Vermont Clinical Practices Guide

for the

Assessment and Treatment

of Adult Sex Offenders

Vermont Center for Prevention and Treatment of Sexual Abuse
Department of Corrections
State of Vermont

Vermont Clinical Practices Guide

for the

Assessment and Treatment

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INTRODUCTION

This first edition of the *Vermont Clinical Practices Guide for the Assessment and Treatment of Adult Sex Offenders* has been prepared by and for the network of mental health professionals who provide assessment and treatment services to adult male sex offenders throughout Vermont. The primary focus of the guide is directed toward intervention with convicted sex offenders who are under the supervision of the Vermont Department of Corrections.

The development of this guide has been strongly influenced by the conviction that the primary goal of intervention with sex offenders is to protect the community by preventing further sexual abuse. The guide provides a framework to help focus the care of individual clients, to provide clinicians with objective assessment and treatment criteria, to promote ethical practice, and to promote quality in the provision of clinical services. In addition, the guide serves as a reference for professionals who refer sex offenders for clinical services and for professionals who supervise sex offenders in the community.

The guide is largely based on a cognitive-behavioral and relapse prevention model of treatment and supervision. This model, subscribed to by the majority of professionals treating sex offenders in North America, has been pioneered and used in Vermont for more than twelve years. Specific practices that are promoted in this guide have been derived from clinical and research literature and from the experience of senior clinicians who are involved in the day-to-day provision of services to adult sex offenders.

This guide is not meant to be an absolute standard of care. In all cases, clinicians must rely on their own professional judgment and experience when conducting assessments and developing treatment plans for the individuals they serve. Many treatment approaches not described in this guide may enhance outcomes for individual clients. It is understood that the experience of individual clinicians and the complexities of various clinical presentations cannot be codified in such a document. This is the nature of a guide.

The guide is divided into three parts. Part 1 recommends qualifications for professionals who provide clinical services to sex offenders. Part 2 outlines a series of general assessment and treatment guidelines and principles. Part 3 identifies six broad treatment goals that are relevant to clinical intervention with most sex offenders. These six treatment goals are further divided into sections on defining treatment rationale, conducting the assessment, developing a treatment plan, and evaluating treatment response. At the end of the document can be found a bibliography that identifies some of the research sources that were relevant to the development of the guide.

As with any clinical manual, this guide should be considered a work in progress. As knowledge and skill evolve, so will this manual. Clinicians and other users of the manual are encouraged to be involved in the revision process by recommending suggestions to any member of the guidelines committee. This guide is another step toward our goals of preventing sexual abuse and providing better care for our clients.

Part 1

PROVIDER QUALIFICATIONS

PROVIDER QUALIFICATIONS

Providers shall have specialized training in the assessment and treatment of paraphilias and sexual offending behaviors, an advanced degree in a mental health discipline, and a state license or certification to practice independently. Providers who are not state licensed or certified to practice independently shall be supervised by an individual who meets the qualifications listed above.

Providers shall comply with the ethical guidelines of their respective mental health discipline.

Providers shall treat clients with dignity and respect, regardless of the nature of the client's offenses or crimes.

Providers shall be familiar with the client's legal status, knowledgeable of relevant legal statutes, and knowledgeable of research data relevant to the practice of sex offender assessment and treatment.

Part 2

GENERAL ASSESSMENT AND TREATMENT GUIDELINES

GENERAL ASSESSMENT GUIDELINES

Clarify the nature and appropriateness of the referral request. Assessments should generally be limited to those clients who have been found guilty of or who admit to committing a sexual offense. Assessments shall not be used to determine whether an event or a crime has taken place. Appropriate referral requests concerning identified sex offenders include such issues as diagnosis, treatment amenability, dangerousness, disposition planning, and treatment planning.

Use particular caution in assessing risk. Absolute predictions that a client will or will not reoffend are not warranted. Consider relevant research data on the reoffense rates of subgroups of sex offenders, and identify the conditions under which a client would be more or less likely to reoffend.

Obtain voluntary informed consent from the prospective client prior to commencing an evaluation. If the client is not competent to give informed consent, obtain consent from the client's parent or guardian. At a minimum, a client should be informed about the purpose and nature of the evaluation, the limits of confidentiality, and the fee structure.

Review background data from as many sources as is reasonable and appropriate prior to meeting with the client. Assessments should not be based solely on a client's self-report. At a minimum, reasonably available collateral reports such as police affidavits and victim statements should be reviewed.

Utilize psychological and physiological tests as appropriate. Testing is used at the discretion of the evaluator.

Screen for comorbid psychiatric disorders and refer for further assessment and treatment services as appropriate.

Maintain a written assessment record for each client.

GENERAL TREATMENT GUIDELINES

Employ a written acknowledgment of limited confidentiality and waiver. This shall be agreed to and signed by the client prior to commencing treatment. If the client is not competent to agree to and sign the waiver, obtain consent from the client's parent or guardian. The waiver shall, at a minimum, facilitate communication among treatment staff and the mandating supervising agency. Treatment staff shall obtain other releases from the client as necessary for coordinating treatment and monitoring his behavior in the community.

Employ a written treatment agreement that provides the prospective client with voluntary informed consent. The treatment agreement shall be agreed to and signed by the client prior to commencing treatment. If a client is not competent to give informed consent, obtain consent from the client's parent or guardian. The client should be informed about recommended treatment procedures, risks and benefits of treatment, disadvantages if treatment is not obtained, alternative methods of treatment if available, limits on confidentiality, and the fee structure.

Identify the appropriate treatment modality. Group treatment is generally the preferred primary treatment modality.

Introduce the client to models that allow him to make sense of his problem and treatment plan (e.g., relapse prevention, Finkelhor's four factors).

Explain that treatment is designed to assist clients in recognizing, changing, and controlling their deviant sexual thoughts and behavior patterns. Emphasize that clients generally need to apply strategies learned in treatment for the rest of their lives. Clarify that treatment cannot be expected to cure a client's sexual deviancy.

Maintain appropriate boundaries between treatment and the supervising organizations. For example, the court and parole board impose probation and parole conditions, and the treatment staff set treatment conditions.

Collaborate with the supervising agency, the victim's therapist, and other involved professionals in developing a treatment plan, where appropriate and consistent with the client's informed consent.

Report significant treatment and supervision violations to the supervising agency in a timely manner. Significant violations include failure to participate, missed appointments, and high-risk behaviors.

Provide or refer clients to aftercare services to increase the likelihood that gains made during treatment are maintained.

Maintain a written treatment record for each client.

GENERAL TREATMENT RESPONSE GUIDELINES

Provide clients and the supervising agency with regular feedback about the client's progress in treatment.

Evaluate treatment response with multiple sources of information. These may include client observation, client self-report, collateral reports, psychological test data, and physiological test data.

Consider the client's ability and willingness to benefit from treatment. Some clients may achieve an inadequate treatment response and the prognosis for further treatment benefit may be low. Such clients may be terminated from treatment if it appears unlikely that they will benefit from further treatment.

Document problem client behavior that may lead to termination from treatment. Termination from a program for problem behavior should generally be preceded by verbal and written notification regarding remedial actions the client may take in order to remain in the program. Serious behavior problems may result in immediate termination from a program.

Part 3

SPECIFIC GOAL-FOCUSED ASSESSMENT AND TREATMENT GUIDELINES

ESTABLISHING SUPERVISION CONDITIONS AND NETWORKS

Defining Treatment Rationale

Supervision conditions and surveillance efforts designed to oversee and control a client's behavior in the community may reduce his likelihood of reoffending. The supervising agency generally serves as the primary external supervisor. A network of family and significant others may also be enlisted to assist a client in leading a life-style that reduces his risk of reoffense.

Conducting the Assessment

Assist the supervisory agency in identifying high-risk factors for which supervision conditions should be designed. The following conditions should be considered:

- Assessment and treatment participation and completion
- Victim access prohibitions
- Victim contact prohibitions
- Contact with vulnerable populations prohibitions
- Residence location approval
- Employment approval
- Curfew stipulations
- Pornography/erotica possession and use prohibitions
- Alcohol and drug possession and use prohibitions
- Breathalyzer and urinalysis testing requirements
- Weapons possession and use prohibitions
- Travel restrictions
- Searches of person, property, and home provisions

Assist the supervising agency in identifying a network of individuals who could be appropriately engaged to help supervise the client in the community.

Developing a Treatment Plan

Collaborate with the supervising agency to promote the development of appropriate supervision conditions. The supervising agency has the ultimate responsibility for setting supervision conditions.

Collaborate with the supervising agency to assess the appropriateness of modifying supervision conditions such as approving travel requests, chaperons, and family reunification. The supervising agency has the ultimate responsibility for modifying supervision conditions.

Collaborate with the supervising agency and the client to provide education to network members concerning sexual offending and interventions that may be helpful to the client.

Encourage appropriate couples, family, and other ancillary treatments. Provide the client and his significant others with assistance in securing these treatments.

Evaluating Treatment Response

Compliance with external supervision requirements is determined by direct observation, the client's self-report, and collateral reports.

If a client fails to comply with necessary supervision requirements, re-evaluate the client's ability to be safely and effectively treated at the current level of care. Consider issuing a warning, increasing the frequency or intensity of treatment, recommending increased supervision, terminating treatment, or referring the client back to the supervising agency.

ACCEPTING RESPONSIBILITY AND MODIFYING COGNITIVE DISTORTIONS

Defining Treatment Rationale

Sex offenders typically deny, justify, or otherwise rationalize their sexually aggressive behavior. These cognitive processes probably serve to maintain a client's sexually aggressive behavior. Because most treatment interventions rely on the client's ability to admit that he has a problem, accepting at least some responsibility for his sexually aggressive behavior is a crucial initial step in the treatment process. Modifying other cognitive distortions may reduce a client's risk to reoffend.

Conducting the Assessment

Evaluate the degree of responsibility accepted by the client and evaluate related cognitive distortions. Consider whether the client:

- Admits to committing a sexual offense
- Accepts responsibility for committing a sexual offense
- Acknowledges deviant sexual fantasy and arousal
- Acknowledges grooming and planning
- Understands the consequences of abuse to the victim
- Recognizes his risk to recidivate
- Identifies his need for treatment

Review documents that describe the offense such as victim statements and investigation reports, whenever possible, prior to conducting evaluation meetings with the client.

Compare the client's self-report with collateral reports such as victim statements and investigation reports.

Utilize psychological testing as appropriate. Cognitive distortion scales may be helpful and should be employed at the evaluator's discretion.

Developing a Treatment Plan

Provide education about denial and the importance of accepting responsibility. For example, stress that admission of a problem is the first step in solving that problem.

Target initial intervention efforts to assist the client in accepting at least some responsibility for committing a sexual offense.

Clarify that accepting at least some responsibility for one's offenses is a prerequisite for admission to treatment. Clarify that accepting full responsibility is generally a prerequisite for successful completion of treatment.

Confront denial and other cognitive distortions. Appropriate interventions for confronting denial may include challenging discrepancies between the client's version and collateral versions of the offense. Positive modeling by other clients can also be helpful. Appropriate interventions for modifying other cognitive distortions may include educating the client about the relationship of cognitive distortions to sexually aggressive behavior and a variety of cognitive restructuring procedures.

Evaluating Treatment Response

Treatment response can be evaluated by observation and collateral reports. Review post-test scores on psychological tests as appropriate.

Favorable treatment response is evidenced by a client's willingness to admit to and accept responsibility for his deviant sexual behavior and to modify his distorted cognitions.

If after reasonable treatment efforts a client continues to deny and refuses to accept responsibility for committing the sexual offense for which he has been referred, consider terminating him from sex offender treatment, and inform the supervising agency.

If a client partially admits to and accepts responsibility for committing the sexual offenses for which he has been referred, consider whether his level of admission or degree of progress warrants continuation in sex offender treatment.

Further disclosures of prior offenses and discussion of current lapse behavior by the client during the course of treatment is expected and should generally be viewed as progress in accepting responsibility.

DEVELOPING VICTIM EMPATHY

Defining Treatment Rationale

Many clients ignore, minimize, or misattribute the consequences of their sexually aggressive behavior toward their victims. Their failure to appropriately empathize with their victims may be causative and maintaining factors in their sexually aggressive behavior. Treatment efforts designed to teach clients about the consequences of sexual victimization and how to understand and value others may reduce their risk to reoffend.

Conducting the Assessment

Evaluate the client's level of empathy toward others and toward the classes of individuals he has targeted for victimization. Consider the offender's ability to:

- Recognize another person's emotional distress
- Identify another person's perspective
- Experience vicarious emotional responses
- Communicate empathy to others

Utilize psychological testing as appropriate. Empathy scales may be helpful and should be employed at the evaluator's discretion.

Developing a Treatment Plan

Provide psychoeducation about the effects of sexual abuse on victims. Appropriate interventions may include lectures, readings, and audiovisual programs.

Provide opportunities for the client to develop an emotional understanding about the impact of his offenses on his victims. Appropriate interventions may include psychoeducation, having the client write essays about the offense from the victim's perspective, having the client role-play the victim, and conducting face-to-face meetings with the client and the victim.

Teach empathy skills. These may include recognizing emotional distress, perspective taking, and communicating empathy.

Evaluating Treatment Response

Evaluate the client's ability to describe the negative sequelae of sexual victimization.

Evaluate the client's ability to communicate a meaningful understanding of the impact of his sexually abusive behaviors on his victim.

Evaluate the client's ability to model empathic behavior in the treatment setting and with others.

Consider collateral information concerning the client's behavior outside the treatment setting.

Consider psychological test results as appropriate.

CONTROLLING SEXUAL AROUSAL

Defining Treatment Rationale

Sexual fantasy and arousal are generally considered precursors to sexual behavior. Treatment strategies designed to reduce a client's deviant sexual fantasies and arousal can assist him in reducing his urges and craving to engage in deviant sexual behavior. Treatment strategies that enhance a client's arousal to appropriate sexual themes can facilitate and support his involvement in healthy consensual sexual activities with age-appropriate partners.

Conducting the Assessment

Evaluate the client's sexual preferences toward appropriate and inappropriate stimuli. Consider his sexual preferences in the following dimensions:

- Age
- Gender
- Behavior

Consider the client's self-report. Consider his present and past sexual offenses, sexual fantasies, use of pornography/erotica, and consensual sexual history.

Consider collateral reports. Consider official records and spouse reports concerning his present and past victims, length of offending, pornography/erotica use, and consensual sexual history.

Utilize psychological testing as appropriate. Card-sorts, picture-sorts, and other self-report measures may be helpful and should be employed at the evaluator's discretion.

Utilize physiological testing as appropriate. Penile plethysmography is an objective and acceptable method of assessing arousal disorders and is employed at the evaluator's discretion.

Developing a Treatment Plan

Provide education concerning the role of deviant sexual fantasy in the development and maintenance of sexual behavior.

Provide arousal control treatment to clients who evidence disordered sexual arousal patterns. Treatment should be designed to help clients reduce deviant sexual arousal patterns and increase appropriate sexual arousal patterns.

Utilize interventions that may help clients develop, maintain, or increase sexual arousal to appropriate themes. Orgasmic reconditioning procedures may be helpful to some clients.

Utilize interventions to help clients interrupt deviant sexual urges and craving. These may include thought-stopping, thought-shifting, collateral monitoring, and environmental manipulation.

Utilize interventions to help clients reduce deviant sexual urges and craving. These may include covert sensitization, assisted covert sensitization, masturbatory satiation, and verbal satiation.

Emphasize the practical application of arousal control procedures at home and in every-day situations. Inform clients that arousal control may require periodic booster sessions.

Refer clients for psychopharmacological evaluation as appropriate. Some clients who are unable to control their deviant sexual urges and craving by other means may benefit from antiandrogens, antidepressants, or other biological approaches.

Evaluating Treatment Response

Evaluate the client's success in controlling, reducing, or eliminating his deviant sexual arousal and developing, maintaining, or strengthening his appropriate sexual arousal.

Consider the client's self-report concerning his fantasies and sexual behavior. Consider collateral reports concerning the client's sexual behavior. Consider psychological and plethysmograph test results as appropriate.

If treatment benefits diminish, the client may need to reapply strategies that have been effective in the past. If treatment response is inadequate, consider other behavioral interventions or medication.

IMPROVING SOCIAL COMPETENCE

Defining Treatment Rationale

Deficits in social competence can inhibit a client's initiation and maintenance of healthy consenting relationships with age-appropriate partners. Deficits in social competence can also result in difficulties managing negative emotions and interpersonal conflicts that are frequently precursors to sexual reoffense. Improving social competence can assist clients in successfully negotiating the interpersonal and intrapersonal demands of a responsible life-style. Social competence is defined broadly and encompasses a wide range of skills.

Conducting the Assessment

Identify those social competence deficits that appear to be most directly related to the client's sexual offending patterns. Consider whether the client has deficits in the following areas that may impair social competence:

- Anger management skills
- Assertiveness skills
- Conflict resolution skills
- Conversational skills
- Daily living skills
- Dating skills
- Leisure time skills
- Marital skills
- Parenting skills
- Problem solving skills
- Sexual knowledge
- Social supports
- Stress management skills
- Substance use

Consider the client's self-report and collateral reports.

Utilize psychological testing as appropriate. Anger scales, substance abuse inventories, sexual knowledge tests, and other tests and inventories may be helpful and should be employed at the evaluator's discretion.

Developing a Treatment Plan

Prioritize and attend to those social competence deficits that appear to be most directly related to the client's sexual offending pattern.

Utilize the process of the treatment group. Social competence is typically enhanced as a natural consequence of modeling, practicing, and rehearsing appropriate social interactions in group treatment.

Refer the client to appropriate community resources and specialized treatment programs (e.g., Alcoholics Anonymous, anger management groups, marital and family therapy), as indicated and available.

Encourage significant others to become involved in treatment as indicated.

Evaluating Treatment Response

Evaluate the client's ability to deal effectively with social situations and to develop meaningful relationships with others.

Consider the client's self-report, behavior in treatment, and collateral information concerning his behavior outside the treatment setting.

Consider the results of psychological testing as appropriate.

DEVELOPING RELAPSE PREVENTION SKILLS

Defining Treatment Rationale

Deviant sexual behavior is typically preceded by an identifiable and predictable pattern of behaviors, emotions, and cognitions. Relapse prevention training provides clients with a variety of cognitive and behavioral strategies for identifying and interrupting these patterns. These strategies may help clients maintain treatment changes over time and reduce their risk to reoffend.

Conducting the Assessment

Identify the client's patterns of and precursors to sexual offending. Consider the following domains:

- Behavior
- Emotions
- Cognitions
- Settings

Assess the client's resources for coping with offense precursors. These may include the client's ability to cope with deviant sexual urges and craving and a variety of interpersonal and intrapersonal events. Utilize appropriate assessment data from other sections in the guide.

Consider self-reports such as autobiographies and fantasy reports.

Consider collateral reports such as victim and police reports.

Utilize psychological testing as indicated. For example, the situational competency test may be helpful and should be employed at the evaluator's discretion.

Developing a Treatment Plan

Teach relapse prevention as a model for identifying and interrupting deviant sexual patterns.

Require each client to construct his relapse cycle and to develop strategies for interrupting or exiting from his cycle.

Teach strategies for avoiding lapses. These include stimulus control procedures, avoidance strategies, escape strategies, programmed coping responses, and behavioral contracts.

Teach strategies for minimizing the extent of lapses. These include lapse rehearsals, decision matrixes, reminder cards, and maintenance manuals.

Evaluating Treatment Response

Evaluate the client's ability to identify and interrupt his deviant sexual patterns.

Consider self-report and collateral reports.

Consider the client's ability to construct his relapse cycle and to identify strategies for interrupting or exiting from his cycle.

Consider the results of psychological testing as appropriate.

BIBLIOGRAPHY

This bibliography references books and reports relevant to the assessment and treatment of sex offenders. It is not a comprehensive bibliography. It specifically excludes, due to space limitations, articles published in professional journals and newsletters.

Appelbuam, P. S., & Gutheil, P. S. (1991). *Clinical handbook of psychiatry and the law.* 2d ed. Baltimore, MD: Williams and Wilkins.

Association for the Treatment of Sexual Abusers. (1993). *The ATSA practitioner's handbook.* Lake Oswego, OR: Author.

Barbaree, H. E., Marshall, W. L., & Hudson, S. E. (1993). *The juvenile sex offender.* New York: Guilford Press.

Barnard, G. W., Fuller, A. K., Robbins, L., & Shaw, T. (1989). *The child molester: An integrated approach to evaluation and treatment.* New York: Brunner/Mazel.

Bera, W., Hindman, J., Hutchens, L., McGuire, D., & Yokley, J. M. (1990). *The use of victim-offender communication in the treatment of sexual abuse.* Brandon, VT: Safer Society Press.

Freeman-Longo, R. E., Bird, S., Stevenson, W. F., & Fiske, J. A. (1995). *1994 nationwide survey of treatment programs and models: Serving abuse-reactive children and adolescent and adult sex offenders.* Brandon, VT: Safer Society Press.

Greer, J. G., Stuart, I. R. (Eds.). (1983). *The sexual aggressor: Current perspectives on treatment.* New York: Van Nostrand Reinhold.

Groth, N. A. & Birnbaum, H. J. (1979). *Men who rape: The psychology of the offender.* New York: Plenum Press.

Haaven, J., Little, R., & Pitre-Miller, D. (1990). *Treating intellectually disabled sex offenders: A model residential program.* Orwell, VT: Safer Society Press.

Hanson, R. K., Cox, B., & Woszcsyna, C. (1991). *Sexuality, personality, and attitude questionnaires for sexual offenders: A review.* Ottawa, Canada: Ministry of the Solicitor General of Canada.

Horton, A. L., Johnson, B. L., Roundy, L. M., & Williams, D., (Eds.). (1990). *The incest perpetrator: A family member no one wants to treat.* Newbury Park, CA: Sage Publications.

Knopp, F. H. (1984). *Retraining adult sex offenders: Methods and models.* Orwell, VT: Safer Society Press.

Laws, D. R., (Ed.). (1989). *Relapse prevention with sex offenders.* New York: Guilford Press.

Maletsky, B. M. 1991. *Treating the sexual offender.* Newbury Park, CA: Sage Publications.

Marshall, W. L., Laws, D. R., & Barbaree, H. E., (Eds.). (1990). *Handbook of sexual assault: Issues, theories, and treatment of the offender.* New York: Plenum Press.

Melton, G. B., Petrila, J., Poythress, N. G., & Slobogin, C. (1987). *Psychological evaluation for the courts: A handbook for mental health professionals and lawyers.* New York: Guilford Press.

Money, J. (1986). *Lovemaps: Clinical concepts of sexual/erotic health and pathology, paraphilia, and gender transposition in childhood, adolescence, and maturity.* New York: Irving Publishers.

Murphy, W. D., & Barbaree, H. E. (1994). *Assessments of sex offenders by measures of erectile response: Psychometric properties and decision making.* Brandon, VT: Safer Society Press.

Myers, J. E. B. (1992). *Legal issues in child abuse and neglect.* Newbury Park, CA: Sage Publications.

National Task Force on Juvenile Sexual Offending. (1993). The revised report from the National Task Force on Juvenile Sexual Offending, 1993 of The National Adolescent Perpetrator Network. *Juvenile and Family Court Journal* 44(4), 1-120.

O'Connell, M. A., Leberg, E., & Donaldson, C. R. (1990). *Working with sex offenders: Guidelines for therapist selection.* Newbury Park, CA: Sage Publications.

Patton, M. Q. (Ed.). (1991). *Family sexual abuse: Frontline research and evaluation.* Newbury Park, CA: Sage Publications.

Pithers, W. D., Martin, G. R., & Cumming, G. F. (1986). *Vermont program for sexual aggressors.* Waterbury, VT: Vermont Department of Corrections.

Prentky, R. A., & Quinsey, V. L., (Eds.). (1988). *Human sexual aggression: Current perspectives.* New York: New York Academy of Sciences.

Ryan, G. D., & Lane, S. L., (Eds.). (1991). *Juvenile sexual offending: Causes, consequences, and correction.* Lexington, MA: Lexington Books.

Salter, A. C. (1988). *Treating child sex offenders and victims: A practical guide.* Newbury Park, CA: Sage Publications.

Schwartz, B. K., (Ed.) (1988). *A practitioner's guide to treating the incarcerated male sex offender: Breaking the cycle of abuse.* Washington, DC: US Government Printing Office.

Trepper, T. S., & Barrett, M. J. (1989). *Systematic treatment of incest: A therapeutic handbook.* New York: Brunner/Mazel.

West, D. (Ed.). (1994). *Sex crimes.* Aldershot, England: Dartmouth Publishing.

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