

# Involving concerned others in the treatment of individuals convicted of sexual offences - rationale and critical review of current strategies

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[Sexual Offender Treatment, Volume 12 (2017), Issue 1]

## Abstract

*Our traditional approach to understanding risk focuses on factors internal to the individual (e.g., paraphilic sexual interests, antisocial personality traits) and by only engaging the convicted individual in treatment. But propensities for sexual offending do not manifest in a vacuum; they most likely are caused and maintained by the interaction between internal (e.g., genetics, brain structures) and external (romantic partners, family, friends, and the community) forces present in an individual's life. The objective of this paper is a justification for enhancing treatment-as-usual by involving individuals in clients' interpersonal network (e.g., partners, friends, family, staff, community volunteers). This paper contains a summary of the theoretical framework for involving others in treatment and a review of the involvement of social supports in current treatment programs. There are three main conclusions: First, sexual offending is an interpersonal problem - offenders' interactions with others shape their risk for offending. Second, the involvement of concerned others varies widely across treatment programs and is often limited to education. Third, limited involvement of concerned others is due to both theoretical (i.e., the absence of consensus in defining the role of interpersonal relationships) and practical (i.e., difficulties in recruitment and treatment delivery) issues.*

*Keywords: Sex offender treatment, recidivism, interpersonal functioning, social support, systemic treatment*

## 1. Introduction

Individuals are less likely to engage in criminal behaviour when they have strong, nurturing relationships (Cullen & Gendreau, 1989; Eher, Grunhut, et al., 1997; Gendreau, 1996; Gendreau & Andrews, 1994; Laub & Sampson, 2003). This is also true for individuals convicted of sexual offences (Hanson & Thornton, 2000; 2003). Other benefits also include increased involvement in treatment programs (Abel et al., 1987) and improvement on treatment targets (e.g., social skills, self-regulation, attitudes, sexual functioning; Geer, Becker, Gray, & Krauss, 2001; Miner & Dwyer, 1995). To capitalize on the benefits of positive relationships, several best practice guidelines for adult males convicted of sexual offences (e.g., Colorado Sex Offender Management Board, 2000; Flinton et al., 2010) recommend involving partners, family members, and other support persons who are positive influences - these individuals will be referred to as 'concerned others'. Although the Association for the Treatment of Sexual Abusers (2014) and the World Federation of Societies of Biological Psychiatry (Thibaut, De La Barra, Gordon, Cosyns, & Bradford, 2010) both suggest involving concerned others as part of collaborative case management decision making, it is not always clear how else concerned others should be involved.

A review of treatment programs reveals that concerned others are often only engaged through education, if at all (Eccleston, Brown, & Ward, 2002; Hawkins & Eddie, 2013; McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010). Documented barriers to further involvement include difficulties in conceptualizing how interpersonal functioning is related to treatment goals, resource limitations, and reluctance by concerned others to work with clients (Greineder, 2013; Ricciardelli & Moir, 2013). It is unclear if current treatment strategies offer therapists enough help to overcome these barriers.

The purpose of this paper is to provide the theory and evidence to support therapists involving concerned others in treatment. We begin by examining how interpersonal functioning is articulated within theories of sexual offending, including both internal factors such as social skills and external factors such as stigma. We then outline evidence for the development of these interpersonal factors in clients' histories and how that intersects with treatment planning and provision. Lastly, we compare how current treatment programs use individuals within clients' lives to address interpersonal functioning, as related to these internal and external factors.

## 2. Challenges in Conceptualizing Interpersonal Functioning in Treatment

The principles of effective correctional rehabilitation (i.e., risk, need, and responsivity [RNR]; Andrews & Bonta, 2010; Andrews et al., 1990) shape the framework of most sex-offence-specific treatment programs (Hanson, Bourgon, Helmus, & Hodgson, 2009). Briefly, RNR principles include matching the intensity of treatment to the *risk* of recidivism, targeting services to reduce factors whose change correlates with reductions in future offending (i.e., criminogenic *needs*), and delivering those services in a manner that is sensitive to clients' learning styles and abilities (i.e., *responsivity*). Although evidence supporting the general efficacy of treatment programs is only promising, RNR principles provide a common language to discuss the role of interpersonal functioning (Kim, Benekos, & Merlo, 2016; Schmucker & Lösel 2015).

Clarifying the role of interpersonal functioning in the RNR framework may increase motivation to involve concerned others (Looman & Abracen, 2013; Ward, Melser, & Yates, 2007). In treatment programs, interpersonal functioning is addressed as a criminogenic need of the individual convicted of a sexual offence. Marshall (1989) postulated that a sexual offence can result from an individual's failure to develop meaningful intimacy with romantic partners. Developing the ability to form intimate relationships is now a common part of most treatment programs; therapists focus on developing communication skills, sharing emotional skills, and seeking healthy relationships (Marshall, Marshall, Serran, & O'Brien, 2011). Because treatment occurs in remote settings, it can be challenging to assess the influence of clients' social networks and how well treatment will generalize for individuals re-entering the community.

Interpersonal functioning can also be conceived of as a responsivity factor as the characteristics of the client and others influence the client's ability to benefit from treatment and implement what they have learned. Clients have to learn how to adapt their behaviour based upon the interpersonal functioning of others with whom they have regular or meaningful interactions. Such a non-linear account of causality requires a more robust theoretical framework; ours is based in the social ecological framework, which is the result of applying General Systems Theory (von Bertalanffy, 1950) to human behaviour. Kurt Lewin (1935, 1936) first proposed a perspective of "ecological psychology," in which he argued that individuals exist within external systems of influences.

Bronfenbrenner (1979, 2005) applied Lewin's ecological model to human development. He argued that children are shaped by a series of nested sub-systems that have different types and amounts of

influence across development. These sub-systems are made up of similar elements (e.g., parents, siblings, peers, school, community). Influence is bi-directional, as the child's responses shape their environment, and can occur across multiple systems. A systems-based view of human behaviour provides the ability to construct complex explanations for clients' offending.

Bronfenbrenner's (1979, 2005) work has importance for understanding developmental factors related to criminal behaviour. For example, Kumpfer and Turner (1991) argued that prevention efforts for adolescent substance abuse were most effective when they involved multiple systems of influence (e.g., family, peers) rather than focusing only on the individual. Maintaining antisocial peers are particularly problematic, in both adolescence and adulthood, as they increase risk for future criminal behaviour (Laub & Sampson, 2003).

The social ecological framework has also been applied to theories of sexual offending (e.g., Marshall & Barbaree, 1990; Ward & Beech, 2006). Individuals' immediate social system can contribute to increased risk of offending by introducing a triggering stimuli (e.g., availability of potential victims) that exacerbates underlying internal risk factors (e.g., pedophilia), or reduces opportunities to behave prosocially. Even larger social systems exert influence on risk. For example, community members who express negative attitudes toward individuals convicted of sexual offences may increase the likelihood of offending (Hanson & Harris, 2000). We argue that sexual offending is an inherently interpersonal phenomenon, and thereby treatment may be optimized by more adequately addressing the influence of external systems on the development and maintenance of risk factors.

### **3. Impact of External Factors on Interpersonal Functioning**

Social systems (i.e., interpersonal relationships, the community, and larger social and cultural forces) impact the development of risk for general and sexual criminality. The contribution of external factors within clients' social systems may be undervalued in routine treatment delivery because these factors can be historical (e.g., developmental experiences), not physically present (e.g., intimate partners or family members), or abstract (e.g., social norms). The following section summarizes evidence of the impact of external factors that therapists could consider when developing case formulations.

#### **3.1 Impact of the Family and Peer Systems**

Children learn self-regulation skills and how to interact with others from early attachment figures (Craig, Thornton, Beech, & Browne, 2007). Compared to the general population, men convicted of sexual offences were more likely to have experienced physical abuse, verbal abuse, and neglect (Dhawan & Marshall, 1996; Glasser et al., 200; Levenson, Willis, & Prescott 2016). The frequency of these adverse experiences was positively correlated with greater criminal versatility and a higher frequency of offending amongst men convicted of sexual offences (Levenson & Socia, 2016). These experiences may contribute to a general propensity for rule breaking and criminal behaviour by shaping maladaptive interpersonal behaviors (e.g., argumentative, isolating) that interfere with the development of healthy physical and emotional intimacy (Marshall, 1989; Marshall, Serran, & Cortoni, 2000).

Individuals may also form dysfunctional beliefs about themselves (e.g., that they are unworthy of love or respect) and others (e.g., they are emotionally unavailable), or individuals may view the world as a dangerous and unforgiving place because of their adverse developmental experiences. Individuals who endorse beliefs that condone sexual activity with children or minimize any

associated harm are also more likely to report experiencing sexual violence in childhood (Marshall & Barbaree, 1990). If a client is exposed to violence against women or related patriarchal cultural beliefs early on, he may come to view women as inferior to men and as objects to satisfy his own needs (Featherstone & Fawcett, 1994; Finkelhor, 1984). These learning experiences can form core beliefs (i.e., implicit theories or schemes; Ward & Keenan, 1999) that increase risk for offending (Mann, Hanson, & Thornton, 2010).

Experiencing childhood abuse and insecure attachments to caregivers are factors associated with difficulties in regulating mood states, solving problems, and controlling behaviours (Sperling & Berman, 1994). Children develop the ability to regulate emotional processes through interactions with and observations of prosocial care providers and peers (Marshall, 1993). Attachment figures can model healthy problem solving and coping strategies. These skills are mastered through successful navigations of social encounters (Marshall & Barbaree, 1990). Without these experiences, children often struggle to regulate their internal processes.

When these vulnerable individuals enter puberty without a satisfactory repertoire of interpersonal skills to navigate their environments, it is more likely that their attempts to form healthy intimate relationships will be unsuccessful and result in anger, negative attitudes, and lower self-esteem (Marshall & Barbaree, 1990). Interpersonal and self-regulation deficits increase the probability that individuals will turn to unhelpful coping strategies (e.g., excessive or reliant alcohol use or sexual activity; Hanson & Harris, 2000; Looman, Abracen, DiFazio, & Maillet, 2004). Using sexual behaviour to reduce feelings of anger, tension, or sadness can prevent an individual from learning other effective self-regulation skills. The excessive or reliant use of sex may also set a dangerous precedent for future problem solving, especially if this pairing includes arousal to unhealthy sexual targets (Cortoni & Marshall, 2001). The lack of interpersonal skills and a negative social environment can interact and increase risk for sexual offending.

### **3.2 Couples and Individual Deficits in Adult Intimate Relationships**

Clients convicted of sexual offences report higher levels of emotional loneliness, fear of intimacy, and isolation than individuals without such offence histories (Bumby & Hansen, 1997; Fisher, Beech, & Browne, 1999) - all of which have been connected to problems with conventional sexual functioning (Proulx, McKibben, & Lusignan, 1996). It seems that these interpersonal deficits are less to do with attracting partners than with these relationship qualities that may curb the likelihood of sexual offending (e.g., intimacy, sexual satisfaction). Despite the prevalence of historical external risk factors and current relationship problems, there is a paucity of empirical research on clients' intimate relationships that can inform treatment efforts.

The relationships of individuals convicted of sexual offences may be fraught with more difficulties than others. Individuals convicted of incest offences (and their partners) retrospectively reported more marital conflict in terms of mistrustfulness, lack of mutual friends, and leisure time spent together, as well as emotional instabilities that exacerbate marital problems such as infidelity, sexual dissatisfaction, and lying as compared to individuals with non-criminal histories or individuals with sexual dysfunction (Lang, Langevin, Van Santen, Billingsley, & Wright, 1990; Metz & Dwyer, 1993). Compared with individuals convicted of nonsexual violent or nonviolent offences, individuals convicted of sexual offences were significantly different on most relationship variables, scoring lower on measures of couple self-disclosure, sexual satisfaction, expression of affection, support received and given, intra-partner empathy, and healthy conflict resolution (Ward et al. 1997). These findings provide some information about the functioning of couples post-convictions. However, a limitation of this research is the potential confound of the sex offence conviction worsening relationships and biasing recall. Data was often collected from the male partner only who may give

a more biased appraisal of the relationship than his partner.

Iffland, Berner, and Briken (2014) collected information on personality and relationship attitudes from both heterosexual men convicted of sexual offences as well as their female partners. Many of the female partners (47.1%) had a history of sexual abuse. They also reported being more anxiously attached and had higher rates of neuroticism, conscientiousness, and openness to experience than their male partners. Despite these personality and attachment differences, there were no significant differences between male or female partners regarding relationship attitudes. Both partners highly valued love, eroticism, and understanding - factors that contribute to positive relationship outcomes in couple therapy (Snyder, Mangrum, & Wills, 1993). These studies provide initial evidence that the distress and impairment present within the clients' intimate relationships is substantial, even in comparison to other clinical and forensic populations, despite the presence of some positive prognostic factors (i.e., relationship attitudes).

### 3.3 Broader Familial Problems Related to Sexual Offending

Criminality influences the dynamics of families both directly, through family members' relationships with clients, and indirectly, through community responses to family members because of their association with clients. Incarceration leads to a reorganization of roles within the family unit, including a potential newfound independence for non-incarcerated partners (Farkas & Miller, 2007). Qualitative research has shown that some family members experience an enhanced sense of community and deeper bonds forged through overcoming communication constraints, such as by scheduling visitations, making telephone calls, and engaging in letter writing (Farkas & Miller, 2007). This positivity declines, however, upon release and as reintegration potentially creates new issues for the family (Naser & La Vigne, 2006).

Family members may perceive reintegration as a threat to their new role(s), exacerbating pre-existing problems, or creating new ones (Fishman, 1981). Families who choose to reunite with individuals convicted of sexual offences may be asked to provide housing, along with emotional and financial support (Farkas & Miller, 2007). In a survey of 584 family members of convicted individuals, most (86%) reported experiencing a significant amount of stress, and almost half (49%) felt afraid for their own safety because of their association with the convicted family member (Tewksbury & Levenson 2009). These difficulties can overwhelm family members, leading them to draw support from extended family members and friends (Carlson & Cervera, 1991). This secondary support network may be unsympathetic to clients' family members (Young-Hauser, Hodgetts, & Coleborne, 2016), leading to the deterioration of the family members' social supports and increasing resentment of the client (Farkas & Miller, 2007). For these reasons, clients are often excluded from larger family celebrations and social functions, or shunned completely (Zevitz & Farkas, 2000). Reintegration can be especially challenging if the offences were committed against children, because laws or requirements of conditional release are very likely to place residency and other restrictions on the individual who committed the offence (Tolson & Klein, 2015).

An additional challenge to reintegration occurs when the offences were committed against a family member. In these cases, familial bonds may be irrevocably damaged or broken (Farkas & Miller, 2007). Clients are more likely to experience hostility from family members and there may be considerable fear of reoffending within the family (Ullman & Siegel, 1993). The rights of the individual offended against are likely to come into conflict with attempts to reintegrate the individual convicted of the sexual offence. Even if the family accepts him back, he may not be allowed to live at home because of the access to children. He may not be able to attend school functions or the family may be forced to move to a location far away from schools, daycare centres, or parks. Despite these issues, family members often desire to keep the family intact and choose to reconcile

with the convicted individual (Wiehle, 1990).

These effects are compounded if more than one individual in the family has a criminal history; individual risk factors (e.g., substance use, attitudes) can impede the successful reintegration of the other family member. Remaining family members may compare these two individuals and create expectations or attitudes about the likelihood of successful reintegration based upon one individual's past successes or failures. Few, if any, correctional or community supports are available to aid family members dealing with these problems (Farkas & Miller, 2007).

### **3.4 Stigma and Social Barriers**

Charges of sexual offences confer stigma and lead to social rejection (Ricciardelli & Moir, 2013). During incarceration, these individuals are more likely to experience harassment and violence at the hands of other inmates and even staff. Their experiences are so severe that they will often conceal their status and create more socially acceptable offence histories (e.g., robbery; Schwaebe 2005). Stigma continues upon release into the community, because depictions of individuals convicted of sexual offences fuels public fears. For example, individuals with pedophilia are more disliked by the public than individuals with alcohol problems, antisociality, or sexual sadism (Jahnke, Imhoff, & Hoyer, 2015). Reactions toward these individuals intensify as community registration and notification policies publicize details of their offence history and their residence (Anderson & Sample, 2008).

Because of these external factors, individuals convicted of sexual offences struggle to find employment and stable housing, becoming more isolated (Lasher & McGrath, 2012; Zevitz & Farkas, 2000). Negative community reactions to reintegration of these individuals have been likened to a contagion: fear is created when individuals' criminal histories are quickly disseminated through media and internet outlets, (Hackett, Masson, Balfe, & Phillips, 2015). Policies that increase social awareness about an individual's sexual offence history do not necessarily increase safety - they may only provide a further way to punish and dehumanize (Bedarf, 1995). These external factors contribute to a higher likelihood of recidivism (Taylor, 2015; Zevitz, 2006; Zevitz & Farkas, 2000).

Factors external to the client can influence their rehabilitation and help shape case formulation and treatment. Adopting a social ecological framework motivates therapists to assess how external factors within the client's social networks contribute to the development, maintenance, and worsening of internal risk factors. Therapists should consider how their program prepares clients to be successful in their interactions with others.

## **4. Current Treatment Strategies That Involve Concerned Others**

There is significant variability in the role and involvement of concerned others in sex-offence-specific treatment programs. A 2009 survey reported that approximately half of institutional programs and 80% of community programs in the United States explicitly addressed clients' social networks, but in most cases, the degree of intervention was the provision of psychoeducation (McGrath et al., 2010). Less than 30% of programs offering any type of family or couple therapy. Programs that more directly integrated concerned others varied by setting (e.g., institutional or community programs), type of concerned other (e.g., family, partners, volunteers), and type or timing of inclusion (e.g., consultation, post-release support; Dowden, Antonowicz, & Andrews, 2003; Wilson, Cortoni, & McWhinnie, 2009). The following section includes a review of how concerned others are integrated into treatment programs.

## 4.1 Involving Concerned Others within Institutional Settings

External factors are rarely prioritized in institutional settings beyond post-treatment planning (Laws & Ward, 2011). If relationships are discussed, it is often in the context of internal factors, such as intimacy deficits (Marshall, Marshall, Serran, et al., 2011; Stinson & Becker, 2013). The degree of accountability for completing activities with others and the amount of focus given to selecting appropriate individuals is unclear. Clients need support upon release, as they will likely face stigma, rejection, and hostility when interacting with their families and the community. If clients find program content challenging, practicing skills with others may evoke feelings of shame and reduce motivation to engage in treatment (Castellino, Bosco, Marshall, Marshall, & Veglia, 2011). Having clients build these skills with others will likely improve interpersonal functioning, yet few studies have been conducted.

If intimate partners or family members are involved in treatment, the nature of their role can vary from occasional support (e.g., the Support and Awareness Group, Braden et al., 2012) to regular attendance. Eher, Dwyer and colleagues (1997) examined the impact of having concerned others attend a 90-minute monthly session with 11 clients beyond treatment-as-usual. Concerned others included female partners, mothers, and fathers, with a total of 22 others attending at least one session, but only 12 regularly attending sessions. A one-year follow-up revealed significant reductions in attitudes supportive of sexual offending, based upon therapists' ratings. Clients also demonstrated an increased ability to apply concepts and skills learned in treatment. Both clients and their concerned others reported a more positive attitude toward the clients' sexuality and overall functioning.

The limited research about, or implementation of, similar programs in institutional settings is a gap in the literature that can, in part, be explained by practical limitations of connecting incarcerated individuals with their social networks. Even if family or friends are emotionally prepared to visit the individual during their incarceration, there are practical obstacles. The Federal Bureau of Prisons in the United States (2006) attempts to place clients in institutions that are within a 500-mile radius of their residence, acknowledging that a greater distance may be necessary for security concerns. The emotional and financial costs, distance, and institutional security policies make in-person visits very difficult if not impossible for many families.

## 4.2 Involving Concerned Others in Community Supervision and Programming

Community therapists are much more likely than those in institutional programs to be able to connect clients with social supports (Griffiths, Dandurand, & Murdoch, 2007). One strategy for involving concerned others in community rehabilitation is based in relapse prevention principles (Laws, 1989), where these individuals have been recruited to monitor and report upon clients' functioning (Cumming & Buell, 1996; Cumming & McGrath, 2000). Cumming and colleagues argue that motivating concerned others to report information on the clients' behaviours improves risk assessment and management. Clients are, however, required to discuss their offences and risk factors in detail with their concerned others to prepare them to report to staff. Disclosure of risk-relevant details (e.g., warning signs, risky situations) can indeed improve risk management, but focusing on extraneous offence details and acceptance of responsibility can create an adversarial atmosphere that can be counter-therapeutic and interfere with addressing criminogenic targets (Dowden et al., 2003; Hepburn & Griffin, 2004; Ward & Gannon, 2006).

Community-based support programs (Silverman & Wilson, 2002), including the Circles of Support

and Accountability (CoSA), were developed to help individuals who were at a high risk of committing future sexual offences, yet who did not receive community supervision upon their release from prison because they had served their entire sentences (Mennonite Central Committee of Ontario, 1996; Wilson, 1996). Community members volunteer to act as prosocial guides to model adaptive behaviours and assist clients in meeting their needs as they adjust to living in the community. Although initially apprehensive, most clients in one study (90%) reported that they would have had difficulties adjusting to the community in the absence of CoSA (Wilson, Picheca, & Prinzo, 2005). Two-thirds felt they would have likely returned to crime without help from their support network. Participation in CoSA programs was associated with lower rates of recidivism than expected and an improved community perceptions of safety (Gutierrez-Lobos et al., 2001; Wilson et al., 2005, 2009).

An alternative community-based strategy for clients' family and partners is being piloted in Australia. The Assessment and Support Consultation model (Hawkins & Eddie, 2013) is based on a brief, one-to-two session psychoeducation model for family members of individuals with schizophrenia (McFarlane, Dixon, Lukens, & Lucksted, 2003; McFarlane, Hornby, Dixon, & McNary, 2002). Like risk-based strategies, the therapist gives information to concerned others on the client's current risk factors, but then describes how treatment addresses these needs. This approach provides an opportunity for the client and his concerned others to ask questions and discuss plans for successful reintegration into the community. The flexibility in timing and setting of delivery makes this approach a more feasible option for community therapists.

#### **4.2.1 Multisystemic Treatment for Adolescent Sex Offenders**

Multisystemic treatment (MST) is one of a few comprehensive treatments for adolescents involved in the justice system. What makes these treatments comprehensive is the influence of Bronfenbrenner's (1979) theory of social ecology on the focus of intervention both within the individuals and between the individual and their family system. In addition to the family therapy, traditional cognitive-behavioural interventions, such as altering offense-supportive attitudes, and skills training are given to individuals, as well as to the youth's family and peer group (Henggeler, Letourneau et al., 2009). Delivery of these treatments is highly flexible to the needs of the youth and their family; MST can include individual treatment for the youth, individual treatment for parents or guardians, family treatment, couple treatment, and skills groups. Therapists also give after-hours support and consultation to ensure generalization and skill development for both the youth and their family.

A series of small randomized clinical trials provide preliminary evidence for the efficacy of MST. Youth convicted of sexual offences had lower rates of sexual and general recidivism and spent fewer days spent in detention after attending MST (Borduin et al., 1990; Borduin, Schaeffer, & Heiblum, 2009; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009). Youth receiving MST also had reduced scores on indices of problematic sexual interests, antisocial behaviour (i.e., rule breaking, substance use), and both externalizing and internalizing mental health symptoms (Letourneau et al., 2009). The mediators of change for youth receiving MST were the amount and quality of social support; youth benefited when caregivers were more likely to use an authoritative parenting style (Henggeler, Letourneau et al., 2009). Although a recent variation of MST has been piloted for emerging adults (i.e., individuals aged 17-26 years; Davis, Sheidow, & McCart, 2015), no comprehensive treatment program for adolescents has been formulated or tested for men convicted of a sexual offence. Until such studies are completed, the resource requirements may make MST less appealing for widespread implementation in institutions and community supervision (Chung, O'Leary, & Hand, 2006).

A similar treatment approach is Functional Family Therapy (see Sexton & Alexander, 1999), which differs from multi-systemic therapy because it focuses on the family rather than multiple systems. There is evidence that functional family therapy is effective in reducing delinquency and other unwanted outcomes for troubled youth, however no study has yet demonstrated that functional family therapy can successfully treat youth who have sexually offended

## Summary

Best practice guidelines recommend involving social supports, where possible, in sex-offence-specific treatment programs to address clients' interpersonal functioning. These social supports can be romantic partners, family, or friends who are a positive influence and concerned about the individual's successful reintegration - also referred to as concerned others. Addressing interpersonal functioning with concerned others allows for a multi-level, systemic view of sexual offending that may optimize our understanding of why an individual committed a sexual offence and how we may intervene to prevent further offending.

We presented a view of interpersonal functioning that expanded beyond social skills and individual capacities to include characteristics of intimate partners, family, and friends, and how these sets of factors interact. Individuals convicted of sexual offences often describe patterns of abuse, hostility, and neglect in childhood that can impede the development of social skills and self-regulation, as well as healthy attitudes about others and sexuality. They are also more likely to have intimate partners that have their own problems that make developing and/or maintaining healthy relationships challenging. Relationships are often destabilized by the criminal justice system's response (e.g., incarceration, community notification, registration policies), which in turn can increase risk for recidivism (Lasher & McGrath, 2012; Mann et al., 2010). If social supports are engaged in case management as informants, the power imbalance increases the risk for conflict.

Therapists have used psychoeducation and, in rare cases, systemic therapies for couples and families, to engage social supports in helping to prepare clients return to the community. Systemic therapies provide the best means to address interpersonal dysfunction because therapists can directly address external factors, such as problems experienced by intimate partners or family members and their interactions with clients. However, systemic treatments represent a separate area of competence that therapists must demonstrate by obtaining appropriate education, training, and supervised experiences (Evans, 2011). Training to competently deliver couple or family therapies requires an understanding of the theory and literature on systemic treatment, non-specific therapy skills related to delivery of treatment within a couple or family framework, and intervention-specific skills to engage the couple or family in addressing treatment targets (Nelson et al., 2007).

Setting also creates a barrier to involving social supports. The distant and isolated nature of institutions usually makes it unrealistic for intimate partners and family members to regularly engage with clients in person. While on community supervision, clients' social supports are usually contacted for risk-related purposes and, if the client consents, provided with information about the clients' rehabilitation plan. Psychoeducation-based involvement of social supports has been praised as a cost-effective solution (e.g., Hawkins & Eddie, 2013), but have yet to show efficacy in reducing risk and are not designed to address the problems in clients' social systems. Programs like CoSA more actively address the external factors related to clients' reintegration. Unfortunately, these groups are usually offered for high risk clients who did not receive community supervision prior to statutory release.

In a companion paper, we provide specific recommendations for therapists to involve concerned

others by changing how they deliver treatment. Clients' often have concerned others who are avoidant for many reasons, if they have any positive relationships at all. Increasing motivation and building capacity is important for both the client and people with whom they engage. We describe how to enhance treatment-as-usual by having clients discuss and practice session material with individuals who are concerned about their recovery. The focus of these recommendations will be on adapting treatment delivery in community settings due to the myriad challenges to involving concerned others in institutional settings and consistent evidence that community settings are most effective in reducing risk (Schmucker & Lösel, 2015).

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