Illinois Association for the Treatment of Sexual Abusers

April 2014 *Membership Newsletter*

President's Message

~ Guy Groot

It is my hope that as you receive this newsletter, you are doing well personally and professionally. This edition of the Illinois- ATSA newsletter is dedicated to sharing and discussing several items related to assessment. Treatment is informed by assessment, and decisions made by and about many of our clients are informed by assessment. Not the only thing we do, but, an important piece.

As a group, the board members of Illinois-ATSA have endeavored to revitalize the organization. A plan was set, and progress has been made toward fulfillment of steps in that plan. In the area of communication, we have renewed our dedication to reach out to membership through a periodic newsletter. We hosted a networking meeting at the ATSA national conference in late October.

At this point, we have also begun updating our website. As the website is updated, succinct professional resources that provide guidance in the areas of best practices, empirically based treatment, and accurate information about the scope, problem and ways to address the issue of sexual abuse to the public and policy makers will be available.

We continue our commitment to issues surrounding training. For the third year, IL-ATSA will sponsor a series of webinars where members and others can receive up-to-date training in a low-cost manner right at their own desk. Commitments have already been set for a 5/16 webinar on relevant updates to the DSM-V, and a 6/13 webinar on offender manipulation tactics. We are also in the process of scheduling a webinar on the use of ACT: Acceptance and Commitment Therapy with offenders. Sometimes technology issues continue with the webinars; we will continue to address these speed bumps.

Our long term goal of examining the need and ability to present a local conference is also in the pipeline. Collaboration with the Illinois Sex Offender Management Board to facilitate annual training for providers is improving.

Every ATSA member in good standing who works or resides in Illinois is a member of Illinois-ATSA. I would like you to consider being a more active member. There are myriad opportunities available. With recent resignations from the board as a result of either movement out of state or movement to different area of employment, there are open spots on the board.If you have skills or inclination to assist in the area of website management, training and webinar development, or newsletter production, please consider volunteering to assist the organization in one of those areas.

In this issue:

IL-ATSA to Host Webinar Series

IL-ATSA will be hosting a series of webinars. Each webinar will cost $25, and will be held Fridays from 12 to 1:30 pm. Mark your calendars now for these exciting trainings!

5/16/14: **DSM-V Update: Paraphillias, 5 Axis Model, and other changes from the DSM-IV.**
Richard "Bo" Travis, Psy.D.

6/13/14: "**Masters of Manipulation: Tactics Sex Offenders Use to Gain Access To Children.**
Greg Barrett

7/18/14 - **ACT: Acceptance and Commitment Therapy; Behavior, Context, Responses, Antecedents & Consequences.**
Nicole Hernandez, Ph.D.

8/8/14 - **Polygraph 101: What it is and What it Actually Tells us; Developing Question Areas to Inform Treatment and Supervision.**
Edgar "Rusty" Wright

Illinois Association for the Treatment of Sexual Abusers

Evaluating Female Sexual Offenders

~Jeff Reynolds

As intolerance of adult females sexually offending against minors increases, more and more women are being referred for sexual offender evaluations. While all sex offender evaluations are designed to address risk, treatment needs, community safety, and issues surrounding offenders' access to children, addressing these issues with female offenders can be very tricky. Having few testing instruments to address risk factors of females, the evaluator is often left with his or her clinical judgment, and self-report of the offender.

Although testing instruments are limited, there are tools that can aid the evaluator. One instrument that can be used in assessing female sexual offenders is the MSI-II Adult Female Form. According to Nichols and Molinder Assessments Inc, The *MSI II* Adult Female Form is designed to measure the sexual characteristics of an adult female alleged to have committed a sex offense or sexual misconduct, and can be used both to conduct a sexual deviance evaluation and also to measure treatment progress. This self-report instrument addresses paraphilia assessment in the areas of Child Molest, Rape, Exhibitionism, Voyeurism and Obscene Calls, as well as indices such as Pornography, Prostitution, Fetishism, Bondage/Discipline, Sadism and Masochism. In addition to the MSI-II, the Hare PCL-R 2nd edition can be used as a guided interview and will provide a psychopathy score for the offender. Both these tools can be useful when determining treatment issues to be addressed.

In 2007, the Center for Sex Offender Management identified three primary types of female sex offenders (U.S. Department of Justice [U.S. DOJ], 2007).

- **Male-coerced**: These women tended to be passive and dependent individuals with histories of sexual abuse and relationship difficulties. Fearing abandonment, they were pressured by male partners to commit sex offenses, often against their own children
- **Predisposed:** Histories of incestuous sexual victimization, psychological difficulties, and deviant sexual fantasies were common among these women, who generally acted alone in their offending. They tended to victimize their own children or other young children within their families
- **Teacher/lover**: At the time of their offending, women in this subtype were often struggling with peer relationships, seemed to regress, and perceive themselves as having romantic or sexually mentoring "relationships" with under-aged victims of their sexual preference, and, therefore, did not consider their acts to be criminal in nature.

In 2010, Wijkman, Bijleveld and Hendriks studied female sexual offenders in the Netherlands and found that overall, women commit sexual offenses from a very varied background and in different settings. In the study they identified four prototypes, namely, the young assaulters, the rapists, the psychologically disturbed co-offenders, and the passive mothers. The first two groups are relatively young offenders who abuse victims outside of their family; the last two are mainly mothers who abuse their own children. Understanding risk factors for reoffending is an important part of assessing for risk.

Although risk factors for female sexual offending have not been as well-researched and normed as have male risk factors,

Continued on page 3…

Evaluating Female Sexual Offenders...continued from page 2

the Center for Sex Offender Management (U.S. DOJ, 2007) identified several characteristics that may be common in female sexual offenders. These include:

- Histories of childhood maltreatment, including sexual victimization
- Mental health symptoms, personality disorders, and substance abuse problems
- Difficulties in intimate relationships, or an absence of intimate relationships
- A propensity to victimize children and adolescents (rarely adults)
- A tendency to commit offenses against persons who are related or otherwise well known to them
- An increased likelihood of perpetrating sex offenses in concert with a male intimate partner.

In 2009, Sandler and Freeman found that of the female sexual offenders studied, the ones who recidivated were more likely to have had at least one misdemeanor conviction, at least one felony conviction, and at least one drug conviction, as well as having averaged more total convictions prior to their first sexual convictions.

While knowing the characteristics of the offenders and which offenders may have recidivated more than others is helpful when evaluating female offenders, there is not enough research in this area to accurately predict who is more likely to reoffend. This information can be used to guide clinical judgment, offering recommendations concerning treatment needs and community safety. Hopefully more research will continue in this area, so that we can do a better job evaluating women who have sexually offended.

~Jeff Reynolds

References

Sandler, J., & Freeman, N. (2007). Topology of Female Sex Offenders: A Test of Vandiver and Kercher. *Sexual Abuse: A Journal of Research and Treatment 19,* 73-89

U.S. Department of Justice, Office of Justice Programs, Center for Sex Offender Management. (2007, March). *Female Sex Offenders,* 1-16.

Wijkman, M., Bijleveld, C., & Hendriks, J. (2010). Women Don't Do Such Things! Characteristics of Female Sex Offenders and Offender Types. *Sexual Abuse: A Journal of Research and Treatment 22(2),* 135–156

Evaluating Juveniles with Sexual Behavior Problems

~Glen Ensinger

Evaluating juveniles with sexual behavior problems created a conundrum, as the process was initially conducted in the same manner as adults. Conflict arose when evaluators realized there were two issues that needed to be addressed; 1) the developmental issues specific to the child and 2) the family dynamic issues. As a result, there were studies done and formal risk evaluations developed. Research also showed that other adjunctive tools were effective for the evaluation of juveniles; work was also done on actuarial tools as well as what was effective for unstructured interview.

As stated earlier, adult tools for risk assessment were not appropriate for youth. As a result there was a need for risk assessments which were reliable and valid for juveniles. Some of the risk assessment tools included: J-SOAP II (Juvenile Sex Offender Protocol, Prentky and Righthand , 2003), ERASOR (Estimate of Risk of Adolescent Sexual Offense Recidivism, Worling and Curwen, 2001), LA-SAAT (Latency Age-Sexual Adjustment and Assessment Tool, Stetson School), J-SORRAT (Juvenile Sexual Offense Recidivism Risk Assessment Tool-II, Epperson, Ralston, Fowers, DeWitt, & Gore, 2006), with the MEGA (Multiplex Empirically Guided Inventory of Ecological Aggregates for Assessing Sexually abusive Adolescents and Children, Miccio-Fonseca, 2006) and AFFINITY (Affinity Archetype Ranking Task, Laws and Glasgow) developed more recently. The SAVRY (Structured Assessment of Violence Risk) and CSBI (Child Sexual Behavior Inventory) are also assessments that can be used to aid in determining risk. The GLAT (Good Lives Assessment Tools) is another tool, yet to be released by G-MAP (organization in the UK). As you will read, there a numerous issues to be identified before using one of these tools.

Therapists are also asked to make a diagnosis or understand the nosology (classification) of the disorder and then determine the etiology (sexually reactive perpetration, as an example). This author believes it is necessary to understand the epidemiology of the issues as well. The nosology and etiology comes from the medical model, which at times conflicts with a strengths-based model, or as this author calls it, a healthy model. It is necessary to be aware of ***Continued on page 4…***

Evaluating Juveniles…continued from page 3

~Glen Ensinger

the conflict, as nosology and etiology for mental health issues is more difficult to understand, as compared to someone who has lung cancer due to smoking cigarettes. This all plays out in the evaluation process as one develops a diagnosis, an understanding of the incidence of the behavior, and eventually understands the possible reasons the sexual behavior occurred. Some tools can assist with diagnosis, while other assessment tools are considered specific to risk and are empirically guided, such as the ERASOR.

When evaluating youth, another issue for consideration is the gender of the client. Until the MEGA, there were no tools designed for female juveniles who had sexual behavioral problems. As a result, clinically unstructured evaluations were done. They were considered unstructured as there was no guideline for how to proceed with the evaluation.

So how do you gather some of the information to answer questions for SOMB approved evaluations? To develop a systemic/holistic evaluation the therapist/evaluator would benefit from understanding medical issues as well as psychosocial and behavioral issues. Medical issues such as thyroid issues, traumatic brain injury or some other organic brain issue certainly are factors which can affect the evaluation process as well as treatment. It is beneficial if the client gets blood work and a physical at some point, or at least have a medical professional rule out underlying medical issues.

There are also numerous other tools such as the TSCC (Trauma Symptom Checklist for Children), HIT (How I Think), Abel, Becker and Kaplan Adolescent Cognitions Scale, CBCL (Child Behavior Checklist) and ACE (Adverse Child Experiences). There are also depression scales, anxiety scales or questionnaires, Vanderbilt ADHD scale, and so on and so forth. The goal is to develop a systemic/holistic assessment. If the therapist identifies, through the course of the assessment, that there are issues beyond the scope of his or her expertise, then it will be important for the therapist to provide the appropriate referral.

Many times, issues related to PTSD are identified, as many juveniles with sexual behavioral issues have been victims themselves. Within the PTSD diagnosis there are also issues such as de-realization and depersonalization, which are a part of dissociation. Tools like the Cambridge Depersonalization Scale, S.D.Q.-20 and DES can assist in determining dissociation. Evaluators should keep in mind the use of these tools is more about identifying symptoms rather than diagnosing symptoms. For adult populations as many as one in five adults on mental health units have dissociative symptoms.

The use of these scales, questionnaires and tools provides an actuarial as well as more structured empirical guidance for assessment and treatment. Once the therapist has met with the client and has done an unstructured clinical interview, it is possible to compose a plan to provide a systemic/holistic evaluation of the client and care providers.

The role of family dynamics needs to be assessed as well. Identifying who lives in the home and who plays a significant role in the child/adolescent's life is key to developing success in therapy. Are there mental health or substance abuse issues in the home? Is there only one parent, and how does the single parent interact within and outside the family unit? What is the trauma history of the parent(s) and how might that influence the overall family functioning? William N. Friedrich found that mothers who were sexually abused might withdraw from their children, resulting in the children finding unhealthy ways to meet their intimacy needs.

Developing an understanding of how the client meets his or her needs is another part of evaluation. The Good Lives Model has developed a method of identifying what needs or goods are important to the client. This approach is positive and focuses on helping clients meet their needs in healthy, pro-social ways. (GLAT)

Again, a holistic approach increases the potential for a successful evaluation that will provide the necessary information to develop a treatment plan for the juvenile. Shawn Christopher Shea reported in his book, Psychiatric Interviewing, the Art of Understanding, that interviewing is a creative act. He compared interviewing to exploring a darkened Victorian house only using a candle for illumination. Dr. Richard Grant and others have compared interviewing to peeling an onion a layer at a time. The result an evaluator gets depends on how the evaluator approaches the process.

References available upon request, from the author.

Licensing for Treatment Providers/Evaluators

Shortly before the end of the year, the Governor signed Public Act 98-612 into law. This Public Act ***changes the effective date for licensure from January 1, 2014, to July 1, 2014.*** In addition, the new changes simplify the licensure requirements for some practitioners. The main change is that **practitioners that have been listed on the Sex Offender Management Board's Approved Provider List for a minimum of two years do not have to document or demonstrate the required hours of supervised experience and training.** **'Grandfather'** applications for the Evaluator and Treatment Provider licenses are now available on the Department's website. Please note that the **'grandfather' path to licensure will only be available until January 1, 2015.**

The Sex Offender Evaluation and Treatment Provider Act creates three licenses:

Sex Offender Evaluator
Sex Offender Treatment Provider
Associate Sex Offender Provider

Please note: *There is a separate fee and application for each license. There is no reduction in fee for applying for both the Treatment Provider and Evaluator Licenses.*

There is no combined Evaluator and Treatment Provider license.

Licenses under this act will expire on July 31 of odd years.

Processing of applications takes approximately 4 weeks.
(Licenses have already begun being issued!)

Individuals that have licenses in other states are required to submit Certifications of Licensures from those states, even if they currently hold an Illinois license.

Requirements for each of the licenses can be found using the links below.

PROFESSION SPECIFIC PAGE

SEX OFFENDER EVALUATION AND TREATMENT PROVIDER ACT

RULES

APPLICATION FORMS

PUBLIC ACT 98-0612

ILLINOIS DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION

Questions regarding applications should be directed to the Department's phone support staff at 1-800-560-6420.

The Illinois Juvenile Justice Commission recently published a report*: **"Improving Illinois' Response to Sexual Offenses Committed by Youth: Recommendations for Law, Policy, and Practice"*** which can be found at: http://ijjc.illinois.gov/youthsexualoffenses Scroll down and you can access the full report, including press releases and other documents. The "Executive Summary" is 6 pages.