



Innovative Treatment Approaches with Civilly Committed Sex Offenders

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Background on Illinois SVP



SVP Law components

- ◆ Typically, three criteria must be present to qualify as a Sexually Violent Person/Predator:
 - Conviction for sexually violent offense (or found delinquent, or NGRI, etc.).
 - Presence of a mental disorder
 - The mental disorder creates a substantial probability that the person will engage in acts of sexual violence in the future



Assessment of Risk

- ◆ Clinical risk assessment by Psychologist or Psychiatrist
- ◆ Most common approach is Guided Actuarial
- ◆ Clinical judgment alone is inferior

SVP Treatment in Illinois

- ◆ **Assessment** – comprehensive assessment of offense-specific and general psychological and interpersonal functioning.
- ◆ **Accepting Responsibility** – residents are asked to disclose all of their offenses and take full responsibility for their sexual offenses, complete and present their autobiography, and begin learning about cognitive processes supporting past decisions to offend.
- ◆ **Self-Application** – residents now begin to use the information about their offending and life histories to understand their offense patterns, important choice points within those patterns, the impact of those offenses on victims. Residents learn how to use journaling as a tool for self-monitoring and developing insight and critically examine individual thinking errors related to their offending behavior.
- ◆ **Incorporation** – during this phase of treatment residents develop interventions to prevent reoffending and, to the extent possible within the facility, begin the practice necessary to intervene and interrupt their cycle of offending.
- ◆ **Transition** – the phase of treatment in which residents begin the process of returning to their communities.



Illinois Population Statistics



◆ At present in Illinois:

- 342 resident in the program in various stages of legal detainment
- The committed total is 200
- The detained total 142
- There is approximately 62% of residents in treatment

Illinois Diagnostic Profile

◆ Axis I

- Pedophilia – 60%
- Paraphilia NOS 35%
- Sexual Sadism 3%

◆ Axis II

- Antisocial 58.0%
- PD NOS 34.5%
- Narcissistic 3.0%
- Avoidant 2.4%
- Borderline 2.4%





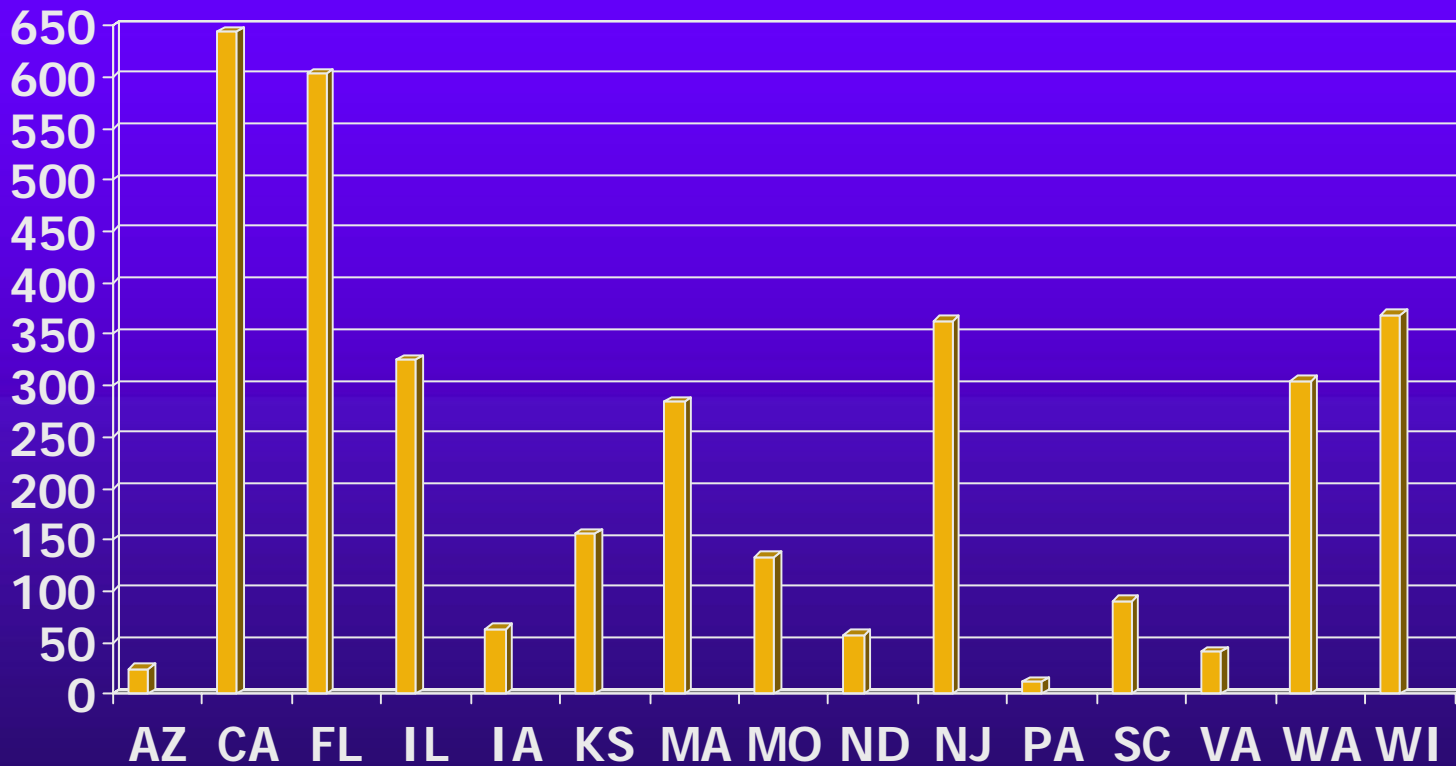
Comparison of SVP Programs' Statistics



Jurisdictions with SVP Laws

- ◆ *Arizona*
- ◆ *California*
- ◆ Federal Gov't. (Adam Walsh Act). (2007)
- ◆ *Florida*
- ◆ *Illinois*
- ◆ Iowa
- ◆ Kansas
- ◆ Massachusetts
- ◆ *Minnesota*
- ◆ Missouri
- ◆ Nebraska
- ◆ New Hampshire (2007)
- ◆ New Jersey (2007)
- ◆ New York
- ◆ North Dakota
- ◆ Pennsylvania
- ◆ South Carolina
- ◆ Texas* (outpatient only)
- ◆ Virginia
- ◆ *Washington*
- ◆ Wisconsin

Inpatient Census





Mean Age

- ◆ Illinois 44
- ◆ Arizona: 44
- ◆ Minnesota: 38.3
- ◆ Washington: 46.82
- ◆ Florida: 41.2



Ethnicity

- ◆ Majority Caucasian
 - Arizona: 69% (and 14% Hispanic)
 - Minnesota: 82%
 - Florida: 55%
- ◆ If bias exists, it likely varies based on the individual state
- ◆ Illinois has 76% White and 20% Black



Education

- ◆ The mean education level attained in the Florida sample was 11.2 years.
- ◆ In the Arizona sample, 38% had earned a high school diploma or equivalent, and 22% attended at least some college.
- ◆ Nationally, 80.4% of people over age 25 are high school graduates (U.S. Census Bureau, 2000).
- ◆ Lower education achievement was not predicted by I.Q. (mean of 95 in the Arizona sample).
- ◆ Illinois IQ average 89.1 with High of 127 to low of 65



Other Notable Findings

- ◆ A history of abuse was present for many.
 - In Arizona, 36.6% had been physically abused, and 43% had been sexually abused.
 - In Florida, 40% had been sexually abused.

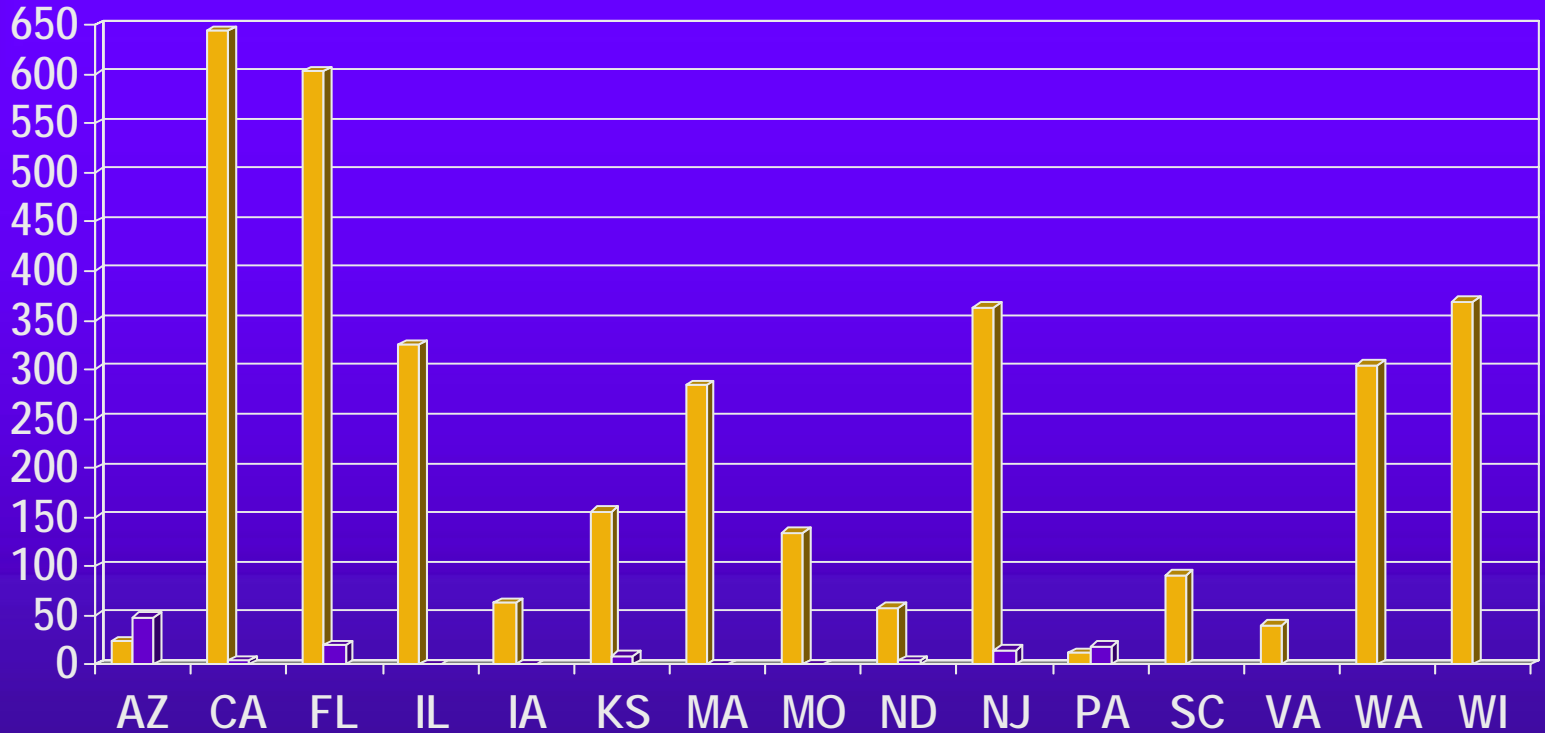
SVP Psychopathy Statistics

- ◆ Illinois Preliminary results
 - Mean score 26 those > 30+ = 39.0%
- ◆ Washington: mean=24.12
- ◆ Florida: mean=20.7
- ◆ California: 23.6% of the sample was above the cutoff score.



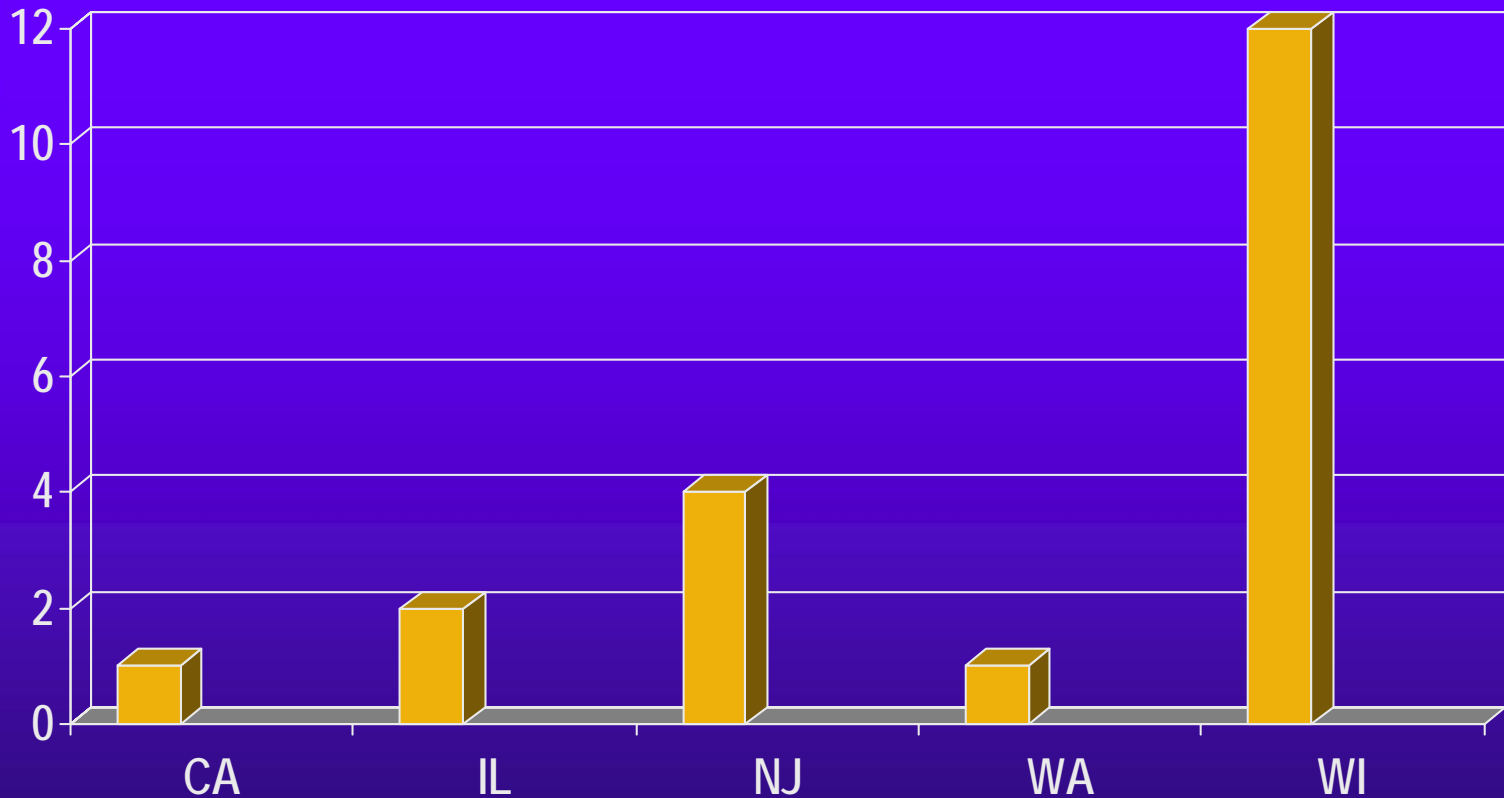
SVP

Inpatient Census vs. Conditional Release/Discharge



Texas does not have an inpatient component. Current Inpatient data not available for New York, New Hampshire, MN, Feds. According to Wash Inst Pub policy, 4,534 individuals have been 'involved with petition or certification for commitment since law took effect' –this includes those detained but not committed, etc. this data as of 2006.

Number of CR Released from Monitoring



Five states reported residents who graduated from conditional release programs and are now living in the community with no supervision other than registration. They include CA(1), IL(2), NJ (4), WA(1), and WI(12).





Working with the Developmentally Delayed & Mentally Ill Sex Offender



“Special Needs” Residents

- ◆ **Developmental Disabilities:**
 - Borderline Intellectual Functioning
 - Mental Retardation
 - Learning Disorders
 - Difficulties with Adaptive Functioning
- ◆ **Mental Illnesses:**
 - Schizophrenia
 - Bipolar
 - Major Depression
 - Schizoaffective
 - Psychotic Disorder NOS



Relevant Research: Differences Between DD and Non-DD offenders

◆ James Haaven:

– Self-esteem

- Less successful
- Exaggerate accomplishments
- Sensitive to criticism
- Resist change

– Denial

- Cling to rationale or distortions
- Generalized fear as defense mechanism
- Initial denial not prognostic



Relevant Research: Differences Between DD and Non-DD offenders

- ◆ James Haaven : Teaching Approaches
 - Poor general skills
 - Low tolerance for frustration; history of failure
 - Visual/ tactile learners (learn by doing)
 - Slower learning rate
 - High anxiety in typical learning situations results in diversionary acting out
- Thinking Processes
 - Power thrust
 - “Poor Me”
 - “I Won’t”- means “I Can’t”



Entry to Treatment Evaluation

- ◆ Purpose:
- ◆ to determine appropriate treatment recommendations
- ◆ to provide an overview of social history, criminal history, and treatment history

Phase II



◆ Old Me

- Hot Head
- I Quit
- Phony
- Know It All
- Unhealthy Follower
- Unhealthy Sexuality
- Me First
- It's Not My Fault

◆ New Me

- Cool Head
- I Can Do It
- The Real Me
- Open-Minded
- Healthy Leader
- Healthy Sexuality
- Others Are Important
- I'm Responsible



Phase III

- ◆ Examining “Old Me” thoughts & behaviors related to offending
- ◆ Examining old beliefs supporting offending behaviors
- ◆ Intervening & Thought-stopping

Visual Aids

- ◆ Use of dry-erase board
- ◆ Use of pictures to depict concepts

Promoting Understanding

- ◆ Use of breaks in group
- ◆ Use of Role Plays
- ◆ Less groups
- ◆ Use of repetition
- ◆ Use of handouts



Simplifying Concepts

- ◆ Use of Old Me/ New Me
- ◆ Breaking down questions
- ◆ 4-point sexual assault cycle
- ◆ Use of specialized journals

Additional Support

- ◆ Group numbers
- ◆ Lower caseloads
- ◆ Extra-help group
- ◆ Mentor group





Specialized Ancillary Groups

- ◆ Thinking Errors
- ◆ Anger Management
- ◆ Sex Education
- ◆ Substance Abuse



Psychopathy



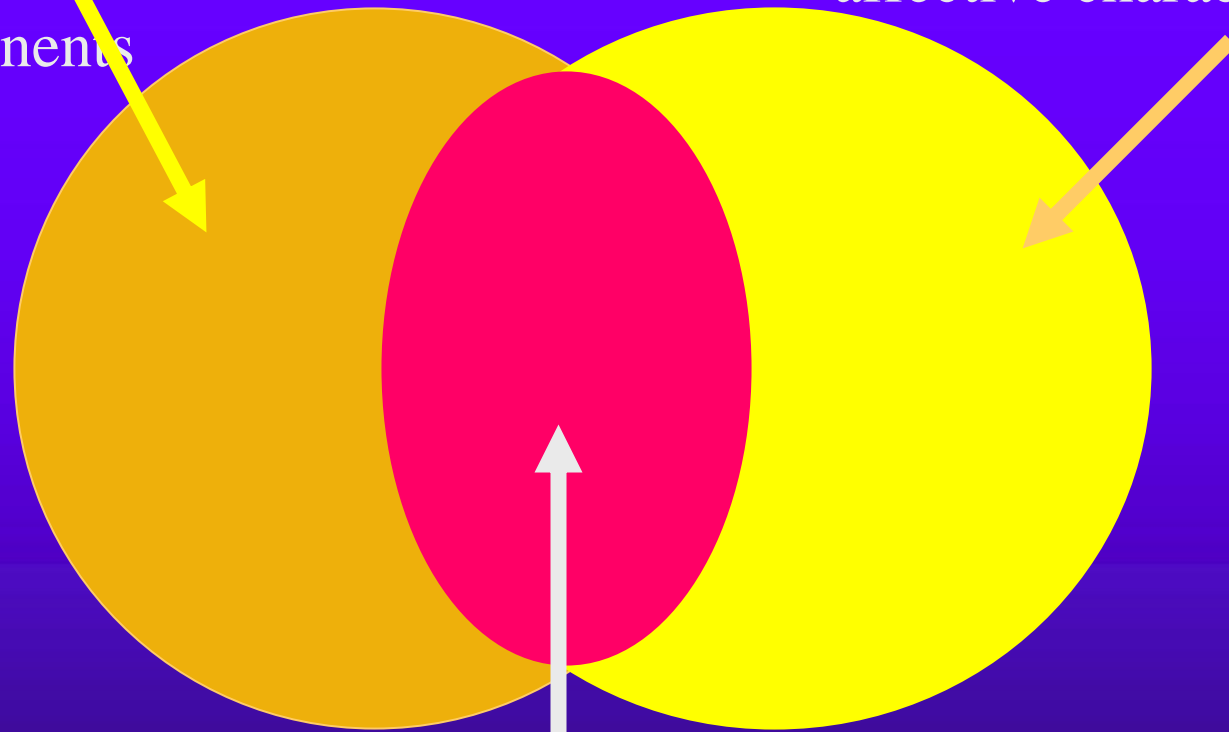
II. Psychopathy -Definition

- ◆ Association for the Treatment Sexual Abuser (ATSA) (2005) defined psychopathy as follows:
“Psychopathy represents an extreme manifestation of antisocial personality traits, including callousness, glibness, need for stimulation, impulsivity, irresponsibility, and grandiosity. Individuals who are high in psychopathy are very likely to have serious criminal histories, likely to engage in violence, and likely to re-offend. Psychopathy overlaps with antisocial personality disorder but the two clinical diagnoses are not synonymous,” (p.55).



Antisocial
Personality
Disorder –
behavior
components

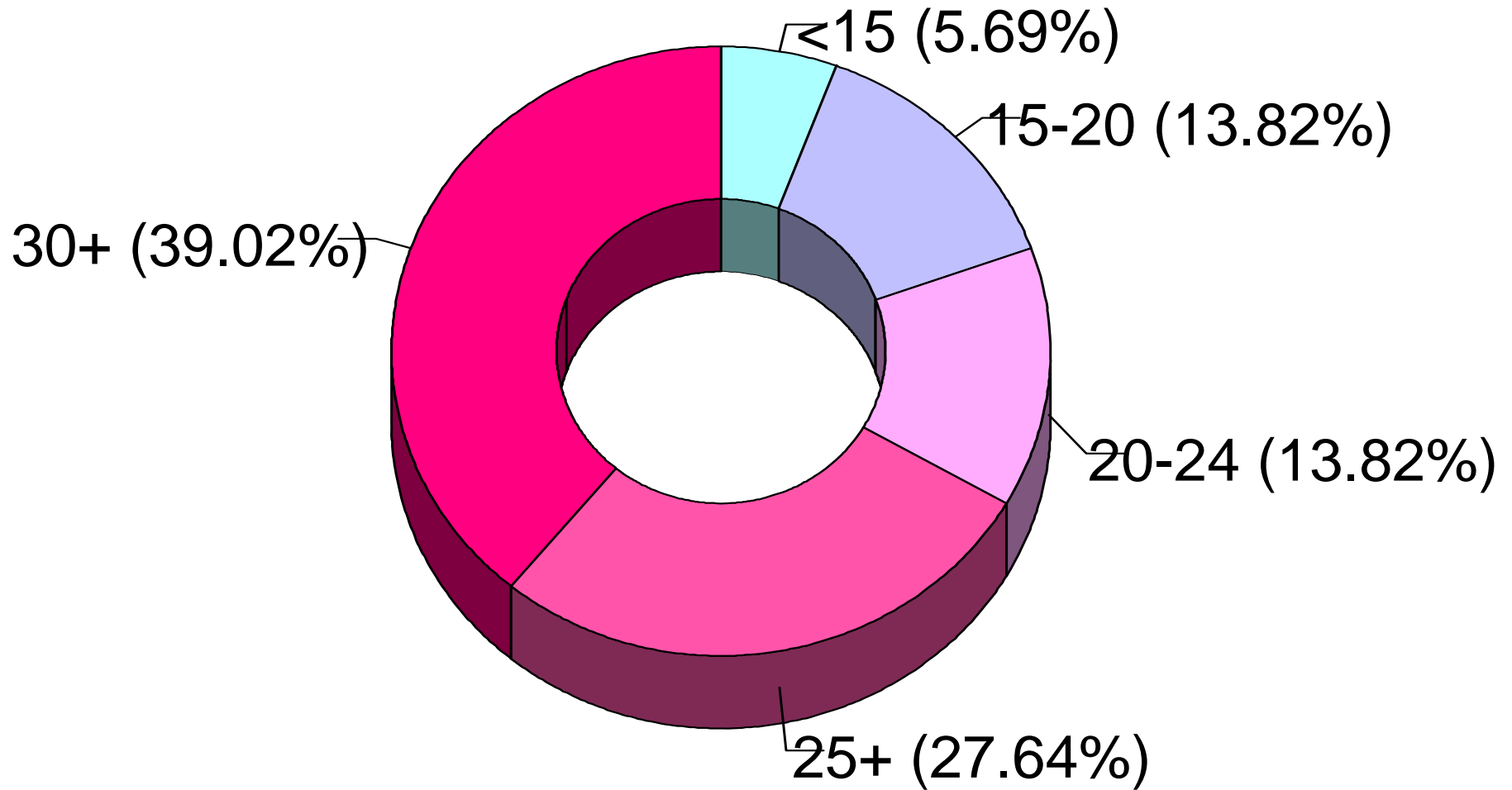
Psychopathy~
interpersonal &
affective characteristics




Chronic antisocial
behavior since
childhood

Quinsey, Harris, Rice, &
Cormier, (1998)

Frequency of Psychopathy Scores SVP Program



II. Psychopathy - Definition

- 
- ◆ The results of the Hare PCL-R scores are broken down into factors:
 - **Factor 1: The callous, selfish, remorseless use of others**
 - **Facet 1a:** Interpersonal
 - **Facet 1b:** Affective
 - **Factor 2: A chronically unstable and antisocial lifestyle**
 - **Facet 2a:** Impulsive Lifestyle
 - **Facet 2b:** Antisocial Behavior

PCL-R: 2nd Edition Robert D. Hare, PhD

4 -Factor Analysis

<u>Hare PCL-R Items</u>	FACTOR ONE callous, selfish use of others		FACTOR TWO Unstable, antisocial lifestyle	
	1a	1b	2a	2b
	Interpersonal	Affective	Implusive Lifestyle	Antisocial Behavior
1.Glib And Superficial Charm	x			
2.Grandiose Estimation Of Self	x			
3.Need For Stimulation			x	
4.Pathological Lying	x			
5.Cunning And Manipulativeness	x			
6.Lack Of Remorse Or Guilt		x		
7.Shallow Affect		x		
8.Callousness And Lack Of Empathy		x		
9.Parasitic Lifestyle			x	
10.Poor Behavioral Controls				x
11.Sexual Promiscuity	e	e	e	e
12.Early Behavior Problems				x
13.Lack Of Realistic Long-Term Goals			x	
14.Impulsivity			x	
15.Irresponsibility			x	
16.Fail To Accept Responsibility For Actions		x		
17.Many Short-Term Marital Relationships	e	e	e	e
18.Juvenile Delinquency				x
19.Revocation Of Conditional Release				x
20.Criminal Versatility				x

4 -Factor Analysis

<u>Hare PCL-R Items</u>	FACTOR ONE		FACTOR TWO	
	1a	1b	2a	2b
	Interpersonal	Affective	Impulsive Lifestyle	Antisocial Behavior
<input type="radio"/> 1.Glib And Superficial Charm	<input type="radio"/>			
<input type="radio"/> 2.Grandiose Estimation Of Self	<input type="radio"/>			
<input type="radio"/> 4.Pathological Lying	<input type="radio"/>			
<input type="radio"/> 5.Cunning And Manipulativeness	<input type="radio"/>			
<input type="radio"/> 6.Lack Of Remorse Or Guilt		<input type="radio"/>		
<input type="radio"/> 7.Shallow Affect		<input type="radio"/>		
<input type="radio"/> 8.Callousness And Lack Of Empathy		<input type="radio"/>		
<input type="radio"/> 16.Fail To Accept Responsibility For Actions		<input type="radio"/>		
<input type="radio"/> 3.Need For Stimulation			<input type="radio"/>	
<input type="radio"/> 9.Parasitic Lifestyle			X	
<input type="radio"/> 13.Lack Of Realistic Long-Term Goals			<input type="radio"/>	
<input type="radio"/> 14.Impulsivity			<input type="radio"/>	
<input type="radio"/> 15.Irresponsibility			<input type="radio"/>	
<input type="radio"/> 10.Poor Behavioral Controls				X
<input type="radio"/> 12.Early Behavior Problems				X
<input type="radio"/> 18.Juvenile Delinquency				X
<input type="radio"/> 19.Revocation Of Conditional Release				X
<input type="radio"/> 20.Criminal Versatility				X
<input type="radio"/> 11.Sexual Promiscuity	e	e	e	e
<input type="radio"/> 17.Many Short-Term Marital Relationships	e	e	e	e

How Psychopathy may influence TX participation

◆ 1A. Interpersonal Facets (Hare, 2003)

- 1. **Glib And Superficial Charm**
- 2. **Grandiose Estimation Of Self**
- 4. **Pathological Liar**
- 5. **Cunning And Manipulativeness-**



How Psychopathy may influence TX participation

◆ 1B. Affective Facets - (Hare, 2003)

- 6. **Lack Of Remorse Or Guilt**
- 7. **Shallow Affect**
- 8. **Callousness And Lack Of Empathy**
- 16. **Fail To Accept Responsibility For Actions**



How Psychopathy may influence TX participation

◆ 2B. Impulsive Lifestyle Facets

- 3. Need For Stimulation/ Proneness to Boredom
- 13. Lack Of Realistic Long-Term Goals
- 14. Impulsivity
- 15. Irresponsibility
- 10. Poor Behavioral Controls



Cognitive Distortions/Criminal Thinking

◆ Thinking Errors –

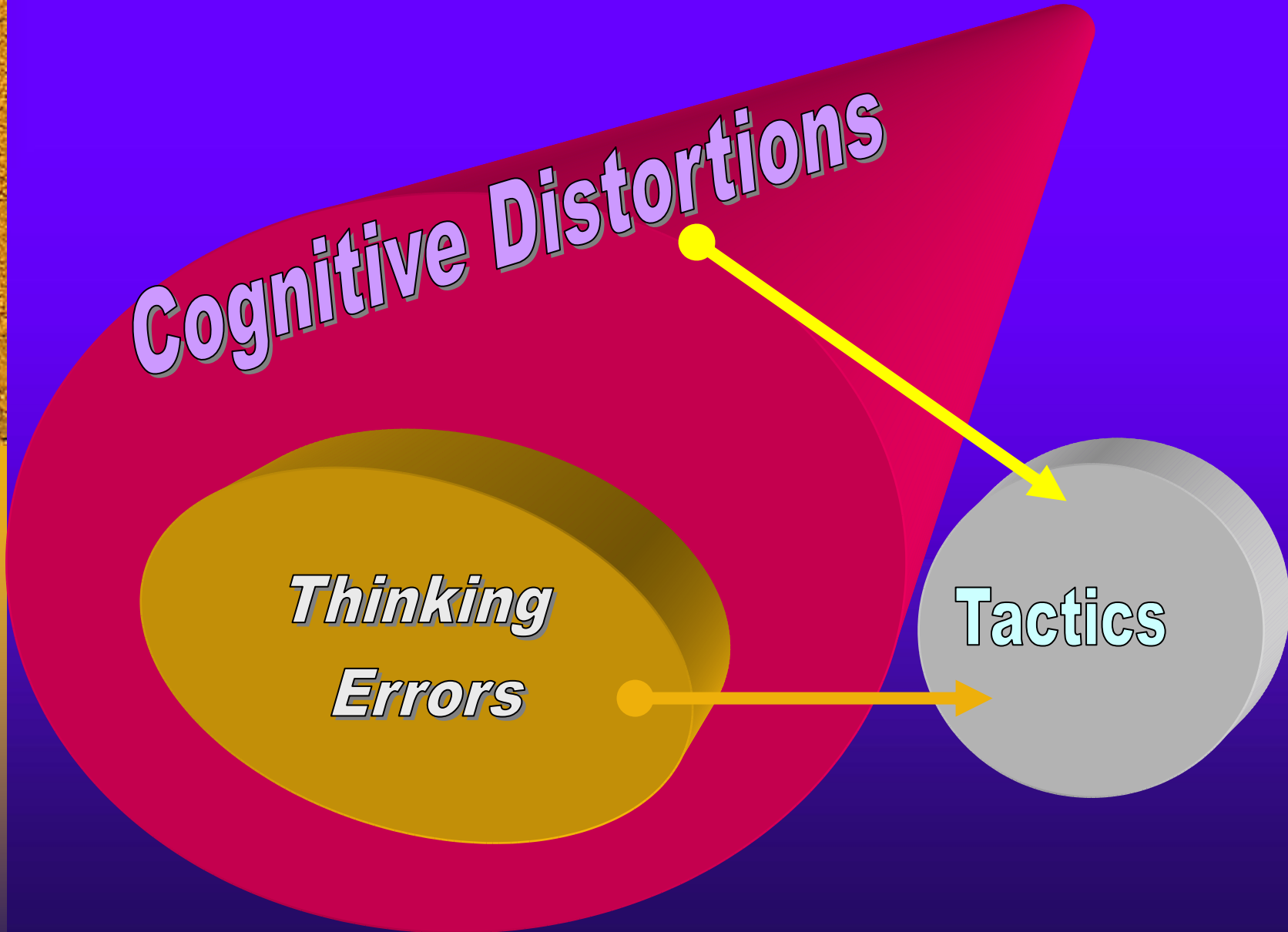
- Thoughts that allow someone to avoid taking full responsibility for his actions.
- Thoughts that allow someone to be concerned with only his needs and wants.
- Thoughts that allow you to ignore the impact your behavior has on others.

◆ Tactics -


- Behaviors resulting from Thinking Errors.
- Behaviors which prevent/block change.
- Behaviors that shift the focus off of the person on focus.




Cognitive Distortions/Criminal Thinking




Cognitive Distortions/Criminal Thinking

- 
- ◆ Research on Psychopathy & Cognitive Distortion (Thinking Errors)
 - Vein & Beech, (2006) indicated that the underlying cognitions psychopaths' hold remain unclear. Even though certain offense related schemas can be attributed to psychopaths, such as rape myths, there has been little empirical work in this area, and as yet a systematic way of assessing offense-related schemas in psychopaths.
 - **Detailed analysis of cognitions is required to succeed in treatment.**

Treatment of Psychopathy

- 
- ◆ **Hobson, Shine, & Roberts, (2000)**
 - Psychopaths' disruptive behavior during treatment has been attributed to the personality characteristics of glibness and/or superficial charm and grandiose sense of self-worth.
 - ◆ **Skeem, Monahan, and Mulvey (2002)**
 - concluded from their study that patients with psychopathic tendencies appeared just as likely to benefit from treatment as non-psychopathic (as cited in Vein & Beech, 2006).
 - ◆ **Bourget & Bradford (2008)**
 - Cognitive restructuring used to challenge offenders' cognitive distortion ~which help maintain deviant sexual interest and justify minimize sexual victimization of others
 - Many Sex Offenders lack adequate adult social skills
~interpersonal skill training to develop appropriate interactions.

Treatment of Psychopathy


- 
- ◆ Abracen, J., Looman, J. & Langton, C.M., (2008)
 - Best practice indicates that cognitive behavioral approaches are the treatment of choice with sex offenders.
 - relapse prevention which include development of an offense cycle which indicate all factors related to an offense/series of offense
 - ◆ Quinsey, Harris, Rice, & Cormier, (1998)
 - Argued that a cut-off score of 25 may be used as a reasonable threshold for high psychopathy as it would produce a “pure sample of psychopathic individuals.” (p. 85)
 - ◆ ATSA (2005)

Treatment of Psychopathy @ TDF

- ◆ How TDF determine what special needs residents required to be able to fulfill objectives of treatment
 1. To aid these individuals in functioning in sex offender-specific treatment, it was necessary to create specialized treatment programs to first of all, get their attention.
 2. The next step is to provide incentives and techniques to take responsibility for their actions while reducing their defensiveness and cognitive distortions.



Treatment of Psychopathy @ TDF

- 
- ◆ Ancillary Group
 - Orientation – required by all residents entering treatment
 - Presents an overview of treatment
 - Introduces staff and their functions
 - Thinking Errors – required for all residents
 - Ice breaker into group process
 - Introduces concepts in less threatening environment



Steps To Take Full Responsibility

- ◆ Recognize and tell others that you harmed them.
- ◆ Accept and admit the full impact your behaviors had.
- ◆ Be truthful to self and others about all harmful behaviors.
- ◆ Acknowledge you are completely responsible and can make decisions and choices.
- ◆ Accept all positive/and negative consequences of behaviors.
- ◆ Ask others how they think/feel about your behaviors.
- ◆ Accept and admit your true feelings about your behaviors.
- ◆ Understand/accept others' response to your behaviors.
- ◆ Find ways to change your behavior that gets what you want without harming others.



VI. Treatment of Psychopathy @ TDF

- ◆ Ancillary Group
 - Power to Change –
 - DBT – used for social skills training and to learn emotional regulation.
 - Core mindfulness skills
 - Interpersonal Effectiveness
 - Emotional regulation skills
 - Distress Tolerance skills
 - Tactics-
 - Tactics Core-

Types Of Thinking Errors

- 
- ◆ My Way
 - ◆ Super Optimism
 - ◆ Closed Channel
 - ◆ Vagueness
 - ◆ Assuming
 - ◆ Minimizing
 - ◆ Failure To Plan Ahead
 - ◆ Redefining
 - ◆ Lying
 - ◆ Victim-Stance
 - ◆ Ownership
 - ◆ I'm Unique
 - ◆ Making Fools of others
 - ◆ Catastrophizing

Tactics

– Definition:

- Behaviors resulting from Thinking Errors.
- Behaviors which prevent/block change.
- Behaviors that shift the focus off of the person on focus.



Tactics

- ◆ Payoffs Of Using Tactics:
 - Gets the focus off of you.
 - Allows you to avoid taking responsibility.
 - Allows you to avoid accepting limitations.
 - Allows you to see others as the problem.
 - Allows you avoid changing.



Tactics



◆ Simple Facts:

- Virtually all people engage in tactics from time to time.
- Simply engaging in tactics is not the major problem.
- People can learn to identify when they are using tactics and stop the behavior.

Types Of Tactics:

- ◆ Attack:
- ◆ Diversion:
- ◆ Generalization:
- ◆ Minimization:
- ◆ Silence:
- ◆ Vagueness:
- ◆ Casing: I'll feed you what you want to hear
- ◆ Splitting
- ◆ Gossiping
- ◆ Demanding
- ◆ Seductiveness
- ◆ Playing on weaknesses of others
- ◆ Grooming





Use of the Polygraph as a Psychological Tool



Polygraph Referral, Quality Assurance And Appeal Procedures

Index Offense Polygraph - a resident may be referred to the Polygraph Review Committee by his Core Group therapists if the resident's account of his most recent sexual offense differs substantially from the official records of this offense.



Polygraph Referral, Quality Assurance And Appeal Procedures

Sexual History Polygraph - All residents are referred to the (PRC) upon completion of their Sexual Offense History Questionnaire, and successful presentation of this to their Core group.



Polygraph Referral, Quality Assurance And Appeal Procedures

Polygraph Re-examination - Residents who previously have failed the polygraph examination, or received inconclusive results not accepted by the PRC may also be required to re-take the polygraph examination.



Polygraph Referral, Quality Assurance And Appeal Procedures

Maintenance/single issue polygraph: residents may be referred for maintenance polygraph by treatment providers as needed throughout the program, to address ongoing behavioral concerns, etc



Polygraph Referral, Quality Assurance And Appeal Procedures

- ◆ The TDF polygrapher meets all requirements for Post-Conviction Polygraph Standards for Sex Offender Training and Testing as set forth by the American Polygraph Association. In accordance with the Standards of Practice of the American Polygraph Association, all examinations will be audio or videotaped for quality assurance purposes.



Polygraph Referral, Quality Assurance And Appeal Procedures

Upon completion of the polygraph examination, all test results are reviewed by the PRC for acceptance:

Non-deceptive polygraph findings: to be reviewed by the committee prior to acceptance, to control for false negative errors.

Deceptive polygraph findings: to be reviewed in consideration of domains listed in (B) above, to attempt to control for false positive errors.



Polygraph Referral, Quality Assurance And Appeal Procedures

In reviewing Deceptive and Non-deceptive polygraph findings, the committee considers all relevant clinical and historical information, including but not limited to:

- ◆ Validity indicators on the Entry to Treatment Evaluation, Penile Plethysmograph (PPG) and Abel Screen.
- ◆ Consistency between reported offenses and offenses of record and the extent of sexual offense history disclosure.
- ◆ Review of potential indicators of deception including participation in Core and Ancillary treatment groups, unit behavior, primary therapy relationships, review of TDF clinical and master files, etc.
- ◆ Results of predicate offense polygraph examination (if taken).



Polygraph Referral, Quality Assurance And Appeal Procedures

Inconclusive findings: The Committee examines the polygraph results in consideration of domains listed above to determine whether the resident's treatment would differ meaningfully if the results had been conclusive.

If it is determined that the course of treatment would not be meaningfully different if the results had been conclusive, the resident's current polygraph examination will be held to satisfy the CORE treatment objective regarding the polygraph.



Appeal Procedures

Residents may appeal the polygraph review committee's decisions regarding acceptance of the polygraph findings. The appeal process is divided into two tiers, which must be followed in sequence.

- ◆ **Tier 1:** Residents whose polygraph findings are found by the committee not to have satisfied the polygraph requirement on the Core Treatment Objectives Checklist may submit a written letter requesting that the PRC reconsider their decision regarding acceptance of their polygraph results.
- ◆ **Tier 2:** involves a review of the polygraph charts and audio or videotape of the original polygraph examination by an independent polygrapher of the resident's choosing (and must meet minimum qualifications)



Use of the PPG as a Treatment Tool



“The single best predictor of sex offender recidivism was deviant sexual arousal as measured by the penile Plethysmograph.”

Hanson and Bussière, 1996

Theories

- ◆ Physiological
- ◆ Cognitive Theories
- ◆ Affective Theories
- ◆ Developmental Theories





Why Arousal Reconditioning?

- ◆ Sex offenders are not generally open about their true deviant sexual arousal.
 - homophobia
 - fear of being “worse” or “abnormal”
 - fear of being seen untreatable or higher risk
 - outside the “man box”
 - denial
- ◆ An untreated deviant arousal is similar to a “little” critical choice point that is ignored.



Risk Factors for Sexual Recidivism (Hanson & Bussière, 1996, 1998)

- ◆ 1. Plethysmograph preference for children
- ◆ 2. Scale 5 (Masculinity/Femininity) of the MMPI
- ◆ 3. Severely disordered
- ◆ 4. Deviant sexual preferences (pretreatment)
- ◆ 5. Prior sexual offenses
- ◆ 6. Any personality disorder
- ◆ 7. Negative relationship with mother
- ◆ 8. Scale 6 (Paranoia) of the MMPI
- ◆ 9. Low motivation for treatment
- ◆ 10. Victim stranger
- ◆ 11. Antisocial personality disorder
- ◆ 12. Plethysmograph preference for boys
- ◆ 13. Victim female child
- ◆ 14. Prior offenses (any nonsexual)
- ◆ 15. Anger problems
- ◆ 16. Age
- ◆ 17. Early onset of sexual offending
- ◆ 18. Prior offenses
- ◆ 19. Victim related child
- ◆ 20. Single (never married)
- ◆ 21. Diverse sex crimes



Additional Supporting Studies

- ◆ Rice and Harris (1997) report that the combination of Psychopathy, measured by the PCL-R, and sexual deviancy, based on phallometric test results, resulted in the highest recidivism rate in their sample of sex offenders.
-10 year study of 288 sex offenders.
- ◆ Deviant sexual interest are most prevalent among those who victimize strangers; use force; select boy victims or select victims much younger or older than themselves (Barbaree & Marshall, 1989; Freund & Watson, 1991; Quinsey, 1984, 1986).

Program Overview

Arousal
Management and
Reconditioning
at DHS-TDF

Introduction to
Arousal
Management

Arousal
Management and
Reconditioning

Minimal Arousal
Conditioning



General Treatment Goals

- ◆ **Appropriate Sexual Arousal**
- ◆ Develop
- ◆ Maintain
- ◆ Strengthen



General Treatment Goals

- ◆ Deviant Sexual Arousal
- ◆ Control
- ◆ Reduce
- ◆ Eliminate



Introduction to Arousal Management

- ◆ This course is designed to introduce residents to concepts related to the acquisition, reinforcement, and maintenance of unhealthy arousal.



Introduction to Arousal Management

- ◆ This course is 50% psycho education and 50% insight oriented
- ◆ Residents are asked to apply concepts to their sexual offense hx in an effort to gain insight regarding arousal pattern(s).





Topics within Introduction to Arousal Management

- ◆ Orientation and why do I need arousal management?
- ◆ What are behavioral interventions?
- ◆ Sexual response cycle, hormones, and deviant sexual arousal
- ◆ Psychological theories covering learning behaviors (Bandura, Watson, Pavlov...)
- ◆ How will PPG be used and common Myths



Topics within Introduction to Arousal Management and Reconditioning

- ◆ Brief review of Introduction Group
- ◆ Gaining control over your sexual urges
- ◆ Disputing irrational thoughts
- ◆ Learning empathy
- ◆ Behavioral interventions
- ◆ See Chart from McGrath, R.J. (2000)
- ◆ See Script
- ◆ Myths




Minimal Arousal Conditioning

- ◆ Topics and techniques will be tailored to individual client needs.
- ◆ Plethysmograph will be used as a biofeedback instrument.
- ◆ This group is for residents with continuing unhealthy arousal despite initial groups



Referral Criteria and Who to treat???

- ◆ Demonstrated commitment to treatment
 - Phase III or beyond (some exceptions may be made) and Completion of Intro to AM
 - Verbalizing need/desire to address unhealthy arousal
- ◆ Non-deceptive results on history polygraph
 - We need some sort of objective data to identify treatment objectives (self report is not enough)



The use of the Polygraph in the Arousal Management Program

- ◆ Sexual Offense History prior to AMR
- ◆ Maintenance upon suspicion of reinforcing unhealthy arousal (acting out or masturbating to deviant themes)?