The Containment Approach: A Strategy for the Community Management of Sex Offenders

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Introduction

We begin this chapter with a reminder that all research related to sex offenders suffers from what criminologists point to as "the dark figure" of crime (Sellin & Wolfgang, 1964). The dark figure refers to crimes that are never discovered or reported. While this measurement problem affects research on all types of crime, it especially haunts research on sex offenders because these are the least likely crimes to be discovered or reported. For this reason, it complicates the management of sex offenders. Lack of information about past and current sexually abusive behavior can leave professionals at a considerable disadvantage, operating without the knowledge required to make the most effective case management decisions. The hidden nature of these crimes can mask the risk and treatment needs of individual offenders. Obtaining and sharing knowledge, including information about individual offenders, is among the fundamental reasons that the containment approach emerged in the 1980s, and it is why containment remains an important method for managing sex offenders and protecting victims and potential victims.

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Background

The findings from a federally funded, nationally focused research study identified and documented the five-part containment approach for managing adult sex offenders (English, Pullen, & Jones, 1996; English, Pullen, & Jones, 1997; English, 1998, 2004). Small groups of professionals in jurisdictions in Oregon, Washington, Arizona, Minnesota, Wisconsin, Texas, and Colorado were implementing variations of the containment approach described here. The efforts involved therapists, probation and parole officers, judges, victims' advocates and therapists, child services workers, defense and prosecuting attorneys, and law enforcement. These collaborations created a multidisciplinary, cross-agency perspective that focused on the protection of victims and the humane treatment of offenders. Motivated by the secret nature of the offense and the considerable harm done by the crime, professionals were working together to identify and reform official agency practices and policies that created barriers to the safe management of known sex offenders.

It seems difficult to imagine today, but in the 1980s and early 1990s the most consistent problem voiced by professionals was that the criminal justice system managed sex offenders as if they were the same as other offenders (English et al., 1996). Many professionals who were working directly with convicted sex offenders reported that they struggled to convince their fellow professionals—their supervisors, their agency administrators, their colleagues in other agencies, and sometimes their colleagues across the cubical divide—that this population did significant damage to victims even when overt violence was not involved in the crime (see Johnson (2011) for an important discussion of psychological force). These offenders—both violent and nonviolent—operated in secret, were usually manipulative, blamed others, and groomed victims deliberately and skillfully. Safely managing these offenders in the community required special conditions of supervision and surveillance methods.

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It was common in the 1980s and even in the early 1990s for therapists to provide conventional psychotherapy to sex offenders in treatment, reflecting a considerable lack of knowledge of the literature on sex offender treatment. In fact, it was not uncommon for sex offenders in the 1980s to be court-ordered to participate in therapy at the local mental health center where they received counseling on stress management. Often both the offender and the victim were considered to share culpability, even when victims were quite young. Usually convicted offenders were either allowed to continue living with their victims or the victim was placed in foster care while the offender's life was undisrupted.

But many professionals suspected that these crimes were not one-time events. When perpetrators had access to family members, they often abused them for years before getting arrested. Those who continued to have access to their victims frequently abused them again while they were under correctional supervision. Those who were arrested for new sex crimes while under correctional supervision were often sent to prison on technical violations without incurring a new sex crime conviction, thus distorting recidivism statistics.

The containment approach grew out of the frustration of probation and parole officers who were constrained by ineffective policies and procedures resulting from social attitudes that minimized the crime. In the same way that intoxication was once viewed by the court as a mitigating rather than aggravating circumstance, sexual abuse was seen as a family problem or a simple misstep by the perpetrator. Even Prentky and Quinsey's (1988) statement about adult sex offenders was thought to apply only to the few offenders who used overt violence: "This is a distinct correctional population, a group whose crimes involve a dangerous interaction of sex and power" (page).

It was within a social and judicial context of remarkable apathy that the containment approach developed. Professionals from multiple agencies gather ED together in grassroots efforts, educating each other, raising awareness, and seeking to reform existing sex offender supervision and treatment strategies. They needed to change policies, practices, and common attitudes that minimized all but the most violent sex crimes. These early innovators were clear that their common interest was to prevent known sex offenders from harming again. They wanted those who perpetrated sex crimes to be held accountable by the criminal justice system, and to prevent further offenses while being offered every opportunity to change the behaviors that victimized others.

This chapter details the five-part strategy for managing adult sex offenders in the criminal justice system and reviews research that may provide a fresh understanding of containment. The focus of this chapter is #3 below, the use of a variety of containment strategies, particularly the polygraph examination, since it is the most likely aspect of containment to be misunderstood. Despite that focus here, each of the five parts represents a fundamental element of an effective sex offender containment approach. All five must be present and integrated to maximize the effects of risk management efforts by criminal justice professionals and treatment providers. These are the five components of the containment approach first described in English et al. (1996) which are discussed in detail in this chapter:

1. A clearly articulated community safety/victim-oriented mission;
2. The coordinated activity of many well-informed, multidisciplinary, intra- and interagency collaborative teams;
3. The use of a variety of containment strategies;
4. Consistent, informed public policies; and
5. Resources dedicated to state and local quality control efforts.

Component 1: Victim and Public Safety-Centered Philosophy

The Jackson County, Oregon, sex offender management process incorporated the phrase "making the victim whole" (English et al., 1996, pp. 2–7). The sex offender treatment program at the Colorado Department of Corrections has a mission statement that reads "No More Victims." The Colorado Sex Offender Management Board has among its guiding principles these statements: "Community safety is paramount" and "Victims have a right to safety and self-determination." This focus on victim and community safety is intended to confront the apathy, cultural denial, and lack of knowledge of the trauma associated with sexual victimization. It is critical to remain vigilant about this aspect of the containment approach because the purpose of managing sex offenders differently from other offenders is rooted in understanding the prevalence rates and impact of sexual abuse victimization.

Millions of individuals are victims of sexual abuse because many sex offenders commit an untold number of sex crimes: 1 of 6 U.S. women and 1 of 33 U.S. men have been victims of a completed or attempted rape in their lifetime, and many are raped more than once (Tjaden & Thonnes, 2000, using a definition of forced oral, anal, or vaginal penetration). This prevalence rate reflects a high frequency of sexually abusive behavior, much greater than official arrest records would suggest. In fact, Ahlmeyer, Heil, McKee, and English (2000) found a ratio of 100 self-reported contact and noncontact sex crimes for every crime recorded in official records (page). This pattern has held constant since researchers began to actively study prevalence rates. In 1988, Abel, Becker, Cunningham-Rathner, Mittelman, and Rouleau interviewed paraphiliacs under conditions of guaranteed confidentiality and found that only 3.3 % of the paraphiliacs'

self-admitted hands-on sex offenses, such as rape and child molestation, resulted in an arrest. The numbers of victims along with the numbers of offenses are difficult to conceptualize. Even harder is quantifying the effect that this level of abuse has on a society and culture that values personal safety.

Studies have found that the consequences of these crimes can be brutal and long-lasting (see Wyatt & Powell, 1988). Sexual assault victims compared to non-rape victims are at significantly higher risk to abuse alcohol and drugs, to suffer from depression, anxiety, nightmares and social isolation, and to attempt suicide (Kilpatrick, Edmunds, & Seymour, 1992; Peters, 1988; Briere & Runtz, 1988). Because most sexual assaults occur in the context of an established relationship, experts explain that this trust violation causes great confusion and nearly unbearable trauma to the victim (Herman, 1992). Summit (1988) is one of the few to discuss the psychological damage inherent not only in rape but in touching: "Sexual touching, so often trivialized by words such as fondling or molestation (annoyance), is only the physical expression of a climate of invasion, isolation and abandonment" (page). The victim-centered philosophy of the containment approach assumes that every sexual assault, from a violent stranger-rape to voyeurism by a family member, represents a significant act resulting in fear and a sense of betrayal. The victim's need for safety and empowerment thus becomes a priority in the management of the offender's case.

If the societal or criminal justice system response to an attack is to place the victim at fault, the trauma is magnified and recovery may be delayed (Hindman, 1989). Finkelhor (1988) describes how important it is for agency officials to respond appropriately: "Clinicians have often observed that the harm of some sexual abuse experiences lies less in the actual sexual contact than in the process of disclosure or even in the process of intervention" (pages 77–78). This point is fundamental to the containment approach. The power and authority of police officers, lawyers, judges, and social workers can weigh as heavily on the victim as on the perpetrator. Laws seeking to hold offenders accountable, but that are not mindful of the complex nature of victimization, particularly when the victim is a child and the perpetrator is a family member, can profoundly affect the victim. For example, community notification laws and Internet postings of offenders' addresses or pictures may have a devastating effect on the victim if the perpetrator is a family member. In an effective containment approach, the healthy recovery of the victim and the well-being of the community guide policy development, program implementation, and the actions of law makers and professionals working with both sexual assault victims and perpetrators.

Adopting a victim-centered philosophy sometimes requires a significant shift in agency values, as every case management decision will require considering the risk the offender presents to past and potential victims. Probation and parole agencies may be challenged to dissolve usual job and agency boundaries so that risk management decisions can be made quickly and in an ongoing fashion.

Reporting Rates

The victim-centered focus of the containment approach becomes especially important when those in the justice system have few opportunities to protect and empower victims of sexual assault. Most victims never report the crime to authorities and so cannot participate in a criminal case. Of course, many crimes go unreported. In fact, the 2011 National Crime Victimization Survey found that only 39 % of property crimes and 49 % of violent crimes were reported to law enforcement; 27 % of sexual assaults were reported (Truman & Planty, 2012, page). Importantly, this survey omits crime victims under the age of 12. Tjaden and Thoennes (2006) surveyed 16,000 adults and found that 22 % of women and 48 % of men who experienced a completed or attempted rape were under age 12 at the time of the assault (page).

Young victims are least likely to report assault. Diane Russell (1983) conducted face-to-face interviews with 930 randomly selected adult females in San Francisco and found that 5 % of extrafamilial sexual abuse and 2 % of incestual abuse were reported to law enforcement. Smith et al. (2000) found that reporting was delayed when the victim was young or knew the perpetrator, which was most of the time: only 11 % were raped by strangers. Smith et al.'s study of over 3,200 women reported that 28 % of the respondents had never told anyone about the rape until the researcher asked. Of those who told, 47 % did not do so for 5 or more years after the assault, making prosecution unlikely. A particularly discouraging finding in a study by Roesler and Wind (1994) found that one-third of incest victims disclosed the abuse prior to age 18, most commonly to a parent, but in 52 % of disclosures the abuse continued for at least another year. The women in this sample who disclosed as children said they were likely to be met with disbelief or blame rather than with support, validation, and protection. See Pipe, Lamb, Orbach, and Cederborg (2007) for more information about childhood disclosure of sexual abuse.

Older victims report at slightly higher rates. Kilpatrick, Saunders, and Smith (2003) found that 14 % of adolescents who were sexually assaulted reported the crime to law enforcement; 74 % knew their perpetrators. Tjaden and Thoennes (2006) found 19 % of women and 13 % of men who were raped since their 18th birthday said their rape was reported to the police. Only 17 % of marital/intimate rape was reported to law enforcement.

Arrest, Prosecution, and Conviction Rates

While the literature is replete with data substantiating the lack of reporting by victims of sexual abuse, less is known about what happens next. Tjaden and Thoennes (2006) surveyed 8,000 women and 8,000 men and found that 18% of *adult* rape victims reported the crime to police. Of these, 43 % resulted in an arrest. This figure drops precipitously when the victim is a child. Howard (2000) found that 27 % of reported sex crimes against children resulted in arrest.

Tjaden and Thoennes (2006) found that 18 % of the adult rapes that were reported to law enforcement resulted in prosecution, and one-third of those were convicted. Overall, Tjaden and Thoennes (2006) found that, of adult female rapes, 19 % were reported to law enforcement, 7.8 % were prosecuted, 3.3 % resulted in convictions, and 2.2 % resulted in incarceration (p.34).

Why are these rates important? First, every effort should be made to develop policies and practices that protect children and empower adults whose victimizations come to the attention of authorities. How victims are treated can affect reporting rates. Many victims want their privacy protected and fear being blamed for the offense (Kilpatrick et al., 1992, page). In fact, 99 % of those in Kilpatrick et al. (1992) said that public education about acquaintance rape would increase reporting rates, suggesting that holding sex offenders accountable regardless of their relationship to the victim would empower some to report the crime, along with efforts to move the blame away from the victim and on to the perpetrator. Still, many victims are reluctant to report abuse by a trusted person upon whom the victim may be emotionally or financially dependent. These low reporting rates reflect the complicated nature of this crime, since in most cases the victim knows the perpetrator.

Second, these figures should serve as a sober reminder that we know very little about this crime; it occurs in secret and remains almost entirely hidden from researchers and others trying to develop and implement prevention and containment methods. It affects our ability to assess immediate and long-term risk for offenders. The assessment of long-term risk is especially plagued by underreporting, since actuarial scales that rely on official record data will underestimate risk of actual (as opposed to recorded) reoffense. Underreporting will be discussed later in the chapter.

Finally, even those offenders who come to the attention of the criminal justice system due to a sexual assault may have incomplete information in their official records. Frequently, these crimes are plea bargained to another classification and so may not result in a sex crime conviction. Of felony sexual assault cases filed in Colorado in 2008, 76 % were convicted of sexual assault, 20 % were convicted of a nonsexual, nonviolent crime, and 4 % were convicted of a nonsexual violent crime (Colorado Division of Criminal Justice, 2011). For those individuals who actually committed a sexual offense, the factual basis of the crime is usually lost in this bargaining process. This masks the true offending history as recorded by official records and can distort our understanding of risk for individual offenders.

Component 2: The Coordinated Activity of Many Well-Informed, Multidisciplinary, Intra- and Interagency Collaborative Teams

Various teams form and work together as cases proceed through the criminal justice system and the child protection system. These teams contribute to the development of consistent policies focusing on victim protection and offender accountability. Representatives from these organizations also train staff in other organizations to ensure an integrated approach. These teams can overcome the fragmentation that naturally arises from the multilayered nature of the criminal justice system, and the communication barriers that often exist across agencies. The team approach minimizes duplication of effort and maximizes resources. It also strengthens both the motivation and the effectiveness of individual workers. These teams frequently provide an important support network for coping with frustration, stress, and the burnout often experienced by those who work with sex offenders (English et al., 1997; Edmunds, 1997; Kadambi & Truscott, 2003; Thorpe, Righthand, & Kubik, 2001; English and Heil, 2006).

Members of intra-agency, multiagency, and multidisciplinary teams typically include representatives from law enforcement, child protection, rape crisis centers, prosecutor's offices, defense attorneys, probation and parole, hospital emergency room staff, treatment providers, polygraph services, school counselors, crime victim advocates, and child victim advocates. The teams develop policies, procedures, and protocols for managing sex offenders and monitor their own implementation of these practices. Assembling professionals with different areas of expertise creates a rich pool of information and perspectives to improve the management of sex offenders. State and local sexual assault organizations representing victim concerns are an important resource to those involved in defining and implementing a containment approach. In fact, a major litmus test of any specific containment practice, as well as the overall management approach, should be support from victim service organizations.

A strategy that commonly emerges within this context is job specialization. Specialization is the assignment of one or more workers to specifically handle sex offense cases. It

may take the form of a unit, as is typical in law enforcement, or a single professional designated to manage all sex assault cases. The effect of specialization is to greatly increase the expertise of professionals, in turn enhancing the ability of team members to educate each other. With specialization, case experience is multiplied and agencies can target training resources. These teams and job specialists, then, are responsible for understanding and incorporating into their work very specific issues associated with sex offender case management such as victim trauma, investigation methods, interview techniques for victims and perpetrators, medical assessments, dynamics of offending, offender denial, local policies and procedures related to sex offender management, and professional burnout. These teams can play an important role by improving each others' understanding; cross-training allows physicians to learn the evidentiary issues prosecutors face, law enforcement officers and prosecutors learn about common reactions to trauma from rape crisis counselors, and victim advocates learn more about the criminal justice system so they can better help victims prepare for court (Epstein and Langenbahn, 1994, p.85).

Interagency and multidisciplinary collaboration can occur in many ways. In Colorado, for example, a state-level Sex Offender Management Board with multidisciplinary membership is defined in legislation and meets monthly. The Board developed guidelines for the evaluation, treatment, and behavioral monitoring of adult sex offenders, including sex offenders with developmental disabilities. It also developed release criteria for sex offenders serving lifetime probation or parole sentences, a sentencing strategy undertaken in lieu of civil commitment. Smaller multidisciplinary groups meet regularly within judicial districts. The State Division of Probation Services regularly convenes two groups, the officers who specialize in juvenile sex crime cases and those who manage adult caseloads. In Oregon, quarterly meetings were held for all the probation and parole officers from across the state that specialized in the supervision of adult sex offenders, and law enforcement and treatment providers also attended these meetings. In Alaska, the Department of Corrections regularly gathered stakeholders within the agency to develop policies related to sex offender management. In Ohio, a parole officer initiated a meeting with colleagues working in the local police department's sex crime unit, and they subsequently worked together to solve cases. Frequently, line staff forges these types of relationships, with one committed professional seeking out the expertise of another. Regular meetings and communication ensue. These small acts of collaboration continue to change the way this work gets done in many jurisdictions across the country (English, 2004, page).

Component 3: The Use of a Variety of Containment Strategies

Case processing and case management in a containment approach must be tailored to the *individual sex offender* and his or her patterns of sexual offending. This focus on the individual is a fundamental aspect of containment. In fact, we return to this point many times in this chapter. Not only is this individual focus central to the containment approach, but individualized assessment and treatment is a basic tenet of evidence-based correctional practices, specifically the Risk-Needs-Responsivity Model (Andrews & Bonta, 2010; Wolff, 2008; Andrews, Bonta and Wormith, 2011) that promotes the development and use of a very specific treatment plan based on a thorough assessment of specific treatment needs. Sex offender treatment experts also promote this approach (for example, Heil & Simons, 2008; Ward & Stewart, 2003a), which should also include an assessment of cognitive deficits that require special programming (Haaven & Coleman, 2000, page). Ward and Brown (2003) emphasize that individuals who are assessed as low risk may display high needs requiring intervention, so needs and not risk should drive treatment in this event. This is especially true for offenders convicted of sex crimes who score low risk on actuarial scales. Typically, actuarial scales are heavily weighted by incomplete official record data. Additional offense history is frequently disclosed when offenders proceed in treatment with polygraph testing, further illuminating the seriousness, frequency, and range of deviant behaviors, reflecting new levels of needs and risk and an associated need for more intensive, long-term treatment.

Containment Strategies

Individualized case management incorporates multiple tools that become part of containment. These include confidentiality waivers, collateral contacts, home visits, employment restrictions, Internet restrictions, family reunification policies, positive informed support, urinalysis testing, law enforcement registration, conditions of supervision, and leisure time monitoring for the offender. Additional strategies include professional cross-training, surveillance officers, victim services, and multidisciplinary teams. The core strategy, which is a focus of this chapter, is the formation of a containment team consisting of a specially trained treatment provider, a supervising officer (including the probation or parole officer in the community and the correctional staff prison), and a polygraph examiner. Some jurisdictions include a victim advocate as part of the team, operationalizing the victim

orientation described in Component 1 above. Including a victim representative on the team ensures that the victim's perspective is routinely incorporated into case management decisions.

In fact, to be most effective in these collaborations, victim organizations must provide support and sometimes training to staff to ensure that they have sufficient confidence to keep treatment providers, supervising officers, and other practitioners and policymakers focused on public safety. For example, when offenders reach the end of time-limited probation or parole terms, often professionals develop family reunification plans even for offenders who have not made meaningful life changes because the offender is "going home anyway." The individual may still present a significant risk to the community and potentially specific family members, despite the presence of a reunification plan. Scott (2011) notes that in a 3-year period in Maricopa County (Phoenix), half the reoffenses for sex crimes occurred because family members allowed their children to be in contact with offenders, even though they had been appropriately informed.

The containment approach depends on obtaining and sharing key pieces of information about the abuser with the containment team: "The criminal justice supervision activity is informed and improved by the information obtained in sex-offender-specific therapy, and therapy is informed and improved by the information obtained during well-conducted post-conviction polygraph examinations" (English, 1998, p.225). Each anchor must be perceived by the offender as separate-yet-aligned with the other.

The containment team must be prepared to consistently respond to shared information in order to minimize the offender's access to victims and high-risk situations. This additional information allows professionals to develop meaningful treatment and supervision plans. It also means that professionals obtain much more information about offenders' violations of these plans. It is this aspect of containment that is one of the most difficult to implement: increasing the information on each case requires significantly more time on the part of both the treatment provider and the supervising officer. This additional information can multiply the amount of case time required.

Sharing information requires that the supervising officer, treatment provider, and polygraph examiner establish common and clear public safety goals and consistent responses to new information disclosed by the offender during the course of treatment and supervision. In poorly functioning containment teams, members sometimes withhold information disclosed by offenders that may result in greater containment (such as curfews or GPS monitoring) or criminal justice sanctions, usually for the purpose of protecting the offender. Team members who withhold information about the offender are either feeling conflicted in their role or are being successfully groomed by the offender, or both. The value of working together as a team is to obtain feedback from fellow professionals. Sharing information and respectfully giving and receiving feedback are necessary to create the transparency required to safely manage this population of offenders. Working well as a team is reflected by this information sharing, and it models the honest and open lifestyle that is the goal for the offender.

The core containment strategy—polygraph, treatment, and correctional supervision—is discussed in detail below, beginning with the polygraph examination since its use informs and frames treatment and supervision.

Post-conviction Polygraphs

The post-conviction polygraph is the only type of polygraph exam used in containment, and its regular use is fully integrated into treatment and supervision. Understanding how the information disclosed during the polygraph exam is integrated into case management is essential to successful implementation of the containment approach.

The greatest value of the polygraph examination is that its use facilitates the offender's progress in treatment (Knapp, 1996; Grubin, Madsen, Parsons, Sosnowski, & Warberg, 2004). Clients know that they will be regularly polygraphed as part of the treatment process and are encouraged from the onset to fully disclose those aspects of their lives that they have traditionally kept secret. Preparation for the polygraph examination includes clarifying behaviors that are abusive. This is often educational for clients who are expected to disclose their history of offending so that an appropriate treatment and supervision plan can be developed and implemented. We discuss the accuracy of the polygraph later in the chapter, but it is this important process of disclosing harmful behaviors that helps move the offender through denial and early resistance to treatment where the polygraph proves it mettle.

In addition to verifying the accuracy and completeness of self-reported sexual history information gained in treatment, the polygraph exam is also used periodically (preferably at least every 6 months) to corroborate the offender's compliance with criminal justice and treatment conditions. This information about compliance is a critical component of public safety because it taps the offender's actual life behaviors, going beyond how one behaves during therapy. It is a relatively simple task for offenders to learn the language of treatment and to assess and respond to the expectations of the containment team. In fact, many sex offenders can easily employ elsewhere the skills developed in the service of manipulating victims. Grooming therapists and supervising officers should be expected; feigning engagement in treatment should also be expected. Assessing behavior change *outside* of treatment using the polygraph exam and other

monitoring methods, then, is a critical barometer for managing this population of offenders safely.

Safe management means every effort is under way to prevent a new sex crime by a known sex offender. The polygraph examination is an essential component of the containment approach because its use reveals much necessary information about the offender. Its use is also critically valuable in determining those for whom this is their only sex crime and who, therefore, may be at low risk of offending again.

One objective of containment is to improve public safety by obtaining information that will prevent known offenders from harming again. The polygraph targets behaviors actually engaged in, not sexual interest or sexual arousal. This occurs primarily through the synergistic effect of combining sex-offense-specific treatment, criminal justice supervision, and post-conviction testing. Working together, these strategies can facilitate the offender's compliance and increase the information he or she discloses, thereby increasing the effectiveness of treatment and supervision. The effective use of the polygraph depends in large part on how a treatment provider reacts to newly disclosed information. We return to this issue later in the chapter.

Types of Polygraph Exams

The post-conviction polygraph examination gathers information after the individual has been convicted of a sex crime. In containment, sex offenders are tested for three time periods: sex crimes that occurred prior to the current criminal event, the time between arrest and treatment onset, and abusive and other noncompliant behavior during treatment. Each of these time periods provides different sets of information for different purposes. Questions covering the time period prior to arrest or conviction for the current crime uncover age of onset, duration, frequency, and variation (types of victims and assaultive behaviors) which are critical elements of therapeutic and risk assessment (Heil & Simons, 2008, page). The time between arrest or conviction and sentencing or the onset of treatment can be a very active period for some offenders and indicates how they might behave under stress, while polygraph testing while the offender is under supervision and in treatment provides information about the extent to which the offender is responding to external controls and applying the tools learned in treatment.

The Colorado *Standards and Guidelines* (2011) specify five types of polygraph examinations. Four of these are discussed here (the fifth type, the child contact assessment polygraph, is used specifically to assess the individual's risk to their own children, and will not be discussed here). Although the polygraph procedure itself remains the same, the questions and consequences for deception vary depending on the time period involved and the seriousness of the information withheld or disclosed.

The *sexual history examination* is used to thoroughly investigate the person's lifetime history, including the identification of victim age/gender/relationship and victim selection behaviors. The sexual history addresses age of onset, frequency, seriousness, and variety of past sexually abusive behavior. Revealing this information allows the offender the opportunity to be accepted by the therapist despite the level of harm he or she has caused others. It reveals to the therapist how entrenched the deviant behavior may be and begins to clarify the true risk the offender presents to the community. This information should inform the therapist on the intensity and duration of treatment needed to effectively address the offender's issues, and the number and type of containment strategies that might be necessary to safely manage the person in the community, such as GPS tracking, curfews, daily phone calls, and using a "buddy system" with other members of treatment programs. Therapists and supervising officers must also determine who, if anyone, needs to be warned given the information learned during the course of treatment and polygraph examinations.

The sexual history polygraph examination requires that the offender has completed in treatment a written sexual history disclosure journal prior to the examination. The Colorado *Standards* require that the therapist provide the sex history material to the examiner in advance of the exam, and the examiner is required to read the information in the packet before preparing for the examination. Both the supervising officer and the treatment provider must work together to prepare the offender to take the sexual history examination. Effective preparation, according to polygraph examiners, improves an offender's ability to resolve questions and issues of concern. Preparation for the examination in therapy should *not* include a review of possible test questions, but rather should involve discussing the examination process, expectations regarding honesty, and the need to disclose—in treatment rather than the polygraph office—noncompliant behaviors and risk concerns. The focus should remain on treatment and supervision compliance, risk and need factors, cognitive distortions, and the "stuff" of therapy.

The maintenance/monitoring polygraph examination is first used within 90 days of treatment onset and then at least semiannually. It should be used more frequently for those who present high-risk behaviors, who recently experienced a life change (such as changing their residence or starting to date), or who have previously unresolved examination results, and it can be used as frequently as weekly. This examination investigates the offender's compliance with supervision and treatment, and many offenders anecdotally report to polygraph examiners that it has a deterrent effect on their behavior. In a small study of only 28 offenders who were guaranteed confidentiality, Harrison and Kirkpatrick

(2000) found that over half reported that they altered their behavior in anticipation of the polygraph examination. Specifically, more than half reported a decrease in grooming behavior, 43 % reported a decrease in probation violations, 36 % reported reduced substance use, and 27 % reported decreased sexual touching of children. Grubin et al. (2004) also found polygraph testing to have a deterrent effect on high-risk behaviors in a small sample of sex offenders voluntarily participating in polygraph exams: 20 out of 21 offenders reported that they thought the polygraph examination helped them avoid reoffending. The average number of high-risk behaviors reported by sex offenders significantly decreased between the first polygraph test and the second, suggesting that polygraphy was effective in decreasing these behaviors. At the same time, disclosures of high-risk behaviors to treatment providers and supervising officers increased. Grubin et al. (2004) concluded that the polygraph might be better considered a truth facilitator rather than a lie detector (page). Abrams and Ogard (1986) also studied the deterrent effect of polygraph testing on probationers and determined that 69 % of offenders who received polygraph testing with supervision successfully completed probation as opposed to only 26 % of offenders who received supervision alone.

The *event-specific* polygraph examination is used to investigate the details of a person's specific involvement in a known or alleged incident, or to resolve discrepancies or inconsistencies in the offender's account of a specific event. Polygraphs should not be conducted on active criminal investigations unless law enforcement officials agree to the procedure. The *child contact assessment*, mentioned above, is used in Colorado to assist the containment team in making a recommendation about the offender's contact with his or her own children who are not already known to be victims as well as siblings of victims. The event-specific polygraph examination is used in situations of unknown risk to identify possible risk based on past behaviors and inform decision makers regarding the offender's potential risk to the children.

The event-specific examination may be used when offenders deny the instant offense or aspects of it. Nannetti and Greer (1996) noted that common defenses for child sex offenders include (1) the touching was not sexually motivated or was accidental or innocent, (2) the victim's graphic description is based on prior knowledge, (3) the alleged abuse is a fantasy; the child wants attention, and (4) the identification of the perpetrator is inaccurate (page). Offenders of adult victims may maintain that the sexual contact occurred with the victim's consent. These issues can be addressed with a careful interview that includes the definition of terms to be used during the examination, and targeting questions specific to the behaviors of concern. Strate, Jones, Pullen, and English (1996) describe the value of these examinations to help the offender take responsibility for his or her damaging behavior, moving them forward in the treatment process. Additionally, details of the instant offense are often incomplete. Polygraph examiners report that, upon questioning, clients will often disclose the use of force or violence that was not recorded in the police report or other descriptions of the offense. Victims of sex crimes are often reluctant to disclose the use of aggression, especially if they are acquainted with the offender.

The Polygraph Test

The polygraph exam is a verification of the offender's self-reported information about his past and current behaviors. Its focus is actual behavior undertaken by the client, not feelings, thoughts, motivations, interest, or attraction. The polygraph examination lasts approximately 90 min; most of this time is spent discussing the exam process and the potential questions, calibrating the equipment, and interviewing the client. Each examination can test on only three or 4 questions. These few questions reflect the need to identify the offender's patterns of behavior and immediate risk concerns. This question limit reveals that the polygraph can never substitute for the combination of therapy and supervision. In fact, it is possible that the questions asked could completely miss a part of the offender's life that is teetering out of control. This is a sober reminder that the use of the polygraph cannot replace the vigilance required of a supervising officer and a treatment provider to continually look for cues that the offender may be slipping into dangerous patterns of behavior.

Question construction is a critical dimension of the polygraph examination. There can be no surprise or trick questions, and they must elicit only a yes or no response. Questions must be concise, well-defined, and easy to understand. Broad and vague questions such as "does your written sex history journal include every victim?" are likely to generate an anxious response whether or not someone is intentionally withholding information. Instead, questions should be discussed and completely defined in advance of the test procedure, during the pretest interview between the examiner and the client. The American Polygraph Association's *Model Policy for Post-Conviction Sex Offender Testing* (2009) reads: "Before proceeding to the test phase of an examination, the examiner should review and explain all test questions to the examinee. The examiner should not proceed until satisfied with the examinee's understanding of and response to each issue of concern" (181).

The polygraph examiner focuses on the technical and physiological requirements of the exam itself, the threats to validity, careful construction of questions, a methodical execution of the pretest (where every question is reviewed with the offender), the test itself (measuring heart rate, blood pressure, respiration, and perspiration), and the posttest

Table 1 The polygraph, supervision, and treatment work together to identify behavior problems

How violation was discovered	Total
Self-disclosure during polygraph examination	15.6 % (77)
Probation officer found out (including self-report)	14.0 % (69)
Treatment provider found out (including self-report)	12.1 % (60)
Lab result (UA)	11.3 % (56)
Fail to appear for treatment	9.7 % (48)
Probation officer (PO) did home visit	8.1 % (40)
Fail to appear for probation appt.	7.3 % (36)
Law enforcement	5.5 % (27)
Roommate called PO or treatment provider	4.3 % (21)
Group member called PO or treatment provider	2.8 % (14)
Both PO and treatment provider found out (including self-report)	2.0 % (10)
GPS/EHM	1.4 % (7)
PO called or visited employer	1.2 % (6)
Sex offender's friend called PO	1.2 % (6)
Victim advocate called PO	1.0 % (5)
PO called residence	0.8 % (4)
Computer surveillance	0.8 % (4)
Employer called PO	0.4 % (2)
PO called nonresident family member	0.4 % (2)
TOTAL	100 % (494)

Source Colorado Division of Criminal Justice (2004). *Report on safety issues raised by living arrangements for location of sex offenders in the community*. Denver, CO: Sex Offender Management Board. Special analysis conducted by Amy Dethlefson

interview (review of test results with the offender). Well-trained examiners who actively participate in workshops and educational experiences and are open to quality control reviews by their colleagues are important members of the containment team.

The synergy of containment—polygraph exams, treatment, and supervision—can be seen in the data presented below. In a study of 130 mostly high-risk sex offenders during the first 15 months of community supervision in Colorado, 443 violations of probation were recorded in the probation files of 103 offenders. Most of these violations did not result in revocations; they do, however, reflect the large amount of information that became available to the containment team in the course of their work with individuals in the sample.

Table 1 displays how the violations were discovered. Note that the violation could be discovered by multiple sources. The polygraph examination identified 77 (15.6 %) of the violations, the probation officer discovered 69 (14.0 %), and the treatment provider reported 60 (12.1 %). These violations were revealed primarily by the sex offenders in the study who self-reported the information. Of course, it is possible and even likely that many of these violations would have been discovered without the polygraph; however, the important point is that the three leading sources of detected violations were from the three components of the containment approach.

In this study, 15 new sex crimes were committed by 13 offenders in a 15-month period. All of these were noncontact crimes, and 11 were disclosed during polygraph examinations. In two cases, a treatment group member phoned a probation officer, 1 offender self-reported to the treatment provider, and law enforcement detected one crime (Colorado Sex Offender Management Board, 2004).

Violations and Stages of Change

The number of violations detected in the study referenced above underscores the difficulty of working with this population. Sex offenders are almost always an involuntary treatment client. In a meta-analysis of 125 studies of therapy retention, Wierzbicki and Pekarik (1993) found 50 % of clients dropped out of treatment—and the study did not differentiate between voluntary and involuntary clients. In a study of proactive recruitment, Lichtenstein and Hollis (1992) investigated a program where physicians spent time with every smoker to persuade them to sign up for a state-of-the-art, action-oriented clinic. If that failed, nurses spent up to 10 min more, followed by 12 min with a health educator and, finally, a counselor's call to the home. The result was a base-rate participation of 1 %. Note that, with smoking, there is no social stigma associated with getting help.

Most therapists are aware of Prochaska and DiClemente's (1982) groundbreaking work which identified the processes involved in producing individual change. It is a process that unfolds over time and involves a progression through six stages: precontemplation, contemplation, preparation, action, maintenance, and termination. Termination occurs when individuals experience zero temptation and complete self-efficacy: they are confident that they will not return to their old unhealthy pattern of behavior. In fact, it is as if they never experienced the problem or acquired the pattern in the first place. Snow, Prochaska, and Rossi (1992) found that this stage was reached by less than 20 % of smokers and alcoholics. Prochaska (2001) reported on a study of the stages of change by Rossi (1992) of 15 unhealthy behaviors in 20,000 HMO members. Rossy reported that 40 % were in precontemplation (people are not intending to change or may take action "in the next 6 months"), 40 % were in contemplation (people intend to change in the next 6 months), and 20 % were in the state of preparation, meaning they have a plan for action such as consulting a counselor. Again, involuntary treatment was not studied, so these figures are likely less optimistic with court-ordered clients.

Prochaska (2001) discusses how individuals who begin to contemplate acting seriously vacillate between the costs and

benefits of change: "There is no 'free change." The balance between the costs and benefits of changing can provoke profound ambivalence. This ambivalence can keep people immobilized in this stage for long periods. We often characterize this phenomenon as chronic contemplation or behavioral procrastination" (231). And it might be expressed by sex offenders as behaviors that violate the conditions of supervision and treatment.

Sex offender ambivalence regarding personal change contributes to significant treatment attrition and community supervision revocation rates. Treatment providers and supervisory agents must attempt to motivate offenders' investment in the change process through the use of Motivational Interviewing (Miller & Rollnick, 2002, page), appropriate therapeutic relationships such as promoting offenders' hope for change, supporting offenders' change efforts, and respectfully holding offenders accountable to change. Motivating change also occurs through the use of behavioral monitoring, incentives, and sanctions. While therapists cannot instill hope or will in the offender, they can provide logic and delineate the benefits of behavioral change. It is understandable that court-ordered clients may find it difficult to become self-motivated or remain self-motivated about the difficult work that change requires. Yet, allowing unmotivated offenders to remain in group treatment without being held accountable for completing homework and applying what they are learning rewards negative behavior and undermines those who *are* engaged in the change process. Change is not absorbed by passive participation in treatment. Rather, it requires active and sometimes painful work. In Colorado, termination from community treatment can result in a prison sentence if the individual does not reconsider and recommit to the process of change. The decision to terminate treatment should be made by the containment team or, in the case of prison treatment, the treatment team. This ensures multiple perspectives consider the offender's stage of change, ambivalence, and level of motivation.

Therapist Response to the Polygraph Information

Often, therapists find the information disclosed by the offender during the polygraph examination difficult to absorb. Some therapists experience a dissonance between the reality described in the polygraph report and their hopes for the client. Therapists enter the profession to positively influence the lives of their clients, and the information generated via the polygraph examination is often disappointing, especially when it indicates that the offender is continuing to engage in risky or abusive behavior. Frequently, the first reaction of the therapist is to doubt the polygraph results rather than doubt the progress the offender has made (or not) in treatment. If the therapist does not move past these impulses and recognize them as rooted in personal disappointment, the successful containment of the offender is seriously jeopardized. In this situation, the therapist values his or her image of the offender over the potential harm the offender may present to the community. It is this reason that the containment approach requires a victim orientation and a public safety mission. Learning that the revelation of secrets and risk behaviors is a goal of treatment and supervision, and that public safety is the ultimate outcome, is how professionals guide and support behavioral change that is helpful to the client.

Containment is rooted in the humane management of sex offenders (English et al., 1996, page). Containment professionals who cannot hold offenders accountable for the risks they pose as revealed by self-reported information may allow the offender to be in high-risk situations, such as living with family members or children. New victimizations may result in very long prison sentences for the client. Those who consistently struggle with recognizing and managing their disappointment with court-ordered clients may be more suited to working with a noncriminal population.

It's About Honesty

The treatment provider and the supervising officer need to set the expectation that the offender will be found nondeceptive on the examination. That is, honesty is expected and with appropriate preparation in therapy, the client will "pass" the examination because they are willing to be honest. Some treatment programs work with the correctional agency to specify, in advance, written consequences for deceptive results and incentives for nondeceptive results that indicate the offender is engaged in the change process. This clarity provides support for changes the offender may find difficult to undertake, and it promotes understanding and a common goal: for the offender to succeed in therapy.

In fact, research conducted at the sex offender treatment program at the Colorado Department of Corrections found that the proportion of successful (nondeceptive) polygraph examinations varied considerably over time based on variables such as the reluctance of the treatment staff to support the use of the polygraph combined with consistent application of sanctions related to polygraph test findings. When sanctions were poorly implemented for nondeceptive exams, 37 % of the tests were nondeceptive (over a 1-year period); when staff were reluctant to use the information from the polygraph examination, 51 % of exams were found nondeceptive. However, when staff attitudes changed and sanctions were consistently implemented, 63 % were found nondeceptive, a statistically significant difference (Simons, Heil, & English, 2004).

For those who have not worked with the polygraph examination, it may be helpful to know that the polygraph examination itself is relatively proscriptive and predictable. The American Polygraph Association has detailed standards of practice (APA, 2009). It is not a mysterious instrument or process so it should not distract from the work of treatment. Nevertheless, all members of the containment team, including the examiner, require special training to be effective with this population. The skill of the examiner should build confidence in the offender: honest clients worry that the examiner is unskilled, and dishonest clients worry that the examiner is very skilled.

Polygraph Controversies

Donald Krapohl (2007), former president of the American Polygraph Association and member of the Defense Academy for Credibility Assessment Department (formerly the Department of Defense Polygraph Institute), has comprehensively summarized the controversies concerning the use of the post-conviction sex offender test (PSCOT). Polygraph critics cite concerns about accuracy, the lack of research, the possibility of false accusations, and the possibility of mistreatment of offenders as an outgrowth of the examination process. Proponents point out that traditional methods of detecting or deterring sex crimes by known offenders are inadequate, and identifying precursor behaviors is critical to protection of vulnerable victims. Both camps agree that more research is needed.

The value of the polygraph in the containment approach is its ability to facilitate self-reporting of the frequency and variety of sexually abusive behaviors. The information obtained using the combination of treatment and polygraph testing seems to be reluctantly disclosed, rendering it all the more important because of the value it holds to the offender. The self-reported information should be used to improve treatment, supervision, and public safety, and new crimes admitted during supervision should be subject to further investigation and, if verified, prosecuted. It should be viewed as one tool in the toolbox of sex offender management and should not be overly relied upon. A nondeceptive examination may be the result of targeting the wrong behaviors, so clearly its use should never displace active supervision by the criminal justice agency. Polygraph screening combined with skilled interviewing techniques produces high value information that would be nearly impossible to uncover by other methods, according to Krapohl (2007) who discusses PSCOT along with the use of the polygraph in U.S. counterintelligence agencies.

Amid the controversies outlined by Krapohl (2007), two valuable outcomes result from the consistent use of the polygraph in the containment approach. First, it takes the onus of responsibility for disclosing sex crimes off the victim and places it on the offender (English, 1998). Even after reporting a crime, and even after that crime has resulted in a conviction, victims may withhold important but embarrassing or humiliating aspects of the crime. Victims who know the offender are often uncomfortable reporting acts of violence or threats, or prior assaults, yet this information is vital for the assessment of risk and treatment needs. The offender is in the best position to report on his or her behavior, and disclosing details of the current crime places responsibility for our knowledge on the offender and not on the victim.

Second, the polygraph has significant value for identifying the one-time, low-risk sex offender. Individuals with one or few offenses will be easily identified. This narrows the field of questioning and increases the rate of accuracy. Most examiners report that they do, indeed, identify first-time offenders while conducting sexual history examinations. Low-risk offenders should be separated from medium- and high-risk offenders in treatment and supervision planning. Given the incomplete nature of official record data, this is a significant and often-overlooked benefit provided by the polygraph examination.

Polygraph Accuracy

Critics of the use of the polygraph in sex offender management often question the accuracy of the instrument. It is important to remember that the reliability and validity of the polygraph exam is not in question when the offender self-reports additional or new victims prior to or after the examination. These self-reports are similar to self-reports during other circumstances. The National Academy of Sciences (2003) explored the use of the polygraph in the detection of espionage and, despite criticizing the paucity of well-controlled research on the instrument, concluded "specific incident polygraph tests can discriminate lying from truth telling at rates well above chance, though well below perfection. Because the studies of acceptable quality all focus on specific incidents, generalization from them to uses for screening is not justified" (4). The NAS concluded its accuracy investigation with the determination that specific incident polygraph testing had a median accuracy rate of 86 %. Indeed, accuracy declines as the test moves toward multiple issue testing, and this speaks to the need to focus on each offender's specific vulnerabilities: drinking, driving "aimlessly," masturbating to inappropriate sexual fantasies, and other types of specific precursor behaviors such as stalking (English & Heil, 2006).

Krapohl and Stern (2003) compared counterintelligence testing with post-conviction sex offender testing. In espionage testing, the assumption is that there may be one out of

1,000 or 10,000 tested subjects who engaged in espionage. However, in sex offender testing, the situation is reversed: it is likely that 500 or 800 or 950 offenders out of 1,000 are hiding important information (the base rate depends on many factors [Simons, Heil & English, 2004]). Krapohl and Stern (2003) estimated a conservative accuracy rate of 80 % (page). This rate can increase or decrease with the skill of the examiner, but on average 760 of the 1,000 sex offenders will be correctly identified as deceptive on the exam. Many of these offenders will disclose important risk-related information to the polygraph examiner during the course of the examination. The disclosures may not be complete, but significantly more information now exists for treatment and supervision purposes. However, the overall error rate along with the fact that the test questions are limited in number (and so may miss areas of concern) underscores the need for ongoing intensive supervision and vigilance on the part of the treatment provider and supervising officer.

Krapohl (2007) makes an important recommendation about the problem of false positives—calling a person deceptive who is telling the truth. Since polygraph decisions are based on scores that the examiner assigns to the polygraph data, he suggests altering the polygraph decision rules such that false-positive errors are less likely to occur. This, of course, increases the incidence of false negatives, classifying deceptive individuals as nondeceptive. In addition, recognizing that multiple-issue screening tests have lower accuracy than do single-issue criminal tests, Krapohl (2007) recommends a successive hurdles approach (Meehl & Rosen, 1955). Applicable to most medical and psychological diagnostic tools, this principle refers those who produce a "positive" finding on a screening to a subsequent, more focused test. The examiner explores the issues with the examinee, seeking resolution of the positive result. This is followed by another test with more focused questions. This is an iterative process, and successive tests can involve resetting the scoring cutoffs to correct for the reduction in false positives, discussed above.

This approach requires research to better understand its affect on decision accuracy. Nevertheless, the successive hurdles strategy is recommended in the *Model Policy for Post-Conviction Sex Offender Testing* (American Polygraph Association, 2009). Containment teams should ensure that examiners are following the APA's model policy, are members of their local polygraph association, and receive frequent training to improve their testing and interviewing skills.

Self-incrimination is discussed in greater detail in English and Heil (2006), but it is somewhat less of a concern today than in the early days of post-conviction testing. In January 2005, in *U.S. v. Antelope,* 05 CDOS 745, the 9th U.S. Circuit Court of Appeals ruled that Antelope had been unjustly denied his Constitutional right against self-incrimination when a Montana district court judge required that he undergo treatment and disclose past crimes as a condition of probation supervision. The court found that Antelope could not be forced to participate in treatment unless he was promised that he would not be prosecuted for past crimes. This ruling, while applicable only to the jurisdiction covered by the 9th Circuit Court, marks the critical need to clarify with offenders and the containment team exactly how the information obtained during therapy and polygraph examinations will be used. This case codified the need to develop a specific strategy that precludes professionals from obtaining crime details necessary for prosecution: the name of victim, the geographic location, and date and time of offense. Should victims come forward independently and report the sex crime to law enforcement, prosecutors may choose to pursue criminal charges.

Despite the *Antelope* decision, some programs continue to obtain full details, including the name of the victim and their current location if this is known by the offender. These programs operate on the assumption that this information is critically necessary to provide the potential for counseling to child victims or to be included in the client's exclusionary zones on GPS. Newly revealed victims are reported to the supervising agency; however, this information is rarely used for prosecution or a change in sentence.

The Polygraph and Therapeutic Alliance

A commonly expressed criticism about the use of the polygraph is that it may negatively affect the therapeutic alliance since it communicates distrust of the client (for example, McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010). However, its use is analogous to the urinalysis testing during substance abuse treatment, a strategy recommended by the National Institute on Drug Abuse (2006): "Monitoring drug use through urinalysis or other objective methods, as part of treatment or criminal justice supervision, provides a basis for assessing and providing feedback on the participant's treatment progress" (3). Substance abuse treatment providers routinely overcome the problem of monitoring behavior and therapeutic alignment.

Nevertheless, the therapeutic relationship is one of the foundations of psychotherapy outcome and individual change (Hubble, Duncan, & Miller, 1999). Lambert and Barley (2001) summarize the research on the therapeutic relationship, and they define the therapeutic alliance as a condition that includes both the therapist's skills and the client's contributions to the relationship (page). This means that the client is also responsible for building therapeutic alliance, and few would argue that the client's honesty is important in this regard.

Lambert and Barley (2001) caution therapists to "watch for a reduction in their ability to empathize and relate to clients that can indicate professional stress or burnout" (page). Certainly, all containment team members must strive to encourage and support offenders' change efforts while holding them accountable because of the challenges presented by this population. In fact, Lambert and Barley (2001) close their discussion of the therapeutic relationship with these words: "It is clear that some therapists are better than others, at least with some clients. This is probably related to the therapist's contribution to the therapeutic alliance, especially in working with severe cases" (359).

Ackerman and Hilsenroth (2003) reviewed therapist characteristics and the therapeutic alliance and suggested that clients who perceive the treatment relationship to be a collaborative effort are more likely to invest in the therapy process and, in turn, experience greater therapeutic gains (page). Lambert and Barley (2001) refer to Bordin's (1976) classic work and describe the therapeutic alliance as having three parts: tasks, goals, and bonds (359). *Tasks* are behaviors and processes within the therapy session that constitute the actual work of therapy. Both the therapist and the client need to view these tasks as important and appropriate for a strong therapeutic alliance to exist. The *goals* of therapy are the objectives that both the client and therapist endorse. *Bonds* are the positive interpersonal attachment between a therapist and client of "mutual trust, confidence, and acceptance." It is important to remember here that court-ordered, offense-specific treatment means that the client has been found responsible for a crime. Involuntary treatment requires a shift in the burden of producing the therapeutic alliance: the client must prove willing to engage in treatment because it is a condition of supervision and therapy. This inherently requires that the offender demonstrate behavioral changes, making them in large part responsible for the therapeutic alliance. Additionally, the use of the polygraph examination, collateral contacts with family members and roommates, urinalysis testing, driving logs, sex history journals, leisure time logs, and other therapeutic tools are not mutually exclusive from building a strong therapeutic alliance. In fact, offenders who have the experience of feeling understood, accepted, and valued when the truth about them is known (and continually verified) are in a strong position to make use of the new skills and attitudes that accompany successful cognitive-behavioral therapy.

Understanding the sex offender client means that therapists should expect most of these individuals to struggle with honesty. Therapists should look for signs of the offender's use of manipulation in the service of keeping secrets. Because the secrets can lead to significant harm, the therapist's continual and reality-based skepticism benefits the client. Experienced offense-specific therapists explain this dynamic as a critical safety-oriented perspective. Part of the therapeutic interaction that makes use of the alliance is *reframing*. Reframing involves reflecting back to the client what he has said and putting it in a new light; it is not simply to agree with the client but to offer new interpretations. Polygraphs and other tools can be part of this process. Developing a positive therapeutic alliance will be challenging regardless of the containment tools involved in treatment because the tasks, goals, and bonds—the essence of the alliance—may be faced with considerable ambivalence and even hostility by the involuntary client. The client can positively affect the alliance by learning to view the containment tools as beneficial to himself and the community.

The polygraph examination can be framed simply as a tool to verify the offender's self-reported information and to clarify the person's immediate level of risk and compliance, much like the use of urinanalysis testing for substance abusing clients. Skilled therapists present it to the client as a helpful tool, while acknowledging the offender's anxiety about its use. Therapists help the client understand that the use of the polygraph helps unveil many secrets that lead to hurting people, and it is the offender's responsibility to stop these behaviors, including the precursor behaviors that lead up to the assault. The polygraph is just one tool to assist in this aspect of the change process. Rather than focusing on the examination, therapists focus on the value of honesty and openness during the treatment process.

Sex Offense-Specific Treatment

Sex offender treatment uses cognitive-behavioral therapy to target the thoughts, feelings, attitudes, reasoning, and problem-solving that contribute to sex offending behavior along with denial, minimizations, motivations, and justifications (see for example, Marshall & Serran, 2000; Terry, 2000; Ward, Hudson, Johnston, & Marshall, 1997). Lipsey (1992) found that programs that were classified as being structured, cognitively and behaviorally oriented, multimodal, and which were directed at building concrete skills had significantly better outcomes than other programs (Cooke & Philip, 2001). Fernandez, Shingler, and Marshall (2006) discuss the need for treatment goals to be based on individual needs, deficits and strengths, and the use of "shaping" to reward and reinforce small steps toward prosocial behavior change (page).

Schwartz (2011) discusses reasons group therapy is preferred over individual therapy. The common characteristics of guilt, denial, and secrecy "make sex offenders especially difficult to treat in individual therapy. Because these offenders often lie, minimize and rationalize their behavior, it is quite a task for a lone therapist to muster the strength or the evidence to confront their defenses" (page). Moreover, Schwartz suggests that individual therapy can replicate the dynamics

of the sexual assault because the therapist and offender "are in a 'secret' (confidential) relationship" and offenders can more easily, in private, exercise power and control in the relationship (Schwartz, 2011, 24).

Sex-offense-specific treatment begins with assessments and planning that take into account the duration, frequency, variety, and intensity of the client's sexually abusive behavior. Many convicted sex offenders have extensive sexually abusive histories beginning when the person was young. Heil and Simons (2008, page table is located on) summarized the following information. Wilcox, Sosnowski, Warberg, and Beech (2005) found the mean age of onset was 13; Freeman-Longo and Blanchard (1998) reported ages 18 for rapists and 15 for child molesters; Simons, Heil and English (2004) reported age 12; and English, Jones, Patrick, Pasini-Hill, and Cooley-Towell (2000) reported age 11 for those convicted of incest and 13 for non-incest offenders. Wilcox et al. (2005) found the average age from onset to detection to be 14 years; Freeman-Longo and Blanchard (1998) found 6 years for rapists and 13 years for child molesters; Simons, Wurtele, and Durham (2004) reported 16 years; and English et al. (2000) estimated 10 years.

Lengthy and intense treatment may be required for many sex offenders, particularly since these behaviors are likely to result from the interaction of biology and social learning (Ward & Beech, 2008). Abel, Becker, Cunningham-Rathner, Mittelman, and Rouleau (1988) and others (Abel & Rouleau, 1992; Ahlmeyer et al., 2000; English, Jones, Patrick, & Pasini-Hill, 2003a, 2003b, English, Jones, & Patrick, 2003b; Heil, Ahlmeyer, & Simons, 2003; O'Connell, 1998, Simons et al., 2004; Wilcox et al., 2005) have documented the presence of multiple paraphilias. Abel et al. (1988) discussed a "wave effect" in some offenders with multiple paraphilias where preferences changed over time and the intensity of one behavior rose while others subsided but sometimes overlapped (page).

Additional treatment needs may become apparent after the full pattern of sex offending is identified. The offender generally discloses information incrementally over the course of treatment, with careful integration of the polygraph test and treatment; much of the offending pattern and history can be discerned within 12–15 months. During this period, issues such as compulsivity, impulsivity, and hypersexuality often become evident. The experience of childhood trauma may also be revealed: "For some offenders, their own childhood victimization has been so severe and traumatizing that several years of [therapy] work are needed before they can work through issues blocking their progress" (Scott, 2011, pp. 27–11). Therapists may consider psychiatric referrals for medication (e.g., SSRIs) as an adjunct to cognitive-behavioral treatment when necessary; monitoring medication use then becomes an important component of containment. To be relevant to the offender and to be effective in terms of public safety, comprehensive individualized treatment plans and relapse prevention/community safety plans should also be based on more complete information. These plans are thus revised and made more specific over time.

The offenders' officially recorded crimes may not reflect their most serious sex offending behaviors. There is little utility to a relapse prevention or risk management plan that is only designed to prevent sex offenses identified in the official record without addressing the actual range of sex offending behavior. For example, a relapse prevention plan for a rapist may permit him to reside with his children based on an assumption from the official record that he does not pose a risk to children. However, as revealed in studies with guaranteed confidentiality or treatment with polygraph, approximately 50 to 65 % of rapists have committed child sexual abuse (Abel et al., 1988; English et al., 2000; Heil, Ahlmeyer, & Simons, 2003; O'Connell, 1998; Wilcox et al., 2005). Therefore, determining whether the rapist has a history of child molestation becomes an important consideration in developing an effective relapse prevention or community safety plan. In addition, comprehensive sexual history information may help therapists assess sex offending motivations and risky lifestyle patterns. This will lead to the identification of alternative skills that the offender may need to develop in order to decrease opportunities to reoffend. Skill development consists of assistance in building a new lifestyle that includes productive leisure time, satisfying vocational skills, and authentic relationships.

Treatment and Disclosures

The victimization data discussed earlier suggests that the majority of sex crimes are never disclosed or recorded in official records. And for those that are in the criminal justice system, "Once an individual has been arrested…he stops talking about the kind of behavior he has been involved in" (Abel, 2012,D-4). The hidden nature of the behavior for which the offender seeks treatment means that the therapist can best care for the client by uncovering the extent of his or her deviant sexual history. Treatment providers help the offender to disclose the full extent of his or her deviant sexual history because this is necessary to develop an individualized treatment plan that addresses his or her full scope of issues and needs. As previously stated, age of onset, duration of offending, frequency of offending, and the variety of behaviors the offender engaged in must be understood in order to develop a meaningful treatment plan. In addition, allowing the offender to hold on to powerful secrets about their past abusive behavior is not therapeutic and if allowed by the therapist may perpetuate the secrecy at the core of the offender's lifestyle. Marshall (1994) describes procedures for overcoming denial and reducing minimization and

clarifies a critical part of the disclosure process: people are most likely to take the risk to admit to acts that they believe others view as repugnant if they know they are not going to be rejected and if they are assured that support and help will continue (page). This idea is a foundation of the containment approach.

In containment, the treatment provider and the supervising officer work closely together in a collaborative team. To participate in community treatment, the offender agrees and consents to a waiver of confidentiality to permit information sharing among containment team members, including the polygraph examiner and law enforcement. An essential role of treatment in the containment approach is to obtain details about each individual's offending history, patterns, and precursor behaviors necessary for criminal justice officials to develop risk management plans. The information is verified using a polygraph examination as discussed above.

Uncovering the Offender's M.O.

Specific information about a sex offender's *modus operandi* is obtained though sex offense-specific treatment and validated and expanded by post-conviction polygraph examinations performed by specially trained examiners. Pithers' (1990) description of the assault pattern is a reminder of the need to be alert to what may, at first, appear to be accidental or occasional victim access: "Many aggressors, seeking to minimize their responsibility for offenses, would also have us believe their behaviors are the product of irresistible impulses overwhelming their self-control....In reality, many offenders carefully plan offenses so that they appear to occur without forethought" (334). Amir (1971) found that 75 % of rapes involved some degree of planning, while Pithers et al. (1988) reported that 90 % of their sample of sex offenders reported experiencing specific, strong, emotional states before reoffending. Hudson, Ward, and McCormack (1999:179) stated that "much of the optimism that has pervaded the treatment of sexual offenders in the last 15 years has come from the notion that the processes that these men follow are comprehensible and, therefore, under ideal circumstances, at least controllable" (179).

This idea is central to the containment approach. This attention to planning increases the likelihood that each offender's MO can be identified, allowing the supervising officer and the treatment provider to apply appropriate restrictions to reduce the likelihood of reoffense. Some examples of pre-assaultive behavior include stalking a victim prior to an assault, standing beneath a stairway to view underwear, going to children's movies or toy stores, purchasing toys and child-friendly videos, secretly watching family members, engaging in substance abuse, and jogging through neighborhoods at night. Having knowledge of these pre-assaultive behaviors can allow supervising officers to intervene before a sexual assault occurs. For example, one offender, who described in his sex history journal his use of shelter dogs to get the attention of child victims, was prohibited from owning a dog when released on parole. During his first home visit, his parole officer found a newly purchased dog collar, and the offender was revoked to prison. In another example, an offender with a pattern of stalking victims can be asked on a polygraph examination questions specific to stalking. The very specific nature of the question increases accuracy, and failing on a very specific question related to the offending pattern should result in an immediate response by the criminal justice system. This can include law enforcement surveillance, but it can also include changing the individual's living situation, requiring the individual to team up in a buddy system with other members of the (milieu-oriented) treatment program, using GPS monitoring, and alerting at-risk individuals in the offender's life.

As previously described (see also English, 1998, 2004; English et al. 2000; English et al. 2003b), early in the treatment process, the offender will be assigned the job of writing a sex history journal detailing past sexual activity, consenting and nonconsenting (since sometimes what appears to be consenting to the client is actually coercive), a description of the victim (age, gender, general relationship to offender), and the circumstances surrounding the assault. In this extensive exercise, the offender reveals the range and frequency of sexually abusive behavior. This information, typically not otherwise disclosed by the client, will be used to manage current and future risk, and to ensure that the offender's treatment plan is appropriately directed at real patterns of behavior. Because many individuals have early onset of sexually abusive behaviors, information about the duration of the offending history can inform the treatment plan. Abel and Rouleau (1990) found that over 50 % of his sample of more than 500 noncriminal justice-involved men reported they were below the age of 18 when they began sexually abusive behaviors (page); English et al. (2000) found an average age of onset of 12 (11 for those convicted of incest) for contact and noncontact behaviors in their study of offenders on probation and parole in three states (page). This early onset, particularly when combined with frequent offending, suggests a need for intensive, long-term treatment, supervision, and positive support to change what is apt to be a deeply entrenched lifestyle.

Once the client's sex history information is provided to the polygraph examiner, the therapist and the supervising officer work with the examiner to construct monitoring questions specific to that offender's MO, such as "Since you were released from prison on January 15, have you stalked anyone?" (The word *stalk* will have been carefully defined by both the examiner and the offender before the polygraph examination began). Deceptive findings on the exam should be followed by a subsequent and more narrowly focused exam at a later date.

Challenges for Therapists

Many of those providing treatment services to sex offenders believe their skills can overcome the client's patterns of secrecy and denial and are surprised to learn that many offenders still withhold information that is only revealed during the polygraph testing process. Moreover, many professionals can be deeply affected by the full scope of harm the offender has inflicted on victims. These issues present significant challenges to treatment providers who require specialized training and support from their colleagues to learn how to integrate polygraph assessments as a therapeutic tool.

It becomes easier to incorporate polygraph-related information into the treatment and supervision process when the containment team members prioritize public safety. The full details about the offender's past behaviors and dynamic risk factors that are revealed through the sex history journal and ongoing polygraph examinations often leave therapists feeling negatively about their clients. Ward and Fisher (2006) discuss the need for clinicians to have a "mixed view of human nature," meaning that those who work with sex offenders should believe that "individuals have innate tendencies to behave both altruistically and aggressively or selfishly toward their fellow human beings" (155). The therapist must use the information gathered through the polygraph testing process to manage risk and also engage the offender in the process of change. Managing the information obtained by using the containment approach, especially the polygraph, is part of the necessary challenge for professionals.

Avoiding information can lead to serious gaps in containment and real gaps in public safety. English et al. (2000) collected detailed data by hand from the treatment and polygraph files of 180 convicted sex offenders on probation or parole in jurisdictions in three states. The information provided below shows what information was available in the official records prior to the onset of treatment/polygraph and afterward. Nearly all the individuals were convicted of crimes against children, and 80 were convicted of sex crimes against their own children; 31 were preparing for the polygraph examination; self-report data were collected just prior to their first exam.

Table 2 shows the proportion of the sample admitting to sex offenses committed as an adult against victims in specific age/gender categories. Before treatment and polygraph, 4.4 % reported sexually assaulting a boy younger than 6 years old, and afterward, 10.3 % of the sample admitted assaults against this age and gender group. This information tells both treatment providers and supervising officers what specific groups of potential victims offenders must avoid and suggests that multiple MOs may be involved when a wide range of age groups is targeted. When multiple MOs are involved, this must be carefully addressed in the relapse prevention/community safety plan. Also, 95 % of the sample was convicted of a crime against a child or adolescent, but 36.7 % reported a history of sexually assaulting adult women and 7.2 % reported assaulting adult men. Abuse of multiple age groups may reflect the need to assess compulsivity or hypersexuality. Also, an expanded evaluation targeting a wide range of thinking distortions, beliefs about consent, hostility, and entitlement may be necessary to ensure that the treatment approach is comprehensive enough. According to Heil and Simons (2008) "multiple paraphilias are difficult to detect, monitor and treat" (542). The greater the range of problems, and the more engrained the belief system, the more likely the need for intense treatment and monitoring of sufficient duration to allow the offender to make sustainable changes and begin to experience the benefit of a prosocial lifestyle.

Table 3 shows a larger proportion of the sample disclosing the listed assaultive behaviors after treatment with polygraph examinations. The proportion of the group reporting

Table 2 Percent offenders admitting to victims in each age and gender category before and after the polygraph

Age and gender categories of victims	Total ($n=180$) Represents sexual offenses committed as an adult	
	% before	% after
Males 0–5	4.4	10.3
Females 0–5	11.1	23.9
Males 6–9	7.2	10.6
Females 6–9	22.8	30.6
Males 10–13	5.6	11.1
Females 10–13	38.9	44.4
Males 14–17	5.0	11.1
Females 14–17	39.4	57.2
Males 18+	.6	7.2
Females 18+	15.0	36.7
Elderly/at risk	1.7	2.8

Table 3 Percent of offenders with admitted behavior before and after participation in treatment/polygraph ($n=180$)

History of sexually assaultive behaviors	Before treatment/ polygraph (Information from court file) (%)	After treatment/polygraph (Information from treatment and polygraph records) (%)
Vaginal penetration	56.7	72.8
Oral sex	36.7	56.1
Anal penetration	9.4	18.3
Urination with sex act	1.7	8.3
Excessive aggression	3.9	9.4
Fondling/frottage	66.7	85.6
Exhibitionism	13.9	46.7
Voyeurism	8.9	53.9
Bestiality	4.4	36.1

Table 4 Disclosure differences across containment sites

History of sexually assaultive behaviors	Site A ($n=57$) Most offenders had multiple polygraphs; containment team very tight; 66 % of exams found "truthful"		Site B ($n=62$) Most offenders had multiple polygraphs; containment team rarely communicated; 49 % of exams found "truthful"		Site C ($n=31$) For all offenders, first polygraph; containment team newly established; 30 % of exams found "truthful	
	Before treatment/ polygraph (%)	After treatment/ polygraph (%)	Before treatment/ polygraph (%)	After treatment/ polygraph (%)	Before treatment/ polygraph (%)	After treatment/ polygraph (%)
Vaginal penetration	57.9	71.9	51.6	75.8	60.0	66.7
Oral sex	52.6	75.4	35.5	59.7	22.6	32.3
Anal penetration	7.0	22.8	12.9	22.6	6.5	9.7
Urination with sex act	3.5	17.5	0	4.8	3.2	6.5
Excessive aggression	1.8	10.5	6.5	12.9	9.7	9.7
Fondling/frottage	71.9	87.7	64.5	91.9	61.3	67.7
Exhibitionism	12.3	49.1	17.7	54.8	12.9	35.5
Voyeurism	7.0	54.4	9.7	62.9	6.5	41.9
Bestiality	5.3	47.4	3.2	45.2	9.7	19.4

these behaviors increased substantially "after" treatment/ polygraph. For example, excessive aggression nearly tripled. Over one-third of the group reported engaging in bestiality as an adult, suggesting that the supervision plan should disallow access to animals. Learning that an offender has engaged in bestiality presents a significant opportunity to learn more about the secrecy and likely shame associated with this behavior. The treatment provider may want to address this behavior in individual sessions when the therapist can ask very specific questions about intimacy and violence with the animal. Gene Abel, M.D. (2007) describes bestiality as "very relevant: these individuals are adept at ignoring many things, including fur, feces, and the animal trying to get away from you" (page). Abel believes this behavior signifies "deep denial that leads to the idea that having sex with a child is no big deal" (page). In addition, it is noteworthy that nearly half of those in Sites A and B reported engaging in bestiality. Others have studied the prevalence of bestiality among convicted sex offenders. Heil and Simons (2008) found 59 % of child sexual abusers engaged in bestiality compared to 30 % of rapists (page). In the same study, 81 % of those who assaulted both children and adults reported bestiality. Simons, Wurtele, and Durham (2004) found that those who had abused animals were at significant risk to children (page). Without the combination treatment/polygraph, this important marker for dangerousness—assaulting another species—may remain unknown and therefore not a focus of treatment or supervision.

Of particular interest are the noncontact sex crimes of exhibitionism and voyeurism, which seem to be especially underreported initially. These behaviors may occur early in the offending cycle or fuel compulsive behavior. Both are therefore important in terms of risk assessment; understanding the role of hands-off crimes in the assault cycle can alert both the offender and the containment team to the need for an immediate increase in external structure (which may include house arrest), supervision, and support to provide the containment necessary to avert the progression to a hands-on sex crime.

While the information in Tables 2 and 3 may seem alarming, it is consistent with the groundbreaking work of Abel et al. (1988) and Abel et al. (1987) using federal certificates of confidentiality and other polygraph studies (see Heil & Simons 2008 for a review). Further, the findings presented here are likely to be underestimates because many of the examination results were deceptive. Additional polygraph examinations result in a greater proportion of nondeceptive examinations and, correspondingly, additional disclosures as reported by Heil et al. (2003). Note that the consistent application of sanctions and incentives increases disclosures and nondeceptive findings on the polygraph examination (Ahlmeyer, Heil, McKee, & English, 2000).

To underscore the need for the polygraph to be well integrated with treatment and supervision, Table 4 shows differences across the sites where data were collected. Site A had containment teams that were well established and closely coordinated. Site B was composed of experienced professionals who considered themselves to be working in containment teams but in fact communicated infrequently. Consequently, treatment services and supervision strategies were not well integrated and in practice did not consistently incorporate the additional information obtained during polygraph exams. Site C had just implemented the polygraph into treatment and supervision only months prior to the study, and offenders had not yet received pressure from the containment team to fully disclose. Harrison and Kirkpatrick (2000) found that offenders tend to think they can "beat the

polygraph" prior to their first examination, suggesting they might not be forthcoming with complete information early in the treatment/polygraph process. Finally, in none of the sites were there consistent consequences for lack of disclosure.

Longer implementation and greater containment team cohesion were generally correlated with higher rates of nondeceptive responses: 66 %, 49 %, and 30 %, as shown in Table 3. Greater rates of disclosure were found generally in the first two sites compared to Site C. This supports the assumption that the information in Tables 1 and 2 underreports the actual frequency of engaging in these specific sexually abuse behaviors, and it underscores the need for those implementing the containment approach to work together closely. Of course, some unknown portion of the variation across sites may also reflect actual differences in behavior.

Over half (57.8 %) of the study cases disclosed sexually assaulting family victims in addition to the current victim (data not displayed). Of these, 34.8 % self-reported assaulting strangers and 56.7 % said they also had victimized another from "a position of trust." This "relationship crossover" is important for both treatment providers and supervising officers because it reveals the range of the preferred and expanded victim pool. Twenty-nine percent reported assaulting both males and females (data not presented). Abel et al. (1988) found that 23 % of his sample offended against both family and nonfamily victims and, of those who raped adult women, 50.6 % admitted to also molesting children (page). Twenty-percent reported assaults against both males and females. Ahlmeyer et al. (2000) found 50 % of the adult rapists also admitted sexually abusing children, and 82 % of the child molesters reported sexually assaulting adults (page). Even those convicted of "hands-off" crimes require careful assessment: Abel et al. (1988) found that exhibitionists were highly likely to engage in additional sexually assaultive behaviors: 46 % had assaulted young girls, 22 % had assaulted young boys, and 25 % admitted raping an adult (page). Based on this information, Abel and Rouleau (1990:10) said: "Therapists need valid, reliable information from the sex offender. Without this, the treatment is less likely to identify the precise treatment needs and to quantify treatment's long term effects" (page).

This analysis of multiple targets begins to reveal information about offending frequency. Among those who started offending before the age of 18, Abel and Rouleau (1990) reported an average of 380 contact and noncontact sex crimes by the time the men reached adulthood (page). In a small sample of inmates, Ahlmeyer et al. (2000) found that inmates reported an average of more than 500 contact and noncontact sex offenses and an average of 184 victims. Freeman-Longo and Blanchard (1998) studied 23 rapists and found that this small group reported 319 incidents of child sexual abuse. Heil et al. (2003) studied 233 inmates who reported an average of 137 sex offenses committed against an average of 18 victims. Emerick & Dutton (1993), Simons et al. (2004), Weinrott & Saylor (1991), and Wilcox et al. (2005) report similar findings.

Containment in Prison

Although there are more external controls and supports in prison, there are many opportunities for inmates to sexually act out (Heil et al. 2009, page). This is important risk and treatment information, so there is value in using the containment approach, including the polygraph examination, in prison. Since containment is about using multiple strategies to obtain information from the offender that can be shared for the sake of enhancing public safety, prison is an excellent environment to implement containment strategies. Prison treatment staff can establish relationships with law enforcement, engage in collateral contacts including working with families, provide intense treatment, and prepare offenders to release into containment when they are placed on parole supervision. Preparing offenders for community-based containment can greatly enhance their likelihood of success, as shown in Table 5, along with their longer term outcomes, as shown in Table 6.

Table 6 Any rearrest 3 years: Colorado prison treatment program

		No arrest	New arrest	Total
No treatment	*n*	491	607	
	%	44.7 %	55.3 %	100.0 %
Phase 1	*n*	170	127	297
	%	57.2 %	42.8 %	100.0 %
Phase 2	*n*	78	41	119 %
	%	65.5 %	34.5 %	100.0 %
Total	*n*	739	775	1,514
	%	48.8 %	51.2 %	100 %

Source Lowden et al. (2003)
Note Sex offenders discharged from parole between April 1, 1993, and July 30, 2002. Difference is significant at $p < 0.001$

Table 5 Parole outcomes: Colorado prison treatment program

		Completed	Revoked	Total
No treatment	n	685	625	1,310
	%	52.3 %	47 %	100.0 %
Phase 1	*n*	112	48	160
	%	70.0 %	30.0 %	100.0 %
Phase 2	*n*	97	18	115
	%	84.3 %	15.7 %	100.0 %
Total	*n*	894	691	1,585
	%	56.4 %	43.6 %	100.0 %

Source Lowden et al. (2003)
Note Sex offenders placed on parole between April 1, 1993, and July 30, 2002. Difference is significant at $p < 0.001$

The Sex Offender Treatment and Management Program at Arrowhead Correctional Center in Colorado has been using the polygraph exam in treatment for over 15 years. It is well integrated into the program (for a full description of the program and recidivism outcomes, see Lowden et al. 2003). Because the program is unusually comprehensive compared to what is available to offenders serving community sentences in Colorado (where 90 min group therapy once or twice per week is typical), and because program evaluation outcomes were positive (See Tables 5 and 6), a brief description of the program is included here.

Phase I is a time-limited therapy group that includes an initial curriculum on criminal thinking errors, anger management, and stress management. Some of the sex-offense-specific issues and areas that are addressed include characteristics of sex offenders, development of victim impact, cognitive restructuring, sex offense cycles, relapse prevention, healthy sexuality, social skills, and relationship skills. The program lasts 6 months and offenders participate in group treatment for 2 h/day, 4 days/week. Phase 1 does not include the use of the polygraph examination. Lowden et al. (2003) found that the average length of time in Phase 1 approached 9 months because some offenders were terminated for nonparticipation and were required to start at the beginning when they reentered the program (page if available). Phase 1 operates in five facilities, including the women's prison; two facilities accommodate low functioning inmates, one accommodates the hearing impaired and one accommodates Spanish-speaking inmates. All those who complete Phase 1 are eligible to participate in Phase 2. Phase 2 is a modified therapeutic community where offenders live and work together. Polygraph testing is part of the Phase 2 program. Lowden et al.'s (2003:31) description of Phase 2 remains consistent with current operations:

> To participate in the TC, inmates must be motivated to work toward eliminating sexual assault behavior and they must accept responsibility for changing their destructive actions. The TC program addresses offenders' life skills and their understanding of the world, others, and themselves. It also seeks to teach offenders to develop socially appropriate and non-sexually aggressive responses to their problems. Treatment topics include relapse cycle and prevention, cognitive restructuring, sexuality, social skills, and levels of denial (page).

Phase 2 offers 15 different types of therapy groups, including a probation group for those who have been placed on treatment probation for lack of progress. The average time in treatment for Phase 2 participants is more than 12 months. To be recommended for parole by the treatment program, inmates must meet the following criteria:

- Actively participating in treatment and is applying what he or she is learning
- Completed a nondeceptive polygraph assessment of his/her deviant sexual history; any recent monitoring polygraph exams must also be nondeceptive
- Practicing relapse prevention with no incidents of institutional acting out within the past year
- Defined and documented his or her sexual offense cycle
- Reviewed and received a therapist-approved copy of the sexual offense cycle
- Identified at least one approved support person who has attended support education
- Compliant with any psychiatric recommendations for medication that may enhance his or her ability to benefit from treatment and/or reduce his/her risk of reoffense
- Benefited from treatment and/or reduced his/her risk of reoffense
- Able to be supervised in the community without presenting an undue threat

Resources limit the number of inmates served. In 2009, there were approximately 2,500 sex offenders serving time in the Colorado Department of Corrections; 172 offenders participated in Phase 1 and 100 participated in Phase 2.

The use of the containment approach in prison can improve success rates in the community, enhancing public safety. Parole officers reported that parolees who had participated in the prison treatment program understood what was expected of them in community containment (Lowden et al., 2003, page) and more easily transitioned into community residences. The structure offered by containment on parole seemed valuable to offenders: 70 % of the Phase 1 participants successfully completed parole, and 84 % of the Phase 2 participants successfully completed parole, compared to 52 % of sex offenders (in an unmatched comparison group) who did not participate in treatment.

Apart from providing treatment and containment services to inmates, a program mission is to enhance knowledge and understanding of this offender population. Table 7 shows the results of a study of offenders in Phase 2 sex offender treatment at the Colorado Department of Corrections who were found nondeceptive on their sexual history polygraph examination. The table shows self-reported "hands-on" sex abuse histories of 408 individuals who participated in Phase Two. It excludes noncontact behaviors such as exhibitionism, voyeurism, and Internet sex crimes. The findings show that 2 %, or 9 people, reported only one offense and were found to be nondeceptive on the polygraph examination. For these individuals, this single victim and crime represented the crime

Table 7 Frequency of contact sex crimes: nondeceptive polygraph findings ($n=408$)

One victim	5 % (19)
One sex offense	2 % (9, 8 were violent with force/weapon)
Number of victims (median/mean)	14/23
Number of offenses (median/mean)	42/263

Source Colorado Department of Corrections, Sex Offender Treatment and Management Program

for which the inmate was imprisoned. Eight of those with a single offense were convicted of violent sex crimes. The remainder of the inmates, 98 %, reported more than one offense. The nondeceptive program participants reported a median of 14 victims (mean of 23) and a median of 42 (mean of 263) contact offenses.

Assessment is Ongoing

The information obtained using the combination of treatment and polygraph shows that offenders with multiple paraphilias, multiple victims and offenses, and early age of onset are not unusual. Rather, many of the offenders who come to the attention of the criminal justice system seem to have these complicated patterns of behavior. Yet, there are important differences among offenders that must be identified to individualize the treatment intervention. Simons, Wurtele, and Durham (2004) found that offenders who were primarily child sexual abusers (i.e., those who reported that at least 80 % of their victims were children) had child sexual abuse histories, earlier onset of masturbation, early exposure to pornography, and sexual activities with animals (page). Heil and Simons (2008) discuss these findings in terms of social learning theory and the need for treatment to help the offender resolve childhood trauma as it relates to sexual abuse. Simons et al. (2004) found that sex offenders who were primarily adult rapists had childhood experiences involving physical abuse, parental violence, emotional abuse, and cruelty to animals. These individuals tended to respond to emotionally charged situations with aggression and violence. Finally, those offenders who Simons et al. (2004) labeled "indiscriminant" because they did not meet the 80 % threshold for rape or child molestation had childhood experiences with both heightened sexuality and violence. Discussing the issue of multiple paraphilias, Heil and Simons (2008:542) state that these individuals "have structured their lives to gain access to sexual outlets, and consequently they may have developed few other interests and social contacts" (page). They recommend that treatment providers use information gained from polygraph examinations to evaluate for multiple paraphilias and evaluate for trauma and attachment issues, attention-deficit/hyperactivity disorder (ADHD), depression, and social phobia. Comprehensive treatment for multiple paraphilias includes cognitive-behavioral treatment, pharmacology, trauma therapy, attachment interventions, and containment.

In sum, information about patterns of sex crime behavior—age of onset, duration of offending, frequency, seriousness, and variety—routinely provided by offenders in the written sexual history journal described above and verified polygraph examinations can provide relevant information about the risk offenders present to individual victim groups, and illuminate treatment needs and patterns of dangerous behavior. The containment approach involves using knowledge of these behaviors to develop relapse prevention/community safety plans that account for preferred targets while helping the offender learn to replace destructive patterns with prosocial behaviors. Offenders have a range of criminogenic needs that must be targeted in offense-specific treatment. Offenders can learn to avoid new criminal behavior while learning to build a "good life" (Ward & Stewart, 2003b; Ward & Marshall, 2004; Yates, 2004; Ward and Fisher, 2006). However, the polygraph data used in the containment approach suggest that many sex offenders in the criminal justice system have multiple paraphilias. This information may not be available early in the assessment and treatment process, suggesting that assessment should be an ongoing part of treatment. The prevalence of multiple paraphilias in the sex offender population suggests that treatment, to be effective, must be intense, frequent, and long term.

The Impact of the Polygraph on Therapists

As addressed above and referred to elsewhere (English & Heil, 2006), the information disclosed during the polygraph examination can be alarming. Reflective of the disquieting effect of information disclosed during the polygraph examination, examiners and supervising officers frequently reported to us during dozens of interviews that some therapists were resistant to the examination findings (English et al., 2000, page). In these cases, therapists often did not return phone calls from the examiner and, when they did speak on the phone, the therapist was skeptical rather than feeling relief at getting information previously withheld by the offender. Clearly, some therapists struggle with reconciling their perceptions of the offender's treatment progress with the new information obtained from the polygraph process (Grubin et al., 2004, page). Once the information is revealed, the therapists and team members must reevaluate their treatment and supervision plans to develop appropriate responses to the information. The polygraph testing procedure becomes less useful without this response. Research at the prison sex offender treatment program in Colorado found that participants were significantly more likely to fail polygraphs when the therapist was rated as ambivalent about the use of the polygraph (Simon, Heil, and English, 2004, page). The therapist's commitment to the use of the polygraph is a critical aspect of its successful implementation.

Nevertheless, its use is challenging. The polygraph examination results can be especially concerning when certain clients, thought to be progressing well in treatment, are found deceptive on the polygraph test. Sometimes these exams involve disclosures by the offender of high-risk or

actual offending behaviors. When the offender fails to disclose new information—and sometimes when he does—the situation can give rise to professionals' concerns that the polygraph is not accurate or the examiner is not competent. Sometimes this leads to significant conflict between the therapist and the supervising officer, who may act on the information by increasing surveillance and restricting the offender's lifestyle. If the offender discloses new criminal behavior, the officer may pursue an arrest.

This series of events can create considerable tension among the examiner, officer, therapist, and offender. All containment team members need to remain mindful that they can be groomed by the offender to disregard concerns. Since addressing manipulation is an inevitable aspect of treatment and containment, the polygraph is a helpful tool. The development of policies, protocols, and agreements regarding the use of the information learned from the polygraph exam will be especially helpful at this time. Additionally, there is no substitute for enthusiasm and purposefulness about this work. Understanding the value of working with sex offenders may be the most important antidote for the difficulty of the work itself.

As we have discussed before (English and Heil, 2006), it may be helpful to those who find themselves uncomfortable with the polygraph process to consider that the examination is intended to help prevent the offender from harming again. This is a humane undertaking. Offenders reluctantly report that the use of the polygraph is valuable, even though they dislike taking the exam. Therapists who dislike the use of the polygraph may benefit from visiting the examiner at his office, observing an exam via short circuit television or videotape, talking with other therapists who use the polygraph, and obtaining training that specifically focuses on how best to use post-conviction polygraph results.

The polygraph examination should only be used in conjunction with sex offense-specific treatment. These two components, acting together and consistently, provide a powerful incentive for an offender to be truthful and to refrain from behavior that puts the community at risk while helping the offender adopt prosocial thinking and behavior. Without the use of the polygraph examination process, the information necessary to manage the risk of offenders is significantly incomplete, and the offender's risk to the community remains uncertain.

Risk and treatment plans may need to be adjusted when more complete information is obtained. Thus, low risk on sex offender actuarial scales should be questioned later when the offender discloses a more serious offending history. In fact, comprehensive treatment with a consistent focus toward new, potentially risk-related information necessarily moves the management team to focus on a case-by-case basis. To maintain a public and victim-safety perspective, it is necessary to move away from cookie-cutter interventions and toward individualized treatment based on learning information that an offender may be trying to hide. This specific focus on each offender means that a centerpiece of community-based containment is the use of technical violations as one option to preventing new sex crimes.

Criminal Justice Supervision

It is imperative that community supervision within the containment approach be well implemented, since most sex offenders serve all or part of their sentences in the community. In Colorado, in fiscal year 2012, one out of three adults (37 %) convicted of a sex offense received a direct sentence to prison. The remainder were sentenced to probation or a combination of probation and jail.

The supervising officer is empowered primarily by the authority of the criminal justice system, which can exercise its containment powers a number of ways. These include specialized conditions of supervision, longer probation and parole sentences, restrictions on high-risk behaviors, restrictions on contact with children, random home visits, urinalysis testing, and verified law enforcement registration. Computer and Internet monitoring of sex offenders (Bullens, 2004) and GPS and electronic monitoring (Padgett, Bales, and Blomberg, 2006) are also important containment tools.

Supervising officers should be familiar with the stages of change (Prochaska et al. 1992, page) and understand that personal change is hard. A supervising officer in Colorado works with offenders to develop a life plan, which starts with him/her asking new clients to make a list of (prosocial) activities they would like to accomplish. Developing this list is usually an exercise that takes several visits with the officer. One offender expressed a wish to attend college, and the officer helped the offender access financial aid to accomplish this. Involvement in college courses also had the advantage of removing the offender from his negative peer group and involving him with prosocial others. This is an excellent example of a supervising officer proactively assisting the offender with the change process. In the containment approach, supervising officers are obligated to help the offender succeed while recognizing the difficulties involved in the change process. Indeed, officers should be aware of each offender's preferences, strengths, competencies, and resources: "This crucially involves identifying the internal and external conditions necessary to implement the [treatment] plan and designing a rehabilitation strategy to equip the individual with these required skills, resources and opportunities" (Ward & Fisher, 2006, 154). The supervising officer should work closely with the treatment provider to support and reinforce the work of therapy (see Scott, 2011).

Among the most important of containment tools is the relationship between the supervision officer and the client.

Recent research has underscored this often-overlooked aspect of supervision: Skeem et al. (2003) state that the relationship between the officer and the offender can be "a pivotal source of influence on the implementation of treatment mandates" (see Alexander et al. 2008). Skeem et al. (2007) found that relationship quality involves caring, fairness, trust, and an authoritative not authoritarian style (page). The content of the conversation between the supervising officer and the offender also matters. Emerging research in Canada suggests that focusing on the offender's criminogenic needs during the supervision meeting rather than the conditions of supervision reduces recidivism (Bonta et al. 2010, page).

The supervising officer represents the criminal justice agency responsible for the offender, and so he or she generally convenes the containment team. In prison treatment, the therapist often plays both roles, although correctional officers, especially work supervisors, can be trained to assist in the containment process. Supervising officers depend on a variety of information tools including collateral contacts with an offender's family members, roommates, employer, and the victim's therapist, for example.

Officials can define the behavioral changes required of sex offenders as they move through stages of treatment and show themselves to be managing their own risk. The Colorado Sex Offender Management Board (*Standards and Guidelines,* 2011), at the request of the state's General Assembly, documented the behaviors necessary to show successful progress through offense-specific treatment and completion of treatment. The behaviors can be monitored by the supervising officer and used to set clear expectations for supervision and treatment compliance. The following is a list of some common behavioral compliance expectations.

The offender:

- is, and consistently has been, in compliance with all recommended prescribed psychiatric medications used to reduce arousal or manage behaviors related to risk
- can identify objectification and inappropriate sexual gratification in relationships and is developing skills to address them
- is addressing any domestic violence history with appropriate domestic violence treatment and has not engaged in domestic violence
- is addressing drug and alcohol programs in treatment and is maintaining abstinence if recommended
- the offender demonstrates control over arousal and interest through plethysmograph or Abel Screen "improvement"
- the offender consistently completes nondeceptive polygraph examinations regarding high-risk and precursor behaviors and masturbation to deviant arousal fantasies
- the offender consistently demonstrates self-motivated use of a relapse prevention and safety plan and has distributed written copies of the plan to any cohabiters and significant others
- the offender consistently demonstrates self-motivated use of treatment techniques for identifying and correcting cognitive distortions

These are just a few examples of the specific behavioral requirements of sex offenders under supervision and in treatment in Colorado. For more information, refer to the Colorado Sex Offender Management Board's *Standards and Guidelines* (2011).

Leverage and Sanctions

Criminal justice systems can encourage, even leverage, the offender to engage in treatment. This is a long-valued role in the substance abuse treatment community. The National Institute on Drug Abuse (2012) lists the following as "Principle 8" in its description of substance abuse treatment with criminal justice populations: "The coordination of drug abuse treatment with correctional planning can encourage participation in drug abuse treatment and can help treatment providers incorporate correctional requirements as treatment goals" (3).

Consequences for failure to follow the directives of treatment and supervision can take a variety of forms. At a minimum, surveillance can be increased (house arrest, electronic monitoring, additional home visits by the supervising officer, requirements to phone the officer or others with location information) and orders for additional treatment sessions or homework can be imposed. Intermediate sanctions include community service activities, short-term jail sentences, or placement in a halfway house for sex offenders. At the extreme end of the sanction continuum is revocation of the community sentence and placement in prison. But prison sentences are not the end of risk management concerns, since most prisoners eventually are released into the community whereupon the containment approach should be reinstated.

Consequences can be clearly spelled out because this clarity promotes consistency and communicates what is expected of an offender. Sometimes this takes the form of a lengthy and explicit treatment contract. Members of the Colorado Department of Corrections sex offender treatment team and parole officers joined with local treatment providers to develop a "decisions grid" specific to polygraph testing (see Fig. 1) although other types of grids can be valuable. Low-level sanctions included starting regular urinalysis testing, restricting community activities, requiring additional treatment homework, and imposing a curfew or geographic restrictions. Medium-level sanctions included withdrawing driving privileges and travel permits for vacation, more visits

	Admissions Prior to Polygraph Examinations	Admissions During Polygraph Pretest	Admission to Non-deception findings at Posttest	Admissions to Deception Posttest	No Admissions to Deception
Past offenses & High Risk Behaviors					
Behavioral Lapses & Basic Rule Violations					
Serious Treatment Rule Violations					
Offenses & High Risk Behaviors					

Fig. 1 Decisions grid provides clarity

with supervising officers, frequent searching of the residence, and prohibiting community activities. High-level sanctions included moving the offender to intensive supervision status, contacting law enforcement for surveillance, requiring community service, and imposing a curfew with daily scheduled call-ins to the officer. All sanctions included increased supervision. Incentives for treatment progress and nondeceptive results were also included. The decisions grid is discussed with every offender and is attached to a form that requires the signatures of the therapist, supervising officer, and offender. The grid is an excellent example of coordination and collaboration among stakeholders who wanted to be clear and consistent regarding the use of sanctions.

The use of sanctions in the containment approach is consistent with substance abuse treatment as recommended by the National Institute on Drug Abuse (2012), "Rewards and sanctions are most likely to change behavior when they are certain to follow the targeted behavior, when they follow swiftly, and when they are perceived as fair" (21). Many treatment providers have reported that without the leverage of the criminal justice system's consequences for noncompliance, they could not engage sex offenders in the treatment process (English et al., 1996, page). When the offender engages in a long-term process to change what is often a deeply entrenched pattern of behaviors, motivation to change can be expected to ebb at times. Sanctions, including treatment termination and revocation, provide important public safety leverage because ambivalence is part of the nonlinear change process (Prochaska, DiClemente, & Norcross, 1992, page). Personal change is difficult, and many sex offenders enter treatment without a complete understanding of the full extent of their abusive behavior and the psychological difficulty associated with acknowledging the extent of the harm they have done. Treatment must address these issues early on, while providing the offender the tools to learn to rebuild their lives in a healthy way.

Nevertheless, it is important to recognize the dangerousness presented by an offender's inconsistent effort to change. Without external pressure on the offender to adhere to the behavioral expectations detailed in the conditions of supervision and treatment contract, community safety depends on the offender's good will alone. In this way, community supervision and sex-offense-specific treatment are continuously linked, providing the greatest opportunity for the offender to experience the leverage that is often necessary to engage in the difficult change process. Even so, revocation rates are high for failure to comply with treatment requirements, often above 50 %. This should not come as a surprise, however. As mentioned above, Wierzbicki & Pekarik (1993) conducted a meta-analysis of 125 treatment studies and found nearly 50 % of clients dropped out of psychotherapy (page). Prochaska (2001:235) calls this fact a "skeleton in the

therapy closet" (page). In containment, individuals are expected to participate in the therapeutic process because without going through the change process, the risk looms that the client will victimize others with continued sexual offending. Failure to participate in treatment after multiple efforts are made to engage the client will likely eventually result in revocation to prison. Prochaska (2001) reviews studies he conducted with colleagues that focused on clients involved in therapy for substance abuse, smoking, obesity, and a broad spectrum of psychiatric disorders and found that those who quickly and prematurely dropped out of treatment were in the precontemplation stage of change. Precontemplation is defined as the stage in which people are not intending to change or take action in the near future (usually measured as "the next 6 months") (Prochaska, 2001, page). It is not uncommon for treatment programs to offer "deniers' groups" that last up to 6 months; some jurisdictions offer psychoeducational classes in place of deniers' groups (English et al., 1996, page). Marshall and Moulden (2006) report encouraging results from "preparatory programs" that are designed to enhance the effects of subsequent treatment (page).

Case-specific supervision requires planning, documentation, and visits to the offender's home and work. Often, safety considerations require that fieldwork be conducted in teams of two officers. Ongoing training is also necessary to keep professionals at the top of their game. Probation and parole officers should have caseloads limited to 20 or 25 sex offenders, and they should have flexibility in work hours to monitor the offender's activities at night and on weekends (English, 2004, page). Burrell (2006) recommends a caseload of 20 for high-risk offenders (page).

Component 4: Informed and Consistent Public Policies

Clear policies facilitate containment. As described most recently in English (2004), the fourth component of a sex offender containment approach requires local criminal justice practitioners to develop public policies at all levels of government that institutionalize and codify the containment approach (page). Harris and Lurigio (2010:478) reflect on the need to move toward evidence-based public policy and note that "a significant and widening gap exists between the effective practices that are employed by criminal justice and clinical practitioners and the policies that have been created by state and federal legislators" (page). Indeed, local agency policies can be most responsive to the needs of their workers, and the expertise of these workers along with research should be the driving factor behind policy development.

Sex offender policies should hold offenders accountable and, to be effectively implemented in the field, must empower those who work closely with these cases. Policies must define and structure the discretion authorities need to manage each offender individually. Criminal justice practitioners must organize and document local and agreed-upon practices that support a victim-oriented approach to sex offender risk management. English et al. (1996) provide examples of areas that require written guidelines for uniformly managing sexual assault including the following: The weight given in sentencing to an offender's denial of the crime, the use of polygraph information, family reunification assessment protocols, presentence investigation report information, failure to progress in treatment, revocation procedures, third-party liability/duty to warn potential victims, and employment and leisure time restrictions for sex offenders under criminal justice supervision; and the use and limitations of actuarial risk assessment instruments.

Ideally in the containment approach, policies are based on research and best practices. Policies should focus on addressing gaps in risk management activities and empowering the ability of the supervising officer to quickly respond to offender behaviors that are out of compliance with treatment requirements and supervision conditions.

Written policies and procedures are an essential part of the justice process. An offender deserves to know what is expected of him or her and what to expect from the criminal justice and mental health systems. Often, behavioral expectations are spelled out in lengthy treatment contracts. Clear expectations will help keep the focus on the offender "working the program" rather than complaining about the system. Additionally, some policies undermine sex offender containment and minimize the seriousness of the crime. Policies that undermine sex offender containment include allowing plea bargains to lesser charges, to non-sex crimes, or to misdemeanor sex crimes when the evidence exists to fully prosecute the case. Lowering the charge, granting diversion, or issuing a deferred judgment minimizes the case to the offender ("it wasn't that bad, I won't do it again") and the victim ("I'm not important to the court"). When sex crimes are disposed as assaults or trespassing—outside the family of sex crimes—the sexual assault is eliminated in the official record. Aiding in the minimization process will ultimately make it harder for the offender to begin and sustain the lifelong changes required to ensure public safety.

Prosecutors and judges who specialize in sex crimes and receive regular training from national entities understand the power of the court to set in motion the healing process, referred to as therapeutic jurisprudence (see LaFond and Winick, 2004). Evidence-based sentencing practices to reduce recidivism suggest increasing the discretion of the judge so he or she can make decisions based on the risks and needs of each individual and the treatment necessary to reduce the likelihood of reoffending (Wolff, 2008, page).

Clear, consistent, and documented agreements on sex offender polices, developed in a spirit of cooperation among agencies responsible for managing sex offenders, enable the successful implementation of the containment process outlined here. The range of activities that require such documentation is quite large, but primary among them is the need for open communication and information sharing at all stages of the process of managing sex offenders in the community.

Risk Assessment and the Limits of Actuarial Scales

New information about the offender's risk to reoffend is frequently revealed in the first months and years of supervision and treatment. In fact, risk is essentially unknown in the early stages of treatment. It is imperative, then, that intervention strategies and policies encourage an elastic response to risk. Although most sex offenders do not have an extensive arrest or conviction record, much of the research reviewed in this chapter indicates that many have a long history of hurting different types of victims.

Having a sex crime conviction is the most powerful predictor of risk of future sex crime. An often overlooked fact in the Bureau of Justice Statistics study is that a 5.3 % sex crime rearrest rate over 3 years among over 9,600 offenders released from prison means that the convicted sex offenders were four times more likely to be rearrested for another sex crime compared to other offenders (Langan, Schmitt, & Durose, 2003, page). Many reoffended quickly, too: 40 % were rearrested within a year of release from prison. Harris and Hanson (2004) reviewed 10 recidivism studies and found 37 % of sex offenders with a prior sex crime were rearrested within 5–6 years (page). After reviewing the literature on sex offender risk scales and recidivism rates, Doren (2002:150) reported "lifetime sexual recidivism by previously convicted sex offenders is not a statistically 'rare event.' ….[L]ong-term recidivism statistics approach 50 %." (page).

The lack of officially recorded crimes can cloud risk assessments conducted with actuarial scales since these usually depend on past arrests or convictions for sex offenses. Additionally, actuarial scales place individuals into groups with certain statistical probabilities to reoffend and thus do not measure individual-level specific and immediate risk. Policies should reflect the limitations of actuarial instruments to predict short-term risk and to predict unreported sex crime events. Treatment providers, evaluators, judges, and supervising officers need to consider additional information along with actuarial scores when considering risk to the public.

Component 5: Quality Control

Quality control is a fundamental tenet of evidence-based correctional practice (Cohen 2002; Latessa et al. 2002). Program monitoring and evaluation activities combined with professional standards of practice ensure that victim safety and the humane treatment of offenders are not compromised (Przybylski and English, 1996, page).

As addressed in English et al. (1996) and English (2004), the containment approach requires broad discretion on the part of the criminal justice system professionals, treatment providers, polygraph examiners, and others collaborating to protect public safety. This discretion allows for individualized treatment and supervision plans, and quick responses to the ongoing assessment of risk and progress. It also recognizes that these cases often involve complicated relationships between the perpetrator and the victim. Such discretion must be systematically monitored to ensure fairness, justice, and the humane treatment of offenders. For this reason, quality control is fundamental to the administration of any sex offender management program, project, or system-wide process. Quality control activities should include, at a minimum:

- Monthly, multi-agency case review meetings to ensure that prescribed policies and practices are implemented as planned
- The requirement of annual training on the topics of sexual assault, conflict resolution, teaming, victimization, trauma, family reunification, treatment efficacy, and research related to each of these
- Developing and tracking performance measures associated with the policies and procedures specified in the jurisdiction
- Videotaping of all polygraph examinations to avoid recanted statements and to facilitate periodic review of examinations (including chart reviews) by a quality control team
- The collection of case data describing the characteristics of offenders who fail in treatment or commit new sex crimes so gaps in containment can be identified and closed

Sexual abuse cases are difficult to manage, and offenders frequently attempt to manipulate the management system just as they did their victim(s). Containment professionals can burn out, get soft, miss "red flags," become cynical, and otherwise become ineffective. Empathy toward victims and repeated exposure to traumatic material can also result in *compassion fatigue* (Figely, 1995; Stamm, 1995). Police, firefighters, and other emergency workers report that they are most vulnerable to compassion fatigue when dealing

with the pain of children (Beaton and Murphy 1993, page). In addition, "trauma is contagious" (Herman, 1992,180). Compassion fatigue, a near certainty in this work, presents a significant threat to the quality of the program and the well-being of the dedicated professionals who are working to make our communities safer. Ongoing training, flexible hours, a supportive environment, and safe working conditions are important ways that administrators can help fight compassion fatigue.

A final aspect of quality control consists of clearly defined and agreed-upon measures of success. It is challenging to identify measures of detection, detention, and revocation that target offenders *before* the commission of a new assault. Addressing these issues requires the allocation of resources for monitoring and evaluation. Indeed, resource allocation is a key component of quality control.

Effectiveness of the Containment Approach

Lowden, et al. (2003) conducted a comprehensive process and outcome evaluation of the sex offender treatment program at the Colorado Department of Corrections. This program, described earlier in this chapter, employed the containment approach in the institution, including intense treatment with polygraph testing. When paroled, the offenders participated in treatment, supervision, and polygraph testing in the community.

Researchers found that 84 % of the offenders who participated in the therapeutic community component of sex offender treatment in the institution successfully completed parole, versus 52 % of the sex offenders who had not participated in institutional treatment. By the third year following parole discharge, 21 % of the offenders who had participated in institutional treatment had been arrested for any type of crime versus 42 % of the offenders who had not participated in treatment. Treatment and supervision effects lasted for the duration of the outcome period, nearly 8 years. However, over time, individuals in both the treatment and comparison groups continued to fail. After nearly 8 years, 40 % of those who had participated in the therapeutic community were rearrested for any type of crime; 50 % of those who participated in Phase 1 were rearrested, and 62 % of sex offenders who had not participated in treatment were rearrested. These findings may provide the most compelling argument for the value of containment—treatment combined with polygraph examinations and specialized supervision—but the fact that the effect of treatment eroded over time is an equally important finding. Few offenders in Colorado receive the intensity of treatment available to them in prison, yet only half in the prison study remained arrest free after nearly 8 years. Given the lack of reporting by sexual assault victims, actual reoffending rates are likely higher. This suggests the need for ongoing containment for many convicted sex offenders. In a discussion of child pornography offenders, Abel testified to the U.S. Sentencing Commission in 2012 that treatment and follow-up "maintenance" should range from 5 to 10 years and, for some offenders, lifetime maintenance is required (U.S.S.C. 2012)

Other studies also reveal the value of the containment approach. A preliminary study of the containment approach in the Framingham, Massachusetts, parole agency also produced promising results (Walsh, 2005, page). Of the 152 sex offenders managed under containment between 1996 and 2005, 15 were still actively under parole supervision, 81 had successfully completed supervision, and 58 had returned to custody. Eight offenders had been arrested for new crimes, none of which were sex offenses.

A study of the Jackson County (OR) probation and parole program also found support for the containment approach. Comparing outcome data on offenders in the Jackson County program with a comparison group from a nearby county, researchers found that offenders who stayed in treatment/containment for at least 1 year were 40 % less likely than those in the comparison group to be convicted of a new felony (England-Aytes et al. 2001, page). The Jackson County program dates back to 1980 and was featured in English et al. (1996).

The Maricopa County (AZ) Adult Probation Department has been using the containment approach since 1986. An evaluation by Hepburn and Griffin (2002) of the program involving 419 probationers with an average 36-month follow-up period found 2.2% of the offenders were arrested for a new sexual offense and 13.1 % were arrested for a new criminal offense. This appears to compare favorably to Losel and Schmucker's (2005) meta-analysis which found average sexual recidivism rates of 11.1 % and criminal recidivism rates of 22.4 % for treated offenders over an average 5-year follow-up, but the differences in time-at-risk are important.

Stalans (2004) conducted a comprehensive study of probation sex offender programs in three counties in Illinois that were implementing the containment approach. Stalans (2004) concluded that "…all specialized probation programs should be based on the containment approach and should include (a) at least three unannounced random field visits per offender every month, (b) a full-disclosure polygraph and a maintenance polygraph exams every 6 months, and (c) a tight partnership between probation officers and treatment providers that includes probation officers appearing at random times at the treatment site to check on offenders' attendance" (599).

The Virginia Department of Corrections conducted a study of 1,753 sex offenders in three probation and parole regions; 583 were assigned to one of nine containment programs and the remainder were assigned to non-containment units (Boone et al. 2006, page). The new crime rates after an

average of 4.5 years were comparable at 4.5 % (non-containment) and 4.6 % (containment). More than half of those who returned to prison did so due to technical violations, and those who were in containment programs had a 30 % higher technical violation rate than the non-containment group. The researchers stated the following about the higher rate of technical violations: "Higher technical violations are to be expected in containment units as the purpose of the increased supervision is to deter new crime and detect patterns of relapse before the offender engages in a new crime" (Boone et al., 2006, 40). The authors concluded:

> Sex offender containment models modify recidivism rates in different and opposite directions. The first impact is that offenders who violate conditions of their probation will be detected with greater frequency, thus inflating the recidivism rate. The second impact is that sex offender containment models reduce the likelihood that individuals will engage in new crimes by a combination of deterrence (increased supervision) and treatment (sex offender therapy). Non-containment units with similar rates of recidivism cannot be classified as doing just as well as a containment unit based solely on similar recidivism rates. Non-containment units may in fact be missing, due to reduced supervision and the absence of polygraphs, offenders who are committing new crimes, while less intensive treatment may be increasing their likelihood of re-offense (Boone et al., 2006, p. 40)

Finally, published results of a longitudinal, randomized control group study of the treatment program operating at the Atascadero (CA) State Hospital that compared outcomes of treated sex offenders with those of two untreated control groups: treatment volunteers and treatment refusers. Although the authors point out that the random assignment did not produce equivalent groups—the treated group had higher risk scores, a higher number of offenders previously committed for treatment as mentally disordered sex offenders, and a higher number of unmarried offenders—the program was considered state of the art. The Atascadero program used cognitive-behavioral treatment, relapse prevention, and 1 year of aftercare in the community. The evaluation found that the program was ineffective in reducing recidivism. It is important that the authors note that the treatment program differed in some respects from most current treatment programs. To reduce treatment attrition, offenders were not required to fully participate or progress in treatment to remain in the program. Consequently, the offender's sentence determined program discharge and was unrelated to treatment progress or assessed risk. In addition, these offenders did not participate in polygraph testing. After summarizing these issues, the authors conclude:

> Although it has not been rigorously tested, this "containment approach" (English, 1998) represents the current thinking in the field (Association for the Treatment of Sexual Abusers (ATSA), 2004; California Coalition on Sexual Offending, 2001; Center for Sex Offender Management, 2000; Colorado Sex Offender Management Board, 1999). As we learned in interviews with our treatment failures, a number of RP participants were facing high-risk situations soon after entering the community (Marques et al., 2000). It is possible that added surveillance and teamwork could have prevented some of these early failures (Marques et al., 2005, pp. 101–102)

Indeed, the Atascadero program lacked important aspects of the containment approach, including the use of the polygraph, the consistent application of sanctions—including termination from treatment for nonparticipation—and containment upon release from the institution. Requiring that individuals disclose their assault patterns, develop and implement plans to avoid high-risk environments, develop a positive support system, fully engage in treatment upon release, and acknowledge and manage their ongoing risk—that is, take full responsibility for the risk he or she presents to the community—are key components of the containment approach and were not part of the Atascadero program.

Conclusion

In sum, the containment approach is victim-safety focused, multi-agency, and collaborative. This chapter has focused closely on the containment strategy that involves the treatment provider, the supervising officer, and the polygraph examiner. Since the officer represents the criminal justice agency responsible for the offender, he or she generally convenes the case management team, and our research found that the officer and the treatment provider often go beyond the traditional boundaries of their job descriptions to implement containment (English et al., 1996, page). In other words, they show a particular kind of dedication to public safety, making time for the necessary collaborations, teaming, information sharing, training, and surveillance required to manage this population in the community. Supervising officers and treatment providers depend on a variety of information tools including "collateral contacts" with an offender's family members, employer and victim representatives, home visits, electronic monitoring, and urinalysis testing for drug use. While polygraph testing is one technology in a varied set of tools that are used to improve the management of sex offenders, the integration of polygraph testing with treatment and supervision remains at the core of the case management component of the containment approach.

This description, and certainly the practice of actual containment, is consistent with what Lisbeth B. Schorr called "critical attributes of effective intervention" (year, page). In this important paper, Schorr (1999) states that interventions that are most likely to change the lives of children and families in high-risk circumstances share certain attributes. They are (1) are comprehensive, flexible, and responsive, (2) see children [or victims and offenders] in the context of families, and families in the context of communities, (2) have a long-term orien-

tation with an understanding that deep-rooted problems are unlikely to respond to quick-fixes, (3) are managed and staffed by people who believe in what they are doing, (4) operate with intensity and perseverance to achieve a clear, coherent mission, (5) recognize the limits of a single strategy, and (6) encourage staff to build strong relationships based on mutual trust and respect, often going well beyond the boundaries of their job descriptions. Communities where the containment approach is implemented benefit from its focus on public safety.

Finally, the containment approach should be implemented in the context of emerging research in the field. This includes incorporating the risk-need-responsivity model (Andrews, Bonta & Wormith, 2011, p. 738) which includes respecting the client and providing services "in an ethical, legal, just, moral, humane, and decent manner" (page). Equally important is the research that underscores the importance of the relationship between the supervising officer and the offender in the change process (Skeem, Encandela, and Eno Louden, 2003; Skeem, Eno Louden, Polaschek, & Camp, 2007). Likewise, therapists must have a positive attitude toward the offender (Ward and Fisher, 2006, page) and seek to build a strong therapeutic alliance built on honesty, respectfulness, warmth, interest, and openness (Ackerman and Hilsenroth, 2003, page). Fundamentally, this approach seeks to manage risk and hold offenders accountable; this must occur in ways that are compatible with the humane application of containment.

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