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SEXUAL OFFENDER UPDATE: LABELING IN TREATMENT—HELPFUL OR HARMFUL?

Lorraine R. Reitzel, Ph.D. — Contact: lreitzel@houston.rr.com

In the community mental health setting, discussing a diagnosis with a patient is viewed positively. It gives a name to a myriad of symptoms the patient has been experiencing, explains the etiology of symptoms, presents some idea about time course of the disorder, suggests a treatment approach, and documented prevalence statistics may help the patient feel as though they are not alone in their struggle with the disorder. Lately, I've been wondering: do the same potentially positive effects hold true for individuals given the "label" of sexual offenders, or the "diagnosis" of pedophilia or another paraphilia? Or, is it possible that labeling this group of patients (with either the legal term or the diagnostic categorization) has negative consequences on both self-image and treatment success?

Recent literature speaks to the issue of labeling for sexual offenders. For example, Marshall and colleagues (2005) discuss a framework for sexual offender treatment that focuses on the attainment of "good lives" for offenders. This approach seeks to instill hope by discussing offense behaviors as an inappropriate choice to achieve goals such as sexual satisfaction and intimacy, rather than an indicator of underlying character. This approach also works to change global feelings of shame to guilt about specific acts that do not have to be repeated in the future (Marshall et al., 2005). These authors propose that when clinicians label an individual as a sexual offender or (by extension) a paraphiliac in treatment, it suggests that the person is defined by these inappropriate acts. Put another way, the sexual offender label may lead to internal, stable, and global attributions for problematic behavior (by either the offender, the clinician, or both), creating a less than ideal situation for change (Marshall et al., 2005). Thinking about it in this way suggests the minimization of labeling in sexual offender treatment might be best, so that patients can define themselves as "non-offenders" and work toward positive goals in keeping with this image (cf. Yates, 2005). This concept is not new to relapse prevention: In smoking cessation treatment, smokers are encouraged to use their quit date as a point from which they consider themselves "non-smokers." When experiencing a craving, it is suggested patients tell themselves, "I do not need to smoke because I'm a non-smoker now." In essence, seeing themselves as non-smokers (or former smokers) is a part of their relapse prevention plan. Perhaps the same self-definitional emphasis on approach goals is important for sexual offenders in their relapse prevention progress, and the labeling of offenders may be part of that consideration (cf. from the juvenile literature (Thakker, Ward, &

> *"Is it possible that labeling this group of patients (with either the legal term or the diagnostic categorization) has negative consequences on both self-image and treatment success?"*

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President & Program Chairperson
John L. Gannon, Ph.D.
Central Coast Consultancy
897 Oak Park Blvd., #124
Pismo Beach, CA 93449
(805) 489-0665
pres@aa4cfp.org

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John L. Gannon, Ph.D.
Central Coast Consultancy
897 Oak Park Blvd., #124
Pismo Beach, CA 93449
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Editor, Criminal Justice and Behavior
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(518) 377-1312

The Correctional Psychologist Editors
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Tidmarsh, 2006).

In a recent analysis of the intensity of treatment provided as part of California's Sex Offender Treatment Evaluation Program (SOTEP), it was suggested that non-significant treatment effectiveness results for lower risk offenders might have been due to the receipt of too much treatment and supervision for their risk level (as cited in Looman, Dickie, & Abracen, 2005). Please note that, generally speaking, a non-significant treatment effect for low risk offenders may also reflect the very low base rate of re-offending in this group.

That is, offenders might have seen the intensity and duration of treatment as an indicator that they were much more at risk to re-offend than they actually were. Likewise, the intensity of supervision provided to this group after treatment could have reinforced the need for extensive external monitoring in order to prevent recidivism (as cited in Looman, et al., 2005). Looman and colleagues (2005) suggest that this could have resulted in an unnecessary personal identification as a sexual offender, as opposed to a self-image as an individual who has a history of acting in sexually inappropriate ways. In future high-risk situations, individuals who see themselves as sexual offenders may be at increased risk for engaging in sexually inappropriate behaviors. Alternatively, those who see themselves needing to change behaviors, as opposed to changing themselves as a person, may be more likely to practice relapse prevention techniques (Looman et al., 2005). Looman and colleagues (2005) state, "maintaining some semblance of an identity that does not fully embrace the label of sex offender is important in preventing further sexually assaultive behaviors" (p. 343). Consider this – when many treatment programs contain the phrase "sexual offender" in their title, what is being conveyed to those getting treatment in those programs about who they are? Moreover, whereas acceptance of a sexual offender label was previously viewed as an indicator of treatment progress (i.e., increased accountability and responsibility), recent research suggests that acceptance of this label (i.e., admission/disclosure of sexual crimes and endorsement of need for therapy) may have no connection with sexual recidivism risk (cf. Hanson & Morton-Bourgon, 2005).

Of course, diagnosis and labeling have an important purpose in psychology. For example, diagnosis enhances communication between clinicians and enables research to hone in on discrete constructs. However, the importance of labeling and diagnosis in the treatment process between a sexual offender and clinician is less certain. As correctional clinicians providing treatment, we play the ultimate role in how offenders define themselves and view the relapse prevention process. It might be time for the field to more thoroughly examine and discuss the impact of labeling on offenders' treatment, especially in light of recent research suggesting the importance of attention to risk, need, and responsivity principles in treatment (CJI, 2004), as well as the importance of a comparatively gentler, less confrontational approach to treatment for the prevention of recidivism than was the case a decade ago (Schwartz, 2003).

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The Board of Directors is pleased to submit the following names in nomination as AACFP candidates for President (2 years) Dr. Lorraine R. Reitzel, for President-Elect (2 years) Dr. Richard Althouse, and for Secretary/Treasurer (3 years) Mr. David Randall. No other nominations have been received. It is the consensus of the Board that these nominees are well qualified to provide leadership to the Association. Brief statements from each are included on pages 14 and 15 for your review.

Take a few more minutes to complete the ballot on page 13 and mail it to: AACFP Elections, P.O. Box 7642, Wilmington, NC 28403. Ballots will be counted by our accounting firm, Charlton Associates, and the results will be published in the October 2006 issue of *TCP*. Successful candidates will take office on January 1, 2007.

HANSON'S STABLE DYNAMIC FACTORS: CONSEQUENCES OF EARLY ABUSE

Jay Adams, Ph.D. — Contact: jayklaus@msn.com

The expanding literature on the long-term sequelae of childhood abuse can help us to treat sex offenders more effectively. Moreover, an understanding of early childhood trauma can go a long way in reducing the counter-transference which many therapists experience in working with this population. Virtually all the sex offenders I have worked with in the past 25 years have had some history of sexual and/or physical abuse. Hanson (1999) reports that in file reviews of 409 sexual offenders, he found that 75% had been victims of some form of child abuse, physical, sexual, or neglect. These findings are not incongruent with those of other researchers (e.g., Graham, 1996; Lisak, 1997).

Moreover, there is ample evidence in the literature on adult survivors of child abuse to suggest that research findings may actually be under-estimates. Courtois (1988) found that 50% of female incest victims in therapy do not initially reveal their abuse history. Both she and Sgroi (1989) have noted a variety of reasons why clients do not report a history of sexual abuse. Men in our society are even less likely than women to report a history of sexual abuse, for a variety of reasons, including shame, stigmatization and sexual identity confusion (Vasington, 1989). The persistent evidence in the abuse survivor literature of client denial or omission of abuse history challenges the accuracy of Hanson and Bussiere's (1998) findings that a history of childhood sexual abuse was unrelated to sexual re-offense risk. In contrast, another study (Hanson & Harris, 1998), used official records of physical, sexual or emotional abuse and whether the offender had ever been taken into the care of child protective services, rather than self-report. This study found that the early backgrounds of sexual recidivists were significantly worse than those of non-recidivists in terms of abuse, neglect, and placement.

> *"Virtually all the sex offenders I have worked with in the past 25 years have had some history of sexual and/or physical abuse."*

Most sex offenders can best be understood as a sub-group of individuals who have been abused as children, and who have reacted in a manner not unlike other child abuse survivors. Hanson (1999) suggests that a history of abuse may result in a schema or "core belief" among sex offenders that "given all his hard luck, the world owes him something" (p.83). While this may apply to some individuals, the relationship between childhood victimization and later sex offender behavior is actually much more complex and multifaceted. Hanson et al. (1998) have identified a number of "stable dynamic factors" which offer promise to therapists interested in changing sex offender behavior. These factors include intimacy deficits, negative peer influences, attitudes tolerant of sexual offending, problems with emotional/sexual self-regulation, and general self-regulation. Although not identified as such by Hanson et al. (1998), these are all among the long-term consequences of early childhood abuse.

Intimacy deficits, negative peer influences

Difficulty in forming and maintaining intimate relationships is perhaps the hallmark symptom of a history of child abuse. Briere (1992) has des-

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cribed adult abuse survivors as displaying ambivalence and fear regarding attachment and vulnerability, impaired ability to trust, increased anxiety as closeness increases, expectations of re-victimization, and a need to push others away and sabotage relationships. Virtually every writer in the field cites adult intimacy problems as common among adults abused as children (e.g., Courtois, 1988; Jehu, 1989; Gil, 1988; Lew, 1988). Closely related is the need for control cited by numerous writers (McCann et al., 1988; Sgroi, 1989; Evans & Sullivan, 1995; Briere, 1996) as a preoccupation of many survivors of child abuse. The control dynamics of both rape and child molestation have been widely recognized. Hanson (1999) notes, "For some sexual offenders, the act of forcing, controlling and degrading the victim is perceived as more rewarding than any of the sexual elements of the offense" (p.86). For some offenders, fear of adults and fear of loss of control may be as prominent in their offending behavior as deviant arousal.

Moreover, Hanson's second factor, negative peer influences, appears to be closely related to fear of adult intimacy. Individuals with profound self-esteem problems stemming from a history of abuse do not feel comfortable relating to people who feel good about themselves. This increases the likelihood that they will choose to spend time with people like themselves. Relationships based on substance abuse are particularly attractive because they are superficial and require little true closeness. These factors need to be assessed carefully and their origins explored at an emotional level in sex offender treatment.

"So where do child molesters acquire attitudes that support their deviant behavior? The answer may be that their own histories of sexual abuse also laid the groundwork for attitudes tolerant of molesting children."

Attitudes tolerant of sexual offending

Societal attitudes tolerant of rape have been well researched by Malamuth (1981, 1986), who found that an astoundingly high percentage of male college students (more than 60%) acknowledged that they would engage in an act of forced sex if they knew they would not be caught. Movies, lyrics of pop music, and other aspects of our culture are replete with messages that condone rape. Moreover, many of the rapists I have encountered in my forensic clinical practice have been sexually abused by women, which likely also contributes significantly to their later attitudes regarding women. But our society is generally far less tolerant of the sexual abuse of children. So where do child molesters acquire attitudes that support their deviant behavior? The answer may be that their own histories of sexual abuse also laid the groundwork for attitudes tolerant of molesting children. It is an almost universal victim belief that he or she is to blame for the abuse, or somehow deserved it (Courtois, 1988). Individuals of both genders whose childhood sexual violation has gone untreated often express self-damning sentiments such as "I must have been seductive and provocative when I was young" and "I did not physically resist, so I must have wanted to have sex" (Jehu, 1989). Self-blame stems in part from childhood egocentricity, but may also be a way of maintaining an illusion of control. "The victim may choose to believe that 'I got what I deserved' as opposed to the potentially more frightening notion that violence is random and unjust, and that one cannot do things to avoid being victimized" (Briere, 1996, p.15). It is far too threatening for a child victim to believe that his parent is wrong or bad. It is not uncommon, moreover, for victims to be given direct, overt messages by perpetrators that they are responsible for their

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own abuse.

Sgroi (1989) has noted that many sexual abuse survivors in treatment go through a secondary phase of denial which is designed to reduce their feeling that they are "damaged goods": "Having acknowledged the reality of the abuse in the first stage of recovery, the survivor now attempts to minimize the significance of the abuse in order to shield herself or himself from experiencing the emotional pain ...." (p.120). This is perfectly consistent with the view often expressed by child molesters that having sex with children "doesn't really hurt them." It is the offender's self-blame, self-loathing, and denial of harm, stemming from his own unresolved sexual victimization history, which both allows and drives him to create more sexual victims. Again, this is a connection that must be made conscious in treatment and extensively worked through.

Attitudes tolerant of sexual offending are maintained by the inability to feel empathy, or imagine what the victim is experiencing. Empathy for others cannot exist without empathy for the self. This has been confirmed by research in the field of attachment theory. Main and George (1985) found that a group of toddlers known to have been abused, when in proximity to a distressed peer, reacted with agitation and aggression. In contrast, non-abused toddlers reacted with sympathy and comfort. Lisak (1997) examined the relationship between empathy for the self and empathy for others. He concludes, "A number of studies lend support to the link between people's capacity to tolerate their own distressful emotions and their capacity to empathize with others in distress....These findings suggest that there is a relationship between a person's capacity to experience and express their own painful emotions and the capacity to respond sympathetically to the emotional pain of another person" (pp.166-167). He further suggests that, because of the way in which men are socialized in our culture, males are less likely to be able to process their sexual abuse and are therefore more likely to become perpetrators.

Individuals who attain a secure attachment bond with their primary caretaker in the first 2 years of life develop the capacity for empathy. If they are abused at a later age, they may develop a host of other symptoms, and they may even experience deviant arousal, but empathy prevents them from "acting out." In contrast, individuals who begin life insecurely attached to their primary caregiver do not develop empathy. If they encounter later abuse, there is no feeling of connection with others to mitigate violent or sexually aggressive impulses. Moreover, attachment research has found that insecurely attached adults may change their attachment status as a result of a long-term relationship with an adult who is securely attached. Hanson and Bussiere (1998) concluded that, "A negative clinical presentation (e.g., low remorse, denial, low victim empathy) was unrelated to sexual recidivism" (p.357). However, many treatment modules designed to increase victim empathy are primarily cognitive and put little or no emphasis on the perpetrator's own abuse experiences. They may teach offenders "appropriate" verbal responses that have nothing to do with change at an emotional level.

Difficulties with emotional/ sexual self-regulation

Hanson et al. (1998) next cite "problems with emotional / sexual self-regulation" as an important stable dynamic risk factor. Van der Kolk et al. (1996) have contended that the intrusive and numbing symptoms which define PTSD in DSM-IV are really only a part of the clinical picture of the lasting effects of early trauma. "The combination of chronic dissociation, physical problems for which no medical cause can be found, and a lack of adequate self-regulatory processes is likely to have a profound impact on personality dev-

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elopment" (p.86). These effects were more pronounced in subjects who had experienced trauma before the age of 14. Van der Kolk et al. (1996) conclude: "This study supports and amplifies the existing body of research that has demonstrated an intimate association between the diagnoses of PTSD, dissociation, somatization, and a variety of problems with affect regulation, including difficulties with modulating anger and sexual involvement, as well as aggression against the self and others" (p.89).

Hanson (1999) asserts that "Deviant sexual schema gain their power from their sense of urgency" (p.86). This sense of urgency may, in the cases of those who were sexually abused early and severely, be based in neurobiology, as a result of how the young child's brain is affected by, and subsequently processes, trauma (Schore, 1997; Siegal, 1999). The rapidly growing body of trauma literature has important implications for sex offender treatment. An offender who suffers from extreme emotional lability, whose emotions are experienced more intensely, and who interprets emotional arousal in terms of past rather than current events is very likely to become overwhelmed when in the throes of strong negative emotions. Such a person will have difficulty applying a set of complex cognitive strategies, no matter how well he may have learned relapse prevention or how motivated he may be to change his behavior. For some sex offenders, specifically those who have suffered significant early abuse, more treatment time may be required in which to correct affect dysregulation, using the techniques developed by Linehan (1993) and requiring a great deal of repetitive practice to effect lasting change.

Difficulties with general self-regulation

The fifth and final stable dynamic factor identified by Hanson (1999) as significantly related to sex offender recidivism is problems with general self-regulation, which is obviously closely related to the preceding factor. It is defined by Hanson et al. (1998) as "poor self-control and the inability to follow the conventions of society" (p.3). It has to do with the offender's performance while under community supervision and his overall ability to plan ahead rather than acting impulsively, e.g., not quitting a job without first having another job.

Current public policy has greatly increased stress on sex offenders, drastically limiting their ability to find employment and housing. Megan's Laws have created the additional stress of public humiliation and in some case, physical danger. Moreover, adult survivors of abuse frequently have problems with authority, especially if the authority figure reminds them of their abuser(s). A parole agent who confronts them in a punitive, accusatory manner is likely to trigger rebellion and antisocial behavior, not cooperation and compliance. Early abuse actually affects how the child's brain is wired, causing deficits in his ability to modulate emotions and handle stress. These changes at the neurobiological level play a crucial role in what Hanson (1999) refers to it as "deviant sexual schema." Treatment which remains at a purely cognitive level and ignores the importance of affective components and the therapeutic relationship will result in limited therapeutic success. Legislation which puts ever increasing pressure on sex offenders exacerbates the problem, creating an even greater risk of recidivism.

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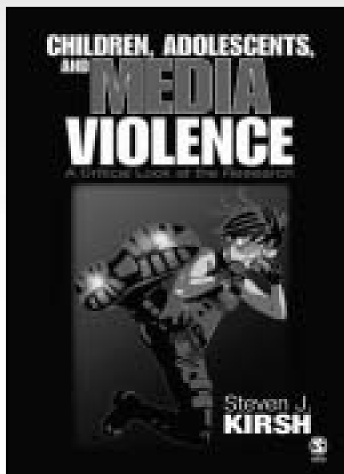

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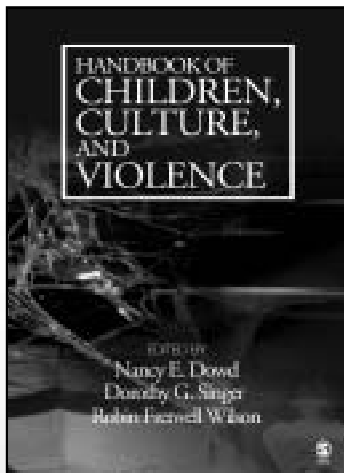

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Nancy E. Dowd, *University of Florida Levin College of Law*
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Professionalism
- The critical balance between treatment and custody
- Ethical issues

Infection Control
- MRSA, Hepatitis C, HIV, TB, Avian Flu
- Hand hygiene
- Antibiotic resistance

Inmate Access to Medical Care
- ACA, NCCHC requirements
- Aging population
- Chronic care clinics

Inmates With Mental Illness
- Assessment and monitoring
- Psychiatric medications
- Suicide
- Crisis intervention teams

Legal Issues
- Key elements of medical malpractice and general negligence
- Red flags for medical record tampering
- HIPAA in the correctional setting
- Defensive documentation

Dealing With Conflict
- Effects of unresolved conflict
- Types of difficult behavior and goals for dealing with each behavior
- Practical strategies for resolving conflict

Objectives

- Learn how to maintain professionalism and the balance between treatment and custody.
- Describe infection control procedures for MRSA, Hepatitis C, HIV and TB.
- List steps for preventing blood body fluid exposures.
- Discuss chronic care clinics as an element of inmate access to medical care.
- Identify and manage the primary psychiatric diagnoses found in the inmate population.
- State how to assess inmates

Biography

Rebecca Hauserman, RN, BC, MSN, CLNC, EMT-B has been a psychiatric nurse for over 30 years. She is currently the Behavioral Health Educator & CISM Coordinator at St. Rita's Medical Center in Lima, OH. She is also adjunct faculty for the nursing program at Rhodes State College in Lima, OH. She is certified in psychiatric and mental health nursing, as well as legal nurse consultant. She has worked in numerous psychiatric settings including a state psychiatric hospital, prison psychiatric hospital, general hospital and community mental health center. At the prison psychiatric hospital she worked as a staff nurse, nurse educator, nurse supervisor, multi-disciplinary treatment team coordinator and infection control nurse.

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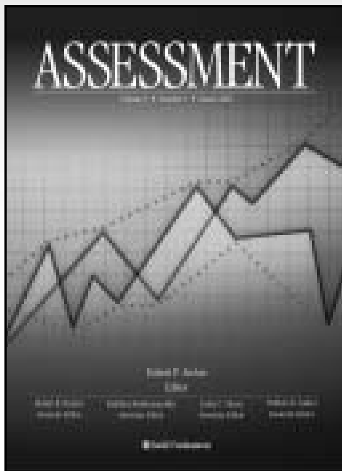

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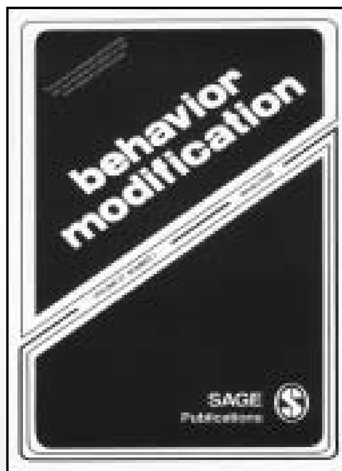

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EDITORS:
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PEARSON ASSESSMENTS TEST CHOSEN FOR ITS QUICK RESULTS AND GROUP ADMINISTRATION

BLOOMINGTON, MN—June 13, 2006—Pearson Assessments today announced that the Delaware Department of Services for Children, Youth and Their Families (DSCYF) selected the BASI (Basic Achievement Skills Inventory) series of tests to assess learning outcomes of students in their school programs. The BASI tests are a versatile, multi-level, norm-referenced series of achievement tests that measure math, reading and language skills for children and adults.

The department provides educational services to approximately 350 students in 10 juvenile justice and mental health school programs at two detention centers. Previously, the assessment instrument they had been using could only be administered individually, requiring a lot of the teachers' time. Theresa Senio, Supervisor of DSCYF's Education Unit, recognized the need to be able to test these students' reading and math levels as a group.

"We need to assess these kids to give teachers useful information that they can employ to develop lesson plans and for student groupings," said Senio. "When I recognized how quickly students were moving through our facilities, we looked for an academic achievement test that would be more conducive to our needs and still meet the students' needs."

Senio arranged for her centers to participate in a pilot study. "I thought that it would be a great experience to pilot it without taking financial risk," said Senio. The teachers in the centers with the highest student turnover rates were especially pleased with the speed at which they received the test results.

The quick and useful test results, along with the ability to administer the tests to groups of students, convinced Senio to replace the individually administered achievement test the department had been using with the BASI tests. The department initially purchased a supply of the paper and pencil version, but now is migrating towards computer-based testing.

When new students arrive at the centers, teachers will administer the computer-based version of the BASI series in an orientation classroom with individual computers for each student. This will allow for group administration and the teachers will get an immediate readout on each student's learning outcomes. Senio says they plan to re-administer the tests to check student progress at least every 6 months, and as often as every 10-12 weeks in some cases. The reports will be kept in the students' files and when students return to their regular school, the reports will be shared with the sending school. More information about the BASI series is available at www.PearsonAssessments.com/tests/basi.htm.

Cut Here

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BALLOT — AACFP 2006 ELECTIONS

FOR PRESIDENT—
LORRAINE R. REITZEL, Ph.D.

☐ YES
☐ VOTE WITHHELD

FOR PRESIDENT-ELECT—
RICHARD ALTHOUSE, Ph.D.

☐ YES
☐ VOTE WITHHELD

FOR SECRETARY/TREASURER—
DAVID RANDALL, MA

☐ YES
☐ VOTE WITHHELD

After Completing the Ballot, Detach and Mail to:
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P.O. Box 7642
Wilmington, NC 28403

CANDIDATE FOR PRESIDENT
LORRAINE R. REITZEL, Ph.D.

My training is as a clinical psychologist. I received my master's degree from East Carolina University in 1997, and my doctorate from Florida State University in 2005. I began working in corrections in 1997, and my experience includes clinical employment with the North Carolina and Florida state correctional systems, as well as two federal prisons in Texas. I have worked with various incarcerated populations, including adult males, adult females, and male juveniles. I have worked in a number of security settings, including medium and close custody prisons, a jail setting, and in two medical centers housing prisoners from an array of security levels. Although my correctional experience has been broad, I have a special interest in treatment and research with sexual offenders. My scientific publications reflect this special interest, as well as my interest in empirically supported therapies and treatment outcome research with underserved populations.

My association with AACFP began in the early 1990s. In addition to being a member, I have been a regular, quarterly contributor to the newsletter, *The Correctional Psychologist*, since 2001. These brief articles continue to reflect my special area of interest, work with sexual offenders, and are intended to keep the membership of AACFP up to date regarding topical areas of research that are relevant to practice in this subfield of correctional and forensic psychology. I also became involved with AACFP's journal, *Criminal Justice & Behavior*, as an ad hoc reviewer beginning in 2001 and continuing to today.

My current affiliation is with the University of Texas, M. D. Anderson Cancer Center, in the Department of Health Disparities Research. My position is a research-based fellowship that allows me to assist in the development and management of federally funded randomized clinical trials designed to explore effective treatments for smoking cessation with health disparities populations.

As president of AACFP, my first goal would be to obtain the requisite approval to offer Continuing Education (CE) credits for current AACFP activities (e.g., The Debate), and develop self-study programs (i.e., book- or journal-based) for CE credit that would be available for AACFP's membership. My second goal would be to establish standing Association committees (e.g., Membership, Awards) that would help to guide the future of AACFP. Additionally, in order to enhance our cohesiveness as an Association, I'd like to see us move toward the development of our own national research conference, and consider the establishment of an Association listserve, based on membership interest.

CANDIDATE FOR PRESIDENT-ELECT
RICHARD ALTHOUSE, Ph.D.

I am currently a psychologist in the Wisconsin Department of Corrections. I obtained my Ph.D. in psychology from Penn State University in l975. My professional experience includes 35 years of clinical experience with both juvenile and adult offenders, working in both correctional and forensic settings in either staff or supervisory positions. Over the years I have supervised correctional psychology interns, provided expert witness consultation and testimony in sex offender and suicide cases, and provided on-going training to both professional and correctional staff on a variety of topics, including ethics and suicide prevention programming.

From the early 1970s through the early 1990s, I was a member and later Fellow of the Wisconsin Psychology Association, founding and editing a newsletter specifically for psychologists in corrections settings, and actively promoting the interests of correctional psychologists in Wisconsin through the state psychology association's Division IV. More recently, I was fortunate to be able to contribute to the development of the

(Continued on page 15)

RICHARD ALTHOUSE, Ph.D. (Continued from page 14)

American Correctional Association and the National Commission of Correctional Health Care health and mental health practice standards. I am a member of the Advisory Board of the Mental Health in Corrections Consortium, and have both presented and contributed to panel discussions at their annual conference on numerous occasions.

I have been an active member and supporter of the American Association for Correctional and Forensic Psychology since l997, and in l998, I was invited by then President David Glenwick to chair the AACP Practice Standards Committee that revised the AACP's 1980 "Standards for Psychology Services in Jails and Prisons," published in *Criminal Justice and Behavior* (2000) as the "Standards for Psychology Services in Jails, Prisons, Correctional Facilities, and Agencies."

I am currently involved with AACFP's Ethics Hot Line, and am a contributing author to a series of articles regarding critical current issues in correctional psychology being prepared for publication. My current research interests include applying systems models to social issues, applying positive psychology to rehabilitative programming, and evidence-based rehabilitative programming.

I have been very enthusiastic about the growth of AACFP over the past 5 years, and I believe it fills a critical need for an association specifically for psychologists and other mental health professionals working in corrections settings. I would be pleased and honored to fill the office of President-Elect to help and support continued growth of the Association.

CANDIDATE FOR SECRETARY-TREASURER

DAVID RANDALL, MA

I received my BS degree from Lee University, and I completed my graduate training at the University of South Florida, receiving an MA in rehabilitation counseling. I am currently enrolled in an MBA program at Walden University.

I have a background in chemical dependency treatment, working for Operation PAR, Inc. for approximately 7 years. Operation PAR is a comprehensive substance abuse/mental health treatment agency located in Pinellas County, Florida. During my years of employment with Operation PAR, I worked in various capacities including Program Supervisor of a 32 bed residential treatment program at Hillsborough Correctional Institution. I also served as the Clinical Director of an Adult TASC program and Department of Correction's outpatient program. While at the agency I was promoted to the position of agency Quality Management Coordinator.

In 1993, I began work for the Florida Department of Corrections. Most of my work with DC has been as a Psychological Specialist providing direct mental health care for mentally ill inmates within the institution. I have extensive experience working with co-occurring disorders, providing sex offender evaluation and treatment, and as a therapist in both inpatient and outpatient settings.

In 2004, I was selected for promotion to the Central Office of Health Services in Tallahassee, Florida, where I work directly for the Director of Mental Health Services. In my current position I am responsible for quality assurance and the coordination of the aftercare planning program for mentally ill inmates re-entering society. I collaborate with multiple federal, state, and community agencies that assist in the successful reintegration of mentally ill inmates back into their communities.

TERRE K. MARSHALL—

The Board regrets noting that our current Secretary/ Treasurer Terre K. Marshall will not be a candidate for office in this election. Terre has been extremely helpful to us during some difficult transitions, and Dr. Gannon and the entire Board express their appreciation for the important contributions she has made.

Robert R. Smith, Ed.D.
The Correctional Psychologist Executive Editor
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AMERICAN ASSOCIATION FOR CORRECTIONAL & FORENSIC PSYCHOLOGY

"THE VOICE OF PSYCHOLOGY IN CORRECTIONS"

The AACFP is a non-profit, educational organization in service to mental health professionals throughout the world. Many of our members are doctoral level psychologists, but neither a Ph.D. nor a degree in psychology is required for membership. If you are interested in correctional and forensic issues, we welcome you to the Association.

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The memberships fee for AACFP is $65.00 per year, paid at the time of enrollment or renewal. Membership includes four issues of our newsletter, The Correctional Psychologist, and six issues of AACFP's highly-ranked, official journal, Criminal Justice and Behavior. (CJ&B will be expanded to 12 issues per year beginning in January, 2007). Membership also includes electronic access to current and archived issues of over 65 journals in the Sage Full-Text Psychology and Criminology Collections.

The easiest way to join AACFP, or to renew your membership, is though our Internet website at www.aa4cfp.org. However, if you prefer, you may also join by mailing this form, with a check payable to AACFP, to our journal publisher, Sage Publications. The address is:

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If you have questions about missing or duplicate publications, website access, or membership status, please contact Ryan Watson at ryan.watson@sagepub.com or at (805) 410-7528. You are also welcome to contact AACFP Executive Director John Gannon at pres@aa4cfp.org or at (805) 489-0665.