CHAPTER 1

A New Approach to Treating Sex Offenders

Sex offender treatment is undoubtedly one of the more difficult and controversial areas of behavioral or mental health intervention. Treatment providers are faced with a number of challenges: sexual crimes that generate strong emotions and negative public sentiment, clients who are reluctant to participate in treatment and divulge deeply personal information about their sexual and violent behaviors, legislative policies that may stigmatize clients and detract from a focus on treatment, personal reactions and frustrations with the treatment process, ongoing concerns about victims and risk management, and questions regarding the effectiveness of available treatment approaches. Individually, any of these factors can make change more difficult. In combination, we face a daunting but not impossible task.

The field of sex offender treatment has evolved since its early days when psychoanalysis, aversive behavior conditioning, and a philosophy of containment prevailed. A number of services now exist for those in need of sex offender treatment. These draw from the broader mental health literature as well as from comparable literatures for addictions and criminology. Yet, as we discuss further below, existing treatment approaches have important limitations.

In this book, we introduce safe offender strategies (SOS), an innovative development in the evolution of sex offender treatment. SOS combines a skills-based curriculum with emerging research on the role of self-regulation in problematic sexual behaviors. This approach signifies a new direction in how we view our clients and the nature of their sexual offending. It builds upon a foundation of empirically supported etiological theory and psychotherapy to equip clinicians with new tools for sex

offender treatment. Unlike most other current approaches, SOS encourages treatment providers to foster a collaborative approach to treatment and elicit individualized change strategies that are consistent with the offender's stated goals and current treatment needs. In this book, we present the theoretical background, features of the client population, treatment techniques, and treatment intervention protocols that are integral to SOS. This text is intended for treatment providers who work with sexual offenders in a variety of settings, but particularly those who are interested in providing long-term or ongoing care for these challenging clients. Our main goals are to familiarize treatment providers with an evidence-based approach to sex offender treatment and to provide material that will be helpful in promoting treatment change across multiple domains.

In the remainder of this chapter, we discuss the current field of sex offender treatments, the limitations of each approach, and how SOS is designed to address these limitations. The chapter concludes with an overview of the rest of the book.

SEX OFFENDER TREATMENT: WHERE WE HAVE BEEN

Current forms of sex offender treatment include cognitive-behavioral approaches, relapse prevention, the good lives model, the risk–needs–responsivity model, sexual addictions, and pharmacological interventions. A brief review of these commonly used treatment interventions follows.

Cognitive-Behavioral Treatment

Recent surveys of North American sex offender treatment providers suggest that over half of all adult sex offender treatment programs use cognitive-behavioral treatment (CBT; McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010). This represents a wide range of possible interventions, given that there are few standardized or manualized CBT approaches for sex offender treatment. As with cognitive-behavioral treatments in general, the underlying theory is that people who commit sexual offenses do so because of offense-supportive beliefs and deviant sexual interests that have been reinforced and strengthened over time. Treatment is thus designed to alter these beliefs, expectations, and interests so that they are more normative and less supportive of offending behaviors. CBT also focuses on decreasing deviant sexual arousal and

increasing or reinforcing normative sexual arousal. This is accomplished through a combination of cognitive restructuring, behavioral reconditioning of deviant sexual arousal, victim empathy training, and social skills training (e.g., Marshall, Anderson, & Fernandez, 1999).

A lack of standardization among different cognitive-behavioral sex offender treatment programs makes it difficult to compare outcomes, as there is much variability in which techniques are utilized, who is selected for treatment, and what outcomes or targets represent successful treatment completion (Rice & Harris, 2003). Though some studies evaluating the effectiveness of CBT for sex offenders have found positive treatment effects (e.g., Marshall, Jones, Ward, Johnston, & Barbaree, 1991; McGrath, Hoke, & Vojtisek, 1998), others have found no significant treatment effects or even found greater change effects in the control or comparison group than in the treatment group (e.g., Quinsey, Harris, Rice, & Lalumiere, 1993; Quinsey, Khanna, & Malcolm, 1998; Rice, Quinsey, & Harris, 1991). Although two recent meta-analyses of treatment effectiveness indicate success in reducing sexual recidivism among treated offenders overall (Hanson, Bourgon, Helmus, & Hodgson, 2009a; Lösel & Schmucker, 2005), Hanson et al. (2009a) caution that this effect is largely dependent on the design of the study rather than on any specific characteristics of the treatment itself. Stronger research designs have produced weak, mixed, or no results, whereas weaker research methodology has been more supportive of treatment effects (Hanson et al., 2009a). Further, few of the common targets of CBT, such as victim empathy, acknowledging the offense, or social skills training, have been significantly correlated with risk of future sexual behavior (Hanson & Morton-Bourgon, 2004, 2005). This finding suggests that targeting these and other related CBT goals may not result in the reduction of future sexual violence.

Relapse Prevention

The second most common approach reported by North American sex offender treatment providers (McGrath et al., 2010) is relapse prevention, a cognitively based therapy originally adapted from the substance abuse treatment literature (Laws, 1989; Laws, Hudson, & Ward, 2000; Pithers, Marques, Gibat, & Marlatt, 1983). Relapse prevention focuses on immediate risk factors that precipitate and perpetuate repeated sexual offending. But relapse prevention does not offer a specific explanation as to what initially prompts a sexual offense. Clients in treatment utilizing this approach are asked to recount their "cycle" of offending, describing

environmental and internal factors associated with one or more of their offenses. The goal is to identify factors that present potential risk for future sexual offending and then to develop a concrete plan for avoiding or coping with these risks.

Critics have noted the inconsistency in clinical service across many programs labeling themselves as "relapse prevention," and marked differences in quality and duration of treatment services, research samples, and measures of treatment outcome (e.g., Hanson et al., 2009a). Much like CBT research, empirical evaluation of relapse prevention's effectiveness has been inconsistent and disappointing. The most prominent and well-designed study involving the use of relapse prevention with sexual offenders was the California Sex Offender Treatment and Evaluation Project (SOTEP). Initial findings suggested some positive trends (Miner, Marques, Day, & Nelson, 1990), but final project results confirmed that there were few, if any, significant differences between treatment and control subjects with regards to sexual recidivism during the posttreatment follow-up period (Marques, Wiederanders, Day, Nelson, & Van Ommeren, 2005).

Surveys have shown a steady decrease in the use of relapse prevention over time, particularly following the 2005 study cited above (e.g., McGrath et al., 2010). In addition to concerns regarding the lack of strong empirical support, other limitations include the adversarial approach and confrontational interpersonal style often associated with the delivery of relapse prevention (e.g., Mann, 2000; Serran, Fernandez, Marshall, & Mann, 2003), doubts about the effectiveness of avoidance as a viable strategy for lasting behavioral change (e.g., Mann, 2000; Mann, Webster, Schofield, & Marshall, 2004), and difficulties with implementing such a cognitively based treatment method with some populations of offenders (e.g., people with intellectual and developmental disabilities).

The Good Lives Model

A growing number of North American sex offender treatment practitioners are using the good lives model (McGrath et al., 2010), a strengths-based, positive psychology approach emphasizing client abilities and values (Ward & Brown, 2004; Ward & Mann, 2004; Ward, Mann, & Gannon, 2007; Ward & Stewart, 2003a, 2003b; Yates, Prescott, & Ward, 2010). The good lives model focuses on common goals and values, characteristics, or experiences associated with psychological well-being. These include concepts like healthy living, autonomy and self-directedness, inner peace, creativity, and social connectedness (Ward et al., 2007).

These values translate into treatment outcomes, so rather than targeting risk factors, practitioners help clients draw on these positive values to improve their circumstances and develop meaningful and satisfying lives. Conceptually, the basic principles of the good lives model harken back to CBT approaches, where beliefs, expectations, and behavioral contingencies interplay with values and goals to direct behavior. As a treatment approach, the good lives model could be described more accurately as a framework rather than a solidified treatment approach, though emerging work suggests that more specific methods of implementing the good lives model lie ahead (Yates et al., 2010).

Empirically, the good lives model has not yet been subjected to scientific study. Information available in the literature is mostly descriptive in nature. At present, no comparative or large-scale research has demonstrated the effectiveness of the good lives model in reducing sexual recidivism. In addition to limited empirical support and the lack of clear separation between the good lives model and the techniques of other treatments, this approach has also been criticized on the grounds of being paternalistic (Glaser, 2011).

The Risk–Needs–Responsivity Model

The risk–needs–responsivity (RNR) model (Andrews, Bonta, & Hoge, 1990; Bonta & Andrews, 2007) is a framework for treatment that is also commonly cited as an overarching treatment philosophy by many programs in North America (McGrath et al., 2010). The RNR model, in brief, posits that there are three crucial elements to be addressed during the course of offender treatment. First, the risk principle holds that we must tailor our interventions to the client's risk of future offending. Those at the highest level of risk should receive the most intensive and structured treatments, while those at the lowest levels of risk should receive less intensive and perhaps less restrictive or supervised forms of treatment and risk management. The needs principle examines the role of criminogenic needs, or targets associated with criminal and sexual offending like offense-supportive attitudes and sexual fantasies, poor social support networks, substance abuse, or other risky behaviors. And finally, the responsivity principle refers to factors that impact the individual's response to treatment, including motivation, engagement, cognitive or learning impairments, level of insight, and general progress in treatment.

These principles are applicable to sex offender treatment and risk management practices (e.g., Hanson, Bourgon, Helmus, & Hodgson,

2009b; Harkins & Beech, 2007; Becker & Stinson, 2011), though not directly prescriptive of treatment practices themselves. Treatment approaches already discussed that are consistent with this framework are CBT and relapse prevention, though it should be noted that because of the inherent focus on risk, the RNR model is generally incompatible with the good lives model (Ward et al., 2007; Ward & Stewart, 2003a, 2003b). Ample empirical evidence suggests that an RNR approach is useful and significant in reducing violent crime recidivism when working with correctional populations (e.g., Dvoskin, Skeem, Novaco, & Douglas, 2011), though this approach has not yet been thoroughly evaluated with sex offender treatment.

Sexual Addictions

Less frequently used but still noted among the literature and treatment provider surveys (e.g., McGrath et al., 2010) are approaches using an addictions model to address the problem of sexual offending. The sexual addiction treatment literature originates from the work of Carnes (1983) positing that sexual offending results from a sexual compulsion or addiction, comparable to alcoholism or substance dependence. The most common form of addictions treatment is a 12-step program promoting abstinence through faith-based support, disclosure, risk management and avoidance strategies, and the help of others undergoing similar problems. While these treatment programs are less often seen in Canadian or U.S. residential treatment programs, they are still prevalent in U.S. community-based treatment environments, where many choose to attend available support groups that use this philosophy (e.g., McGrath et al., 2010). There are virtually no controlled or descriptive empirical studies examining the effectiveness of such treatments (e.g., Gold & Heffner, 1998).

Pharmacological Interventions

Another intervention practice (often used in tandem with other approaches) involves using hormonal agents to reduce or alter sexual drive, more commonly known as "chemical castration." These hormonal agents, collectively known as antiandrogens (e.g., cyproterone acetate, gonadotropin-releasing hormone analogue, leuprolide acetate, and medroxyprogesterone acetate), work by either breaking down and eliminating testosterone, interfering with the production of testosterone by inhibiting leutinizing hormone, or increasing other hormones like

estrogen and progesterone. Use of these agents may result in the reduction of sexual drive or physiological arousal, and the assumption is that this will produce a similar reduction in sex offending behavior. However, while some uncontrolled studies suggest that these agents do noticeably reduce sexual arousal (e.g., Maletzky, Tolan, & McFarland, 2006; see also Briken & Kafka, 2007), comparable reductions in sexual recidivism have not consistently accompanied such changes (e.g., Maletzky, 1991; McConaghy, Balszczynski, & Kidson, 1988). Furthermore, significant negative side effects (Giltay & Gooren, 2009), medical and legal ethical concerns, and compliance problems have plagued the use of such medications in many subsamples of men with histories of sexual offending.

A confusing picture emerges from this examination of current sex offender treatment practices. Though each approach has its strengths, notable limitations prevent us from knowing whether or not these interventions will promote change in persons with a history of sexual offending.

SAFE OFFENDER STRATEGIES

SOS offers a new, empirically based framework for treatment that is designed to address some of the problems of the other approaches described above.

Standardization

One of the most prominent criticisms for nearly all forms of sex offender treatment, including those most frequently used like CBT, relapse prevention, and the good lives model, is that there is little consistency across different sites and treatment providers. Each program calling itself "relapse prevention," for example, may look different. This is problematic from an empirical research perspective (e.g., Hanson et al., 2009a), and because one can never be sure that the treatment being claimed is in fact the treatment being implemented. Although these approaches have a common set of goals and treatment targets, there are no manualized protocols or structured texts readily available to assist treatment providers in consistently applying treatment principles. This is not so with SOS. This book presents a structured, manualized approach to treatment. It offers a common set of treatment principles, techniques, and protocols that are to remain consistent across sites and clinicians while allowing flexibility in individual treatment planning.

Multi-modal Self-Regulation Theory

Several of the treatments described above lack a strong, empirically based etiological foundation. This is especially true of relapse prevention, which does not address the development or cause of a client's sexual offense, but this is also true of other approaches that emphasize treatment targets not supported by the empirical literature as relevant factors in sexual offending (e.g., victim empathy, denial). Recent etiological research suggests that an important component in the development of many maladaptive behaviors, including sexual offending, is self-regulation and self-regulatory deficits (e.g., Stinson, Sales, & Becker, 2008; Ward & Gannon, 2006; Ward, Hudson, & Keenan, 1998). We have proposed a theoretical model focused on the role of self-regulation in the development and maintenance of maladaptive sexual behaviors. Called the multi-modal self-regulation theory, it explains these complex phenomena (Stinson, Sales, & Becker, 2008). Preliminary evaluations of the relationships between self-regulatory deficits and maladaptive outcomes have demonstrated significant correlations between these deficits and criminal behavior, substance use problems, suicidality or self-harm, and sexual behavior problems in selected samples of sexual offenders (i.e., sexually violent predators: Stinson, Becker, & Sales, 2008; seriously mentally ill sexual offenders: Stinson, Robbins, & Crow, 2011). We have incorporated these ideas into SOS so that the treatment identifies and targets offenders' self-regulatory deficits. Thus SOS not only addresses the immediate problem of sex offending but also improves the offender's ability to manage emotional, cognitive, and interpersonal distress that may lead to it.

Therapeutic Style and Clinical Strategies

Many approaches to sex offender treatment are characterized by detached and artificial therapeutic relationships, little attention to the client's goals in treatment, and client–therapist interactions that are harsh, confrontational, critical, and judgmental. Discussions of these problems have appeared in the sex offender treatment literature (e.g., Mann, 2000; Serran et al., 2003), and positive psychology approaches like the good lives model and individualized methods like the RNR model have sought to change how providers interact with clients and individualize their treatment. SOS also advocates a different philosophical and interactional style for effective intervention. It is based on the common elements that have been found to characterize effective psychotherapeutic treatment and

includes the therapeutic alliance, therapeutic interpersonal style (e.g., warmth, empathy, and caring), therapist experience with a particular treatment, and client self-direction in treatment (e.g., Luborsky, Auerbach, Chandler, Cohen, & Bachrach, 1971; Messer & Wampold, 2002). These features have all been incorporated into SOS.

Empirical Support for Treatment Effectiveness

As noted, few current forms of sex offender treatment have generated strong empirical support. Research at best is mixed and at worst suggests no significant effect of sex offender treatment on sexual reoffending. The possible reasons range from inconsistent treatment implementation to weak research design to problems in the treatment itself. Also, some treatment-as-framework approaches do not readily lend themselves to rigorous empirical study. SOS has as yet only been subjected to pilot testing at three sites. Still, early findings (discussed in Chapter 2) suggest some support for the effectiveness of this treatment. Its standardization facilitates further research efforts.

SOS is also premised on a number of empirically based methods and therapeutic traditions, like the treatment targets and risk factors identified by the sex offender risk literature (e.g., the protective nature of social support, adaptive self-regulation, regulation of sexual urges and impulses, and prosocial beliefs and behaviors consistent with cognitive self-regulation; Hanson et al., 2009a) as well as the general criminology literature (e.g., the RNR model; Dvoskin et al., 2011; Hanson et al., 2009b). Furthermore, techniques like self-monitoring and skills-based therapy for the development of adaptive self-regulatory functioning are consistent with other empirically supported models like dialectical behavior therapy (DBT; Linehan, 1993), and other cognitively based approaches for mood and behavior management.

AN OVERVIEW OF THIS BOOK

In this chapter we have discussed the current approaches in the field of sex offender treatment and introduced some key features of SOS. Chapter 2 presents the theoretical basis of SOS, with a complete review of the multi-modal self-regulation theory and the empirical basis for this etiological framework. We also discuss how this theoretical viewpoint translates into a treatment approach. Some pilot data from early implementation using inpatient sexual offenders with serious mental illnesses

and intellectual or developmental disabilities is also covered. SOS uses a modular treatment approach, with 10 distinct treatment modules, each spanning multiple sessions, that address clients' treatment targets and needs. Chapter 3 gives an overview of the 10 modules and their format along with a discussion of overall treatment length and structure. We additionally review other pragmatic considerations, such as therapist qualifications and target client population, as well as pretreatment tasks for the treatment provider and methods of measuring client progress. Chapter 4 emphasizes case conceptualization, individualized treatment planning, and fundamental conceptualizations of clients with the SOS frame. This chapter also includes discussion of building a therapeutic relationship with such challenging clients, and strategies for working with clients that will aid clinicians throughout the treatment process.

Subsequent chapters present the materials and protocols that are the fundamental components of SOS. Module 1 (Chapter 5) introduces the treatment. Treatment providers collaborate with clients to orient them to treatment and help them develop relevant treatment goals. In Module 2 (Chapter 6) clients are presented with a number of basic treatment concepts, including sexual health and education, the nature of sexual offenses, and the presentation of the theoretical causes of offending and the role of self-regulation for the clients. Module 3 (Chapter 7) is the first of three modules aimed at different domains of regulation. Here, we address emotional regulation, with a discussion of emotions, emotional distress, maladaptive behaviors, and emotion regulation skills. Sexual behaviors, including normative sexual interests, fantasies, masturbation, and pornography, are introduced in Module 4 (Chapter 8). Covering this material in therapy provides clients a basis for later discussions of sexual relationships and sex-related cognitions. Because personal commitment and individualized treatment goals are such a crucial component of this treatment, clients return to a review of their commitment to treatment, self-assessment of their readiness to change, and reevaluation of treatment goals in Module 5 (Chapter 9).

Module 6 (Chapter 10) turns to the cognitive domains of self-regulation, with a concentration on expectations and beliefs about interpersonal relationships and the ability to regulate thoughts and perceptions about others. This discussion examines important beliefs and expectations, how these may be linked to maladaptive sexual behaviors, and cognitive regulation skills. Interpersonal regulation is addressed in Module 7 (Chapter 11), reviewing the role of expectations and boundaries in relationships, conflict with others, problem solving, and interpersonal regulation strategies. The clients' own experiences of trauma or

negative events as well as their reactions to their own harmful behaviors are included as the subject of Module 8 (Chapter 12). In this module, treatment providers cover key elements of the impact of trauma, acceptance versus forgiveness, and repairing damaged relationships with others. Finally, Modules 9 (Chapter 13) and 10 (Chapter 14) conclude the treatment with a review of self-management strategies, adaptive skills, and future treatment and aftercare needs, as well as a review of the client's commitment to ongoing treatment and progress made thus far. Tables and sample worksheets throughout these chapters will aid treatment providers in conceptualizing group discussion.

The book closes with a discussion of the role of families in treatment, aftercare, and community reintegration concerns, including the relationship between treatment progress and dynamic measures of risk (Chapter 15). Tables within this chapter provide additional materials and information to assist with aftercare planning.

Chapter 2 now details the theoretical and empirical basis for SOS. This foundation is important, as it facilitates our understanding of intricate relationships between the 10 modules of treatment and the therapeutic techniques designed to promote client growth and change. Learning these underlying principles will assist treatment providers in case conceptualization, the formation of therapeutic relationships, and ultimately the implementation of the therapy itself.

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