**Section 1905.100 Treatment Methods**

a) Treatment providers working with sexual abusers shall utilize empirically supported methods of intervention. Recommended methods include structured, cognitive-behavioral, and skills-oriented treatment approaches that target dynamic risk factors.

1) Treatment providers deliver services to clients using a variety of modalities, including individual, family and group therapy, that are matched to each client's individual intervention needs and responsivity factors.

2) Treatment providers assist clients with identifying and analyzing the individual's factors (e.g., environmental, cognitive, affective and relational) that increase the individual's vulnerability to engage in sexually abusive behaviors.

3) Treatment providers use cognitive-behavioral techniques, at the earliest opportunity, to help clients develop and rehearse strategies (i.e., avoid or escape high risk situations, use adequate coping skills) to effectively manage situations that may increase their risk of sexually abusing or otherwise reoffending.

4) Treatment providers use behavioral methods, such as education, prosocial modeling, skill practice, rehearsal of strategies, redirection and positive reinforcement, to teach or enhance skills that will help clients achieve prosocial goals.

5) Treatment providers encourage clients to practice the skills they learned in treatment and ensure that these skills generalize to clients' environments.

6) Treatment providers assist clients in developing individualized strategies and plans for effectively managing their risk of sexual abuse or other harmful or illegal behaviors. These plans include specific strategies for avoiding or limiting access to potential victims, recognizing and coping with risk factors, and building social support systems.

7) Treatment providers assist clients with identifying and enhancing prosocial interests, skills and behaviors that the clients themselves seek to enhance or attain (i.e., approach goals that are oriented toward a nonoffending lifestyle), as opposed to strictly focusing on managing inappropriate thoughts, interests, behaviors and risky situations (i.e., avoidance goals).

b) Dynamic Risk Factors

Treatment providers shall focus treatment interventions primarily on research-supported dynamic risk factors that are linked to sexual and nonsexual recidivism (i.e., criminogenic needs) over factors that have not been shown to be associated with recidivism, as outlined in this subsection (b).

1) General Self-regulation

A) Treatment providers assist clients in learning to self-manage emotional states that support or contribute to their potential to sexually abuse.

B) Treatment providers assist clients in learning and practicing problem-solving and impulse control skills.

C) Treatment providers assist clients in obtaining appropriate services for evident problems related to the clients' mental health and substance use patterns.

2) Sexual Self-regulation

A) Treatment providers use cognitive-behavioral, behavioral and/or pharmacological techniques to promote healthier sexual interests and arousal, fantasies and behaviors oriented toward age-appropriate and consensual partners.

B) Treatment providers use cognitive-behavioral, behavioral and/or pharmacological techniques known to be associated with:

i) reductions in sexual preoccupation (paraphilic and nonparaphilic) and deviant sexual interests and arousal; and

ii) improvements in the management and control of sexual impulses.

C) Treatment providers target cognitions that are supportive of age-inappropriate and nonconsensual sexual interest, arousal and behavior in order to assist clients in enhancing their sexual self-regulation.

D) Treatment providers help clients find effective ways to minimize contact with persons or situations that evoke or increase clients' deviant interests and arousal.

3) Attitudes Supportive of Sexual Abuse

A) Treatment providers recognize that client attitudes and beliefs that are tolerant of sexual abuse (e.g., women enjoy being raped, children should be able to make up their own mind about having sex with adults) are important treatment targets.

B) Treatment providers:

i) use established cognitive therapy techniques to strengthen attitudes, beliefs and values that support prosocial sexual behaviors; and

ii) help clients manage or decrease those that support sexually abusive behavior.

C) Treatment providers are aware that, although clients may hold attitudes, beliefs and values that are unconventional but unrelated to their risk for sexually abusive or criminal behaviors, these attitudes, beliefs and values are not deemed appropriate primary treatment targets.

4) Intimate Relationships

A) Treatment providers assist the client in the development of skills that can enable the experience of prosocial intimate relationships with adults. Treatment providers orient their interventions so that they build on strengths in the client's existing relationships, when appropriate.

B) Treatment providers aim, when possible and appropriate, to include adult romantic partners in treatment in order to maximize treatment gains and enhance prosocial lifestyles.

5) Social and Community Supports

A) Treatment providers encourage and assist clients in identifying appropriate, prosocial individuals who can act as positive support persons.

B) Treatment providers encourage family members and other support persons to actively participate in the treatment process and to help clients achieve and maintain prosocial lifestyles.

C) Treatment providers assist clients who are transitioning to the community or are already in the community to develop and maintain stable prosocial lifestyles, which are characterized by stable and appropriate housing, employment and leisure activities.

D) Treatment providers recognize that developing a support network may be contraindicated with clients who have a history of violence toward support persons and have not been violence-free for a significant amount of time. Hence, treatment providers encourage clients to make small and gradual changes and closely monitor these changes to ensure clients are receiving or have received interventions to address these issues and reduce the risk for violence.

6) Treatment providers may, as warranted for a given client based on a comprehensive assessment, also include treatment targets that are not clearly established by research to be dynamic risk factors (e.g., denial and minimization, low self-esteem) but that, when addressed, enhance therapeutic alliance, treatment engagement and treatment responsiveness.

c) Treatment Engagement and Goal Setting

1) Treatment providers shall strive to foster clients' engagement and internal motivation at the onset, and throughout the course of, sexual abuser-specific treatment, recognizing that these process-related variables enhance treatment responsiveness and outcomes.

2) Treatment providers recognize that, although many clients present for sexual abuser-specific treatment as direct result of legal or other mandates, external motivators alone are generally insufficient for producing long-term change among clients.

3) Treatment providers provide services in a respectful, directive and humane manner and facilitate a therapeutic climate that is conducive to trust and candor.

4) Treatment providers recognize that client engagement may increase, and resistance may decrease, when the treatment provider and client are in relative agreement about treatment goals and objectives. To the extent possible, treatment providers involve clients in the development of their treatment plans and in the identification of realistic goals and objectives.

5) Treatment providers clarify, at the onset of sexual abuser-specific treatment, the client's understanding of the problems for which the client referred to treatment and that primary treatment objectives are often specific to modifying deviant sexual attitudes, interests, arousal and behaviors.

6) Treatment providers are aware that clients present with differing levels of internal motivation to change (and varied types and levels of denial and minimization related to sexually abusive behavior, interests, arousal and attitudes and beliefs), but that such characteristics do not preclude access to treatment.

7) Treatment providers recognize that denial and minimization may impact the client's engagement in treatment, but that the influence of denial and minimization on sexual recidivism risk has not yet been clearly established and may vary among client groups.

8) Treatment providers support the client in being honest in discussing the client history and functioning, but acknowledge that it is not the role of treatment providers to attempt to determine or verify a client's legal guilt or innocence or to coerce confessions of unreported or undetected sexually abusive behaviors.

9) Treatment providers are aware that attempting to provide treatment for problems that a client persistently denies having results in limitations in making reliable clinical recommendations about the individual's treatment progress and re-offense risk, and that this has ethical implications.

10) Treatment providers routinely seek and explore the client's perspectives and offer feedback on the client's engagement, motivation and progress in treatment, or lack thereof.