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TECHNICAL NOTE

PSYCHIATRY & BEHAVIORAL SCIENCE

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Effect of Sex Offenders Treatment Program on Cognitive and Emotional Characteristics of Mentally Ill Sex Offenders

ABSTRACT: This study assessed the effect of a 10-week cognitive behavior treatment program in 30 mentally ill sex offenders. The effect of the program was evaluated using the Interpersonal Responsiveness Index (IRI), UCLA Loneliness Scale (UCLALS), Coping Using Sex Inventory (CUSI), and Rape Myth Acceptance Scale (RMAS). Data were analyzed using the paired *t*-test. The ability of sex offenders to cope with sexual acts when they faced stressful situations and to accept the rape myth was significantly improved on CUSI ($t = 2.09$, $p = 0.04$) and RMAS ($t = 5.45$, $p < 0.001$). Feelings of isolation and the ability to empathize based on IRI ($t = 0.62$, $p = 0.54$) and UCLALS ($t = 0.88$, $p = 0.38$) were not significantly improved. To prevent recidivism, treatment for mentally ill sex offenders should focus on changes in their cognitive and emotional characteristics in addition to their main psychiatric illness.

KEYWORDS: forensic science, forensic psychiatry, sex offender, cognitive behavior treatment program, mentally ill, recidivism

Sexual crimes often have serious consequences for the victims and their families and cause strong feelings of fear, anger, and concern in society. Recently, the numbers of sex crimes have rapidly increased in Korea. Since 2000, rape and offenses against the Sexual Criminal Law and the Juvenile Protection Law have increased by two, four, and two times, respectively (1,2). However, the majority of sex offenders are not fully aware of the gravity of the destruction caused by their criminal acts. The fact that sex crimes stem from the most fundamental instincts, sexual impulse and aggression, contributes to recidivism among sex offenders despite the imposition of strong legal penalties. The gradually increasing rate that recidivism adds among the total number of sex crimes reflects the nature of these crimes (1,2). Such an increase in recidivism rate indicates that the existing punishments and correctional procedures fail to properly rehabilitate the offenders. Advanced countries have already adopted psychiatric assessment and treatment for rehabilitation of sex offenders (3,4), focusing on the psychopathology frequently found in sex offenders, such as cognitive distortions about sex, biased sexual fantasies, lack of empathy for the victims, and lack of experiences to establish normal attachments in general interpersonal relationships. The goal of the Cognitive Behavior Treatment Program for Sex Offenders (CBTP-SO) is to have offenders be responsible for their criminal acts and to strengthen their cognitive-behavioral ability to avoid high-risk situations that could increase the possibility to offend again on their own accord (3). Over long periods, the scope of CBTP-SO has expanded to include the processes of cognition and perception, attitude, empathy, self-esteem, intimacy, attachments, stress-coping ability, substance abuse, and anger management (4). In Korea, recently voiced opinions indicate that psychiatric treatment for the deviant sexual behaviors of sex offenders is needed to decrease the recidivism rate (1,2,5). The National Institute of Forensic Psychiatry (NIFP), operated by the Ministry of Justice, has been primarily responsible for the hospitalized treatments for sex offenders. Because of the nature of the NIFP providing conditions of special security, the offenders in NIFP were mainly patients with major mental illnesses including schizophrenia, bipolar disorder, mental retardation, or organic mental disorder such as epilepsy, who were proven to be guilty but mentally ill or not guilty by reason of insanity. Treatments for these offenders have mainly been pharmacotherapy and psychotherapy focusing on major mental illnesses. The treatment approach in line with the nature of sex offenders has been highly limited. However, according to Craissati and Hodes (6), sex crimes by patients with schizophrenia or other psychoses could be related to their disinhibition secondary to psychoses. Smith (7) insisted that even though these individuals meet the criteria for mental illness (e.g., schizophrenia), sex crimes occur because of the deviant sexual fantasies of the offenders. According to Gordon and Grubin (8), treatments for psychiatric illness itself are insufficient to prevent the repetition of sex crimes. Thus, additional approaches to treat deviant sexual fantasies that are not directly related to major mental illnesses would be required (8). This study examined whether the cognitive and emotional characteristics of mentally ill sex offenders can be significantly corrected through the CBTP-SO, which includes cognitive

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behavior treatment for sex crimes, self-esteem improvement programs, lectures, and audiovisual education.

Methods

Subjects

The study included sex offenders admitted to the NIFP to undergo compulsory psychiatric treatment instead of being sent to prison because they were proven to be guilty but mentally ill or not guilty by reason of insanity at the time of their crimes based on their mental status examinations. Subjects who scored >40 on the Brief Psychiatric Rating Scale (BPRS) (9), >18 on the Hamilton Rating Scale for Depression (HAM-D) (10), or <70 on the Korean version of the Wechsler Adult Intelligence Scale (K-WAIS) (11,12) and those who were illiterate were excluded because they were deemed incapable of going through the CBTP-SO. Thirty subjects who met the inclusion criteria were enrolled in the study.

Assessment

Psychiatric symptoms were assessed with the BPRS, depression with HAM-D, alcohol abuse with the Michigan Alcoholism Screening Test (MAST) (13), and level of intelligence with the K-WAIS. Psychiatric diagnoses based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) were made by a skilled psychiatrist (14). The risk of recidivism for sex crimes was assessed using the revised STATIC-99 (STATIC-99-R) (15). STATIC-99-R is a tool devised to predict the risk of recidivism for sex offenders, consisting of unchangeable factors influencing the recidivism rate of male adults. Those with a score of 0–1 on the STATIC-99-R were classified as a low-risk group, 2–4 as a medium-low-risk group, 4–5 as a medium-high-risk group, and >6 as a high-risk group (16). The effectiveness of treatment was assessed based on the Interpersonal Responsiveness Index (IRI) (17), University of California, Los Angeles (UCLA) Loneliness Scale (UCLALS) (18), Coping Using Sex Inventory (CUSI) (19), and Rape Myth Acceptance Scale (RMAS) (20,21). The IRI assesses the ability to empathize from a multidimensional angle, consisting of four subscales: Perspective Taking Scale, Fantasy Scale, Personal Distress Scale, and Empathic Concern Scale. The stronger the ability to empathize, the higher the score on the test. UCLALS is a rating scale that measures the subjective loneliness and social isolation felt in friendships and personal relationships. The more intense the subjective social isolation felt, the higher the score (0–60). CUSI was developed to assess the degree to which sexual acts are used as a coping strategy for distress, with four categories of behaviors: sexual fantasy, masturbatory acts, use of pornography, and forced sexual acts. The score increases with the frequency of sexual acts used as a coping strategy as the distress increases. RMAS measures the degree to which the subjects accept society's myth about sex crimes; the test consists of six subscales, including the victim's past sexual experiences, misperceptions about women's behaviors, attribution of rape responsibility to the victim, the victim's rashness, rape fabrications, and the victim's promiscuity and background. The higher the acceptance of these myths, the higher scores on the assessment.

Data collection and analysis were performed in an anonymous manner. All subjects gave informed consent before they participated in the study. This study was conducted with the approval of the Ministry of Justice and according to the guidelines of the Declaration of Helsinki.

Cognitive Behavior Treatment Program for Sex Offenders

The CBTP-SO was developed by amending the existing sex offenders' treatment programs (22,23) developed at the Atascadero State Hospital in California to fit the situations of the NIFP. Cognitive behavior treatment, psychodrama, self-esteem improvement program, lectures, and audiovisual education were components of the program. It was conducted by six professionals including one psychiatrist, two social workers, one psychiatric nurse, one clinical psychologist, and one occupational therapist. The programs were carried out concurrently in a group therapy format, with the 30 subjects divided into three groups of 10 for a session. During the 10 weeks, treatments were carried out twice per week, and the total of 18 sessions lasted 120 min. The treatment program schedule and details are listed in Appendix. Pharmacotherapy provided during the CBTP-SO was suitable for the psychiatric diagnoses to each patient. However, medication was not adjusted during the program. Patients whose psychiatric symptoms were unstable and who required more medication adjustments were excluded from this study.

Statistical Analysis

Descriptive statistics such as average and standard deviation were used for continuous variables. Frequency and percentage were used for categorical variables. The paired *t*-test was used to analyze the change in various scales before and after the CBTP-SO. The significance level was set at $p < 0.05$. The statistical process was conducted using SPSS version 14.0 (SPSS Inc., Chicago, IL).

Results

Demographic and Clinical Characteristics

Among 30 sex offenders, all men, who participated in the CBTP-SO, 23 completed the program. One subject dropped out because of the aggravation of psychotic symptoms, and six have not finished the pretreatment and posttreatment rating scales (Table 1).

The average age of the subjects was 38.7 ± 8.2, and average amount of education was 13.5 ± 3.1 years. Twenty subjects (86.9%) had no spouse (unmarried or divorced). Schizophrenia was the most common psychiatric diagnosis, at 43.5%, followed

TABLE 1—*Demographic and clinical characteristics of the subjects.*

	Participants (N = 23)	Dropouts (N = 7)
Age, year (mean ± SD)	38.7 ± 8.2	39 ± 12.1
Education, year (mean ± SD)	13.5 ± 3.1	13.6 ± 2.1
Unmarried or divorced (%)	20 (86.9)	6 (85.7)
Diagnosis (%)		
Schizophrenia	10 (43.5)	2 (28.6)
Personality disorder	4 (17.5)	1 (14.2)
Mood disorder	3 (13.0)	2 (28.6)
Alcohol-use disorder	3 (13.0)	2 (28.6)
Pedophilia	3 (13.0)	—
No prior treatment (%)	5 (21.7)	—
Problem drinker (%)	20 (86.9)	7 (100)
TIQ (mean ± SD)	91.3 ± 12.3	79.8 ± 8.6
HAM-D (mean ± SD)	7.0 ± 1.8	8.4 ± 1.0
BPRS (mean ± SD)	30.9 ± 7.9	35.6 ± 4.1

TIQ, total intelligence quotient; HAM-D, Hamilton Rating Scale for Depression; BPRS, Brief Psychiatric Rating Scale.

by personality disorders (17.5%), mood disorder (13.0%), alcohol substance abuse (13.0%), and pedophilia (13.0%). Five (21.7%) subjects had no previous history of psychiatric treatments, either with hospitalization or on an outpatient basis. Comorbid alcohol dependence (MAST $\geq$ 26) was high at 86.9%. The average score of HAM-D was 7.0 ± 1.8 and that of BPRS was 30.9 ± 7.9, showing mild symptoms for depression and psychotic symptoms.

Characteristics Related to Sex Crimes

The average number of previous convictions for sexual crimes was 2.3 ± 0.6. The average age at the first arrest for sex crimes was 34.6 ± 9.6 years. The victims of the sex crimes were 12 adults with the highest percentage (52.2%), followed by five elementary school students (21.7%) and five preschoolers (21.7%). The percentage of any unrelated victims was 92.9% and that of any stranger victims was 89.3%. Sixteen subjects (69.6%) showed medium-high to high risk of recidivism. None belonged to the low-risk group (Table 2). Considering that the average IRI score before treatment was 87.8 ± 11.2, the subjects showed a lack of emotional empathy in their overall interpersonal relationships. The average score for UCLALS was 42.3 ± 7.8, suggesting a high subjective sense of isolation. The average CUSI score before treatment was 29.3 ± 12.4, showing tendencies for escaping stressful situations through sexual fantasies or acts. The average score for RMAS before the treatment was 91.4 ± 39.0, suggesting high cognitive misconceptions about rape (Table 3).

Treatment Effects

As shown in Table 3, scores on the CUSI were significantly reduced after treatment ($p < 0.05$), suggesting that the frequency of sexual fantasies or acts the subjects used in response to distress had decreased after CBTP-SO. Cognitive distortion about rape assessed using RMAS was also significantly improved after treatment ($p < 0.001$). In particular, among the six subelements of RMAS, the victim's sexual experiences (the myth that the victim must have had previous sexual experiences), misperception of woman's behaviors (the myth that certain behaviors of women are invitations for sexual intercourse), attribution of rape responsibility (the myth that the responsibility for the sexual violence is on the behavior of female victims and that the blame is attributed to the victim), and victim's pleasure (the myth that the victim wishes to be raped or enjoys it on an unconscious level or the myth that the victims of rape are usually from the low-income families) showed significant improvement, suggesting that the CBTP-SO could be effective in correcting cognitive distortions in sex offenders. On the other hand, the cognitive distortions such as the victim's rashness (the myth that the victim must have contributed to the incidence of rape in some way by having worn something revealing or walking alone in the middle of the night) and victim fabrication (the myth that the victim reported to law enforcement authorities with the concocted rape charge as some sort of a payback to the attacker) did not change significantly. The ability to empathize and the sense of isolation assessed using IRI and UCLALS scores did not change significantly.

TABLE 2—*Characteristics of sexual offenses.*

	Participants (N = 23)	Dropouts (N = 7)
Number of sex offenses (mean ± SD)	2.30 ± 0.63	2.40 ± 0.54
Age at initial sex offense, year (mean ± SD)	34.6 ± 9.6	34.8 ± 13.9
Age of victims (%)		
Preschool	5 (21.7)	1 (14.3)
Elementary	5 (21.7)	1 (14.3)
Middle-high school	1 (4.3)	—
Adult	12 (52.2)	5 (71.4)
Risk of recidivism using STATIC-99-R (%)		
Medium-low risk	7 (30.4)	2 (28.5)
Medium-high risk	11 (47.8)	2 (28.5)
High risk	5 (21.8)	3 (43.0)

TABLE 3—*Effect of cognitive behavior treatment program (n = 23).*

	Pretreatment Mean ± SD	Post-Treatment Mean ± SD	Statistics t	Statistics p
Interpersonal Responsiveness Index	87.78 ± 11.17	86.00 ± 11.15	0.62	0.54
UCLA Loneliness Scale	42.30 ± 7.82	40.26 ± 8.20	0.88	0.38
Coping Using Sex Inventory	29.34 ± 12.44	24.04 ± 7.97	2.09	0.04*
Rape Myth Acceptance Scale				
Rape Myth I	21.00 ± 11.26	9.47 ± 6.24	7.39	0.000†
Rape Myth II	19.86 ± 9.74	15.17 ± 7.98	2.57	0.017*
Rape Myth III	15.69 ± 7.15	11.95 ± 7.48	2.33	0.029*
Rape Myth IV	8.30 ± 4.91	6.69 ± 4.48	1.67	0.108
Rape Myth V	6.65 ± 4.45	5.78 ± 4.25	1.03	0.312
Rape Myth VI	19.86 ± 9.74	7.69 ± 4.67	6.35	0.000†
Total Rape Myth	91.39 ± 39.04	56.78 ± 28.74	5.45	0.000†

Rape Myth I: victim's sexual experiences; Rape Myth II: misperception of woman's behaviors; Rape Myth III: attribution of rape responsibility; Rape Myth IV: victim's rashness; Rape Myth V: victim fabrication; Rape Myth VI: victim's pleasure.

*$p < 0.05$.

†$p < 0.001$.

Discussion

With recent increases in recidivism rates, sex crimes have been highlighted in Korea. Confronting the current recidivism rate of 70%, concern for the limitations of legal punishment in preventing the recidivism of sex crimes is prevalent. The social consensus is that psychiatric intervention should be integrated into the correction process for sex offenders, which has spurred development of new treatment programs for sex offenders (1,2,5). The offenders must be proved to be guilty but mentally ill or not guilty by reason of insanity at the time of their crimes to be admitted into the NIFP. Sex offenders hospitalized in NIFP were those with relatively major mental illnesses. Since its inauguration in 1987 up through 2007, 189 patients committing sexual crimes have been admitted to the NIFP. Table 4 shows the distribution of psychiatric diagnoses. The number of sex offenders with personality disorder or paraphilia, both of which are known to be highly related to sexual violence based on Western studies, was just 7 (3.7%) and 4 (2.1%) respectively. Because of the characteristics of the patients in NIFP, treatments focused on the major mental illness and treatments specialized for sex crimes were not administered. However, the risk of recidivism of the patients in this study assessed using STATIC-99-R was medium to high. Moreover, based on the various scales used to measure the common characteristics for general sex offenders, mentally ill sex offenders also showed distinctive cognitive and emotional characteristics that are in common with those of general sex offenders. Based on these findings, improvement in symptoms of mental illness itself cannot lower the risk of recidivism

TABLE 4—*Diagnostic distribution of patients admitted to National Institute of Forensic Psychiatry because of sex offenses from 1987 to 2007.*

Diagnosis/Age	20–29	30–39	40–49	50–59	60+	Total (%)
Schizophrenia	6	24	33	5	5	73 (38.6)
Bipolar disorder, manic	3	7	7	2	—	19 (10.1)
Personality disorder		2	4	1	—	7 (3.7)
Mental retardation	7	19	9	2	1	38 (20.1)
Epilepsy	1	4	3	1	—	9 (4.8)
Substance abuse	2	4	1	1	—	8 (4.2)
Alcohol-related disorder	—	1	4	4	2	11 (5.8)
Organic mental disorder	2	3	5	1	—	11 (5.8)
Pedophilia	—	3	—	1	—	4 (2.1)
Others	1	3	2	1	2	9 (4.8)
Total (%)	22 (11.6)	70 (37.0)	68 (36.0)	19 (10.1)	10 (5.3)	189 (100)

for sex offenses. The intervention program for the distinct cognitive and emotional problems similar to those of the general sex offenders may be needed to prevent recidivism.

Rape myth and sexual coping strategies were significantly improved after the CBTP-SO. Rape myths refer to the myths that people believe that are different from the truth. Chiroro et al. (24) reported that the higher the degree of acceptance for the rape myth, the greater the tendency to commit sex crimes. Plaud and Bigwood (25) stated that the cognitive distortions about rape worked as factors causing sex crimes. Before treatment, scores on the sex myth scale were also high for mentally ill sex offenders but were significantly reduced after the treatment. This result suggests the possibility of reducing the recidivism rate through CBTP-SO. Moreover, sex offenders are reported to be experiencing an intense sense of isolation and resort to committing sexual activities to relieve such loneliness and to satisfy their need for intimacy. Such desire to relieve negative emotions using sex has its beginning in adolescence. These sexual acts give positive feedback such as control and mastery for teenagers in their development that was rare in their general interpersonal relationships. Such positive reinforcement facilitates their tendency to cope using sexual acts when they faced difficulties such as negative emotions and problems in interpersonal relationships. In fact, it has been reported that many sex offenders resort to a broad range of sexual acts as coping strategies to alleviate the negative emotions arising from severe distress or problematic situations (19). Cortoni and Marshall (19) insisted that by using CUSI, 89% of sex offenders can be differentiated from the non-sex offenders and recidivism of sex crime offenders could be predicted. Considering this point, a sex offender's trait to relieve negative emotions using sexual acts should be corrected. Fundamentally, stressful situations that cause the increase in such sexual acts must be managed. The issues regarding the sense of isolation and the lack of intimacy felt by sex offenders need to be resolved. The fact that the coping strategy through sex has been considerably reduced after completing the program could lead to a positive appraisal that the program could be effective in reducing the risk of recidivism.

However, the sense of loneliness has not improved significantly, indicating that the intense sense of isolation builds over the years because of a number of complex social and psychological factors. There is evidence that child sex offenders have a history of problematic parent–child relationships, significantly lower levels of maternal and paternal care, and thus emotional loneliness across the life span (26). Therefore, it may be difficult to improve this characteristic existing from the childhood through the short-term treatment program. In addition, the ability to empathize is a factor that mediates friendly behaviors (27). The ability to empathize also helps to foster consideration for others and works to inhibit aggression (28). The promotion of empathy among sex offenders has been a core component in the majority of programs in Britain and the United States (29). Empathy is multidimensional and includes not only the cognitive and emotional components but also communicative and relational elements (30). Thus, it is difficult for therapists to enhance empathy, and it is likewise too difficult for sex offenders to learn and generate empathy (31). The correction of such attributes would require a longer-term treatment plan.

Although it is suggested that even the mentally ill sex offenders need cognitive behavior treatment programs specialized for their sex crimes, CBTP-SO had to be readjusted as easier and simpler than general cognitive behavior treatment programs because of the residual symptoms or cognitive impairment of mentally ill sex offenders. Therefore, the assessment and treatment processes for sex offenders with major mental illness must be differentiated from those used for the general sex offenders. Broxholme and Lindsay (32) insisted that distinctive assessment tools or methods must be devised for sex offenders with low intelligence.

Published reports have indicated that the recidivism rate for sex crimes has been high in patients with antisocial personality disorder or pedophilia, who show sexually deviant symptoms. Dunsieth et al. (33) examined the prevalence of mental illnesses in 113 sex offenders referred to the detention center, penitentiary, and probation office. Eighty-four sex offenders (74%) were diagnosed as having paraphilia and 63 as having antisocial personality disorder. The patients with paraphilia had a high comorbid rate with other psychiatric disorders. Although they spent less time in incarceration compared with sex offenders without paraphilia, their victims were greater in number, especially for the victims of juvenile sexual violence. Hanson and Morton-Bourgon (15) conducted a meta-analysis on 82 reports of research on recidivism (analysis of 29,450 sex offenders as subjects). The results showed that deviant sexual preferences and antisocial personality tendencies were the strongest factors in teenagers as well as in adults for recidivism related to sex crimes. However, the patient groups with a high risk of recidivism, such as antisocial personality disorder or pedophilia, were almost excluded from psychiatric treatment in Korea. In the past 6 years, 214 people were admitted to the NIFP, referred for psychiatric evaluations because they committed sex crimes. Among them, 10 subjects (4.7%) were diagnosed as having paraphilia, and only one was sentenced to the compulsory psychiatric treatment in NIFP. In case of pedophilia, psychiatric treatment is effective in reducing recidivism, which indicates

that future intervention programs for this patient group are essential. Based on a 2008 amendment to current law, obligatory psychiatric treatment can be part of a sentence for the sex offenders with psychosexual disorders in Korea. Sex offenders diagnosed with pedophilia now incarcerated throughout correctional facilities nationwide can receive psychiatric treatment if it is needed.

In this study, subjects were heterogeneous in terms of psychiatric diagnoses, educational levels, age range, and the characteristics of their victims. The mental health professionals in the treatment process had difficulty in setting the level of the program and developing a bond of sympathy among the participants. Those difficulties may make it problematic for the participants to get actively involved in the treatment. Because of the brevity of the treatment period, by the time the atmosphere progressed to the point participants felt able to freely share their stories, treatment was completed.

This study has some limitations. First, this was a small study with 23 subjects and no comparison group. It is also difficult to know whether improvement on the RMAS and CUSI scales will have any effect on actually reducing the recidivism rate. Our results should be verified with long-term prospective follow-up studies with larger samples. However, in a recent study by Marques et al. (34), program participants who "got" treatment (had good posttreatment scores on a simple additive scale) reoffended at lower rates than those who did not; the difference was significant for child molesters who show deviant sexual interests. Based on this finding, our results have some meaning. Second, STATIC-99-R used in this study to measure the risk of recidivism has the advantages of being simple and time-effective, but it does not include situational or dynamic risk factors. Given its lack of dynamic factors, it cannot be used to select treatment targets, measure change, or evaluate whether offenders have benefitted from treatment (35). The area under the curve of the STATIC-99-R tends to be smaller when looking at mentally ill offenders. Third, using self-report measures is another limitation of this study. The self-report instruments can be influenced by the defensiveness of the offenders. To reduce this influence, we did not offer any kind of incentives for participating in the program or improving on the assessment scales. Participating in the program was purely voluntary.

Conclusions

This study is significant in that the cognitive behavior treatment program focusing on the nature of sex offenders was used for mentally ill sex offenders. Results showed significant improvements. For the mentally ill sex offenders, the treatment program specialized for their sex crimes had to be provided along with their treatment for major mental illnesses to reduce the recidivism rate. In addition, further cognitive behavior treatment programs that are fit for the characteristics of the mentally ill sex offenders based on accumulated research and experiences should be developed. Long-term studies with adequate follow-up are necessary to determine whether or not such improvements on the assessment scales can be correlated with an actual reduction in the recidivism rate.

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Appendix

Schedule of Cognitive Behavior Treatment Program

Week	Session	Contents
1	Session #1	Orientation
	Session #2	Self-survey assessment
2	Session #3	Lecture 1. The truth and lies about sexual violence Socio-psychodrama 1
	Session #4	Self-esteem improvement program 1 Cognitive behavior program 1. Establishing relationships
3	Session #5	Lecture 2. Is it the sex crime or not? Audiovisual education 1. Video on sexual harassment
	Session #6	Self-esteem improvement program 2 Cognitive behavior program 2. Dealing with negative emotions
4	Session #7	Lecture 3. Sexual harassment from the victim's perspective Socio-psychodrama 2
	Session #8	Self-esteem improvement program 3 Cognitive behavior program 3. Sexual experiences in childhood
5	Session #9	Lecture 4. Self-centered attitude in sexually violent act Audiovisual education 2. Riding the waves Self-esteem improvement program 4
	Session #10	Cognitive behavior program 4 Taking responsibilities for acts of sexual violence
6	Session #11	Lecture 5. The damage to the victims of sexual violence Socio-psychodrama 3 Self-esteem improvement program 5
	Session #12	Cognitive behavior program 5. Taking responsibility for the acts of sexual violence
7	Session #13	Lecture 6. Education on sexual violence (concept of consent) Audiovisual education 3 Self-esteem improvement program 6
	Session #14	Cognitive behavior program 6. Speaking out on the acts of sexual violence
8	Session #15	Lecture 7. Looking at sexual violence from the victim's perspective Socio-psychodrama 4
	Session #16	Self-esteem improvement program 7 Cognitive behavior program 7. Empathizing with the victim's agony 1
9	Session #17	Lecture 8. Empathizing with the victim's pain Audiovisual education 4
	Session #18	Self-esteem improvement program 8 Cognitive behavior program 8. Empathizing with the victim's agony 2
10	Session #19	Self-survey, assessment, and conclusion