Abusers who were Abused:

Myths and Misunderstandings

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Native American Topic-Specific Monograph Series

Purpose

The purpose of the Native American Topic-Specific Monograph project is to deliver a variety of booklets that will assist individuals in better understanding issues affecting Native communities and provide information to individuals working in Indian Country. The booklets will also increase the amount and quality of resource materials available to community workers that they can disseminate to Native American victims of crime and the general public. In addition to the information in the booklet, there is also a list of diverse services available to crime victims and resources from the Department of Justice.

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CCAN believes that the information contained herein is factual and that the opinions expressed are those of the consultants/writers. The information is not however, to be taken as warranty or representations for which the Center on Child Abuse and Neglect assumes legal responsibility. Any use of this information must be determined by the user to be in accordance with policies within the user's organization and with applicable federal, state, and tribal laws and regulations.

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Introduction

The goal of this monograph is to present knowledge that will help individuals understand the increased risk abuse and neglect can have on American Indians to offend sexually. Treatment and management needs for American Indian adolescents and adult sexual offenders will be addressed. Most individuals who were victims of sexual and other forms of abuse do not become sexual offenders, however, a relationship has been found between maltreatment and sexual offending (Ryan, Miyoshi, Metzner, Krugman, & Fryer, 1996). For purposes of this monograph, abuse experiences will be defined to include sexual abuse, physical abuse, and neglect.

American Indians are recognized as a specific minority group in the United States, but they represent several different cultures and both urban and rural life styles. Most reservations are located in the western part of the United States and several urban areas have large populations of American Indian people, (May, 1989). While there is little research data that has addressed the effects of sexual abuse on American Indians, there have been many efforts to understand the effects of sexual abuse. This monograph will attempt to generalize these efforts to American Indians.

Some victims of abuse become abusers but this does not mean that the abuse caused this outcome. Several other factors must be considered. Various factors to consider include cultural destruction and boarding schools, (Swinomish Tribal Community, 1991), coping by using substances and high levels of substance dependence, (Herring, 1994), and relationship or attachment problems from an accumulation of unresolved trauma experiences, (Osofsky & Fenichel, 1994).

This monograph is organized into five remaining sections. The first section gives information on the types of sexual offenders that might be encountered. The second section addresses the progression from being a victim to becoming a sexual offender. Information is given on how to start an outpatient sex offender program in the third section. Recommended content of a sexual offender program for American Indians is detailed in the fourth section. A summary and conclusions are offered in the last section. It is hoped that this monograph can offer guidance and suggestions to professionals and leaders in American Indian communities who are faced with the tasks of preventing sexual abuse and providing treatment to sexual abuse victims and sex offenders.

Types of Sexual Offenses

There is no single type of sexual offender but there are types of sexual offenses that are frequently encountered. It is important to understand and classify sexual offenses because this information can be used to estimate risks for repeat offenses (also called recidivism), and to determine if an offender can be safely managed in the community. Some important variables in this process are if the sexual offense was committed against someone in the offender's family or home (incest offenses), the sex of the victim, the age of the offender, extent of sexual deviancy displayed by the offender, and other factors related to criminal behavior.

One definition of sexual deviancy is a diagnosis of a paraphilia. The standard reference used to make such a diagnosis is the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association, 1994). Sexual deviancy is also defined in terms of unlawful sexual acts such as rape. In addition, sexual deviancy involves other considerations such as a history of sexual offenses, sexual offending beginning in childhood, and failure to develop expected sexual relationships through dating, partnerships, or marriage. Factors related to criminal behavior or criminality includes previous nonsexual offenses and personality disorders.

Societies define acceptable sexual behavior in different ways, but a general guideline is for sexual partners to be chosen from the person's peer group. Partners also need to give consent for sexual activities. Consent implies at a minimum, an understanding of the behavior, knowledge of possible consequences, information about the expectations of the community, and the freedom to make a choice. People can't give consent if they are too young, developmentally disabled, in a relationship where the person who wants to have sex with them has power or control over them, or incapacitated by drugs or alcohol. Sexual offenses can be impulsive or planned. Impulsive offenses may result in the planning of additional offenses. An impulsive offense requires that some opportunity is available to offend and the probability of these offenses is increased by disinhibition, or a history of central nervous system dysfunction.

Two studies are summarized below that have combined the results from research with sexual offenders and different types of offenses. This information is offered to help the reader understand some of the important issues that are considered when predicting treatment needs for the offender, or protection needs for victims and communities. All of the information presented below is based on male offenders. Limited information is becoming available on female sexual offenders. This information suggests that female offenders have a higher incidence of prior sexual abuse than male offenders, but sufficient data is not available to draw further conclusions. Some areas that have been addressed include females who offend against children they are caring for such as babysitters, and females who offend in conjunction with a male partner that is also an offender.

A study by Hanson and Brussiere, (1996), reviewed 61 research studies conducted in six countries from 1943 to 1995. These 61 studies included a total of 28,972 sex offenders. Recidivism rates are known to vary based on how re-offense is defined and over the length of time offenders are followed. Re-offense can be defined as including only sexual offenses or any criminal behavior. They can be based on official law enforcement or court services records, self-reports from offenders, or some combination of these sources. Recidivism increases as offenders are followed over longer periods of time. Hanson and Brussiere reported average recidivism rates over a four to five year follow-up period of 18.9% for a sexual offense against an adult victim or rape, and 12.7% for child molestation. When a broader definition was used of any re-offense, these rates increased to 46.2% for rapists and 36.9% for child molesters. Those who dropped out of treatment or who failed to attend treatment were at a higher risk to re-offend than those who completed treatment.

Alexander (1999), reported a more recent study using results from 79 outcome studies of 10,988 sexual offenders. Recidivism was defined as re-arrest for a new sexual offense. The subjects were divided into different subtypes. One subtype was juveniles. All juveniles received treatment and they had the lowest recidivism rate of 7.1%. Other subtypes were treated and non-treated rapists, child molesters, and exhibitionists. An unspecified area was also included. Treated rapists had a recidivism rate of 21.1% compared to 23.7% for untreated rapists. Child molesters who received treatment had a recidivism rate of 14.4% compared to 25.8% for those who did not receive treatment. Treated exhibitionists had a recidivism rate of 19.7% compared to 57.1% for those that received no treatment. Recidivism rates declined between the 1990's and the 1980's for treated rapists, child molesters with female victims, and incest and non-incest offenders. Rates increased for juveniles and child molesters with male victims.

Some conclusions can be gained about treatment response and re-offense from this information. Incest and juvenile offenders with female victims respond well to treatment methods that are available. These offenders can often be managed within the community. Individuals who begin to offend early in life, or that have repeat offenses have higher rates of recidivism. Males who offend against males, or who have higher levels of sexual deviancy or criminality, are more likely to re-offend. Males that dropped out or avoid treatment present higher recidivism risks. Female sexual offenders have been identified but need to be treated as a specialized population due to limited information that is available about their treatment needs and response to treatment.

From Victim to Offender

It is not possible to predict which victims of abuse will offend sexually or display other criminal behavior. Some information is available that may help us understand the risks for such outcomes and to identify protective factors that may prevent a victim from committing a crime.

Windom (1995) reported key findings from research in progress through the U.S. Department of Justice. The focus of this research was to determine if individuals who had been sexually abused were more likely to display delinquent or criminal behavior, particularly sexual offenses, than individuals who had not experienced sexual abuse. Findings from this research suggested that the vast majority of childhood sexual abuse victims were not arrested for crimes as adults. All types of abuse victims were found to have a higher risk to commit crimes as adults compared to individuals who were not victimized. Sexual abuse victims during childhood were found to have a greater risk of being arrested for prostitution. Victims of physical abuse tended to be at a greater risk for committing the crimes of rape and sodomy.

Additional research is available supporting the presence of a maltreatment variable in the developmental history of youthful sexual offenders. Ryan (1989) reported that sexually abused children were at a greater risk to become sexually abusive to others. Information from a large database (Ryan, et al, 1996), suggests that physical and sexual abuse, neglect, and loss of parental figure are common in the history of youth who offend sexually. This sample was 97.4% male and involved youth alleged to have committed sexual crimes. At the point of intake, 41.8% of the more than 1,600 juveniles had been victims of physical abuse, 39.1% were sexual abuse victims, and neglect was documented in 27.9% of the cases. More than half of the youth (63.4%) had witnessed family violence in the home such as spouse or sibling abuse. Substance abuse was indicated in 27.9% of the cases and 45.6% had been seen for some type of therapy before being referred because of alleged sexual offenses.

Loss of a parental figure was present for 57% of the sample, and 13.6% of the youth had suffered the loss of another significant individual in their life. Out-of-home placement accounted for 34.2% of parental loss while death of one or both parents accounted for 12% of the parental loss. Nonsexual offenses were reported for 63% of the sample. A major issue was that most of the perpetrators of abuse towards these youth had not been held accountable through adjudication. These youth were not provided with a model of protection and validation as a result. They may have generalized this model to others by abusing because they did not have a sense of responsibility for their own offending behavior. This data is consistent with an earlier study (Prentky, Knight, Sims-Knight, Straus, Rokous, and Cerce, 1989), which concluded that childhood experiences with caregiver relationships and disruption of these relationships were important to understand adult sexual aggression.

Victimizing by former victims can be viewed as modeling a predator role. Both the abusive behavior and methods to deny accountability may be modeled. These areas are of particular concern within certain American Indian families and communities because a high prevalence of historical and personal trauma is present. These conditions are consistent with the maltreatment variable found to exist in sexual offender populations. The effects of parental loss and substance abuse are of specific concern since these experiences are often common in the histories of American Indian families.

This process becomes a cycle when children model addictive coping styles. This allows the effects of trauma and dysfunctional behaviors to be passed onto another generation. Other behaviors are also modeled that involve acting out within the family structure. A recent abstract by Bunk (1994) concludes that families with poor coping styles can have a traumatizing effect on the development of a child's mental health greater than the traumatic event itself. This abstract is from a study of persecution and extreme traumatization experienced by children in war situations. Osofsky (1995), also supports that ineffective coping processes are an active part of the trauma environment.

One specific ineffective coping process is the development of predator-prey life views. This coping process is formed when individuals begin to develop the philosophy of being either a predator or prey. It is a cognitive process that concludes that safety is gained as the person becomes the "head predator."

The process leads to various acts of violence and several effects are seen such as suppressed intelligence, repressive environments that stultify creativity and foster rigid thinking, and settings that isolate form society's principle resources (Garbarino, Kostelny & Dubrow, 1991; and Garbarino, et al, 1992).

The information presented above identifies several risks that abuse and neglect victims face. This information is based on the general population and has not been specifically based on studies of American Indians. The information is offered here as the best guideline that is currently available regarding expectations of the effects American Indians are likely to experience as a result of sexual abuse, physical abuse, or neglect. These risks are as follows.

1. Abuse victims present increased risks to commit crimes as adults, but the majority of childhood sexual abuse victims do not commit crimes.
2. Sexual abuse victims have an increased risk to be arrested for prostitution.
3. Physical abuse victims are at an increased risk to commit the crimes of rape and sodomy.
4. Maltreatment in the forms of sexual and physical abuse and neglect appears to increase the risk to offend sexually.
5. The loss of parental figures or other significant individuals in a child's life might increase the risk to become a sex offender.
6. An association seems to be present between witnessing violence in the home and later sexual offending.
7. Substance use in the home or by the victim of maltreatment appears to be a risk factor for sexual offending.
8. When a perpetrator is not held responsible for offending, their victim(s) seem to have an increased risk to offend sexually.
9. Ineffective coping such as the formation of predatory cognitive process appear to be a risk factor by forming cycles of dysfunctional behavior.

It is common to develop and provide protective factors as a method to offset risks. A list of potential protective factors is presented below. This list is based on methods that are felt to be useful to combat undesired outcomes from victimization, and not on specific outcome studies.

1. Provide protection from abuse experiences including treatment of sex offenders to prevent further victims.
2. Allow victims to validate the harm and trauma that results from their experiences of neglect and sexual or physical abuse.
3. Hold past victims responsible for any acting out or inappropriate behaviors they display.
4. Establish prevention and early intervention programs for substance use and other addictive disorders identified in abuse victims.
5. Reduce the availability of substances in communities and provided treatment for those with addictive disorders.
6. Ensure that early assessment and treatment is provided for any person who commits a sexual offense, regardless of age, sex, or circumstance.
7. Promote positive caregiver relationships by presenting classes or training for parents and professionals.
8. Provide support and therapy when loss of a significant caregiver is experienced.
9. Improve the availability of models or methods that display or teach appropriate coping.

Tribes and communities can potentially alter the course that a person follows from being a victim to becoming an offender by reducing risks and increasing protective factors. The next section of this monograph addresses how to develop an outpatient treatment program for sex offenders. This section is designed to give information that can be used to protect other potential victims once a person has been identified as a sex offender. Such an effort is based on understanding the treatment response and re-offense issues presented in the second section of this monograph. An outpatient sex offender program also requires developing community support and cooperative efforts between agencies.

Developing an Outpatient Sex Offender Treatment Program

At least four areas need to interact positively to develop an outpatient sex offender treatment program. These areas are the legal, social welfare, mental health systems, and the community at large. Other areas of consideration are likely to become important in specific communities or reservations.

For the purpose of the present discussion, the legal system will be defined to include Tribal and other governments, law enforcement, and the courts. The first issue to understand in the legal system is what jurisdictions are present and to ensure that a tribal code is in place to cover adult and juvenile sex offenses. Agreements regarding prosecution may need to be formed in areas where tribal and federal jurisdiction co-exists. The second need is to gain support form the Tribal Council and Tribal Government. It may be helpful to request a resolution detailing the program that is to be developed, the reason(s) or need for the program, and goals that the program seeks to accomplish.

Training is a second area to consider. Individuals likely to require training include law enforcement personnel, judges, tribal prosecutors, public defenders or defense attorneys, and probation or court services workers. The content of this training should focus on two needs. One is how the community can be protected and risks reduced for further victimization. The other need is ensuring that the rights of anyone accused of a sexual offense are fully protected. Balancing the desire to protect victims or potential victims with protecting the rights of those accused can become a difficult and frustrating process.

The social welfare or social services system generally provides support services to victims and families. These systems may also provide some types of supervision for young offenders. In most locations, social services is responsible to investigate alleged abuse and neglect, and to take measures to protect victims. Workers from this area often become involved with the placement and care of sex offenders that are still minors under the law. They provide necessary and valuable resources to help families adjust to the changes and stress of a sexual offense, and they are often instrumental in helping the families re-unite after an incest offense has taken place.

Mental health systems generally provide assessment and treatment for victims and offenders. Some agencies serve only victims or offenders, but in isolated areas or where few providers are available both victims and offenders are often treated by the same agency. This dual role can be difficult and stressful for providers and patients. Training for mental health personnel is the key element to address when starting an outpatient sex offender treatment program. The areas necessary for training include balancing the role of treating victims and offenders, assessment needs for both populations, appropriate treatment, and coordination with other community programs.

This monograph will only address the assessment and treatment of sex offenders. Balancing the service delivery for victims and offenders, and the assessment and treatment of victims will not be discussed. Assessment issues for American Indian sex offenders will be addressed in this section. Treatment methods for these sex offenders are detailed in the next section.

Evaluations of sex offenders are generally court ordered, or requested by the defense attorney. Anyone completing sex offender evaluations should be aware of reporting requirements for abuse and neglect in their location, and they should make the alleged offender aware of these requirements as a limit in confidentiality. Releases of information should be designed and gained for any evaluations that are to be shared with defense attorneys, and the impact of court orders on releasing information should be understood and communicated to the person being evaluated by the mental health professional.

Proficient sex offender evaluations need to include the use of a specific protocol, objective measurement of sexual arousal, methods to distinguish between acceptable sexual behavior and sex offenses, and alignment with ethical guidelines or standards. The evaluation protocol should involve identifying information and summaries of the alleged sex offense from both the victim and offender's point of view. Historical information on the alleged offender should include areas such as education, employment, daily activities, psychiatric treatment, family, legal, and medical. A mental status examination, history of abuse as a victim, psychological testing, and a sexual history are also needed.

Collateral information such as interviews with the alleged victim(s) and investigative reports are generally used to obtain the content of the offense from the victim's perspective. The same evaluator rarely completes interviews of the alleged victim and the alleged offender. A sexual history should involve chronological information about sexual awareness and ages when specific sexual behaviors began such as romantic kissing, masturbation, petting, and intercourse. Areas of sexual interest need to be questioned and a behavioral timeline developed for any inappropriate behavior. Additional areas of inquiry are the content and frequency of sexual fantasy, impact of sexually explicit material and substance use on arousal, and areas of sexual dysfunction.

The sexual history should detail specific sexual behaviors the person has completed and found to be pleasant, desirable, or likely to be repeated. These behaviors represent the person's sexual response pattern and begin to give information about sexual deviancy. Standard areas of inquiry are kissing, touching the clothed or naked breast of a partner, making oral contact with a partner's breast, genital touching, active and passive oral sex, anal stimulation, anal intercourse, and vaginal intercourse. The number of sexual partners should be obtained as well as specific characteristics of these partners such as marital status, age, and sex. It is usually helpful to question sexual fantasy or attraction for females and males less then twelve years of age, between thirteen and fifteen years of age since age of consent for sexual activity is usually sixteen, and by various age ranges across the life span including the elderly. Questions may need to be modified depending on the age of the person being evaluated.

Other specific areas should be questioned and reported in the sex offender evaluations. These areas include unusual masturbation practices, wearing female clothing, watching people disrobing or having sex, watching strip-tease shows, telephoning an unknowing female to talk about sex, rubbing against an unknown female in public, touching or attempting to touch a female in a lonely place such as in an alley, trying to have sex with someone against their will or with someone that could not consent, public masturbation, exposing his penis in public, or any other sexual behavior they feel is unusual or inappropriate.

The assessment areas noted above are all based on self-reports and subject to attempts at giving misleading information or distortions. More objective measures are available to determine if a person is accurately reporting sexual behavior and interests. Such measures should be included in sex offender evaluations. Psychological tests are not available for this purpose (Murphy & Peters, 1992, and Marshall & Hall, 1995), but psychological testing can help identify disorders that may impact offending behavior or require treatment. The three objective measures that are available are Penile Plethysmography, Polygraph examinations and the Abel Assessment for Sexual Interests (Abel, 1996). Referrals are generally necessary to have Plethysmograph and Polygraph examinations completed. Mental health professionals can obtain training to complete the Abel Assessment, or referrals can be arranged to gain this information. These three measures are controversial and must be used with caution.

Individuals who complete sex offender evaluations need to align with ethical guidelines or standards. The Association for the Treatment of Sexual Abusers (ATSA) is an international non-profit organization that has developed and published ethical standards and principles for the management of sexual abusers (1997). These guidelines recognize that a primary purpose in the evaluation and treatment of sex offenders is to protect the community. Sex offenders are generally manipulative and deceptive, and they are involuntary patients. Mental health professionals who wish to become involved with these patients need specific training. They should begin training with someone that is recognized to provide services to sex offenders, and an on-going consultative relationship is necessary until the trainee has developed the necessary skills and experience to function independently. Continuing education is then needed to maintain this competency. Tribal and other programs serving American Indians need to ensure a commitment to retaining such consultants for the time that their services are required. Once these training opportunities have been designed, an outpatient sex offender treatment program can be implemented.

The final area necessary to begin an outpatient sex offender treatment program is support from the community at large. Elders are an important area of support in American Indian communities. Some communities have Elder Societies that can be consulted, or efforts can be made to develop an advisory

committee of elders. Other areas to gain input from are education programs, youth programs, and shelters or group homes. In some locations it may be appropriate to develop a sub-committee of the child protection team that has the mission to develop and implement the outpatient sex offender treatment program. However the program is developed, those working with the victims and offenders also need support from the community that is being served. Efforts should be made to host community meetings or study groups that provide feedback about satisfaction with the services and ways that the services can be improved, and that recognize the efforts being made by those who provide the services.

Content of a Sex Offender Treatment Program for American Indians

Information will be presented in this section on different treatment areas for American Indian sex offenders. These areas are the need for multiple therapy approaches, areas of specific concern with American Indian sex offenders, and the use of the Life Graph procedure to allow the sex offender to identify his victim issues. Treatment efforts also require that information be shared with the offender about reporting requirements and confidentiality, and a release be obtained to give information about content and expectations of the treatment program, to share information, and to coordinate care.

Multiple Theory Approaches. Four major areas of therapy need to be considered when planning treatment for the American Indian sexual offender. They are providing cognitive-behavior therapy; substance use, abuse and dependency; attention-deficit, conduct and impulse control problems; and affective disorders. These areas are the same as would be considered when treating sexual offenders from other ethnic or cultural groups, but clinicians need to be aware of some distinct differences with the American Indian sexual offender.

Cognitive-behavioral therapy addressing specific sexual deviancy is the necessary treatment for sex offenders. Other therapies such as treatment for substance use, impulse control problems and affective disorders should be provided in addition to but not in lieu of this treatment approach. Cognitive-behavioral methods are designed to impact all areas of the sex offender's life and minimize contact with persons, places, objects, or events that stimulate deviant sexual arousal. These methods focus on areas such as fantasy reconditioning, understanding the risks and consequences of sexual offending, anger control, appropriate socialization, sex education, and arousal deconditioning. Cognitive distortions or thinking errors are addressed during the entire time that a sex offender is in treatment.

Every offender should be required to draft a relapse prevention plan before cognitive-behavioral therapy can be considered successfully completed. This plan provides information to the sex offender that allows him to self-manage deviant patterns that can result in re-offense. Cognitive-behavioral methods are designed for each offender based on his offense history to provide tools to control or avoid dangerous situations. Offenders are instructed in how to develop, maintain and employ support systems and individuals through this process.

Substance use is a second area that needs to be addressed when treating American Indian sex offenders. There are several indications that alcohol and other substance use among American Indians are at epidemic levels. Alcohol use affects entire communities, and it produces an environment of an alcoholic community. Children raised in a family setting of alcohol use display several behavioral and emotional difficulties which are recognized as a pattern often referred to as Adult Children of Alcoholics (Brown, 1988). Children raised in the "alcohol community" often show the same behavioral patterns and emotional reactions as the alcoholic. These families and communities become co-dependent on acting out, trauma, and substance use. Most of the American Indian offenders encountered will have histories of these influences. The caution in assessment and treatment is to take both a family and a community history, and to ensure that the family history includes the kinship and relationship patterns of the extended family.

Alcohol and other substances have a disinhibiting effect on behavior that can lead to an increased potential for offending or re-offending. The need to remain substance free becomes an objective in the sex offender treatment as a result. Methods such as daily monitoring, weekly therapy in group and/or individual settings, and random testing to ensure that the person is substance free are necessary. In the

American Indian population, substance use treatment often needs to be completed concurrently with offender treatment using cognitive-behavioral intervention techniques.

A third concern in addressing sex offender treatment with American Indians is impulse control. Impulse control issues in the American Indian population are impacted by exposure to alcohol during gestation. May and his colleagues (May, Hymbaugh, Aase, & Samet, 1983), estimated that prevalence rates for alcohol related birth defects among American Indians is equal to or several times higher than what is found in non-Indian populations. This makes the issues of alcohol exposure very important in assessment and treatment planning with American Indian sex offenders.

Extensive information regarding the patient's pregnancy and birth history is necessary as the facial and growth patterns associated with alcohol related birth defects have not been found to remain as distinctive after puberty, and subtle offspring effects of alcohol exposure have been found among individuals who use alcohol at a social level (Steissguth, Aase, Clarren, Randels, LaDue, & Smith, 1991). The available data do not support the conclusion that most Indian women consume alcohol while they are pregnant. Care must be taken to avoid this stereotype.

The final area of treatment planning to be addressed in this section is affective disorders. Depression has been found to be present among juvenile sex offenders with a history of abuse (Becker, Kaplan, Tenek, & Tartaglini, 1991), and among sexual offenders in general based on clinical experience of individuals involved in assessment and treatment. A high concern is present with American Indian sex offenders in clinical experience for affective disorders, including suicide and self-harm issues. In addition to depression, the offender and his family often display anxiety over the offending behavior and consequences that may be imposed, as well as panic and other anxiety responses. Efforts should be routinely made to assess treatment needs for affective disorders as a result.

A triad of depression, alcohol abuse, and destructive acting out has been documented among American Indian patients seen for mental health services (Swinomish Tribal Community, 1991). These symptom patterns can be seen as separate issues leading to treatment of the parts, but this avoids an understanding of how these parts interrelate. Care must be taken to view clusters of symptoms from the perspective of the whole person and to develop treatment plans which address all identified needs directly, rather than limiting the areas of therapy provided and making excessive referrals that serve the needs of the therapist at the expense of the patient.

Psychiatric consultation and antidepressant medication may be necessary in the treatment of American Indian sex offenders with affective disorders. Antidepressant medications are also helpful in decreasing sexual arousal, especially Selective Sertone Teuptake Inhibitors (SSRI's). Antiandrogens are another type of chemical therapy employed to reduce sexual arousal. Two drugs have been used for this purpose. They are Depo-Provea and Depo-Lupron. These medications may assist by decreasing the intensity and frequency of sexual thoughts, urges, or fantasies the patient experiences. They act by lowering the testosterone level to a pre-pubescent level, but there are several side effects such as weight gain, hypertension, night sweats and nightmares. Only physicians that have experience in monitoring the side effects should prescribe these medications. The use of these medications is based on the risk benefit ratio regarding re-offense.

Specific Areas of Concern. Many unique issues and concerns will be encountered when treating the American Indian sexual offender. It is not possible to catalog and discuss all these factors in this monograph, but five areas have been commonly experienced. These are Indian identification; differences in defining assertive, passive and aggressive behaviors; non-verbal communication patterns; the need to clarify values in dual systems of social control; and the role of shame in American Indian culture.

Being an "Indian" does not have a single definition. Indian identification areas vary for individuals. It is necessary to determine each sex offender's values and behaviors in relationship to his Indian identity. This same need is present regarding the offender's family. Brendtro, BrokenLeg, and Van Bockern (1990) provide an overview of how Indian cultural groups relate to childcare and daily living activities.

They cite a "circle of courage" which includes belonging, mastery, independence, generosity and mending the broken circle. These concepts can be identified as ways that separate "Indian thought" from how mainstream society views intrapersonal and interpersonal dialogue. The circle is broken when individuals find distorted means of expressing their values. These concepts can be directly applied to treatment with American Indian sex offenders by defining appropriate behaviors under each area of the circle.

Discussions about these areas should be completed during assessment. Any distortions found need to be considered in treatment. These distortions are addressed in the same manner as with non-Indian offenders. It is often necessary to confront these distortions with the knowledge of the traditional views of the family and/or tribal group. Information about traditional views can be gained from tribal elders and written sources. Opinions from written sources should be validated by oral stories from the community or tribal group. Many tribes have established museums and other methods of presenting their history that can be consulted. Gaining this information is part of an acculturation process non-Indian providers need to complete in order to become effective treatment providers. Indian providers may need to validate their belief patterns and knowledge in these.

The second area of concern is cultural differences between the concepts of assertive, passive and aggressive. At least three factors need to be considered in defining these areas. They are behavioral predispositions, patterns of socialization, and thought patterns or content. An excellent method of obtaining a behavioral standard for each of these areas is to consult both family and other community members to develop definitions, and then to compare these definitions to those provided by the offender while in treatment. This becomes a process of giving instruction on Indian culture and providers should qualify all opinions they express regarding source and content.

A third area of concern is non-verbal communication patterns. Non-verbal communication patterns of American Indians have been discussed in other sources. These discussions indicate that specific traditional Indian ways were much different than non-Indian behavior. One area of difference often cited is that traditional Indian ways did not involve direct eye contact. While this is a true statement in general, much has changed for Indian people. Judgments should not be made to expect certain non-verbal patterns as being present or not present because the person is an American Indian. A second often reported non-verbal pattern of American Indian people is that they tend not to show their emotions. It is more accurate to state that Indian people display their emotions and level of trust in different ways, and that these methods change depending on who is present.

Learning styles and methods represent another area of concern in relationship to non-verbal communication patterns. It is generally stated that Indian people learn in different ways and that attention needs to be given to the variables of color, sound, movement, and vision rather than limit to verbal components. Another tradition that is often cited involves learning through doing or association. However, no single learning style has been established to exist among Indian people at this time. This indicates a need to assess learning variables for each person before choosing specific materials and methods for cognitive-behavioral therapy.

A fourth area of specific concern between the American Indian offender and dominant society offenders is in values. Value clarification techniques are frequently employed in the treatment of sexual offenders. A difference exists between the two systems of social control which American Indian people are exposed. One is their identification of being "Indian" and the other is the requirements today's society place on individuals. Issues are present in this process for those treating the Indian offender. One is that you should not assume a particular identification pattern or behavioral code. Each person in treatment needs to make this choice. It is acceptable to require that choices be made in certain areas but the content of the choice must be left to the individual.

Another area regarding values is for providers to be careful of their own issues. All providers bring opinions, belief patterns, learning experiences, and life views to the treatment setting. This is often cited as the reason for training Indian people to assess and treat other Indian people. Providers that are overly sympathetic or overly opinionated are not likely to be able to confront Indian patients effectively. It is

usually best to avoid discussing the "solutions" to the problems of Indian people and focus treatment discussions on individual goals, and on the development and implementation of activities that can prevent re-offending.

The final issue regarding values is how providers identify people as "American Indian." The method recommended as the most appropriate is to allow each patient to determine his own identification and to accept the choice made. It is necessary to have the person present this identification during treatment to ensure that distortions are not included, and to have medicine people or elders available to assist in this process. Elders and medicine people can be included in treatment sessions, and they may hold traditional healing ceremonies with offenders who wish to participate.

Shame is the fifth area of special concern to be discussed. Bryde (1971) outlined five values in the culture of a northern plains tribe. He identifies these areas as the great Indian values of bravery, individual freedom, generosity and sharing, adjustment to nature, and good advice from Indian wisdom. Sharing included the two main areas of food and shelter, and praise and wisdom. Sharing shame increased the responsibility individuals had to the wider social group. This process remains active in many American Indian families and communities. It can have a positive impact on treatment of the sex offender when responsibility is focused on the offender's inappropriate behavior. An undesired impact results if it supports labeling of the sexual offense as some type of traditional behavior, or others blame themselves for the sexual offense and offer an excuse to the offender. Such undesired impacts must be confronted if they are identified.

The Life Graph. American Indian sexual offenders often have victim issues that need to be addressed in treatment as a precursor of their offense. The Life Graph is a method that has been developed to assist in this process. This technique is completed in booklet form usually employing a bound notebook of some type. The patient is instructed to arrange the notebook by years starting with his year of birth. Two pages are used for each year and these pages should be opposite each other in the notebook.

The left hand page is used to list trauma associated with each year. The right hand page is used to list healing experiences. Patients are encouraged to consult family, friends, and any records they have in completing the Life Graph. They are instructed to list important anniversary dates such as births, deaths, marriages, and divorces. Areas of the Life Graph are discussed during therapy sessions as topics correspond within the cognitive-behavioral program. The patient is encouraged to document his own sexual history in the Life Graph. This allows comparison of the history given during the initial sex offender evaluation with the history developed using the Life Graph. Patients are instructed to list the items as topics only and to use pencil so they can move items they find were listed under an incorrect year. Patients who have limited writing skills can employ this technique, and it requires less effort to write than an autobiography or journal. Patients may choose to list items in pictures, poems, or to use other methods that are consistent with how they learn and process information.

Once completed, the Life Graph is used as a reference point for alternative actions or behaviors. It becomes a source of information when the patient writes his relapse prevention plan. Patients can use this material to identify triggers and/or high-risk situations for re-offense, as well as a source for behaviors that have assisted them to cope in appropriate ways. This process helps identify when individual therapy sessions may be needed to help an offender process victim issues that are related to his sexual offense.

Summary and Conclusions

The goal of this monograph was to increase the reader's knowledge and understanding of the risk sexual abuse, physical abuse, and neglect can have on American Indians to become sex offenders. The information was presented in four sections. Topics covered included the types of sexual offenses that may take place, understanding the progression from victim to offender, considerations in starting an outpatient sex offender treatment program, and the content of a sex offender treatment program.

The available data indicates that there are specific types of sexual offenses, but no single type of sex offender. Information in this monograph was limited to male sex offenders because of the small number of female sex offenders that have been identified, treated, or studied. A major concern in understanding sex offenders is the need to comprehend sexual deviancy. This concept can be defined as meeting criterion for a clinical diagnosis of paraphilia, or as displaying sexual behavior that is unlawful by society's standards.

Research is available that indicates treatment can be successful with sex offenders. Greater success has been found with incest and juvenile offenders that have female victims. These offenders can often be managed within a community setting if they are provided with appropriate outpatient treatment. Recidivism rates are higher for individuals who begin offending early in life, those that have repeat offenses, and males who offend against males. Higher levels of sexual deviancy or criminality are predictors of higher risk for re-offense. Males that drop out of treatment or avoid treatment seem to present a higher risk for re-offending.

Several risks were presented that might predict those victims who become offenders. Abuse victims have been found to present an increased risk to commit crimes as adults, but the majority of childhood sexual abuse victims do not commit crimes. This risk can be offset by providing protection from abuse experiences, including treatment of sex offenders to prevent further victims. Sexual abuse victims have been found to present an increased risk to be arrested for prostitution. This risk can be addressed by allowing victims to validate the harm and trauma that they experience from sexual abuse, physical abuse or neglect. Physical abuse victims have been found to present an increased risk to commit the crimes of rape and sodomy. Protective factors for this risk might include holding past victims responsible for any acting out or inappropriate behaviors they may display.

Maltreatment appears to increase the risk for someone to offend sexually. Loss of parental figures and witnessing violence in the home may also increase the risk for future sex offenses. Therapy for maltreatment experiences may help reduce this risk along with providing support when children experience significant losses in their life. Therapy should also be provided to children who witness others being abused. Parenting classes and training for professionals that promote positive caregiver relationships represent another area of protective factors to prevent those who have been abused from abusing.

Substance use has been found to be a risk factor for sex offenses. Protective factors for this risk include establishing prevention and early intervention programs for substance use and other addictive disorders identified in abuse victims, reducing the availability of substances in communities, and providing treatment for individuals who have addictive disorders. Evidence has suggested that when a perpetrator is not held responsible for offending, their victims may have an increased risk to become a future sex offender. This risk factor can be addressed by ensuring early assessment and treatment for any person who commits a sex offense regardless of their age, sex, or other circumstances. Part of the intervention program should be some type of involvement with the court system to reinforce the fact that inappropriate sexual behavior is criminal behavior.

Ineffective coping appears to be another risk factor for committing sex offenses. Protective factors from this risk involve improving the availability of models or methods that display or teach appropriate coping. Communities should approach developing such methods from different perspectives and focus on historical factors or needs assessments from their community or reservation.

Developing an outpatient sex offender treatment program requires cooperation between the legal, social welfare, and mental health systems, as well as community support. The most important part of this process is teaching mental health professionals to complete proficient assessments of sex offenders. This effort will generally require some type of consultive arrangement and an ongoing process of training from someone who is credentialed in the evaluation and treatment of sex offenders. Mental health professionals must learn to complete a detailed history of the person and a comprehensive sexual history

including objective measurements. Another area of assessment need is to identify victim issues that sex offenders present as a precursor to their inappropriate sexual behavior.

Individuals who are training to evaluate and treat sex offenders will gain expertise over time. They should align themselves with some type of national or local organization that provides training standards and ethical guidelines. The Association for the Treatment of Sexual Abusers (ATSA) is an international non-profit organization that has addressed these issues. Membership in this organization is likely to enhance the training mental health professionals receive in the assessment and treatment of sex offenders.

Cognitive-behavioral therapy is the primary therapy needed in treating sex offenders. Treatment plans should include methods that address and provide therapy for other co-morbid areas such as substance or other addictions, impulse control, and affective disorders. These treatments should be provided as an adjunct to sex offender therapy and not in lieu of such therapy. Medications are also used in the treatment of sex offenders. Common medications include antidepressants that have a side effect of reducing sexual arousal, and antiandrogens that reduce sex drive by reducing testosterone levels. Several specific areas of concern in the treatment of American Indian sexual offenders were outlined in this monograph. These areas should be considered and reviewed by providers who are treating American Indian sex offenders.

The most important information to remember from this monograph is that most abuse victims do not become sex offenders. Indian tribes and communities can reduce the potential for abuse victims to become sex offenders by controlling risks and increasing protective factors when victimization has taken place. The greatest single need in this process is for professionals at the local level who can provide assessment and treatment for victims and sex offenders. The available information indicates that sex offenders can be effectively treated. Effective treatment requires appropriate selection factors through assessment that identifies individuals who can be managed at the community level. Other sex offenders will require incarceration and long-term treatment. Treatment completion is necessary, along with monitoring by the legal system. The greatest benefit of sex offender treatment may be the potential to break the cycle of abuse and prevent further victims.

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RESOURCES

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http://www.ojp.usdoj.gov/ovc

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800-627-6872
http://www.ncjrs.org

Center on Child Abuse and Neglect
CHO 3B-3406
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