Practice standards and guidelines for the evaluation, treatment, and management of sexual abusers: bamboozle no more

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The Association for the Treatment of Sexual Abusers' (ATSA) 2005 Practice Standards and Guidelines (PSG) are reviewed with reference to the American Psychological Association's (2002a) Criteria for Practice Guideline Development and Evaluation. The 2005 ATSA PSG show considerable improvement over the 2001 version, and suggestions are made for further improvements. It is recommended that future iterations of PSG should list standards and guidelines separately, and not include treatment guidelines within the same document. Careful review of empirical research should precede development of treatment guidelines, and it is suggested that there is insufficient empirical basis to warrant the establishment of sex-offender treatment guidelines at this time. Significant public damage sparked by the 2001 PSG has not been repaired by simply replacing the old version with a new model. Repairing the damage to states' laws and rules is a priority for mental-health professionals.

AUTHOR'S NOTE: *I would like to thank Philip Witt for his guidance regarding an earlier draft.*

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What if you were invited to join a club, a voluntary professional association that does not confer any license or certificate to practice,[1] but that requires you to accept its ethical standards as part of your choice to join the club? Considering that being kicked out of a club for having violated ethical standards would be much worse for your professional reputation than never having been a member of the club, you'd be wise to check those ethical standards carefully before deciding whether or not to join the club. It would not be better to have affiliated and violated than never to have affiliated at all.

Psychologists, psychiatrists, and other mental-health professionals whose practices include assessment and/or treatment of people who have been convicted of sex offenses might consider joining the Association for the Treatment of Sexual Abusers (ATSA). I have considered joining ATSA, and when I examined their previous (2001) Practice Standards and Guidelines (abbreviated here as PSG), it gave me the willies. I noted that ATSA's Professional Code of Ethics (abbreviated here as PCE) required adherence to PSG, and I concluded that "in their current form [PSG] does no more than provide a consensus of whims, preferences, and personal theories" (DeClue, 2002b, p. 291). The prospect of promising to accept and follow all of those whims and preferences was scary.

Recently, I learned that ATSA revised PSG, which sparked this review. Guidance for critiquing the Guidelines comes from the American Psychological Association's (APA,

2002a) Criteria for Practice Guideline Development and Evaluation (abbreviated here as APA-CPGDE), and the corresponding Practice Guideline Checklist (abbreviated here as APA-PGC; APA, 2002b). ATSA, of course, is not a division of APA and is not in any way required to pay any attention to APA's CPGDE, but APA-CPGDE is intended to be relevant to developers of documents like ATSA's Practice Standards and Guidelines, as APA-CPGDE was "intended for practice guideline development committees composed entirely of psychologists and for multidisciplinary efforts in which psychologists are involved" (APA, 2002a, p. 1048).

ATSA describes itself as "a voluntary association whose members accept its ethical standards as part of their choice to affiliate" (PCE, p. 1). At first glance ATSA's Professional Code of Ethics is similar to that of other professional associations. Indeed, PCE was modeled, in part, from those of the Tennessee Psychological Association and the National Association of Social Workers (PCE, p. ii). I found nothing in PCE itself that would overwhelm me with a feeling of dread, but, by design, PCE links with ATSA's Practice Standards and Guidelines (PSG) as follows:

2. Professional Conduct…

   (h) Members are responsible for familiarizing themselves with the ATSA Standards and Guidelines.

   (i) ATSA recognizes that members must exercise their professional judgment when interpreting and applying the ATSA Guidelines …

   (j) Any deviations from the ATSA Standards … shall be considered an ethical violation, except to the extent that a Standard conflicts with applicable law or professional regulations that pertain to a member's practice (PCE, pp. 3-4).

Thus those who affiliate with ATSA must agree to abide by their Professional Code of Ethics, and that requires (a) adherence to the ATSA Standards and (b) exercising professional judgment when interpreting and applying the

ATSA Guidelines. It is important for professionals to be able to make this distinction carefully, because any deviation from a Standard is an ethical violation, making the professional subject to possible censure and/or sanctions. APA-CPGDE helps to clarify this distinction:

> Guidelines are created to educate and to inform the practice of psychologists. They are also intended to stimulate debate and research. Guidelines are not to be promulgated as a means of establishing the identity of a particular group or specialty area of psychology; likewise, they are not to be created with the purpose of excluding any psychologist from practicing in a particular area. …
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> Guidelines must be reasonable. … All guidelines should be well researched, aspirational in language, and appropriate in goals.
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> The term *guidelines* refers to statements that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Thus, guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice by psychologists. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional and clinical situation. They are not definitive and they are not intended to take precedence over the judgment of psychologists (APA, 2002a, p. 1048).

Within ATSA's PSG, then, which are the Standards and which are the Guidelines?

Standards

That question is not as easy to answer as one might think, because ATSA's Practice Standards and Guidelines does not have one section labeled "Standards" and another section labeled "Guidelines." The difficulty distinguishing between Standards and Guidelines may also be due in part because the current (2001) Professional Code of Ethics was written to complement the previous (2001) version of the Practice Standards and Guidelines; PCE was not revised in 2005 along

with PSG. Here is what the current (2005) PSG has to say about which are Standards and which are Guidelines:

> For the purpose of this document, **standards** are practices that must be followed and **guidelines** are recommended best practices. The Clinical Membership Requirement section of this document includes criteria established in the ATSA by-laws and therefore these practices are considered standards. Other sections of the document include referenced items adapted from the ATSA Code of Ethics (2001) and therefore these practices are also considered standards. The remaining practices in this document are considered guidelines (PSG, pp. iv – v).

Thus Standards include everything in PSG that falls within the Clinical Membership Requirement section, plus every item that is adapted from PCE and is marked as such. Everything else is a guideline, and professionals should "exercise their professional judgment when interpreting and applying the ATSA Guidelines" (PCE, p. 4). I was surprised to find that the Clinical Membership Requirement consists solely of page 1![2] The only additional Standards are those that reference the Code of Ethics, that is, 5 items in "General Training and Qualification," 19 items in "Professional Conduct," 1 item in "Evaluation," 0 items in "Intervention," 0 items in "Risk Management in the Community," and 0 items in the various appendices. The rest of the Practice Standards and Guidelines are recommended Guidelines.

Thus, as I understand it, ATSA's Practice Standards (distinguished from the Guidelines) could be entirely encapsulated as follows:

1. Adhere to ATSA's (2001) Professional Code of Ethics
2. Adhere to ATSA's Clinical Membership Requirements (p. 1 of PSG; see note 2).

I am pleased to report that the 2005 standards do not create the feeling of unrest that the 2001 version engendered.

Here are two other quotes from PSG that do not meet PSG's definition of Standards, and therefore are themselves Guidelines:

1. Members…agree to abide by the ATSA Adult Male Practice Standards and Guidelines [PSG] and integrate these into clinical and programmatic decision making … (p. vi).

2. The guidelines in this document are written broadly to apply to the varied roles of ATSA members. However, characteristics of individual cases may cause a member not to adhere strictly to a particular practice guideline. In these circumstances, members should document their reasons or rationales for deviating from the guideline (p. v).

Thus practitioners should be familiar with the ATSA Guide-lines, should exercise their professional judgment when interpreting and applying the Guidelines, and when they choose to deviate from the Guidelines practitioners should document their reasons and rationales for doing so. As understood, it is not an ethical violation to deviate from a Guideline, and it is not an ethical violation to fail to document one's rationale for deviating from a Guideline.

Guidelines

In my earlier review of the 2001 PSG I wrote:

> [PSG] is replete with statements of fact for which no data are presented or referenced, at least some of which are not supported by research. For example, [PSG] introduces RP [Relapse Prevention] as follows: "It is very clear that, for people who have engaged in crime, treatments that are structured, skills-oriented, and cognitive-behavioral are more likely to be effective than treatments that are unstructured, insight-oriented, and abstract" (p. 23). This statement is not supported by citing research in [PSG], nor does it emerge from careful consideration of [research]. …
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> In their current form [PSG] does no more than provide a consensus of whims, preferences, and personal theories. … [PSG] provides clear descriptions of the currently most popular approach to sex-offender treatment. The downside is that … [PSG] consistently overstates the degree to which there is empirical support for the treatment's effectiveness. Relapse Prevention is a popular approach to treating sex-offenders, but like sex offender treatment generally, its effectiveness has yet to be established. … Policy makers should not treat ATSA's Practice Standards and Guidelines as a research-based summary of what we know about sex offender treatment (pp. 291-292).

I am happy to report that the 2005 version of PSG makes great strides in *not* overstating scientific certainty regarding professional practices in assessing and treating people who have been convicted of sex offenses. For a prominent example, note the differences between sections regarding Relapse Prevention:

2001: “It is very clear that, for people who have engaged in crime, treatments that are structured, skills-oriented, and cognitive-behavioral are more likely to be effective than treatments that are unstructured, insight-oriented, and abstract” (2001 PSG, p. 23).

2005: “Members are aware that treatment for individuals who sexually offend is an evolving science. Research continues to search for new and more effective treatment methods. Similarly, some current techniques, with continued research, may be found to be ineffective. Practitioners, to the extent possible, engage in evidence-based practice as it emerges. Currently recommended treatment methods include *Relapse Prevention Knowledge and Skills*: Members teach clients how to analyze the typical pathway of events – including external circumstances, thoughts and feelings, and behavioral responses preceding their sexual offenses. … (2005 PSG, p. 23).

Bravo! This is a tremendous improvement.

There is, of course, considerable debate about some of the most important issues in the assessment and treatment of people who have been convicted of sex offenses. Two illustrative examples are (1) How effective is sex-offender treatment? and (2) Which approach to risk assessment is most accurate?

How effective is sex-offender treatment?

There is currently some difference of opinion about what to make of recent studies that do show differences in detected

recidivism between treated sex offenders and untreated controls, because those studies all have significant design limitations. LaFond (2005, pp. 79-80) distinguishes between "the agnostic view" that "simply put, the effectiveness of adult sex offender treatment has yet to be demonstrated" and the "cautiously optimistic view" that "the balance of available evidence suggests that current treatments reduce recidivism, but that firm conclusions await more and better research" (p. 80).

Even the cautious optimists acknowledge that there have been "few high-quality research studies" to support their optimism, the apparent positive effects of treatment might not be caused by treatment at all, and the "treatment effects in reducing sexual recidivism were not large in absolute terms (7%)" (LaFond, 2005, p. 80). That is, treated people were 7% less likely to be detected for committing a new sex crime than those who had not been treated. And there are cautious pessimists. Lalumière, Harris, Quinsey, and Rice (2005, p. 172) have reviewed the treatment of sex offenders in great depth, and "we believe that there are too few well-controlled studies of sex offender treatment to conduct an informative meta-analysis." They "conclude that the balance of available evidence suggests that current treatments *do not* reduce recidivism, but that firm conclusions await more and better research" (Lalumière *et al.,* p. 179). "There is no clarity about whether anyone has demonstrated a specific effect of treatment in lowering sexual offender recidivism. The situation is even worse with respect to rapists in particular. There is simply no convincing evidence that treatment has ever caused rapists to desist or even to reduce their offending behavior" (Lalumière *et al.,* p. 188).

In sum, there is considerable controversy over whether and to what extent sex-offender treatment reduces sexual recidivism. A corollary is that if sex-offender treatment does work, we do not know which treatment techniques or methods work best. Nevertheless, one of PSG's 7 Guiding Principles[3] states

"Most individuals who sexually offend will benefit from treatment oriented to reduce the risk of recidivism by using the treatment interventions shown to offer the greatest promise" (p. vi). At present, that is an article of faith, not a proven fact.

Which approach to risk assessment is most accurate?

This can be addressed succinctly via analysis of one recent, highly influential article, the 2004 meta-analysis presented by Hanson and Morton-Bourgon: "The recent research on actuarial risk assessment with sexual offenders also provided an opportunity to compare different approaches to risk assessment (unstructured clinical, empirically guided,[4] pure actuarial), and to compare the predictive validity of the various actuarial measures" (p. 9). Discussion of the results includes: "Risk assessments were most likely to be accurate when they were constrained by empirical evidence. Unstructured clinical assessments were significantly related to recidivism, but their accuracy was consistently less than that of actuarial measures. … Empirically guided professional judgments showed predictive accuracies that were intermediate between the values observed for clinical assessments and pure actuarial approaches. … For sexual recidivism, the predictive accuracies of the actuarial risk scales were in the moderate to large range. There were no significant differences among the sex offender specific measures" (p. 17). The conclusions are straightforward, right? For predicting sexual recidivism, accuracy is greater using structured professional judgments compared to unstructured clinical judgments; actuarial risk scales were better still; and there were no statistical differences among the accuracies of the various actuarial scales.

But while that succinctly summarizes Hanson and Morton-Bourgon's *discussion* of their results, it misrepresents their data. Hanson and Morton-Bourgon failed to highlight the fact

that the most popular instrument for structured professional judgments performed just as well as the actuarial instruments (see Table 1 on page 32; see also DeClue, 2005).

It is also important to notice "There were no sex-offender recidivism studies that examined the accuracy of risk assessments in which judges were presented with actuarial results and then allowed to adjust their overall predictions based on external risk factors" (Hanson & Morton-Bourgon, 2004, p. 17). This is important because, in practice, I know of no one who uses a pure actuarial approach for sexual re-offense risk assessment.

There is simply no empirical basis for declaring that actuarial assessment (which, in practice, is always adjusted actuarial assessment) is more accurate for predicting sexual recidivism than structured professional judgment. Nevertheless, ATSA Guideline 18.07 states "Members conducting risk assessments use an actuarial risk assessment instrument that is appropriate for the client population being evaluated" (PSG, p. 12). In addition to ignoring the lack of empirical basis for favoring an actuarial (in practice, adjusted actuarial) technique over structured professional judgment, that Guideline fails to recognize that in some cases there may be insufficient reliable information to meaningfully score an actuarial instrument (DeClue, 2002a).

Conclusions

Unlike the previous (2001) version, ATSA's current (2005) Practice Standards and Guidelines do not attempt to turn treatment guidelines into ethical strictures. I do not see the current PCE and PSG as impediments to membership in ATSA. I did not find any aspects of PCE or the Standards in PSG to be insurmountable. However, some ATSA Guidelines are not sufficiently empirically grounded to warrant routine

use, and careful compliance with PSG would require considerable documentation of why a practitioner is using professional judgment to deviate from an unnecessary and (in a particular case) inappropriate Guideline.

In my opinion, it is great progress that the current PSG recognizes that practitioners should consider the ATSA Guidelines in our daily practice and exercise judgment in deciding whether and when to deviate from those guidelines in individual cases. But it creates an undue burden to require documentation each time a clinician deviates from the recommended best practices developed by a consensus of the folks who developed the ATSA Guidelines. There is not enough current scientific evidence about the efficacy of sex-offender treatments to warrant strict confidence in any set of treatment guidelines, and it is silly to expect that what we think we know currently will not change significantly before the ATSA Guidelines are revised again.

Any set of treatment guidelines should be flexible enough to allow practitioners to incorporate new research findings into treatment plans without requiring documentation each time the practitioner deviates from a set of guidelines developed at some point in the (even recent) past (cf. APA-CPGDE 2.7 Flexibility: Practice guidelines recognize the importance of professional judgment and discretion and do not unnecessarily or inappropriately limit the practitioner). To illustrate this point, consider how some recent research might affect treatment of some common medical problems. At the time of this writing two of USA's leading medical journals have reported significant new research articles showing the following *within the past month:*

- The efficacy of calcium with vitamin D supplementation in preventing hip and other fractures in healthy postmenopausal women remains equivocal (Jackson *et al.,* 2006).
- Daily calcium plus vitamin D supplementation for an average of seven years had no effect on the incidence of colorectal cancer (Wactawski-Wende *et al.,* 2006).

- Among postmenopausal women, a low-fat dietary pattern did not result in a statistically significant reduction in invasive breast cancer risk over an 8.1-year average follow-up period. However, the nonsignificant trends observed suggesting reduced risk associated with a low-fat dietary pattern indicate that longer, planned, nonintervention follow-up may yield a more definitive comparison (Prentice *et al.,* 2006).
- A low-fat dietary pattern intervention did not reduce the risk of colorectal cancer in postmenopausal women during 8.1 years of follow-up (Beresford, 2006).
- Glucosamine and chondroitin sulfate alone or in combination did not reduce pain effectively in the overall group of patients with osteoarthritis of the knee. Exploratory analyses suggest that the combination of glucosamine and chondroitin sulfate may be effective in the subgroup of patients with moderate-to-severe knee pain (Clegg *et al.,* 2006).

Each of these findings is likely to affect treatment planning for thousands of medical practitioners and their patients. In light of these new studies, practitioners can choose whether to (a) ignore new scientific evidence and treat patients according to pre-existing guidelines or (b) treat each patient in accordance with individual needs and the best available scientific evidence. If those practitioners were bound by overly specific guidelines comparable to the ATSA Guidelines, then every practitioner who chose option “b” would be required to document the deviation from the old guidelines over and over again.

I submit that the level of knowledge about methods to treat people who have been convicted of sex offenses is not greater than the level of knowledge about methods to prevent or treat hip and other fractures, colorectal cancer, breast cancer, or osteoarthritis. As research data accumulate, recommended best practices change, sometimes with at least temporarily contradictory data and recommendations. At this time there is insufficient scientific knowledge regarding sex-offender treatment efficacy to require clinicians to document reasons and rationales every time we deviate from a particular set of treatment recommendations.

Meanwhile, I continue to hold this opinion, as I expressed in 2002: Policy makers should not treat ATSA's Practice Standards and Guidelines as a research-based summary of what we know about sex-offender treatment. I hope that the more cautious language in the current PSG will be recognized and considered, and that policy makers will not be easily misled.

Caution to any professional organizations or states (*e.g.,* Florida, Illinois) who might consider using ATSA Practice Standards and Guidelines as models for rules or laws regarding the regulation of the assessment and/or treatment of people who have been convicted of sex offenses. Please note that the entire PSG can be encapsulated as follows:

1. Adhere to ATSA's (2001) Professional Code of Ethics.

2. Adhere to ATSA's Clinical Membership Requirements.

The authors of the current PSG have recognized that assessment and treatment of people who have committed sex offenses is an evolving field, as it is for assessment and treatment of other people. The authors of the current PSG have recognized that it was a mistake for the authors of the previous version to try to turn recommended practices into ethical requirements. I hope that the authors of the next PSG revision will recognize that it is unduly burdensome to require documentation of every deviance from the Guidelines. Meanwhile, it would be a mistake for professional organizations or states to turn currently recommended practices into rules or laws.

In my review of the 2001 PSG, I quoted Mann and Thornton (2000, p. 349) as follows: "A commitment to evidence-based treatment is, in our minds, a duty of all sex offender treatment providers. As much as we would like to treat sex offenders according to our whims, our preferences, or our personal theories, we do not serve society responsibly in so doing. As behavioral scientists, our treatment programs must

advance on the basis of evidence." I surmised that the authors of the 2001 PSG shared Mann and Thornton's commitment to evidence-based treatment, but I wrote, "in their current [2001] form [PSG] does no more than provide a consensus of whims, preferences, and personal theories" (p. 291). For the most part, the 2005 PSG does not make sweeping, undocumented and unwarranted claims about scientific evidence proving that certain treatment methods are more effective than others and demanding that practitioners do what the 2001 PSG manual said. Instead, the 2005 PSG encourage practitioners to engage in evidence-based practice, to the extent possible, as it emerges. And PSG notes that techniques described therein are *recommended* best practices, and that they are intended to *guide* practitioners. Strict adherence to particular techniques is not demanded by the 2001 PSG.

Implications

For practitioners

In my previous review, I considered the 2001 PSG to be a barrier to membership in ATSA because they required strict adherence to procedures and techniques for which there was little or no evidentiary basis. The 2005 PSG recognizes that its Guidelines are guidelines, intended to guide practice rather than mandate particular techniques. I am thankful for this change, and I do not consider the 2005 PSG to be a barrier to ATSA membership.

As I mentioned previously, I think it is unfortunate that the PSG recommends that practitioners document their reasons and rationales for every deviation from the ATSA guidelines. I consider that to be unnecessarily burdensome, for example, for a practitioner who routinely uses a structured-professional-judgment instrument such as the Sexual Violence Risk-20 (SVR-20) rather than an actuarial instrument such as the Static-99 in risk assessments. Such a practitioner might consider preparing a document that

describes reasons for his or her routine deviations from practices mentioned in the Guidelines, in lieu of documenting those deviations case by case by case.

For ATSA members

Psychologists in several states (including Texas,[5] Idaho,[6] and Illinois[7]) have reported that legislation instigated by ATSA members has restricted which mental-health professionals can provide services to people convicted of sex offenses and how that treatment must be performed. In each case, those restrictions are reported to go beyond any conclusions that could reasonably be drawn from research regarding the efficacy of sex-offender treatment generally and the efficacy of specific sex-offender techniques. I feared this at the time of my review of the 2001 PSG, and I cautioned that "policy makers should not treat ATSA's Practice Standards and Guidelines as a research-based summary of what we know about sex offender treatment" (p. 292).

As described above, the 2005 PSG (p. 23) recognizes "that treatment for individuals who sexually offend is an evolving science." Only 1 item in the Evaluation section of PSG is a Standard: "18.02 Members who do not believe they can be objective, fair, and impartial in conducting an evaluation refer the potential client to another clinician or agency for these services" (p. 18.07). All other statements in the Evaluation section of PSG are Guidelines. For example, this is a Guideline: "18.07 Members conducting risk assessments use an actuarial risk assessment instrument that is appropriate for the client population being evaluated" (p. 12). Earlier in this review I described why I believe it is wise that this is a Guideline rather than a Standard. At this point, I want to emphasize to individual ATSA members that adherence to Guideline 18.07 is not required by PSG or ATSA's Professional Code of Ethics. Neither you nor a fellow ATSA member nor a fellow practitioner who is not a member of ATSA is violating any Practice Standard or Professional Code of Ethics when using structured professional judgment rather than an actuarial tool in a risk assessment.

Similarly, 0 items in the Intervention section of PSG and 0 items in the Risk Management in the Community section are Standards. Every statement in those sections is a Guideline. It is not a violation of any Practice Standard or Professional Code of Ethics for a practitioner to use Relapse Prevention tools, or to not use them, in an individual case. It is not a violation of any Practice Standard or Professional Code of Ethics for a practitioner to utilize group treatment, or to provide treatment on a one-to-one basis, or in combination. It is not a violation of any Practice Standard or Professional Code of Ethics for a physician treating a particular schizophrenic person who engaged in one deviant sexual act one time during one of many psychotic episodes to treat the patient's schizophrenia as the primary diagnosis, and to make a case-specific decision about whether or not to refer that particular person for ancillary group sex-offender treatment.

All ATSA members should take stock. You should carefully review ATSA's 2005 Practice Standards and Guidelines and recognize that the vast majority of the recommended practices are recommended guidelines, not required standards. There has never been an empirical basis for restricting the pool of approved sex-offender treatment providers to those who have done thousands of hours of treatment with people who have been convicted of sex offenses while under the supervision of someone with an ATSA credential, and there has never been an empirical basis for declaring that "it is very clear" that certain treatments are more effective than others. In the absence of definitive research showing that particular treatments are more effective in reducing recidivism, requiring supervision by members of a particular club is illogical. It may promote uniformity in treatment approaches, but there is no reason to expect that it would enhance treatment effectiveness.

For ATSA as an organization

Because we lack definitive research showing which treatments are most effective, it is possible that the treatment methods that *seem* most promising at this point may not

prove to be the most effective if and when definitive research is ever done. This caution is highlighted by recalling that an estimated 40,000 to 50,000 lobotomies were performed on Americans between 1936 and 1960, over 3,400 by Walter Freeman.[8] Dr. Freeman had a tremendous amount of experience in a medical procedure that was considered to be cutting edge at the time, but has since been discredited. It is possible that some currently popular sex-offender treatment techniques will eventually be recognized to be ineffective, and some may eventually be considered to be unnecessarily emotionally invasive and/or counterproductive.

Such considerations sparked APA's Committee on Professional Practice and Standards (COPPS) to (a) distinguish between *practice guidelines* and *treatment guidelines,* and (b) recommend an expiration date for practice standards.

> Although the terms *practice guidelines* and *treatment guidelines* are often used interchangeably, APA draws a distinction between the two and encourages consistent use of terminology within the association. Treatment guidelines provide specific recommendations about clinical interventions. They tend to be condition or treatment-specific and are typically disorder based (e.g., attention deficit/hyperactivity disorder, substance abuse, depression). For guidance in developing treatment guidelines, refer to the "Criteria for Evaluating Treatment Guidelines" (APA, 2002c). In contrast to treatment guidelines, practice guidelines consist of recommendations to professionals concerning their conduct and the issues to be considered in particular areas of psychological practice (APA, 2002a, p. 1048). …
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> **2.3 Delineation of Scope.** … Practice guidelines are focused on professional practice rather than physical or mental disorders or treatment protocols (APA, 2002a, p. 1049).
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> Guidelines include a proposed expiration date (APA, 2002a, p. 1050).

With this in mind, I recommend that future iterations of the ATSA PSG eschew recommendations about specific treatment procedures. I believe that APA's Committee on

Professional Practice and Standards got it right when they separated practice guidelines from treatment guidelines; and ATSA would do well to make the same distinction in its manuals. A brief excursion into consideration of treatment guidelines is in order.

Treatment guidelines (an excursion)

APA's Criteria for Evaluating Treatment Guidelines (2002c) provides careful reasoning about when and how to develop treatment guidelines:

> Generally, health care guidelines are pronouncements, statements, or declarations that suggest or recommend specific professional behavior, endeavor, or conduct in the delivery of health care services. Guidelines are promulgated to encourage high quality care. Ideally, they are not promulgated as a means of establishing the identity of a particular professional group or specialty, nor are they used to exclude certain persons from practicing in a particular area. There are two different types of health care guidelines: Practice guidelines and treatment guidelines. … Treatment guidelines … provide specific recommendations about treatments to be offered to patients. That is, treatment guidelines are patient directed or patient focused as opposed to practitioner focused, and they tend to be condition or treatment specific (e.g., pediatric immunizations, mammography, depression). The purpose of treatment guidelines is to educate health care professionals and health care systems about the most effective treatments available. *When there is sufficient information and the guidelines are done well*, they can be a powerful way to help translate the current body of knowledge into actual clinical practice (APA, 2002c, p. 1052, emphasis added).

APA's Criteria for Evaluating Treatment Guidelines (2002c) is organized on the basis of two related dimensions for the evaluation of guidelines, *treatment efficacy* and *clinical utility*:

> The first dimension is *treatment efficacy*, the systematic and scientific evaluation of whether a treatment works. The second dimension is *clinical utility*, the applicability, feasibility, and usefulness of the intervention in the local or specific setting where it is to be offered. …

The term *treatment efficacy* refers to a valid ascertainment of the effects of a given intervention as compared with an alternative intervention or with no treatment, in a controlled

clinical context. The fundamental question in evaluating efficacy is whether a beneficial effect of treatment can be demonstrated scientifically. … The question of whether particular interventions have beneficial effects is best answered using research methodologies that have been refined over many years to reduce the uncertainties inherent in subjective judgment alone and to increase confidence in the strength of the intervention. …

Criterion 1.0 Guidelines should be based on broad and careful consideration of the relevant empirical literature.

Evaluation is necessary, regardless of the theoretical derivation of the intervention. Individual studies should be evaluated on the logic of their experimental design. Adequate studies may be compiled using qualitative approaches or quantitative methods such as meta-analysis. When guidelines are based in part on compilations of studies, both the analyses and the individual studies on which they are based should be examined carefully, and alternative hypotheses should be explored.

Criterion 2.0 Recommendations on specific interventions should take into consideration the level of methodological rigor and clinical sophistication of the research supporting the intervention. … (APA, 2002c, pp. 1053-1054).

APA's Criteria for Evaluating Treatment Guidelines (2002c) includes 19 additional criteria, many with several subcriteria. As I mentioned above, I recommend that in future iterations of their Practice Standards and Guidelines ATSA should not lump practice guidelines and treatment guidelines together. If ATSA elects to develop treatment guidelines at all, they would be well advised to do so separately from practice guidelines. I recommend that they begin the process with the question of whether a careful examination of the relevant empirical literature reveals a sufficient number of studies with a sufficient level of methodological rigor to warrant any specific treatment recommendations. My current view of the

empirical literature does not support making any specific treatment recommendations at this time. Recall that Lalumière *et al.* (2005), found "too few well-controlled studies of sex offender treatment to conduct an informative meta-analysis" (p. 172) and concluded "that the balance of available evidence suggests that current treatments *do not* reduce recidivism, but that firm conclusions await more and better research" (p. 179; see also Marques, *et al.*, 2005).

Practice guidelines (we return)

The second sentence in the Intervention section of ATSA's 2005 PSG reads, "Structured, cognitive-behavioral and skills-oriented treatment programs that target specific criminogenic needs appear to be the most effective approaches in reducing rates of reoffending in adult male offenders" (p. 19). This sentence exemplifies many of the problems that continue to plague ATSA's PSG. First, the content of the statement is more relevant to treatment guidelines than to practice guidelines (see the discussion above). Second, no empirical basis is provided to support the statement. Third, in my opinion, there is insufficient empirical basis to support the statement (see *e.g.,* Kriegman, 2006).

I recommend that the current ATSA PSG be made available to the public *immediately* on the ATSA website. The recommendations should be available to people anticipating or currently receiving treatment, practitioners considering joining ATSA, regulatory bodies, and the general public. People should not have to pay $40 for the document, as I did. The 2005 PSG improves over the 2001 PSG by not including this on the title page, apparently referring to the entire manual: PLEASE DO NOT CITE OR QUOTE WITHOUT PERMISSION. (What was *that* all about?)

I recommend that future editions of PSG list Standards and Guidelines separately, to avoid confusion.

Recall that on page v of PSG it is noted that "Characteristics of individual cases may cause a member not to adhere strictly to a particular practice guideline. In these circumstances, members should document their reasons or rationales for deviating from the guideline." I recommend that this admonition be dropped, or at least changed significantly. In its current version, this Guideline might be considered as an "or else" admonition. (You really should follow every Guideline, but if you decide not to follow a Guideline, you should document your reasons and rationales, and they had better be good.) Instead, I would like to see this in a way that conveys the expectation that those who follow reasonable practice guidelines might be less vulnerable to legal or professional challenges, and that for safety's sake, when one chooses to deviate from those recommendations, documenting one's reasons and rationales might help to stave off a professional or legal challenge to one's work. The most important thing to do regarding this Guideline in a future revision of PSG, in my opinion, is to make sure it is clear that this Guideline is, in fact, a guideline (not a Standard). This would fit with APA-CPGDE:

> **2.10 Aspirational Language.** Practice guidelines avoid words such as *should* and *must* because they connote mandatory intent. Such intent is more appropriate for standards rather than guidelines. Words such as *encourage*, *recommend*, and *strive* connote the aspirational intent of practice guidelines and therefore are recommended (APA, 2002a, p. 1049).

For other professional organizations

Other professional organizations should consider the differences between ATSA's 2001 and 2005 Practice Standards and Guidelines.[9] Beware requiring practices for which there may be some consensus within a group of people in a professional discipline, or in a group of people from different disciplines who share some common interests. Unless there is a scientific basis for *requiring* those practices and/or *restricting* practice to a particular subgroup of potential practitioners, there is a risk that practice standards might do more harm than good. APA's Criteria for Practice

Guideline Development and Evaluation (APA, 2002a) and Criteria for Evaluating Treatment Guidelines (APA, 2002c) provide carefully reasoned and practically useful guidance.

PCE declares on page 2: “Ethical principles reflect a code of behavior consistent with the performance of professional duties at the highest level of integrity.” I disagree. Although that sounds admirable, “the highest level of integrity” is reasonable for me to include among my aspirations for my own conduct, but it is unreasonable for me (or a professional organization) to demand that of you. When ethical principles are written *requirements* for a professional organization, they should describe performance of professional duties at a minimally acceptable level. By way of analogy, consider the duties of a licensed automobile driver as he or she approaches a pedestrian crossing a street at a crosswalk. The driver is required to yield the right of way, but is not required to offer the pedestrian a ride and, if he or she is hungry, buy dinner.

Considering that the 2001 PCE (which is still current) and 2001 PSG (now defunct) were written to compliment each other, I suspect that the authors of the 2001 PSG attempted to require that every practitioner perform at what those authors considered to be the best and highest level. The authors of the current (2005) PSG appear to have recognized the futility of that overly ambitious and restrictive approach. Perhaps other professional organizations can learn from ATSA’s mistakes and improvements.

For regulatory bodies such as boards of psychology and state legislatures

There has been some serious bamboozling going on. ATSA’s 2001 Practice Standards and Guidelines were fatally flawed. That has now been recognized by ATSA, and PSG underwent major revision fairly quickly, leading to publication of a revised document in 2005. But overly zealous ATSA

members, emboldened by the fatally flawed 2001 PSG, convinced legislators and other regulatory bodies in several states to enact laws that unnecessarily and arbitrarily restrict who can provide treatment to people who have been convicted of sex offenses and how that treatment must be performed. This is a misuse of professional guidelines: “Guidelines are promulgated to encourage high quality care. Ideally, they are not promulgated as a means of establishing the identity of a particular professional group or specialty, nor are they used to exclude certain persons from practicing in a particular area” (APA, 2002c, p. 1052). Although the 2001 PSG have been discredited and replaced, state laws and rules based on those fatally flawed Standards live on.

In my view, bad laws have been enacted based on flawed standards and guidelines, which were in turn based on inadequate science that was grossly misrepresented. I have no reason to think that those lobbying and advising legislatures and other regulatory bodies were intending to increase the danger to the public. I suspect that their lobbying and advising was motivated by some combination of wanting to protect the public and wanting to enhance their business opportunities by restricting the pool of people legally allowed to perform certain services. But the key points are that recent laws restricting the practice of sex-offender treatment do nothing to protect the public, and — by narrowing the field of practitioners and practices to an arbitrary group — may make it more difficult for some sex-offenders to receive the type of treatment that would be most effective for them. Also, release decisions based on an overly optimistic view of the efficacy of sex-offender treatment would lead to increased risk to the public, as still-dangerous people are considered treatment successes and are released from confinement or probationary restrictions.

Recent laws restricting treatment of sex-offenders were based on a set of Practice Standards and Guidelines that has been recognized as being seriously flawed. The resulting laws and rules are seriously flawed and should be repealed. Similar

laws and rules being pushed now (*e.g.,* in Florida) should be stopped before they are implemented, or promptly repealed if they are not stopped soon enough.

Notes

1. "ATSA does not certify or license practitioners to practice in any discipline and Clinical Membership does not confer the privileges of either certification or licensure to practice in any field" (PSG, p. 1).

2. Here are the ATSA Clinical Membership Requirements in their entirety:

   The educational and professional backgrounds of ATSA members are diverse and members have different sets of skills and knowledge from their courses of study and work experiences. A multi-disciplinary approach can enhance our ability to provide services to individuals who sexually offend.

   1. ATSA does not certify or license practitioners to practice in any discipline and Clinical Membership does not confer the privileges of either certification or licensure to practice in any field. Members are responsible for complying with statutory and regulatory requirements within their respective jurisdictions, including any licensure or certification requirements.

   2. Clinical members of ATSA possess a graduate degree in the behavioral, health, or social sciences or a health-related professional degree from a fully accredited college or university. This does not preclude appropriately qualified students working under the supervision of a clinical ATSA member.

   3. Clinical members of ATSA have engaged in direct behavioral research and/or clinical assessment/treatment of sexual abusers for a minimum of 2000 hours.

3. Think "We hold these truths to be self evident."
4. Also known as structured professional judgment.
5. Mary Alice Conroy, personal communication, 3/4/06.
6. Linda Hatzenbuehler, personal communication, 3/4/06.
7. Kirk Witherspoon, personal communication, 3/2/06.
8. See http://www.mcmanweb.com/article-122.htm.
9. See http://kspope.com/ethcodes/index.php for links to additional ethics codes.

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