatment programs use a cognitive-behavioral approach and require an admission of responsibility as a prerequisite to treatment. Even though cognitive-behavioral therapy is a favored approach, it is not specifically mandated by law or policy. However, it could be argued that the admission of responsibility necessary to enter the program has a coercive aspect for offenders.

Cognitive-behavioral treatment proceeds from the assumptions that sex offending is influenced and instigated by cognitive events, perceptions, fantasies, feelings, urges, values, and beliefs, but that these events can also be changed, controlled, or both. Sex offenders examine self-statements for cognitive distortions that allow them to minimize, justify, or otherwise rationalize their sexually aggressive behavior. Thus, a crucial initial step in this treatment is for sex offenders to admit and then give a full disclosure of their offense to the treatment group. This disclosure is compared to official reports and challenged by group members and the therapist. Sex offenders are educated about the relationship between their cognitive distortions and sexual offending through such activities. Relapse prevention is frequently emphasized in cognitive-behavioral treatment in order to reduce the risks associated with relapse and reoffending. Sex offenders discover precursors that predict and support their deviant sexual behaviors. They can then develop and implement alternative thoughts, feelings, and behaviors to avoid, control, or escape risky situations.

Barry Maletzky found that a sex offender who wholly denied allegations of sexual abuse was three times as likely to fail treatment as an offender who even partially admitted his guilt. Moreover, an offender who was totally opposed to treatment had a 2.5 times greater likelihood of failing in treatment. Danielle Polizzi and her colleagues conducted an evaluation of sex offender treatment programs and found that non-prison-based cognitive-behavioral treatment programs were effective in reducing the sex offense recidivism of sex abusers. However, the authors conceded that the research findings are mixed regarding the effectiveness of different types of treatment programs for sex offenders.

In their study of treatment motivation, Karen Terry and Edward Mitchell concluded that it is possible for sex offenders, at least those with adult victims, to benefit from cognitive-behavioral programs even if they have no motivation to participate. The authors found that it was also possible to reduce cognitive distortions among sex offenders who did not think they had a problem or needed help. Therefore, there is some research to support involuntary treatment for eligible sex offenders since they may still receive some benefit despite their resistance. More research is certainly needed to corroborate the value of specific types of treatment for sex offenders and the merit of mandating the treatment.

IV. Polygraphy
Polygraphy is touted as an effective procedure to assess, treat, and monitor sex offenders, and is being increasingly used to assess compliance and progress in sex offender treatment and management. Polygraphy is incorporated into treatment to verify the veracity of offenders
who have a propensity to deny, minimize, and distort their sex crimes. Sex offenders are required to relate a sex offense history, and the polygraph is used as a mechanism to assist with denial and disclosure.\textsuperscript{11} Therapists have used polygraph results to confront sex offenders’ denial of the offense of conviction and their refutation of deviant sexual fantasies and paraphilias.\textsuperscript{32} Treatment providers work closely with polygraph examiners to monitor the sex offender’s progress. Treatment is more effective if an offender is able to admit prior deviant acts and if the therapist is aware of the nature and the full extent of the sexual behavior.\textsuperscript{11}

Several studies with both adult and juvenile sex offender populations have found polygraph testing to be effective in eliciting additional disclosures of offenses beyond the traditional self-report methods.\textsuperscript{34} However, Theodore Cross and Leonard Saxe insist that there is inadequate polygraph outcome research focusing on sex offenders and considerable evidence that polygraph tests are invalid measures of deception.\textsuperscript{35} H. Lawson Hagler reasons that polygraph testing should be used as only one component of a treatment program along with other sources of information, such as police reports and victim impact statements.\textsuperscript{36}

\textbf{V. Treatment Professionals}

How the therapeutic process affects treatment providers is important to understand. Sex offender therapists need to be particularly sensitive to the effects of working with sex offenders. Sex offender therapists have identified both positive and negative aspects of their work.\textsuperscript{37} Positive impacts reported by therapists were the satisfaction of contributing to a safer community when they saw positive changes in their clients and the development of empathy and compassion from their experience of getting to know sex offenders as human beings.\textsuperscript{18}

Conversely, sex offender treatment professionals have also identified many challenges in their work with sex offenders. The recounting of sexualized and nonsexualized violence, deviant fantasies, and horrific acts had a profound impact on therapists, combined with the difficulties of working with clients who are often unmotivated, hostile, deceptive, manipulative, or even threatening.\textsuperscript{19} In a 1999 study by Susan Lea and her colleagues, therapists reported tension and an inability to empathize with clients who had committed particularly violent sexual abuse or when the victim was either very young or older.\textsuperscript{40} Negative or emotionally laden attitudes toward a certain type of sex offender or offense inhibit the development of empathy, affect objectivity, and authenticity in treatment.

An increase in emotional, psychological, and physical symptoms associated with burnout was also described by several treatment providers.\textsuperscript{41} These symptoms were exhibited in rising anger, growing intolerance, and increasing confrontational behavior with their sex offender clients.\textsuperscript{42} Rebecca Shelby and her colleagues compared levels of burnout among sex offender treatment providers to other mental health professionals.\textsuperscript{43} Using a standardized instrument with several dimensions for assessing burnout, the researchers found a higher level of burnout among sex offender treatment providers. They scored higher on the particular dimensions of emotional exhaustion and depersonalization of others.\textsuperscript{44} Moreover, treatment providers who worked with sex offenders in inpatient or prison settings reported higher levels of burnout compared to outpatient treatment providers. Shelby and her colleagues attributed the high level of burnout to client characteristics. Sex offenders are particularly difficult clients who are resistant, usually involuntary, and perceived as a threat to the safety of others.\textsuperscript{45} Sex offender treatment providers may also be more susceptible to burnout due to the severity of client problems and the risk of recidivism.\textsuperscript{46} Toni Farrenkopf surmised that the impact from working with sex offenders progresses from a period of professional zeal to emotional hardening, discouragement about client change, and decreased hope for effectiveness.\textsuperscript{47}

\textbf{VI. The Client/Therapist Relationship}

The development of rapport and a constructive client/therapist relationship in sex offender treatment is difficult for several reasons. The therapist’s authority to wield punitive sanctions surrounding treatment participation and compliance is one obstacle. The relationship is also complicated by a formidable third party, the criminal justice system, which demands certain components of treatment, such as polygraph testing. Therapists may genuinely want to help the offenders change their criminal thinking and behavior in line with their professional responsibility. For the justice system, treatment is another means to manage or control sex offenders and to reduce the risk they pose to community safety.

Divided loyalties may arise when treatment professionals feel a conflict between their professional responsibility to facilitate client change and their legal/criminal justice responsibilities. They must impose sanctions on sex offenders who will not admit responsibility for their crimes of conviction or fully disclose other deviant behavior. This authority to deny privileges and to recommend transfer to a higher security unit has unwittingly thrust the therapists into a more punitive and less therapeutic role. Sex offender treatment providers also experience conflict from the pressure to act in the best interests of their clients versus the community.\textsuperscript{48} They must continually evaluate and assess the deviant thoughts, fantasies, and behavior of sexually abusive individuals for the dual purposes of providing therapy and accurately assessing and managing risk to safeguard societal welfare.\textsuperscript{49}

Sex offenders are hesitant to fully disclose all previous sexual abuse and to openly and freely share their obsessions and sexualized accounts. Michol Polson and Eric McCullom maintain that sex offenders have developed an acute sensitivity to subtle messages of rejection, disapproval, or repulsion, especially from treatment specialists.\textsuperscript{50}
In addition, they have also acquired a basic mistrust and wariness of those holding positions of authority in prison, and this includes treatment staff. They are keenly aware of the therapist’s dual obligations and that the criminal justice obligation will be the overriding one.

VII. Mandatory Reporting

Mandatory reporting further complicates the therapist/patient relationship. The treatment provider, while encouraging offenders to disclose and admit all abuse, is paradoxically required by law to report a previously undisclosed sex offense. Mandatory reporting is viewed by treatment professionals as the major “antithesis” to a therapeutic relationship. Divulging disturbing thoughts may be an indication of the offender’s progress in treatment; nonetheless, the therapist is not free to deal with such issues in a purely therapeutic manner. Jonathan Kaden discusses the concept of limited confidentiality in therapy, which is imposed by statute in all states. Therapists are required to report privileged information regarding an admission of child abuse, whether or not it is related to the offense for which the sex offender is in therapy. Thus, the ethics and professional responsibility of the treatment staff are brought to the fore when sex offenders disclose prior, unreported sexual victimization.

VIII. Discussion

During this time of heightened concern and emotionalism regarding sexual victimization, lawmakers and policymakers must exercise caution and logic in enacting legislation. This Article explored the impact of criminal justice initiatives on treatment delivery, therapists, and their sex offender clients. Laws requiring treatment for certain sex offenders and the mandatory reporting of disclosures of sexual abuse will undoubtedly proliferate. Treatment staff working with a large number of involuntary clients should consider modifying their programs to include motivational techniques or a special orientation unit prior to entering treatment. Engaging the client may encourage self-motivation and a perception of less coerciveness in treatment. With regard to mandatory reporting, Kaden contends that therapists have an ethical duty to inform clients that their communications may not be entirely privileged. Clients should be apprised that disclosures obtained during treatment have limited confidentiality and may be given to law enforcement if prosecutable. Treatment providers need to continually assess their reactions and responses to their clients to identify any bias or strong emotions that may interfere with their therapeutic functions. Staffings and team approaches should be utilized so that treatment providers have a network of support, as well as a forum to discuss treatment, conflicts, and strategies. Jackson, Holzman, Barnard, and Paradis found that therapists considered support from other treatment personnel to be crucial in their work with sex offenders.

Further, these teams should include representatives from a variety of therapy perspectives and, where possible, be multidisciplinary. Such internally diverse teams are positioned to question the dominant assumptions of the cognitive-behavioral approach (particularly its emphasis on criminal thinking) and to introduce new ideas and practices into the treatment of sex offenders.

Additional training might also be instituted to help therapists cope with the stresses and strains of their professional practices. Specialized training for core program staff should be offered. It should include training in new therapy techniques, as well as help in dealing with the dilemmas and problems that arise in working with sex offenders.

An evaluation of research on existing sex offender specific laws and policies is also warranted. An analysis of current measures will reveal many of the unintended consequences that may undermine any attempt to manage and control sex offenders and to protect the community. Further research is also needed to stimulate new ideas for more effectively managing and treating convicted sex offenders.

Notes

5. Mary E. West et al., Colo. Dep’t of Corrections, State Sex Offender Treatment Programs 20 (2000).
6. Id. at 4-5.
7. Clayton, supra note 4, at 8.
8. West et al., supra note 5, at 19.
10. Id. at 23.
11. Id. at 10.
16. Id. at 173.
18. West et al., supra note 5.
22 Id.
25 Id. at 254.
27 Id. at 372.
29 Id. at 670.
30 H. Lawson Hagler, Polygraph as a Measure of Progress in the Assessment, Treatment, and Surveillance of Sex Offenders, 2 SEXUAL ADDICTION & COMPULSIVITY 98 (1995).
31 George H. Baranowski, Managing Sex Offenders in the Community with the Assistance of Polygraph Testing, 27 POLYGRAPH 75 (1998).
32 Loretta J. Stalans, Adult Sex Offenders on Community Supervision: A Review of Recent Assessment Strategies and Treatment, 31 CRIM. JUST. & BEHAV. 564, 583 (2004).
36 Hagler, supra note 30.
38 Scheela, supra note 37.
40 Lea et al., supra note 39.
42 Farrenkopf, supra note 39.
43 Rebecca A. Shelby et al., Factors Contributing to Levels of Burnout among Sex Offender Treatment Providers, 16 J. INTERPERSONAL VIOLENCE 1205 (2001).
44 Id. at 1212.
45 Id. at 1214.
46 Id. at 1207.
47 Farrenkopf, supra note 39, at 222.
48 Eilerby, supra note 37.
49 Edmonds, supra note 41.
50 Michol Polson & Eric McCullom, Therapist Caring in the Treatment of Sexual Abuse Offenders: Perspectives from a Qualitative Case Study of One Sexual Abuse Treatment Program, 4 J. CHILD SEX ABUSE 21, 29 (1995).
51 Scheela, supra note 38, at 757.
53 Id.
54 Pendergast et al., supra note 10.
56 Kaden, supra note 52, at 367.
57 Lea et al., supra note 39.
59 Alec Spencer, Working with Sex Offenders in Prison and Through Release to the Community (1999); Lea et al., supra note 39.