The Treatment of Male Sexual Offenders with Co-Occurring Disorders through an Adlerian Perspective

A Literature Review

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Abstract

The aim of the current paper is to provide information in support of the use of Adlerian Therapy concepts within the current interventions used in sex offender treatment. The definition of a sex offender will be stipulated, an explanation of the characteristics of a sex offender, their behavior, and the elements of risk will be satisfied. Recidivism rates and the reentry conditions will be appraised. Co-occurring disorders and the implication with sex offenders will be defined. The principles, etiological assumptions and general treatment implications of Cognitive Behavioral Therapy, Relapse Prevention Model, Self-Regulation Model, Risk Needs Responsivity Model, Good Lives Model, and the Transtheoretical Model will be furnished. The negative and positive features, as well as the efficacy of each model, will be evaluated. A detailed account of the Adlerian perspective, principles, counseling interventions and the viewpoint of both the criminal and sexual behavior of offenders will be analyzed. Through research of published literature, the paper postulates that the use of the Adlerian lifestyle techniques will be critical in the positive treatment of sexual offenders. Finally, this paper will discuss suggestions for providing effective therapy to specifically male sex offenders, the impact on this career path may have on clinicians and recommendations for future research.

Keywords: sexual offenders, co-occurring disorders, treatment models, Adlerian, psychology
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Kimberly Apel
Dedication

I dedicate this thesis to my children who always showed me support and inspired me to be a better person. I am eternally grateful.
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The Treatment of Male Sexual Offenders with Co-Occurring Disorders through an Adlerian Perspective.

A sexual offender is defined as an individual who has committed a socially unacceptable deviant sexual act that is punishable by law. Sexual offenses include rape, incest, molestation, voyeurism, exhibitionism, deviant fetishism, frotteurism, and child sexual abuse (Laws & O'Donohue, 2008). According to the National Center for Missing and Exploited Children (NCMEC), there are 747,408 registered sexual perpetrators in the United States (Boccaccini, Harris, & Rice, 2017). Recent studies have shown that providing treatment for sexual offenders results in a decrease in recidivism (Duwe, 2015). Defining the criteria that constitute a sex offender is important because of the various types of perpetrators, and their offenses are compiled into uniformed categories the reasons for recidivism becomes disguised and incommensurable. Sex offenders are a sundry mixture of individuals who have engaged in a wide range of other criminal sexual behaviors, committed brutal sexual assaults against strangers, engaged in incestual behaviors, and molested children (Center for Sex Offender Management, 2006). The compiled data depicts that numerous sex offenses are left unreported to authorities. The younger the victim, the less likely that the offense will ever be reported, leaving the perpetrator unaccountable. Even when reported, only a fraction of sex offenses result in prosecution by the current judicial system (Przybylski, 2015). Numerous studies conducted by The National Crime Victimization Surveys characterized that only 1 out of 3 (32%) sexual assaults committed against individuals age 12 or older are conveyed to law enforcement. Kilpatrick, Edmunds, and Seymour (1992) conducted a three-year longitudinal study that surveyed 4,008 adult females. They found that 84% of the surveyed women did not report that they had been raped by the authorities. Currently, there are not any studies that indicate the rate
of reporting child sexual assaults; however, it is commonly presumed that these assaults are correspondingly underreported.

The victims of sexual assault frequently don’t report the attack because they fear further victimization or another form of retaliation by the offender. Family and friends of the offender may also further persecute the victim. In the cases that involve sexual abuse by a family member, the victim may not report for fear of being the cause of the perpetrator being arrested, prosecuted, and incarcerated. Victims may also fear that they will be accused of lying and endure further victimization by the judicial system (Center for Sex Offender Management, 2006).

The diverse population of sexual predators is often labeled as having antisocial behaviors (Looman, Abracen, & Di Fazio, 2014). The antisocial behaviors may include but are not limited to impulsivity, substance abuse, unemployment, and aggressiveness (Gottfredson & Hirschi, 1990). When a person feels their life is lacking in some tangible or intangible area, they often seek to fill the perceived void. For sexual individuals who have offended, filling that emptiness is temporarily achieved when they perpetrate (Duwe & Goldman, 2009). The prognosis is ultimately dependent upon the individual’s willingness to make and maintain a commitment to prosocial change (Duwe, 2015). Some may choose never to recover, and others will incorporate the information that is provided in psycho-educational classes addressing relationships, social skills, and addiction to use as stepping stones toward personal growth. The positive outcome of their efforts and progress in treatment is that the circle of violence is broken, and the generation of healing can begin (Hewitt & Beauregard, 2013).

Currently, much of treatment interventions delivered to sex offenders tend to comprise primarily one method of action. Using one model is not useful because it implies that all persons who have sexually offended are the same instead of recognizing the individualized factors that
led to their choice to offend. Treatment programs would benefit from adapting to implement
treatment plans that address the specific risk factors of each. This approach should utilize
concepts from many models and apply the topics of treatment from an individualized person-
centered approach that encourages the change process.

**Statement of the Problem**

Current sex offender treatment lacks unified programming that effectively addresses co-
occurring disorders (Yoder & Caserta, 2018). The use of substances by persons who have
offended has been revealed sexually manipulative behavior and an increase in physical
aggression during offending (Yoder & Caserta, 2018). Neurobiological evidence confirms that
traumatized individuals, such as sex offenders, attach increased attention on external rather than
internally on their own experiences which has limited the benefit of conventional treatment
methods (Levenson, Willis, & Prescott, 2016). Evaluating the current treatment modalities
utilized to treat sexual offenders with co-occurring disorders, we see that by applying an
Adlerian perspective, we further encourage a positive person-centered approach to create a safe
environment that is both goal-oriented and humanistic (Duwe, 2015). The sex offender is
inspired to form a better self-understanding; lower their levels of defensiveness, guilt, and
insecurity; and, develop and cultivate healthy and affirmative relationships with others. The
productive environment increases the capacity to experience and express emotions as they occur.
Restoring hope and trust are cornerstones of an effective treatment program which benefits
society by creating a safer community.

**Purpose Statement**

The purpose of this paper is to define the parameters of a typical sex offender and the
current treatment programs that serve them. Incorporating Adlerian therapy with the current sex
offender treatment methods will promote a safe and encouraging environment that is both goal orientated and humanistic. The treatment provided encourages the individual to form better self-understanding, lower levels of defensiveness, guilt, and insecurity while establishing positive and comfortable relationships with others.

**Theories of Sexual Offending Behavior**

A scientific theory of human behavior is developed to describe an unobservable phenomenon for the means of explanation and prediction. Research have developed multiple theories and models for understanding the start, progression, and maintenance of sexual based offending behavior (Ward & Beech, 2006). Issues involving biological, psychological, and cultural composition of the offender have been the focus of empirical and theoretical research that has yielded a comprehensive understanding of sexual offending (Cleary, 2004). Defining the offending dynamics of sexual abuse is complex and illustrates a contrast of etiological conduits which led the individual to offend sexually. The causes of sexual abuse are found to be a result of genetic predisposition, adverse developmental experiences (abuse, rejections, and attachment difficulties), psychological dispositions or trait factors (emotional deficits and interpersonal problems), social and cultural structures and processes, and contextual factors (intoxication and severe stress) (Freeman-Longo & Blanchard, 1998). Sexual abuse occurs because of issues that are deeply rooted within a network of causal, biological (evolution, genetic variations, neurobiology), ecological (social, cultural environment, personal circumstances, physical environment) and core neuropsychological variables (Ward & Gannon, 2006).

Sexual offending is explained when the three areas of biological, ecological role and neuropsychological factors converge on an individual. Biological factors are explained by the influence of genetic inheritance and the person's brain development. The ecological factors
encompass culturally, learned, and personal environments. Neuropsychological factors include brain damage and dysfunction (Harris, Mazerolle, & Knight, 2009). Further arguments add that an offender’s genes, social learning, and neuropsychological systems combine as clinical issues evident by deviant sexual arousal, offense-related fantasies and thoughts, positive and negative emotional states, and social difficulties (Goldstein, 2007). Clinical symptoms are evident by difficulty in the regulation of emotions and behaviors, need for intimacy/control, offense supportive cognitions, and deviant sexual arousal which directly correlates to sexually abusive behavior (Thornton, 2013).

Treatment for individuals who have sexually offended requires knowledge of sexual deviance, human sexuality, antisociality, and education surrounding sex offender treatment strategies and assessment (Hewitt & Beauregard, 2013). In theory, brain development (influenced by biological inheritance and genetics) and social learning interact to establish an individual's level of psychological functioning (Freeman & Urschel, 2003). An individual’s functioning may be compromised in some way by poor genetic inheritance, biological damage, or developmental adversity which makes it difficult for the individual concerned to operate adaptively. Inept functioning leads to the problematic psychological functioning and subsequent clinical symptomatology (Freeman-Longo & Blanchard, 1998). The integrated theory of sexual offending provides a clinically useful framework for the assessment and treatment of sexual offenders (Ward & Beech, 2006). Its ability to account for multiple offense trajectories and varying clinical presentations means that it will help clinicians to focus on the offender's unique problems (Sandhu & Rose, 2012). The abstract nature of the integrated theory of sexual offending allows for variety in the types of goals, strategies, contexts, beliefs, emotions, and biological factors involved in different sex crimes.
Co-Occurring Disorders

Treatment for persons who have sexually offended begins with the individual developing the capacity to identify issues associated with mental illness, trauma, and substance abuse (Evans & Sullivan, 1990). This system provides well-rounded therapy focused on healing the whole person to lower risk and increase positivity (Evans & Sullivan, 1990). The term co-occurring is used to describe individuals who have been diagnosed or meet the diagnostic criteria for a substance use disorder, along with one or more mental health conditions (American Psychiatric Association, 2013). In the past, the terms dual diagnosis or dual disorders were used to describe individuals with multiple classified symptoms. A substance use disorder includes alcohol or drug abuse and dependence which impairs an individual’s functioning at work, at school, and in social relationships (Substance Abuse and Mental Health Services Administration, 2005).

Individuals diagnosed with co-occurring disorders often experience more severe and chronic medical, social, and emotional issues than an individual who presents with one treatment issue (Braslow, Fenwick, Guerrero, & Padwa, 2015). They tend to be more vulnerable to substance abuse relapses which will often magnify their mental health symptoms and may express hopelessness or helplessness which intensifies the addiction and increases the likelihood of relapse when the individual attempts to self-medicate. When conducting treatment with those who have co-occurring disorders a high relapse prevention plan needs to be developed (Finkelstein et al., 2015). Co-occurring individuals often experience more frequent and severe crises, and progress at a much slower pace in a treatment program (Substance Abuse and Mental Health Services Administration, 2005). Disorders that commonly affect the mood are widely found in individuals who are experiencing addiction. Additionally, it is even more common for
people with co-occurring disorders to be diagnosed with a severe mental illness (Substance Abuse and Mental Health Services Administration, 2014).

Adler believed that individuals who demonstrated feelings of inhibition, oversensitivity, intolerance, petulance, preferred isolation, and neurotic symptoms such as anxiety, depression, and sexual insufficiency suffered from emotional and mental health problems (Dreikurs, 1990). The Adlerian theory would suggest that these individuals were likely to develop a substance use disorder as a method of coping with the resulting feelings of inferiority (Ansbacher & Ansbacher, 1964). Research has shown that individuals who experience mental health disorders are known to self-medicate by abusing drugs and alcohol to mitigate symptoms (Peters & Rojas, 2016). In effort to reduce recidivism, ensure community safety concerns, and empower treated sex offenders co-occurring services would prove beneficial (Braslow et al., 2015).

There is an increase in incarcerated individuals with substance abuse issues and psychosocial problems which contribute to the offending behavior (Lemphers, Ogloff, Simmons, Talevski, & Wood, 2015). A significant challenge in providing appropriate treatment within the justice system has been a combination of the assessment process, person-specific interventions, and qualified clinical supervision (Bowman & Travis, 2012). Offenders are a diverse culture who differ a multitude of areas such as: choice of substance, origin of disorder, method of treatment, symptoms, collaborative effects of existing conditions, history of criminal behavior, diminished functioning, and the number of healthy support persons available in their life (Hewitt & Beauregard, 2013).

A history or presence of mental health issues and the use of psychotropic medication increase the likelihood of a co-occurring disorder diagnosis. Many areas pose a higher risk for substance abuse. These include being male, young, poor family connections, family history of
mental health and substance abuse, homelessness, criminal behavior, emergency medical treatment (DiClemente, NiDecker, & Bellack, 2008). An individual who exhibits any of these characteristics also tends to pose a higher risk of violent and aggressive behaviors, increased recidivism, failed treatment attempts, as well as other objectionable actions (Evans & Sullivan, 1990). Offenders who exhibit one or more of the above-listed characteristics should be carefully screened for co-occurring disorders. Re-evaluations should be consistently conducted at intervals during their incarceration for both substance abuse issues and mental health concerns. As dynamic and static factors may emerge, the probability increases for a co-occurring disorder. Offenders who experience co-occurring disorders have ineffective involvement in treatment, lower rates of medication compliance, higher risk of hospitalizations, heightened risk of suicidality, and impairments in social interactions (Evans & Sullivan, 1990). Difficulties in these areas are reflected in a history of problematic employment, erratic relationships with family and community, and serious physical health issues. These perpetrators lack an active social support network or significant interpersonal connections, which has been proven to substantially increase their success in treatment and in leading a prosocial lifestyle (Edens, Peters & Hills, 1997).

Offenders have at least one underlining issue that they are attempting to manage by acting on addictive behaviors. These issues can vary but may include mental health problems, chemical imbalances, and emotional dysregulation (Edens, Peters & Hills, 1997). A practical part of the healing process is learning to replace the unhealthy harmful behavior with healthy prosocial behavior. It is pertinent to identify, accept, and treat the underlining issue by developing skills to be able to maintain a consistent positive lifestyle. A person identifies and learns methods to maintain health through self-evaluation, therapy, and psycho-education. There is a complex relationship between interpersonal violence and substance abuse disorders
An individual may experience trauma indirectly by being witness to the event or have direct involvement such victimization. In its simplest terms, trauma is defined as any event that causes a person a degree of emotional distress. Studies have indicated that persons who have offended have a history of early traumatic events in their lives (Levenson, et al., 2016). The response to trauma is often intense fear, horror, and feelings of helplessness. The body’s physical response to trauma is to fight, flight, or freeze this reaction results in a wide array of feedback within the body (Levenson, 2014). Traumatic experiences can persist and manifest into lasting effects on the individual’s ability to function physically, socially, and emotionally along with the impact on their spiritual well-being. Offenders often develop high risk behaviors in effort to deal with the increased stress of abuse (Levenson et al., 2016). To generate growth, it is important first help the individual identify the triggers, process them, and move through the existing crisis (Levenson, 2014). When people can visualize and comprehend achievable goals, hope is established and can be incorporated into a treatment plan. Hope creates a forward movement that is beneficial to the progression of the treatment plan (Oberst & Stewart, 2003). Understanding co-occurring disorders is critical in many areas because each issue will affect the other parts of the physical being and the individual's environment. When a person with co-occurring problems is in crisis, their internal battle can resemble a tug of war. Their mind, body, and spiritual health are comprised which can become toxic and lead to offending behaviors (Finkelstein et al., 2015).

The residual effects of addictive substances often hinder the accuracy of assessments and can frequently disguise or simulate psychiatric symptoms. Severe depression and anxiety can delay conventional forms of immediate treatment hospitalization and require intensive mental health services (Peters & Rojas, 2016). Those offenders diagnosed with co-occurring disorders
don't fully engage in treatment because of their tendency to rationalize negative conduct, blame others for their problems, reluctance to trust authority, and sudden changes in their psychiatric symptoms because of the elimination of their chosen coping mechanism. (Edens, Peters & Hills, 1997) The presence of a co-occurring disorder may also inhibit the offender’s ability to fully comprehend the effects of using substances and how they contribute to their behavior. Treatment communities utilize standard approaches to treat both sex offenders and substance abusers individually (Gottfredson & Hirschi, 1990). The Good Lives Model is best used in a community setting. Therapeutic communities are intended to replicate the individual’s lifestyle and encourage them to challenge their belief system and apply a prosocial behavior within a group or social setting (Willis & Ward, 2011).

**Recidivism**

Recidivism is defined as the execution of a consequent offense by an offender that results in a new arrest, new custodial commitment, and a new conviction (Center for offender Management, 2001). The increased number of convicted sex offenders currently living in our communities has revived the attention of policymakers and the criminal justice practitioners, about the issue of recidivism (Przybylski, 2015). Intervention strategies utilized in the treatment of sex offenders are developed by using research that is focused on recidivism (Center for Sex Offender Management, 2006). Thus far the accuracy of the data can be somewhat prejudiced for many reasons. The recidivism rate of persons who have sexually offended is problematic to quantify because of the devious nature of sex crimes, low report rates, and the way in which data is analyzed varies depending on the individual researchers (Przybylski, 2015).

There are a variety of questions surrounding the handling of sex offenders in both correctional and community settings (Przybylski, 2015). The primary concern is the risk these
individuals place on the safety and well-being of the community. The topic of persons who sexually offend commonly provokes feelings of anxiety, fear, and panic from the public. The perception that communities require protection from sex offenders through incarceration and surveillance habitually dominates the prospects that treatment can also provide public safety (Hanson & Lee, 2016).

Langan, Schmitt, and Durose conducted the single largest study of sex offender recidivism in 2003 (as cited in Fazel, Sjostedt, Langstrom, & Grann, 2006). Their research included the patterns of 9,695 convicted male offenders. The study concluded a sexual recidivism rate of 5.3% over a three-year period. The general recidivism rate significantly increased at 17.1% and 43% correspondingly. In general, that means that 4 of every ten persons who sexually offend were incarcerated again within three years because of committed a new crime or violated the conditions of their release. Langan, Schmitt, and Durose (2003) reasoned that of the offenders they studied, sex offenders were less likely (43%) than other criminals (68%) to be re-arrested for non-sexual crimes (as cited in Fazel, Sjostedt, Langstrom, & Grann, 2006). However, their re-arrest rate for sex offenders committing another sexual offense was four times higher (5.3%) than the rate for offenders (1.3%) that had a non-sexual offense (Przybylski, 2015). The treatment programs currently in use have been correlated to decreased rates from 17.4% to 9.9% of sexual recidivism (Abracen, Ferguson, Harkins, Looman, & Mailloux, 2011).

Offenders diagnosed with co-occurring disorders demonstrated an increased probability of recidivism (Abracen et al., 2011). These offenders are subjected to compounded judgement from society because of their criminal behavior and their mental health (Hanson & Lee, 2016). While any reoffending is of public concern, the presentation of sexual violence is particularly
important, given the irrefutable harm caused to the victim and the fear they generate in the communities. The prevention of sexual violence is of great concern to the public (Center for Sex Offender Management, 2006). In effort to reduce recidivism it is important that the empirical data supports the success of the treatment methods and the risk assessments conducted on sex offenders (Hanson & Lee, 2016).

**Offender Reentry**

About 150,000 of the 1.5 million offenders incarcerated in the Federal and State Correctional Facilities are convicted of committing a sexual offense. Of the 150,000, 60% are convicted of lewd acts committed against children, fondling, statutory rape, molestation, indecent practices, and other regulated offenses and the remaining 40% are those convicted of rape (Beck & Harrison, 2006). Reentry of persons who sexually offend into society is a uniquely hard venture because of the distinct barriers and dynamics that exist during the transition (Hamilton, 2017). The fabrications surrounding victims and sex offenders, allegations that sex offender treatment is unsuccessful, exaggerated reoffending rates, and the upsurge of exposure in the legal proceedings of predatory offenders cause distress among citizens and greatly aggravate the interest of the community policymakers (Hamilton, 2017). Reintegration efforts are greatly impacted by amplified efforts of lawmakers that explicitly attacked the sex offender population (Center for Sex Offender Management, 2006). These laws enforced the lengthening of mandatory sentences for specific sexual offenses, extended the community notification and registrations policy, which created “sex offender free” sectors within communities (Harris & Socia, 2016). The subdivisions include limiting housing, employment, and hinder their ability to travel. While these policies were put into place with the intent of creating a safe community for
both the public and offender they in turn greatly impede the outcome of successful reentry (Center for Sex Offender Management, 2006).

To take full advantage of sex offender reentry labors, it is necessary to function within an “in to out” agenda. This outline means that all authorities involved with the reentry effort have a stake in the success of the reintegration. While incarcerated the emphasis needs to be on their upcoming release (Center for Sex Offender Management, 2006). This focus would include a properly designed treatment program, educational opportunities, services, and other programs that endorses a favorable conclusion (Hamilton, 2017). Producing an atmosphere within the system that provides a healing viewpoint and shapes equivalent opportunities when in the community would encourage the potential for a prosocial lifestyle for the offenders (Center for Sex Offender Management, 2006).

Discretionary release inspires persons who offend to partake in focused services such as developing a realistic release plan including relapse prevention (Center for Sex Offender Management, 2006). These plans specifically evaluate the offending dynamics and negative thought processes that lead to offending. Relapse prevention plans encourage healing of past pain and develop interventions. During the transitional and release process, offenders are encouraged to “reach out” for services in their community and develop a plan or “roadmap for reintegration.” The support system should include services such as sex offender treatment, healthcare, mental health services, substance abuse treatment, educational services, vocational training, employment assistance, and housing assistance (Center for Sex Offender Management, 2006). A successful reentry program not only emphasizes the offender, but it must place significant focus on the victims. A victim-centered approach involves guaranteeing the development of suitable protection strategies, amenities, and care supports are established for the victims. Implementing a
success-orientated method to the post-release supervision process can increase the success rate of reentry.

**Current Approaches to Sex Offender Treatment**

Sex offender treatment is the nation’s response to a significant social concern (Kingston & Yates, 2011). Programs specific to the treatment of sexual predators became more evident during the 1980’s largely due to the Women’s Movement (D'Orazio, 2013). Over the years research has been conducted evaluating evidence-based practices to determine the results of the change within the sex offender population (Yoder & Caserta, 2018). The following section reviews and evaluates the most utilized therapeutic interventions currently used in the treatment of sex offenders.

**Cognitive Behavior Therapy**

Developed by Aaron Beck, Cognitive Behavior Therapy (CBT) suggests that an individual’s distress is caused by distorted thoughts triggered by emotional turmoil (Linehan, 1993). Studies show a history of neglect, sexual abuse, and physical abuse among convicted sex offenders (Levenson, et al., 2016). Cognitive-behavioral treatment has been shown to be effective when helping individuals develop a relapse prevention plan, an integral component of sex offender treatment. The behavioral strategies utilized in CBT assist individuals in identifying maladaptive behaviors that play a significant role in their sexual offending dynamic (Waldram, 2008). Changing the thought patterns that led to the behavior is beneficial, as is learning to weigh the consequences of their behaviors while considering the totality of the impact or ripple effect. The quality of the therapeutic relationship, goal setting, mindfulness, and structure are fundamental pieces to implementing a Cognitive Behavioral Therapy treatment plan (Duckworth
Relapse prevention (RP) is encapsulated within the structure of CBT along with enhancing victim empathy and challenging cognitive distortions (Cohen & Harvey, 2016).

The objective of the Relapse Prevention Model is to enhance the ability to manage deviant needs and compulsions (Laws & O'Donohue, 2008). Examining the behavior chain illustrates a sequence of choices including high-risk situations, internal and external triggers, negative emotionality, and lapse of self-control (Center for Sex Offender Management, 2006). When developing a relapse prevention plan a sex offender utilizes skills from CBT to develop a strategy focused on three specific aspects of skills. The first is self-efficacy which is gaining the confidence for coping with high-risk situations. The second is the development of appropriate coping skills. Lastly, Relapse Prevention focuses on an increased motivation to not reoffend (Laws & O'Donohue, 2008). During Relapse Prevention treatment, a clinician encourages the offender to create a detail recollection of the events that led to the sexual offending. It is essential to explore these details because the activating events often led to a dejected state of mind that prompted maladaptive cognitive schemas.

Cognitive reframing includes advising person who offend to identify the numerous categories of distorted thought processes they may be using, such as catastrophizing, personalizing, blame shifting, filtering, emotional reasoning, fallacy of fairness, all-or-nothing thinking, mind reading, or overgeneralization. Relapse Prevention helps to develop specific treatment management strategies that converge on avoiding the high-risk situations that the offender identified during their treatment. They then try to redirect their actions to a more communally suitable process of achieving needs. Some unassuming interventions consist of replacement behaviors, thought stopping techniques, increasing tolerance of uncomfortable distress, and encouraging adaptive support seeking (Cortoni, 2011).
Self-Regulation Model

The Self-Regulation Model was developed as an alternative to the Relapse Prevention Model. This model was established to focus on the variety patterns demonstrated by sex offenders. The Self-Regulation Model hypothesizes that there are four pathways to offending. The Self-Regulation Theory conjectures internal and external methods that permit individuals to participate in goal-focused behavior (Kingston & Yates, 2006). This model embraces the amendment of behavior to achieve goals, with an important difference made between acquisition goals and inhibitory goals. Inhibitory goals encompass avoidant orientated behavior while in contrast, the acquisition goals include behaviors intended to lead the desired outcome (Kingston & Yates, 2006). Simplified, the model postulates that an individual’s behavior is goal focused, they perform to evade an unpleasant situation or attain a chosen state.

The four pathways acknowledge the offender’s target goal (approach versus avoidance) as well as the way the offender aims to accomplish this goal (passive versus active). The first pathway is known as the avoidant-passive pathway. The offender that utilizes this pathway tries to constrain the yearning to perpetrate sexually but they lack suitable coping methods to regulate themselves (Kingston & Yates, 2006). This type of offender does not try to control the need that’s associated with sexual offending but rather is under-regulated or disinhibited (Kingston & Yates, 2006). The second pathway is the avoidant active pathway which is categorized by the want to evade offending but is misgoverned by the offender. This individual often engages in unsuccessful approaches, such as substance abuse, an an effort to accomplish their goal. The third pathway is the automatic approach pathway which is defined by goals that are stimulated by the process of offending (Kingston & Yates, 2006). The offender’s imprudent behavior is situational and guided by established cognitive and behavioral schemas. Lastly, the fourth
pathway is the approach explicit which is distinguished by the offender’s ability to demonstrate self-regulation. The early augmentation and learning experiences of the individual formed a belief system that contributed to sexual aggression (Kingston & Yates, 2006). This offender’s goal to victimize is deliberate and unambiguously planned by employing meticulous grooming techniques to manipulate the victim and commit the offense.

The Self-Regulation Model explains the different pathways that categorize persons who offend which supports that treatment plans should be individualized to each offender. The treatment plan should focus on the risk factors and dynamics demonstrated during the offending (Kingston & Yates, 2006). The level of intensity of the treatment plan would also vary depending on the pathway of the offender. For example, the individual that demonstrated an approach explicit pathway would be best served by a treatment plan that targets the attitudes that support sexual aggression and deviance. They would gain the most from high levels of supervision and monitoring by external sources in the community. An individual with the avoidant active pathway would gain the most from the Relapse Prevention Model that places importance on building skills and coping mechanisms (Kingston & Yates, 2006).

The Risk Needs Responsivity

The Risk Needs Responsivity (RNR) Model evaluates and targets specific areas of criminogenic needs (Yates, 2013). The Risk Principle specifically examines the factors prognostic to recidivism which are often defined as “static” or unchanging factors. Intervention strategies should be tailored to treat the areas and level of risk. The Needs Principle postulates that treatment planning should address only to addressing the target areas defined by the criminogenic needs. Finally, the Responsivity Principle culminates on targeting the individual's
treatment interventions to factor in their degree of motivation, individual learning style, and is considerate of their ethnic identity (Taxman & Pattavina, 2013).

One of the risks identified for sexual offending is the absence of close relationships with adults (Andrews, Bonta, & Wormith, 2011). Lack of emotionally intimate relationships with adults has been associated with deviant sexual arousal, issues surrounding attachment and emotional dysfunction. A second risk factor is an emotional identification or congruence with children. An individual with this risk factor may engage in relationships with children to be more satisfying than relationships with adults. A third risk factor is an overt hostility towards women or trust. An individual possessing this risk factor believes that females are malicious and deceptive when interacting with males. They believe that females find enjoyment from making men appear or feel foolish. They view females as deceitful and manipulative and are therefore not worthy of respect (Mann, Hanson, & Thornton, 2010). The fourth risk factor is a general social rejection including having few close and healthy friendships, feeling rejected by others, awkward social skills, or feeling undervalued by others. Individuals who experience this risk factor feel that peers do not care about them. The fifth risk factor is having a lack of concern for others including callousness towards people. These individuals demonstrate selfishness, cruelty, lack of sympathy, and tendency to engage in instrumental rather than effectively warm relationships. The sixth risk factor is impulsivity which includes being recklessness, having little self-control, chronic instability in employment and housing, as well as unrealistic long-term goals. The seventh risk factor is having poor problem-solving skills including difficulties in generating and identifying practical solutions to the problems that occur in everyday living. Having poor problem-solving skills can include avoiding problems or using ineffective behavior to address the issue (Mann et al., 2010). The eighth risk factor is negative emotionality which
includes an ongoing excessive sense of having been wronged by others or the world, and hostility towards the world. These individuals perceive that others are responsible for their behavior and deserve to be disciplined (Andrews et al., 2011). The ninth risk factor is categorized as sexual drive and preoccupation which means having an abnormally intense interest in sex, engaging in sex repeatedly for its own sake or as a way of defining the self. The tenth risk factor is sexualizing coping which means that the individual uses sexual behavior to cope with negative emotions such as anger, sadness, rejection, humiliation, and anxiety. The eleventh risk factor has deviant sexual interests which involve sexual interest in children, an attraction to sexual violence, and the presence of multiple offense related paraphilias (Andrews et al., 2011). The twelfth risk factor is negative social influences. This risk factor suggests that the peers the offender associated with supporting their choice to offend sexually. Lastly, the thirteenth risk factor is having antisocial attitudes and behavior that endorse the sexual victimization of others (Andrews et al., 2011).

**The Good Lives Model**

The Good Lives Model developed by Tony Ward is a strength-based rehabilitation program built upon the RNR theory which focuses on the risks and needs of the individual (Good Lives Model, 2015). The Good Lives Model encourages sex offenders to focus on learning the risk factors that led to offending (Jennings & Deming, 2013). Treatment based on the GLM allows the individual to thoroughly explore their unique goals, apply the change, and a safe environment to practice their new behaviors (Ward & Steward, 2003). The Good Lives Model describes that every individual seeks balance by positively addressing eleven specific goal areas to change internal and external coping skills and build confidence (Yates, Prescott, & Ward, 2010). Once they identify those factors, they can interrupt on the faulty thought pattern that
resulted in offending and creates healthy and appropriate challenges to the distortions (Jennings & Deming, 2013). The interventions are derived from the individual’s goals, aptitudes, and interests which are personal, meaningful, and targeted specifically to them (Purvis, Ward, & Willis, 2011).

The Good Lives Model focuses on evaluating the importance of the eleven primary areas and exploring the way the individual is meeting their goals to determine if their behavior is healthy, unhealthy, or criminal. The element of life, including healthy living and functioning, is defined as creating an effective, healthy presence. The element of knowledge includes the desire to gain knowledge, an understanding of self, and the world in which a person exists in. The element of excellence in play and work involves a mastery of experiences and sufficient time balance. The element of inner peace encompasses the freedom from emotional stress and a desire for clarity. The element of relatedness/friendship is the aspiration to connect with others. The element of community is to belong to a society that shares similar goals and interests. The element of spirituality involves having a secure purpose and meaning in life through a connection to a higher power. The element of happiness means to feel a sense of overall contentment with one’s own life and the ability to experience pleasure. The element of creativity is the ability to incorporate imagination and creativity in life (Purvis et al., 2011).

These individuals lack positive interaction with people in their communities resulting in feeling like outcasts. These people lack appropriate social skills and effective communication skills (Good Lives Model, 2015). There is a huge number of incarcerated individuals who would benefit greatly from learning to communicate effectively. They articulate a craving for education. Often the most beneficial therapy is helping them to realize self-worth, build self-confidence, and developing appropriate social skills that include firm yet healthy boundaries (Jennings &
Deming, 2013). Once they start to develop and enhance these skills, they experience positive social interactions and begin to gain a sense of belonging (Oberst & Stewart, 2003). The GLM is an effective tool used in the treatment of sexual offenders as it promotes the ability to separate the individual from their thoughts and actions which allow for heightened self-awareness (Ward & Steward, 2003). The Good Lives Model is often utilized in conjunction with the Cognitive Behavioral Therapy to address the dynamic risk factors associated with sexual offending (Andrews et al., 2011).

**The Transtheoretical Model**

The Transtheoretical Model (TTM) developed by Prochaska & Di Clemente (1983) is used in the treatment of persons who sexually offend to promote intentional change that is categorized into five distinct stages (Clark, 2013). The five stages of TTM include pre-contemplation, contemplation, preparation, action, and maintenance (Prochaska & DiClemente, 1982). The first stage of the TTM is the pre-contemplation stage, where individuals have no intention of changing and deny their behavior (Prochaska & DiClemente, 1982). Sexual offenders who demonstrate behaviors consistent with their active offending cycle create a wall of resistance and denial (Clark, 2013).

The second stage of the TTM is contemplation which requires a decision to commit to making change within a six-month period (Prochaska & Velicer, 1997). This stage can be time-consuming because of the individual struggles with evaluating the positive and negative impacts of committing to change. An offender at this stage is cognizant of their problematic behaviors but continues to demonstrate them. Once the individual has faith that the positive benefits of change will outweigh the negative consequences of their risky behavior they move into the third stage which is referred to as the preparation stage of change (Prochaska & DiClemente, 1982).
During this stage, the individuals enthusiastically pursue knowledge to learn and research change. They acknowledge the problems, make observable and relevant changes, but lapse into old negative behaviors quite frequently.

The fourth stage referred to as the action stage is significant because the individual’s self-confidence begins to grow as they develop trust in the process (Clark, 2013). The individual’s change remains mostly stable and prevalent enough to be recognized by other people (Prochaska & DiClemente, 1982). The last stage of the TTM is referred to as the maintenance stage. During this stage, the individual demonstrates security in their new identity by examining methods and interventions that will protect their advancements by avoiding relapse (Prochaska & DiClemente, 1982). The maintenance stage is a fluid state because the process of change operates on a continuation (Dewhurst & Nielsen, 1999). Integrating the Transtheoretical Model with Adlerian therapy can be utilized as an effective therapeutic model that provides structure and encouragement within the confines of prison setting can be applicable and efficient (Prochaska & DiClemente, 1982).

**Shortcomings in the Current Models**

Overall, the limitations of sex offender treatment mainly surround the reduction of recidivism and the efficacy of the individual models, especially when focused on offenders with co-occurring disorders. Based on recidivism researchers debate the relevance of treatment topics such as dynamic risk factors and personality traits. Studies have shown an ongoing confusion between the Relapse Prevention Model and the Self-Regulation Model. This confusion may be due in part to the lack of expertise demonstrated by clinicians in the important field (Cortoni, 2011).
Cognitive Behavioral Therapy

Research has suggested that the use of Cognitive Behavior Therapy in the treatment of persons who offend has proven to be the most effective (Studer & Aylwin, 2008). However, throughout the model cognitive distortions are identified as the essence of the individual’s psychological development. A variety of factors communally patterns the application of distortions. In an effort to meticulously address the distortions manifested in the behavior of offenders, an improved examination of distortions is necessary (Waldram, 2008). Historically, there has been a lack of acknowledgement into the core development of distortions which hinders the offender’s ability to understand where the behavior began. Without a clear understanding of their thought processes, the ability to reenter into society in a prosocial manner may be futile (Waldram, 2008). The practice of Cognitive Behavioral Therapy can often be confrontational which evokes negative feelings within the offender such as helplessness, powerlessness, self-loathing, and shame (Johnson & Lokey, 2007). CBT tends to limit the importance placed on the internal and external factors that molded an individual’s thought patterns. This limitation perpetuates the feelings of shame and self-loathing. An individual who is ruminating in the negative emotions listed above lacks the motivation to change and will not demonstrate forward movement.

Relapse Prevention

Relapse Prevention has been deemed the most defective of treatment modalities used to lower the recidivism rate among sex offenders (D’Orazio, 2013). This model was originally established as a treatment for individuals with substance use disorders. It was adopted as a mainstay treatment for the sex offender population while RP discounts the exclusive features that instigate an individual who commits sex offenses. Studies have shown that although offenders
are abstinent when they complete relapse prevention treatment, 80% relapse within a year (Laws & Ward, 2010). Relapse prevention lacks individuality and tends to apply the same exact to treatment to each offender regardless of diversity. Research emphasizes that for persons to demonstrate positive lifelong modification, individualized treatment is indispensable (Laws & Ward, 2010).

**Self-Regulation Model**

A shortcoming of the Self-Regulation Model is that there has not been any research about its effectiveness in treating sex offenders with co-occurring disorders. The Self-Regulation Model fails to clarify the rational for the pathways and how they influence sexual deviancy. Experts suggest that the Self-Regulation model is too multifaceted to use as a core treatment method. This method is not supported because it fails to address the offender who demonstrates an approach pathway (Cortoni, 2011).

**Risk Need Responsivity**

Research substantiates the need for adaptations in the Risk Needs Responsibility model to decrease sex offender recidivism. This model discounts the totality of the individual and places much of its concentration on criminogenic needs. Another critique reflected in the research cites that the individual ambitions of the offender are evaded during treatment (D’Orazio, 2013). The explicit focus on criminogenic needs may facilitate oversight of symptoms of mental illness, therefore discounting the essential treatment and support for that individual. Studies reflect that RNR fails to consider the biological factors, strengths, and adaptive skills of the individual, and prosocial possibilities which may impact the offender’s motivation for treatment (Cortoni, 2011).
Good Lives Model

The Good Lives Model has been identified as just a reconceptualization of respectable functioning treatment modalities. The model itself lacks the necessary research to determine the efficacy regarding in reducing recidivism. The primary goods are said to be persuasive, incomplete, and inaccurate. The GLM would be best used as an enhancement to effective treatment techniques, because of its inability to treat those individuals that are high in psychopathy and entrenched in their deviant sexual interests. The Good Lives Model fails to focus on risk factors; it instead focuses on the “feel good” which has been confirmed as unsuccessful in the treatment of offenders (Cortoni, 2011).

Transtheoretical Model

The Transtheoretical Model is greatly limited in its prognostic aptitude and clinical efficacy because of its emphasis on circumstantial instead of the clarifying accounts of behavior (Burrowes & Needs, 2009). The model is deficient because the considerable emphasis is placed on the stages of change rather than the progression through the stages which depress behavioral change (Brug et al., 2005). The Transtheoretical Model fails to acknowledge the social context such as socioeconomic status (SES) where change can transpire. The individual profiles between the stages are subjective with no definite measures in defining an offender’s stage of change. Another fault of the Transtheoretical Model is the postulation that individuals make articulate and rational decisions (Cortoni, 2011).

The Rationale for the New Approach to Offender Counseling

Preparing offenders for reentry into society has been an area that is often disregarded by clinical staff. Using the theoretic foundations of Adlerian Psychology, an innovative model of sex offender’s treatment may propose a holistic approach that changes the emphasis from
criminogenic needs and reduction of recidivism to the inter- and intrapersonal needs of individuals who have perpetrated sex crimes. Conclusively, a new method of treatment may sufficiently prepare persons who have offended to live efficacious lives as industrious, upstanding inhabitants, expand their well-being, life fulfillment, and encouraging emotional understandings of offenders, which decreases recidivism.

Offenders’ incarceration rates tend to be recurrent, and those with co-occurring disorders have a higher rate of recidivism (Duwe, 2015). The treatment provided to individuals who have offended should consist of psychotherapy and a blend of psychopharmacology as well as treatment that focuses on co-occurring disorders (Day, et al., 2017). The psychotherapy portion of treatment provides safety because it allows for the normalcy of their experiences. The psychoeducational fragment of treatment encourages the identification of emotions, triggers, coping skills, and relapse prevention. Pharmacology allows the offender the possibility of managing the symptoms associated with their diagnosis (Schmucker & Losel, 2015). Furthermore, providing educational information to those with co-occurring disorders about diagnosis’ and community support encourages recovery, symptom management, and lowers recidivism.

Cognitive Behavioral Therapy has historically been the most extensively utilized treatment method; however, the contemporary methods of treatment have shown an increased success rates of treating sex offenders (Yates, 2013). The Good Lives Model delegates some attention to the welfare and self-actualization of the offender, but as with other treatment methods, the most substantial emphasis is fixated on criminal desistance. Treatment programs that employ these models convey varied information to the offenders, which inadvertently generates shame and guilt. The negative emotions can damage the therapeutic relationship
because the individual may contemplate the intent of the therapist and the mission of the
treatment (Day, et al., 2017). Given the rising incarceration rates of persons who offend that have
a mental illness diagnosis and the increased likelihood of release into the community, a more
holistic and comprehensive model is needed.

Adlerian Therapy can be promoted as a method aimed at gratifying the prosocial lifestyle
of the individual as they reenter society because the offenders have a definite skillset focused on
coping with daily challenges of life. The focus on recidivism is imperative, but it should be
viewed as a constructive derivative of treatment instead of the goal. Operative treatment requires
emphasis on the education of persons who offended in the areas of purposeful goals,
strengthening positive life aptitudes such as executing decisions, self-sufficient coping skills,
competent communication to promote meaningful associations and acknowledge mental health
matters (Day, et al., 2017). Adlerian Psychology offers a foundation that observes all the
recommendations of an effective reentry program as well as meeting the vast needs of sex
offenders.

Alfred Adler’s Individual Psychology

Adlerian Psychology places emphasis on the human condition (Adler, 1992). Adler
created a process that merged human nature, psychopathology, principles, and techniques of
psychotherapy, the worldview, and a deeply rooted philosophy of living into a holistic theory.
Adler defined human nature as a multilevel concept encompassing social interest, social feeling,
community feeling, and social sense (Ansbacher & Ansbacher, 1964). Adler’s holistic view of
the human equation concluded that an individual’s temperament strived to maneuver
achievement of a life goal. The different parts of the individual work in symbiosis to attain the
common purpose (Corey, 2013). Adlerians utilize the concept of developing courage to evoke
change. The courage to be imperfect, courage to forgive not only self but also others, the courage to act even in the presence of fear, the courage to behave in a manner the represents the presence of integrity are all areas relevant to Individual Psychology (Sweeny & Myers, 1986).

Adler’s theory begins with two goal areas focused on the individual’s level of self-esteem and sincerity to their experience. This would mean the individual has a better understanding of their actual self and their idealized self, lowered levels of defensiveness, decreased insecurity, guilt and an increase in positive, comfortable relationships with others (social interest) (Beames, 1992). The individual would also enhance their capacity to express and experience emotions in the present and spend less time focused on the past. The primary goals of person-centered therapy are increased self-esteem and greater openness to their overall life experience (Carlson, Watts, & Maniaci, 2006). Some of the related changes this form of therapy seeks to foster in clients include closer agreement between the client's idealized and actual self; better self-understanding; lower levels of defensiveness, guilt, and insecurity; more positive and comfortable relationships with others; and an increased capacity to experience and express feelings at the moment they occur (Corey, 2013). Adler identified that movement towards the future represented motivation. A person’s goals, purposes, and ideals (or teleology) are representative of this movement. An unmotivated person will lack teleology and generate no forward progression, therefore, finding themselves stuck in a state of inferiority (Oberst & Stewart, 2003). As this process develops, the client is encouraged to identify problematic thoughts, emotions, behaviors which have become their private logic created from lifestyle, and family constellation (Corey, 2013).

Adlerians believe that an individual private logic is formulated by the approximate age of five. Private logic is the system that guides the individual through the world. If the process is
stunted on some level by poor parenting, malnourishment, lack of community (external support systems such as schools), child abuse, shame, and powerlessness then deviant or useless behaviors are formulated (Carlson et al., 2006). Mistaken beliefs need to be challenged as they have, over time, evolved into problematic behaviors. The Adlerian approach believes that emotions and behaviors have deep roots within the experiences of childhood. Adler stated "We can never tell what actions will characterize individuals if we know only from where they came. However, if we are aware where they are going, we can predict their steps toward their objective" (Adler, 2005).

**Adlerian Principles**

Adler's vital ideologies disclose a profound awareness of the art of therapeutic growth and excellent motivation for reassuring the finest progression of human development. These principles are unity of the individual, goal orientation, self-determination and uniqueness, Socratic questioning, guided and eidetic imagery, and role-playing (Adler, 2005). The principle of unity focuses on an individual's integration which is characterized by rational intellect, sensation, emotion, and conduct subservient to the individual's style of life, or dependable outline of coping with their existence. The individual is not struggling with internal or external turmoil; therefore, the person's life is guided towards a collective goal (Adler, 2005).

The principle of goal orientation applies to the presence of a single vital individualism ensuing over the development and onward drive of one’s lifetime (Adler, 2005). Goal orientation refers to an individual's determination to gain worth, self-pride, or achievement. In treatment, it is an appropriate goal to strive for a communal profit over universal complications; in mental disorders, however, it is maladaptive to strive for impracticable
achievements of embellished implication or power and control over others. Adler believed that the struggle to compensate for feelings of inferiority were established in an individual’s childhood (Adler, 2005). The challenge leads to the creation of a fictional final goal which intuitively seems to be a way to secure a future of sanctuary and triumph. The complexity of the inferiority feeling is often congruent with the culmination of the idea that develops into the concluding root of interactive schemas (Adler, 2005).

The principle of self-determination and uniqueness focuses on hereditary along with cultural factors may influence the principle of self-determination and specificity, although the primary source generates from the individual’s imaginative power qualifying them as unique. To help an individual become aware of their life goals a professional will encourage the examination of birth order, recurrent coping patterns, and earliest memories which will conclude the target as a working premise (Adler, 2005). Social context manifests as an imperceptible entirety, an organization, whereas the individual equally belongs to greater structures such as family, neighborhoods, society, and humankind. In these circumstances, an individual’s encounter social challenges in the form of three significant life tasks: career, love and sex, and connection with others. An individual's response to their family constellation or the first social system may become the preliminary model depicting their attitude and view of life (Adler, 2005).

The principle of the feeling of community implies that every individual has the aptitude to become versed in living congruently within civilization. The feeling of community focuses on experiencing a profoundly ingrained sense of sanctuary, and a profound sense of belonging within society generates good security (Adler, 2005). This is a distinctive procurement for the mutual association which desires to be intentionally cultivated. Having social interest and feeling
indicates communal enhancements which evident even through cultural struggle or insurgency, however, refutes conforming (Adler, 2005).

The principle of mental health encompasses an overall sense of connectedness with others as well as the inclination to mature individually while striving to secure the well-being of others (Adler, 2005). If an individual lacks the motivation to transform and remains disconnected from the communal society they most often endure feelings of inferiority, partake in hostile behaviors towards others, or strive for a maladaptive form of superiority. Thus, the insentient fictional goal of the unhealthy individual will be selfish, self-interested, and expressively or materially repressive to others (Adler, 2005).

Adlerian treatment modalities include individual psychotherapy, brief therapy, couple therapy and family therapy which pursue similar practices. The goal of treatment is to exchange narcissistic character traits with a courageous social contribution that demonstrate integrity (Adler, 2005). When individuals are invigorated, they tend to conquer their insecurities, expand their feelings of relatedness, and readdress forward movement to benefit the shared collective goals. Through the process of Socratic discussion, individuals are challenged to correct misguided expectations, perceptions, actions, and state of mind about the world and self. Individuals are encouraged to place effort into areas they experience as unattainable. The development of self-confidence, pride, and fulfillment manifests into a heightened yearning and capacity to conjoin (Adler, 2005).

Adlerian Counseling

The Lifestyle Assessment

The LifeStyle Assessment (LSA) is a thorough questionnaire that encourages the individual to be able to tell their story specifically as they interpreted it. Adlerians developed the
LSA as a technique to discover and reconnoitre the evolvement and reinforcement of one’s private logic (Carlson et al., 2006) and the development of mistaken beliefs (Oberst & Stewart, 2003). An individual’s private logic is compiled of an individual’s beliefs and insights about themselves and the world which propels their travel through life. These beliefs are refined early in childhood. Through the information gained from the LSA the professional gains insight into the methods that the sexual offender utilizes to survive, how they cultivate skills, and the manner in which they process their environment (Powers & Griffith, 2012). The information gained is crucial in developing an applicable treatment plan to prevent recidivism (Manaster & Corsini, 1982).

A professional navigates an LSA by directing the offender through a succession of Socratic questions in effort to discover insight into areas of morals, assets, work ethic, conflict, gender roles, relationships, love, and spiritual development (Ansbacher & Ansbacher, 1964). While the LSA is critical to obtain pertinent data and assess the offender it is equally as important to acquire information from other resources to accurately identify specific areas of need, support, and the strengths of the individual (Dinkmeyer, Dinkmeyer, & Sperry, 1987). This process is especially important for individuals who are incarcerated for their offending behavior or mandated to attend treatment because those environments tend to be obstructive and violent which creates a resistant attitude within the offender. Just as important as identifying the areas of need the LSA identifies areas of accomplishment and strength therefore increasing self-awareness, building confidences, and creating hope. At this current stage in the treatment process, offenders lack the conscious insight into their thoughts, emotions, and behavior therefore refute any responsibility for their behavior. They are not aware of the issues or possible symptoms which are present (Waldram, 2008). Because of the inadequate intuition into their self,
sexual offenders lack the ability to control the maladaptive behaviors they consider to be normal (Gottfredson & Hirschi, 1990).

As previously discussed, private logic is developed at a young age, for sexual perpetrators whose childhood often included abuse, lack of control, substance abuse, difficulties in school, and a vast amount of other difficulties (Hanser, Mire, & Braddock, 2011). Through the process of conducting an LSA, there is an ability to create a hopeful safe environment that promotes forward movement onto an alternative path than the one that was thought possible by recognizing the individual’s value and strengths. The offender is given the autonomy to pursue the process, and their expertise into their life is reinforced creating a space of empowerment. When an individual can tell their story, there is a great amount of information that can be gained (Ansbacher & Ansbacher, 1964). This information is communicated in the form of words, body language, changes in voice and emotion.

The choice of the words used, their order and the vocabulary that was not verbalized are all significant and serve a purpose. The material provided in the lifestyle assessment provides a vast amount of information encapsulated in the areas of family systems, gender roles, mistaken beliefs, and family constellation (Oberst & Stewart, 2003). These areas define who we are in relevance to how we perceive ourselves, others, and everyone’s roles in society (social interest). The lifestyle is learned and becomes a part of the personality that is developed from birth to age eight (Watkins, 1984). Corey (2013) stated inaccurate beliefs are individual folklore shaped within the lifestyle which allows for individuals to behave as though the myths are accurate. These mistaken beliefs direct the individual’s behavior.

Hence, an essential portion of treatment is the discovery and the assessment of mistaken beliefs, which contributed to an unhealthy offending way of life (Wingett & Milliren, 2004). The
culture of the prison has many facets, and each person carries an arsenal of tools they employ depending on the situation. These masks are worn by some to hide vulnerability (Duwe & Goldman, 2009). Completing the lifestyle assessment means sharing information that could be perceived as harmful to self. The offender’s initial reaction to completing a lifestyle assessment could be highly skeptical for many reasons (Daugherty et al., 2001). Being an incarcerated adult mandated to treatment imposes a negative subculture on the already established cultural identity of an individual (Duwe & Goldman, 2009). There are many emotional responses the person experiences when asked to share information about their personal life. The use of an LSA can have positive results within the treatment setting if the individual can build trust with the assessor/therapist (Edens, Peters & Hills, 1997). Transformation is dependent on their motivation to change and internalization of concepts (Clark, 2013). Building rapport is the foundation for helping them to adjust positively to the assessment (sharing of personal information).

Persons who have sexually offended are often challenging because they have limited trust for others, especially those in an authoritative role. Most of these individuals have had a traumatic history of abuse perpetrated upon them by an authority figure, are predatory, and are highly manipulative (Gilligan, 1997). Utilizing the Adlerian Lifestyle assessment can be a way to gain insight, but also a means to form a therapeutic relationship. Allowing them to answer the Socratic questions can build rapport because the professional is listening to and not controlling the story (Levenson, 2014). By examining the individual’s lifestyle, correlations may be recognized between the guiding roles, thought patterns, and core beliefs explicit to the individual. Understanding those dynamics can help the person to heal and have hope for a better life, therefore, limiting the likelihood of reoffending. Identifying the patterns between thoughts, emotions, and behaviors lead an individual to understand their belief system. Mistaken beliefs
are found within the confines of the individual's childhood perception of the environment around them (Mosak & Maniacci, 1999). Sexual offenders have deep-rooted feelings of insignificance, inferiority, and hopelessness.

Adler believed most emotional issues manifest as problems of discouragement, fear, inferiority, and ignorance about how to succeed at life tasks. Utilizing Adlerian principles, a professional helps the client develop a heightened awareness and offers encouragement to promote social interest. This allows the professional to utilize a vital principle set forth by Alfred Adler which is “To see with the eyes of another, to hear with the ears of another, to feel with the heart of another” (Ansbacher & Ansbacher, 1964). By applying this notion, people should be able to manage the hardships and hindrances in a socially adaptive manner that benefits all of the mankind (Oberst & Stewart, 2003).

**Family Constellation**

A thorough examination of an Individual’s LSA is re-creating and examining their Family Constellation which provides insight into their personality development and learned private logic. Family Constellation refers to an individual’s position regarding birth order among siblings and the presence of parents or caregivers within the structure of family (Sherman & Dinkmeyer, 1987). The position that the individual holds identifies the unique perceptive of the oldest, second, middle, youngest, or only child. For example, the eldest child will assume the attitudes and morals embodied by their parents or caregiver while a middle child will aspire to have some morals and behavior that contrasts from both the parents and the eldest child (Sweeney, 1998). Adler emphasized that the temperaments of the oldest, middle and the youngest children in the family are likely to be relatively different because the experiences of each within the family group are contrasting (Watkins, 1984).
The characteristics of the oldest child include being responsible, organized, and goal orientated. The personality characteristics of the firstborn often include a serious demeanor, aggressiveness, jealousy, competitive, and high self-esteem. The firstborn often has a fear of losing the top place or leader position within the family unit. The middle child often has a sense of not belonging, they may feel lonely and lack the motivation of being driven. The middle child looks to others for direction. They are natural mediators and tend to avoid conflict. The role of the youngest child, according to Adler, is often pampered and spoiled which can lead to dependence, selfless, and irresponsibility. The youngest child tends to be outgoing, endearing, and a delightful friend. They can often be manipulative, control seeking, overbearing, or bossy. An only child will often have the characteristics of either the firstborn or of the youngest child. They don’t encounter having any rivals within the family unit for the attention of the parents which can often lead to being pampered and spoiled (Dreikurs & Soltz, 1964).

Another key concept of the lifestyle assessment is focused on characteristics of an individual’s behavior. Adler strongly believed that all behavior is purposeful, a person’s conduct is based upon the goals that they determine to be an important achievement in their life (Sweeny & Myers, 1986). Behavior is best understood when viewed through a social context lens because a person is striving for their position within their community. They desire to be meaningful in relation to others (Sweeny & Myers, 1986). Adler also suggest that behavior is best understood through a holistic approach. Considering the overall emotional state, attitudes, and ideas that are expressed by the individual is important when conducting an assessment. Each person invents their private logic in an effort to cope with life. Unexamined private logic remains consistent over the span of an individual’s life unless it is examined and determined to be faulty. Adler
advocated that early childhood memories are discriminatory and function to instinctively lead by the guidelines about life, ourselves, and others (Sweeny & Myers, 1986).

**Early Recollections**

The Adlerian technique of gathering and analyzing an individual’s Early Recollections (ER’s) reflects the protocol they use to determine behavior (Papanek, 1972). The perceptions and misperceptions conveyed in the memories provide insight into an individual’s private logic, and mistaken believe about how they view themselves and the world (Ansbacher & Ansbacher, 1964). The ER’s are not necessarily a factual recall of the events that occurred but rather an expression of what used to be which may represent ongoing challenges that were prevalent in one’s life (Carlson et al., 2006). Early memories do not dictate a person’s current behavior. Instead they lend insight and possible understanding into the person’s guiding fiction, progression toward the objective, and the hindrances to conquer (Papanek, 1972). Individual psychology is focused on the present and future instead of in the past, yet there is a significance in the recollection of memories (Ansbacher, 1973). Adler perceived people as active, focused, moderately self-governing organism, rather than submissive and reactive (Ansbacher, 1973).

**Style of Life**

The style of life is represented by the way an individual chooses their life goals, sways the choice of goals, and the way they plan to obtain these targets (Mosak & Maniacci, 2011). To comprehend an individual’s style of life that person’s independent experiences and perceptions need to be understood and explored (Mosak & Maniacci, 1999). Historically, there was little focus invested in the area. Recently it has been discovered that to lower recidivism the style of life must be addressed because choices were made based on mistaken beliefs developed throughout their life (Schmucker & Lösel, 2015)
Combining treatment modalities such as Cognitive Behavior Therapy, which explores the thoughts and emotions that generate decisions, with Adlerian, an exploration of mistaken beliefs and style of life, forms a basis to address change and shapes the individual’s immature sense of social interest (Dreikurs & Soltz, 1964). Within the treatment milieu, it is important to address the area of accountability. Offenders must demonstrate the ability to be accountable and accept responsibility for the choices they made by demonstrating an internalization of empathy (Andrews et al., 2011). Being a part of the healthy therapeutic community helps them develop empathy for others and recognize the consequences of their actions through the shared experiences of others. By applying the concepts that are learned in psycho-educational classes, they are given a chance to explore the effects of victimization on those they offended against, the families, and the communities (Harris et al., 2009). Once an individual begins to conceptualize their responsibilities for their choices change can occur. According to Johnson and Lokey (2007), the development of empathy substantially increased an offender’s level of social interest.

The individual begins to focus their actions and goals based on an internal locus of control rather than an external locus of control. Research suggests that responsibility is observed in treatment by attendance, contributing to the group process, and striving to achieve individual goals (Levenson & Macgowen, 2004). An individual is responsible to attend both group and individual treatment sessions, community meetings, psycho-educational classes, vocational programming, educational programming, health and fitness, as well as any evaluations deemed necessary by the professional treatment team (Duwe, 2015).

Responsible group behaviors include as being engaged in the process, providing self-relating feedback, being encouraging, as well as the ability to confront the distortions used by their peers (Good Lives Model, 2015). Finally, the individual should be attaining their treatment
goals as defined by their own treatment plans. These goals should represent the uniqueness of the individual personality as well as their offending dynamics as determined by gathering information through appropriate assessment tools.

Social Interest

Adler defined human nature as a multilevel concept encompassing social interest, social feeling, community feeling, and social sense (Ansbacher & Ansbacher, 1964). When a person experiences interdependence with others, they are acknowledging that their welfare depends on the well-being of the collective (Ansbacher & Ansbacher, 1979). When there is acceptance on that level that reflects appropriate social interest the individual experiences balance and can maintain emotional regularity with both the comforts as well as the discomforts of life. Behaviorally this is achieved by demonstrating actions that are of benefit and cooperative towards others (Carlson et al., 2006). An individual genuinely wants to feel a connection to others. They strive to feel a sense of belonging and being needed by others in the community. Adler denotes that social interest is a root of human nature. Adler stressed the importance of ego in a socially entrenched entity. If social interest is lacking, then a person feels inferior and discouraged (Ansbacher & Ansbacher, 1979).

An Adlerian perspective of treatment can be seen in the implementation of the treatment milieu where two of Adler's most significant concept is social interest and community. These concepts focus on social responsibility instead of on the needs and responsibilities of a single individual. It focuses less on traditional theories of personality and more on the Adlerian concept of social interest or Gemeinschaftsgefühl (Ansbacher & Ansbacher, 1964). Adler defines social interest as having an active interest in furthering the welfare of humankind. The Adlerian concept of social interest envelops the idea of seeing with the eyes of another, hearing with the
ears of another and feeling with the heart of another. By utilizing this guiding principle, people can manage hardships in a socially adaptive manner that benefits humanity (Oberst & Stewart, 2003).

Based on research conducted by Levenson and Macgowan (2004) prosocial group behavior generates a foundation of social interest allowing the treatment community to increase engagement and achievement treatment goals. As individuals move through life, they make prosocial decisions to influence positive change for the greater good. In the case of persons who offended, they often make maladaptive decisions as a method of instant gratification or to avoid discomfort.

According to empirical research conducted by MacKenzie, Shaw, and Souryal looked at aspects of social interest such as cooperation and responsibility (as cited in Daugherty et al., 2001). The decrease in social interest or responsibility and lack of empathy has been linked to higher criminality and recidivism. These individuals are more likely to be unemployed, have higher arrest records and be incarcerated. According to Mehrabian and Epstein (1972), empathy is separated into two categories: cognitive and emotional. Recognizing another person's perception of feelings is known as cognitive empathy while the ability to share or engage in the feelings or attitudes is referred to as emotional empathy (Mehrabian & Epstein, 1972).

The subject of understanding is important on multiple levels within the treatment milieu of sex offender treatment. To effect critical change, the professional requires a nonjudgmental attitude that avoids the use of guilt and shame for the offender to build a trusting rapport (Freeman & Urschel, 2003). The professional's ability to model genuine empathy toward the offender allows them to build the skills to use within their treatment community by sharing feelings and seeking to not only be understood but also to understand others (Gilligan, 1997).
Empathy is an area that is thoroughly assessed to guide appropriate individual treatment plans. Successful internalization of therapy and true change involves experiencing genuine empathy. Adler noted that the only individuals who can meet and master the problem of life are those who show their striving and tendency to enrich all others who go ahead in such a way that others also benefit (Ansbacher & Ansbacher, 1964). According to Adler the motivators for criminal behavior are impaired social feeling, and impaired courage and concern for others are primary factors in understanding what motivates criminal behavior (Daugherty et al., 2001). Specifically, Adler argued that deficit social interest translate into faulty and mistaken goals, a reduced response repertoire, and, in some cases, a criminal lifestyle. Adler reasoned that because the criminal offender is not interested in others, he or she can cooperate (behave) in a prosocial manner) only to a certain degree. When the level is exhausted, given he stressed and demands of their circumstances, the individual turns to crime (Daugherty et al., 2001).

**Inferiority and Superiority**

A child searches for their significance within their environment, most often their family constellation. Adlerians believe that humans strive for superiority, success, or power (Mosak & Maniacci, 1999). When the child feels that they have a positive role within the family unit they will pursue the useful side of life. Often individuals who sexually offend strive for superiority, acceptance, and power and control which they fill by victimizing others. Adler’s concept of inferiority describes that there is a direct effect on an individual's self-esteem and emotional health (Ansbacher & Ansbacher, 1964). A significant difference is denoted when examining Freud's description that a person is fragmented into the ego, superego, and id. Adler stressed that to understand an individual they must be viewed in their entirety (Mosak & Maniacci, 2011).
Adler’s theory encompasses that inferiority is a factor that unites all individuals as infants (Ansbacher & Ansbacher, 1979). Through that, there is a drive for superiority which for most people is healthy and normal movement through life when there is a clear fictive goal towards the specific goal of fictional finalism. Alfred Adler's description of a depressed individual explains an idea that others are there to serve them; the catalyst to meet their own needs and wants (Sperry & Carlson, 1996). As a child, the depressed individual figured out that they could control others using tears. These children were often the "pampered child" and grew up to be adults who suffered from the substandard problem-solving skills, and feelings of inferiority (Ansbacher & Ansbacher, 1979). These adults are unable to turn their inadequacies into motivation to travel from a felt minus to a perceived plus (Sperry & Carlson, 1996). The depressed individual engages in a manipulative way of life (addiction) and forces their body (purposeful or not) to cooperate. This behavior creates a state of organ inferiority that may be evidenced by changes in appetite, sleep disturbances, and digestive issues (Sperry & Carlson, 1996).

The destabilization of an individual’s life is often evident by anxiety and depression which can manifest or exhibited by substance abuse or unhealthy compulsive behaviors (Adler, 1961). The use of lifestyle assessments often has positive results within the treatment setting if the individual can build trust with and respect for the therapist. Transformation is dependent on their motivation to change and internalization of concepts. Building rapport with the offender/client is the base for helping them to adjust positively to the assessment (sharing of personal information) (Carich, 2001). Building trust while being able to hold them accountable is imperative in this process. Setting boundaries, being consistent, firm yet therapeutic models
acceptance and client-centered approach. Learning to encourage and avoid shaming are all areas that can help to strengthen therapeutic alliance (Daugherty et al., 2001).

**Adlerian Views of Criminal Behavior and Sex Offenders**

Adler believed that criminal behavior developed from a decision to not engage in life tasks instead (Oberst & Stewart, 2003). Criminals believe that the rules that apply to living a communal life are not relevant to their lives and they view themselves as above them. Instead, they rely on seeking power over others by manipulating, cheating, or controlling them among other ploys. They would much rather defraud them through illegal and dishonest ways (Oberst & Stewart, 2003). Encouraging person who offended to acknowledge their inner logic is a goal of Individual Therapy which promotes a sense of well-being and the ability to eagerly reconstruct themselves in a communally embedded manner. Adlerians view misconduct as a longing for safety, acceptance, and yearning to fit in (Carlson et al., 2006). If these profound ambitions can be gently encouraged the possibility of transforming a sexual offender into a productive member of society is conceivable (Carlson et al., 2006).

Adler expressed that being a part of a negative atmosphere does not lead to criminality and being raised in mostly positive circumstances does not assure content, obliging children. Genetics and environment only bequeath an individual with certain capabilities. The experiences and the manner in which the individual perceives their surroundings are the foundation for which the attitude of life is built upon. This attitude then determines their relationship with the world. There are no distinct approaches for treating those who demonstrate criminal behavior compared to those who experience anxiety, depression, or other disorders. It is instead imperative to develop an intervention that is molded to the individual because they may be operating disturbing actions or indications to provide for a concealed goal. Promoting the practice of
Individual Therapy increases the exposure and eradication of fictional goals which promotes cognitive, behavioral, and emotional change.

Regardless of their socioeconomic background, Adler defined that many criminals are subjugated deeply ingrained feeling of inferiority and an absence of social connection. He referred to criminals as recreants who conquer victims by employing destruction, shock, daunting weaponry, or sheer numbers. Ultimately, he emphasized, they are cowards with a discounted complex of superiority that overcome their victims through the darkness, surprise, formidable armaments, or absolute reality. The sex offender avoids their issues because he is concealing their feelings of inadequacy and inferiority (Cleary, 2004). Adler asserted that his methods could transform every criminal while conceding that such a goal would be impracticable particularly as individuals fall into despair. Adler promoted tangible endorsements for averting growth in delinquency. Much like the current treatment practices, he addressed concerns such as unemployment, establishing group meetings to encourage self-esteem and the feeling of community.

**Discussion and Implications for Counseling Male Sex Offenders**

Providing sex offender treatment is often viewed as a specialized area of treatment; however, it is as important to recognize the similarities to other types of treatment. Irrespective of whom the treatment is designed to treat, the different modalities share similar principles. The resemblances begin with a foundation that procedures, risks, and benefits such as informed consent, should be presented to all offenders in a manner that is understood. Official assessments that are individualized to address the specific client should determine the treatment interventions (Center for Sex Offender Management, 2006). Special care should be taken by clinicians to build and maintain effective rapport with the clients. Another area of similarities is focused on
developing treatment goals that are specific and measurable. This allows for the client to succeed and improve self-esteem. Lastly, it is important that all progress of the client, even lack, is clearly and accurately documented. While it is important to recognize the similarities between conducting treatment across the therapeutic frameworks, it's critical to be aware of the differences and adapt accordingly (Center for Sex Offender Management, 2006).

Sex offender treatment encompasses multifaceted dynamics, specific interventions, developing literature, and the risks which are dangerous. Based on the risks it is perilous that the providers are prepared with the knowledge and competency to provide quality treatment in an ethical manner. The specific training, instruction, knowledge, and supervision that is required to effectively conduct sex offender treatment should not be underestimated. There are states that require that clinicians meet specific principles and undergo a formal certification process based on the standards set forth by the Association for the Treatment of Sexual Abusers (ATSA), a chief authority in the field (Center for Sex Offender Management, 2006).

When considering the overall effect of unproductive psychosocial therapy interventions, the impact is moderately restricted to either just that individual or a small number of others who are involved. The likely effect when sex offender treatment fails is much more extensive. The impact is felt by family and friends of both the offender and the victim. Community safety is another concern because of the possibility of revictimization on multiple levels (Center for Sex Offender Management, 2006).

Sex offender treatment providers have an amplified probability of enduring vicarious trauma. Clinicians who work with sex offenders are habitually subjected to detailed accounts of brutally abusive behavior and the beliefs and attitudes that support it. Sex offenders lack accountability and minimize their behavior while placing considerable blame on the victim.
Cumulatively the exposure to this vicarious trauma, the high-volume caseloads, professional seclusion, negative judgments by the public, and the lack of healthy coping mechanisms can significantly impact the best clinicians (Center for Sex Offender Management, 2006).

Vicarious trauma is among the most prominent challenges that determine sex offender treatment to be peculiarly impactful. The effects of providing sex offender treatment have been compared to the vicarious trauma experienced by those professionals who provide treatment to the victims of sexual abuse. It was determined that the characteristics be similar in the clinical levels of afflictive indicators. Studies also concluded that the professionals conducting sex offender treatment were more likely to employ negative coping strategies which greatly intensified the effect of vicarious trauma (Center for Sex Offender Management, 2006).

When working with persons who have sexually offended it is important to be honest and authentic. A great deal of offenders have been socially excluded and denied positive connections throughout their lives which has left them extremely instinctual in recognizing pretenders. If they experience the clinicians as being a counterfeit they will often withdraw emotionally (Sandhu & Rose, 2012). Sex offenders are usually not inclined to participate in treatment, most often they are mandated, therefore their motivation for change is rarely genuine and therapists are met with resistance (Hubbard, 2010). Therapists must always be on guard because criminogenic thinking permeates the treatment setting. Persons who offended demonstrate manipulation, power plays, deflection, grooming, and victim-stance. It is imperative that the therapist be self-aware, self-confident, and uphold strict boundaries. A therapist should maintain a skill set that demonstrates the ability to be direct, confrontational, and authoritative while being compassionate, non-judgmental, nurturing, and empathetic to support the client in successful progression (Olver &
Wong, 2009). This type of therapist will encourage honesty in the therapeutic relationship as well as generate encouragement and hope for change.

Furthermore, besides the likelihood of criminal behavior and the demonstration of mistaken beliefs, the clinical staff must also contend with the co-occurring disorders and the negative emotions impacting the offenders. Depression, shame, substance abuse, psychopathy all pose an obstacle to the progression towards relapse prevention, accountability, and responsibility.

Group therapy has proven to be quite effective when addressing the issues pursued during sex offender therapy. Peers can offer vital support and effectively challenge the distortions of one another, but the safety of the group is a foundation that initially becomes the clinician’s responsibility (Hubbard, 2010). The clinician should also examine the risk factors, cognitive abilities, gender, and age when maintaining the dynamics of the group.

Another facet that faces the clinicians is the public and politicians whom all share a general goal of public safety. The barriers that block the successful recovery of individuals in sex offender treatment were put in place by the public and politicians. The punitive barriers come in the form of lack of employment, housing, sex offender registration, and support which directly reflect the risk factors that led to the initial choices to offend. The barriers can negate the efforts of both the offender and the clinician (Hubbard, 2010). It is a disheartening situation to try to conjure hope into a seemingly hopeless situation especially with those that have been civilly committed and do not have a release date. Changes on this level will necessitate the education of the community to dissuade the myths about sex offenders.
Future research

The future research needs to diminish the ambiguity of the results by distinctly characterizing the aspects of recidivism, studying sex offender’s individualized features, and the development of their lifestyle. It has been determined that much of research has strictly focused on the static risk factors characterized by sexual offenders. Because of this limitation, it is perilous that there is continuous research conducted to identify further the dynamic risk factors accompanying the recidivism rates of sex offenders. By investigating the impact that different dynamic risk factors have had on the lifestyle of the sex offender a better-quality infrastructure can be developed for intervention strategies. In an effort to procure the safety of society, research needs to be conducted in refined areas of persons who sexually offend such as exhibitioners, child molesters, rapists, and the high-risk offenders. Through expanding on the characteristics of the noted deviances, interventions can be developed for each of the diverse populations.

Research into the characteristics of the subdivisions of sexual offending is essential to increase the safety of communities. Historically the research about lifestyle factors of sex offenders has been lacking. Further studies in this area would address the developmental pathways which contribute to the cognitive distortions of the individual. Understanding their unique lifestyle would increase the ability to build an individualized treatment program which ultimately would reduce the recidivism rates of sexual predators.

Upcoming exploration should also be done about the impact of the current conditions of release forced upon sex offenders regardless of their charged offenses. They are not classified by the severity of risk associated with their offense instead they all are subjected to serve the same conditions which seem to be indicative of failure instead of success. The area of civil commitment would also benefit from specific research which focuses on the incarceration rates
per sub categories of offenses. Civil commitment rates seem to be significantly impacted by the quality of defense, and the financial impact on the committing county rather than the risk factors and heinousness of the offense.

**Conclusion**

Identifying and addressing the particular dynamics and static risk factors has been connected to decreased rates of reoffending (Yates, 2013). The therapeutic methods discussed are comparative in their goals in that they all reference a specific need for the client to take an active role in understanding self, developing applicable and appropriate strategies and behaviors along with utilizing the individual’s lifestyle and schema to uncover a deeper understanding of self (Freeman & Urschel, 2003). This process encourages the clients to increase their level of self-awareness, be humble and vulnerable, and learn empathy. As they succeed their self-esteem increases and they are more likely to develop definite social interest.

Adlerians believe that offenders need help to re-evaluate and provide education so that the individual can reshape themselves and consequently their life (Corey, 2013). By assessing the client in a holistic and non-pathologizing way and by helping the client examine their private logic, we assist the client to develop a better understanding and a more positive view of self. Instead of looking at themselves as bad or incompetent they understand that their feelings and behaviors are a result of mistaken goals and start to realize that there are other choices available (Daugherty et al., 2001). Once that perspective opens, there is less need for self-defense, and the person becomes more open to focusing on others. From there, as they start to engage in behaviors that demonstrate social interest, they are likely to receive affirming feedback from those with whom they interact in this new, more positive way, which tends to reinforce the new behaviors (Carich, 2001). Although a high level of social interest is the goal, most frequently we
The Adlerian perspective identifies that self-concept, self-ideal, environmental evaluation, and ethical convictions are all enmeshed to create the individual. Individual Psychology allows for a hopeful and optimistic view of human nature and the world as a social construct (Adler, 1998). Self-concept is what ideas a person has about them as an individual, defining what kind of person they believe themselves to be. Self-ideal relates to their hopes, aspirations, and ambitions to gain their place in the world. The environmental evaluation refers to how the individual interprets the world around them. The ethical convictions are the subjective deeply held beliefs that determine what is right and what is wrong. How a person identifies culturally is an important aspect that fits into Adlerian perspectives, and it is a perilous piece for a professional counselor to consider when developing the proper modality of treatment. Adlerian theory particularly emphasizes the reasoning of emotion and behaviors while applying a cooperative method of therapy (Mosak & Maniaci, 1999).

The Adlerian approach is evident in many of the therapeutic approaches utilized in today’s world of psychology and treatment. Over the years the basic concepts were adopted and adapted to fit a specific group and then re-coined as a new method. Adler believed the style of life was the central concept of an individual's whole being and experience. He also found that a person's behavioral patterns were developed at the early age of four rooted in their environment and perceptions. In other words, the individual’s relationship between their style of life, creative power, and freedom of choice he/she is still capable of change (Manaster & Corsini, 1982). This process of thought rings true throughout the listed therapeutic approaches. They all specify that an individual is capable of learning skills and evoking change within their lives. The therapeutic
methods discussed are all supportive of the therapeutic relationship between the clinician and the client contingent on relationship based on trust, empathy, and honesty. To an Adlerian ear that speaks of community.
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