

Lessons Learned from History and Experience: Five Simple Ways to Improve the Efficacy of Sexual Offender Treatment

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Abstract

This article chronicles the development of the field of Sexual Offender Treatment in the United States since the 1980's. It offers an analysis of the Relapse Prevention model, a case study, and a summary description of contemporary field advancements. Through historical and personal reflection, the author summarizes lessons learned as five simple strategies to enhance the efficacy of Sexual Offender Treatment: (1) Focus first on the client's self, assessing and treating old wounds, (2) highlight affective factors, (3) cultivate empathy for the abuser and a landscape for change, (4) embrace the mystery of wholeness, and (5) care for the therapist.

This article emphasizes and urges a re-focusing in the field of sexual offender treatment in order to both recognize the importance of and prioritize participant response to treatment delivery, the impact of the therapist upon treatment outcome, and a return to the basic principles of general psychotherapy.

Keywords

sexual offender, sexual offender treatment, relapse prevention treatment, sexual offender treatment efficacy

When I was asked to write an article in response to the questions, "Where has the field of Adult Sexual Offender Treatment come from?" "What have you learned through your experience in this field?" and "Where do you think the field is headed?" I was pleased because these questions reflect the historical and personal contemplative approach that guides my own professional development. Indeed, among the principal lessons of our collective journey toward reducing the prevalence of sexual abuse is the indispensable value of a long-lensed perspective that takes in both the history of events and ideas, as well as the experience of those who have walked before and alongside. Absent a commitment to self-reflection as individual professionals and as a field, our solutions will merely be unhelpful reactions and re-enactments to the powerful phenomenon of abuse to which we delve. Embedded in the questions Phil Rich poses to our field in organizing this special journal issue is the valuable reminder that even as healers we can get lured into the cycle of abuse and unintentionally promote solutions that beget further problems.

■ The History of Sexual Offender Treatment in the United States

In the United States, Sexual Offense Specific Treatment emerged as a unique branch of psychotherapy in the 1980s alongside the momentum of the Women's Movement (D'Orazio, Arkowitz, Adams, & Maram, 2009). For the first time in national history, societal attention focused on the problem of abuse against women and children perpetrated by men. Rising from the knowledge that the extant sociopolitical culture had been suppressing the reporting, arrest, and conviction of crimes of abuse upon women and children, there was a spring-like blossom of criminal justice sanctions for sexual offending. Penal codes criminalizing sexual abuse expanded exponentially, rates of detected sexual

offending skyrocketed, and the sexual offender inmate population soared.

Psychiatric facilities that had theretofore primarily treated the psychotically mentally ill found themselves accommodating burgeoning rates of paraphilic and personality disordered patients. The "newly discovered" social malady triggered a pressing demand within criminal and civil justice systems for large-scale treatment programs. Born out of a too long ignored social problem, Sexual Offender Treatment represented a component of justice for a victimized class.

Relapse Prevention (RP) treatment was developed in the 1980s in the substance abuse field by Marlatt and Gordon (1985) who promoted the idea of addiction as a byproduct of social learning as opposed to being a type of biological disease. The RP approach sought to address the problem of maintaining abstinence after treatment; despite initial success in overcoming substance abuse, 80% of substance abusers seemingly fell prey to beliefs they were afflicted and powerless by addiction, and relapsed within just 12-months of treatment (Hunt, Barnett, & Branch, 1971). Central to RP is the theory of a Relapse Cycle where relapse is the result of small knowable events that occur over time rather than in an all or nothing and uncontrollable manner. RP's premise is that abstinence is empowered by the identification of risk factors that drive the abuser toward re-lapse and self-management strategies to avoid or cope with these risks.

As the pendulum of psychotherapeutic popularity swung from psychoanalysis to behaviorism, landing in the 1980s on Cognitive Behavioral Therapy (CBT), pioneers like Gene Abel and Judith Becker popularized CBT as the method of choice for everyone who was anyone in the field of sexual abuse treatment. In an effort to resolve the problem of an exploding sexual offender population at California's Atascadero State Hospital (ASH), an emerging psy-

chologist, Janice Marques, attempted to crossbreed the two applications of abuse treatment – the RP approach of the substance abuse field and CBT. She convened at ASH with Bill George, Richard Laws, Bill Pithers, and others to discuss how the innovative RP model might apply to the problem of sexual offense recidivism. The Relapse Prevention Model of Sexual Offender Treatment was born (Marques, 1982)! Since its timely birth in the 1980s, RP has gained enormous popularity and has been applied to many disorders of impulse control; for example, sexual behavior, gambling, spending, shoplifting, and domestic violence.

Almost twenty years later, as a psychologist myself at ASH, I sat at the same tables Dr. Marques and her colleagues sat. I contemplated the same problem, "How can programming be improved to reduce the rate of sexual offense relapse among repeat sexual abusers?" I had experienced the staff at ASH become overwhelmed with the increasing population of sexual offenders, desperately longing for the days when the place they worked was filled with "simpler offenders, more acutely mentally ill but less emotionally draining." On the contrary, I had sought work there for the very opportunity to work with sexual offenders. My eventual promotion to the post of directing the sexual offender treatment and evaluation program at the newly built Coalinga State Hospital, designated to serve only the sexual offender population, may have been more the result of lack of other candidates than my unique merits.

In the early years of the 21st century, societal disdain and rejection of sexual offenders reached an unprecedented peak, reciprocally pervading news media and political platforms. This pandemic of sensationalized emotional responding to sexual offending resulted in reactive, disorganized and severe criminal justice responses. Irrefutably, sexual offenders have become the pariahs of American society, viewed as more like monsters than fellow human beings. The Governor of California, the body builder, action film actor Arnold Schwarzenegger-turned "Governator," boasted his goal of making California have the toughest laws on sexual offending (Schwarzenegger, 8/16/05). Civil commitment laws for sexual offenders, commonly called "Sexual Predator Laws," reached an all time high in twenty states plus the District of Columbia (Thornton & D'Orazio, 2013). Arguably due to this era of impossibly stringent, financially irresponsible criminal justice responses to the problem of sexual offending, current programs are undergoing significant cut backs, some operating with scarce resources available for critical operations. Meanwhile and sadly, entertainment media continues to flood our children with provocative sexual and violent messaging. When a society's message systems both condemns a class of people whose sexual behavior is considered to be abusive and also promotes early and prevalent sexualization, it both begets further problematic sexual behavior among its members and undermines the kind of self-repair necessary for offenders to rise out of that class.

■ Challenges of the Relapse Prevention Model

Sexual Offender Treatment continued to evolve during the first decade of the 21st century as substantial data came to indicate Relapse Prevention's lack of robust effectiveness in reducing sexual offense recidivism, including that from the gold standard Sexual Offender Treatment and Evaluation Project research study by Dr. Marques at ASH (Marques et. al, 2000). This came as a deep disappointment to sexual offender treatment programs across the U.S. who uniformly endorsed the use of RP in program surveys (Freeman-Longo, Bird, Stevenson & Fiske, 1994). In contemplating the results of the SOTEP study of RP, which found a lack of treatment efficacy, alongside the everyday demands of implementing the sexual offender treatment program at Coalinga State Hospital the wisdom of history and those who've walked before me seemed to echo clearly in the direction the field needs to take to set us on a new path toward improved treatment outcome. As is often the case in the evolution of ideas, it became clear these necessary new developments are not new at all.

In endeavoring to conduct an analysis of the Relapse Prevention Model for Sexual Offender Treatment that was pre-eminently popular by the 1990s, I quickly learned that essentially all programs called themselves Relapse Prevention-based regardless of the degree of fidelity to the original model developed by Marques and colleagues. Relapse Prevention became the catchphrase that described all sexual offender treatment that had the prevention of sexual offense relapse as its goal. Therefore, any critical analysis of studies examining RP is in part an analysis of the broad state of the art of sexual offender treatment up to about the year 2000, and in part an analysis of the RP conceptual model. While a complete analysis of the shortcomings of RP may be useful for some purposes (e.g., Laws, Hudson & Ward, 2000), the lessons that most illuminate our path toward maximizing treatment outcome are described as follows.

Primarily, RP over-looked the heterogeneity and totality of sexual offenders. Its focus was almost entirely on the sexually deviant aspects of functioning and it assumed that the features of offense cycles were similar, inevitably involving a failure of self-restraint over deviant impulses. The RP model was initially developed to address the problem of substance abuse, a form of self-abuse, and did not map adequately onto the problem of sexual abuse, a form of other-abuse. As such, it did not value as worthy treatment objectives the interpersonal attachments, betrayals, and needs embedded in the decision to offend against another.

Similarly, there was a lack of good fit between features of the Relapse Cycle concept borrowed from substance abuse in its application to the cycle of sexual abuse. For example, the definition of a "Lapse" as a minor return to substance use really did not have a correlate in sexual offender treat-

ment as a "minor return" to sexual offending, and was not as forgiving. In the treatment of sexual offenders, even a minor lapse in behavior potentially represents treatment failure. For example, masturbation to a deviant fantasy was viewed as a lapse and therefore undesirable, despite the reality that it may have diverted the creation of an actual victim. Success in sexual-offense-specific treatment was therefore defined as the *elimination* of harm, rather than just harm management or harm reduction, which were equated to treatment failure. This way of labeling transgressions tended to over-pathologize and under-reward sexual offenders in treatment.

A critical shortcoming, also evident in the SOTEP results, is that RP assumed that offenders in treatment possess a high and stable level of motivation to refrain from sexual offending. It did not account for the fact that offenders start treatment at varying stages of change. The kind of motivation that RP assumes is typically present only long after the change process has begun. Facilitating the motivation of offenders who are consciously or unconsciously ambivalent or resistant about giving up sexual offending is a foremost challenge for Sexual Offender Treatment that was entirely ignored by RP. Relapse Prevention neglected to address the most important requisite for successful treatment - willingness to change.

The concept of Cognitive Distortions, the tendency to distort information in a way that serves underlying beliefs, was first applied to Sexual Offender Treatment in the 1980's by Abel and Becker (e.g., Abel, Becker, & Cunningham-Rathner, 1984). In RP treatment programs, lists of cognitive distortions that sexual offenders commonly, and more or less unconsciously, employ to serve offending interests facilitated the identification of these problematic thinking errors of treatment participants. The difficulty for many offenders in treatment is that the standard method of having one's cognitive distortions challenged by group members and therapists is often insufficient to extinguish them from operating in the future. Accurate assessment does not insure successful treatment. These early programs did not include components that address offenders' emotional bonding such that would allow the kind of trust and readiness to receive corrective feedback in a way that facilitates deep cognitive restructuring.

To generalize from the previously detailed shortcomings of RP, early programs did not allow sufficient focus on the internal change process of individuals. In a sense they did not work deep enough. There was also a concomitant over-emphasis on factors external to the offender. While fear-based motivation is in part an inevitable consequence of any treatment mandated as part of a criminal justice system response, it is incumbent upon the program to mitigate feelings of coercion among offenders in treatment. Effortful interventions are required to facilitate a sense of autonomy among even mandated treatment participants. Fear of

further impingements of freedom, harsher institutional conditions, and aversive consequences for unfavorable treatment behavior is often effective at motivating superficial treatment compliance, although undermines long lasting treatment efficacy. It is worthwhile to observe the parallel processes at work in these kinds of circumstances, where the treatment system demonstrates characteristics similar to those it wishes to extinguish in participants. When systems coerce offender clients with high levels of external control, they are in a sense creating an internal experience in offenders that simulates that which offenders instill in their victims. Many sexual offenders have themselves been the victims of neglect or abuse. This means that offenders in treatment already have schema, deep underlying beliefs of both the victim and the powerful abuser, in their psyches. It is not surprising that coercive treatment of offender populations leads to increased abuse supportive attitudes among offenders. Pairing treatment participants' fear with the message from society that they are more like monsters than fellow humans, it is not surprising that our attempts to remedy their behavior are not wholly efficacious. Any treatment, such as RP, that focuses on failures over successes and external motivation over internal motivation for change is sacrificing long lasting change for short-term obedience.

While RP's initial success was in carving the identity of the sub-niche of Sexual Offender Treatment, its long-term gifts are derived from its shortcomings. Of most significance, we learned that a one-size-fits-all approach to Sexual Offender Treatment clearly misses the mark. Treatment style and methods must be broad enough to fit the various psychological sizes and shapes of sexual offenders.

During the reign of RP, Sexual Offender Treatment programs increasingly diverged from the field of General Psychotherapy, abandoning principles of the therapeutic alliance, trust, rapport, and flexibility. While manualized programming does have the benefit of ensuring structure, consistency of program delivery and targeting relevant treatment objectives, treatment that is applied in a step-wise boilerplate fashion akin to following the steps in a recipe entirely overlooks the essential internal ingredients for change. While it may be easier for providers, simply teaching offenders to memorize lists of risk factors and new coping strategies does nothing to ensure that offenders will deploy those new coping strategies when the future need arises. At least in part this problem of oversimplification seems to reflect that RP was insufficiently theoretically informed. While it was promoted to be a treatment application of Cognitive Behavioral Theory (CBT), its implementations did not reflect a sophisticated understanding of the nuances and complexities of CBT.

An additional concern is that RP tends to over-rely on cognitive factors - the "thinking function" of both treatment participants and providers. The Relapse Cycle is espoused to occur in a gradual,

logical manner with offense being the predictable end of this linear chain of events. Properly trained offenders mentally travel back in time, accurately deduce critical events in the chain then mentally proceed forward in time and forecast future events along with successful new responses, which they promise to deploy when exactly those forecasted situations occur in the future. The problem is that the future does not typically happen as forecasted and a variety of contextual and situational factors impact behavioral decision-making. The kind of executive functioning needed to access pre-established RP plans is undermined by strong affective and physiological arousal.

There is also a dynamic element absent from RP. The RP model seems to focus excessively on the past and future, altogether neglecting the here and now present. The cognitive exercises of RP and disallowing the present experience of offenders in treatment is convenient to therapists who are anxious about diving into an unknown and likely pathological psychological space. Clearly a place in treatment is needed to practice new coping skills in reality rather than the cognitive hypothetical. Additionally, RP prioritizes restraint and avoidance of risk factors, which imbues these things external to the offender with a tremendous amount of power, as if to say, "it is so powerful over you that you must avoid it altogether." Many offenders are by disposition influenced by beliefs that they are controlled by external factors. They would benefit more so from opportunities to promote their sense of self-efficacy.

■ A Case Example of RP's Shortcomings

The case of Mr. Brown, whom I treated for five years, exemplifies several of the deficiencies of Relapse Prevention (name, case facts, and other identifying information from this case have been altered to protect client identity). As a young adult he sexually molested his step-son, was convicted, and participated in the SOTEP RP treatment program, which offered him the opportunity to serve part of his sentence at the state hospital instead of prison. Through the SOTEP treatment program, he learned the cycle of his abuse of his step-son and never offended against his step-son again. However, Mr. Brown did go on to sexually molest two-dozen other male and female children even while maintaining his employment as a law enforcement officer. This led to his return to the secure facility through civil commitment. The treatment program there had begun to change aspects of its treatment program given the results from the SOTEP research study which provided some valuable insights about parts of the program that required changing to improve outcome.

Throughout his treatment, Mr. Brown's account of his sexual offending remained consistent. It was lacking in any indication he experienced the Abstinence Violation Effect, which RP teaches is negative affect due to failure to maintain a self-imposed

rule to not re-offend. In fact, Mr. Brown had never tried to "quit" sexual offending altogether; he used words like "eager anticipation" to describe the immediate emotional precursors to his offending. He proudly averred that he "only" molested children who were willing and that he would never proceed if the child said "no" or appeared frightened. He described his periods of sexual offending as the only times in his life he was really happy. At the outset of our treatment he demonstrated no awareness of the harm he created for the victims and their families.

Through our therapeutic relationship we learned that his prior treatment was overly specified to his victimization of his step-son. It had neglected to attempt to motivate him to want to never create another victim. He also had difficulty mapping his offending onto the components of the Relapse Cycle. He struggled to identify the pervasive self-control problems the model told him he had. He did not lack the ability for self-control but rather the desire to restrain one aspect of his functioning - his behavior toward children.

Mr. Brown was very intentional and methodical in his planning to sexually target children. In examining the immediate antecedents to his sexual offending, he could not identify what was going wrong as everything was working well with his plans to offend. RP over-focused on proximal factors and insufficiently on etiological factors. As with Approach Type offenders, he did not lack adequate skills to resist deviant interests; instead, he lacked the motivation to access skills (Hudson, Ward & McCormack, 1999). Importantly, there had been no place in the prior treatment program for him to process his own childhood experiences involving his retreating to sexual activities with other children while his home life rejected him. The treatment program did not strive to instill in him a sense of self-efficacy that he "could make it in the adult world." It did not encourage him to expect value and trust in adult relationships.

The RP based treatment program also did not value therapy process variables, such as Mr. Brown's relational style with therapists and other group members. As a female therapist, at times Mr. Brown projected on to me his feelings toward his ex-wife, which allowed him to process his protective defense of withholding of intimacy and mistrust. At other times he experienced me as his grown adult daughter, and both rejected me and desired to show me an apologetic and protective side of himself. At other times, he showed me an immature flirtatious side as if I were a child female he desired. By my continually and reliably showing up physically and psychologically and by my unwavering professional boundaries, Mr. Brown came to trust me enough to work through the underlying vulnerabilities that fueled his "risk factors." Within a therapeutic landscape of safety, he was able to experience his vulnerabilities in the here and now. In processing these vulnerabilities emotionally, verbally and cognitively, we seemed to create real changes in his

information processing template and motivational system.

After being detained for over a decade, it was legally determined that Mr. Brown demonstrated sufficient reduction in his risk for sexual re-offense and he was released. Throughout the subsequent years to date he continued to maintain his therapeutic gains. While he at times struggled to manage urges to sexualize children he never created another victim and he was able to develop some meaning out of his life. Years after his release he contacted me and shared that the most meaningful aspect of his inpatient treatment experience were the empathy components and the therapeutic relationship. He opened himself to experience the pain of others as he came to feel his own wounds resolve. When exposed to the long-term negative effects of abuse he grieved deeply, and experienced regret and insight. His respect and trust of myself and group members facilitated his amenability to explore and be challenged about his beliefs involving sex with children.

■ Contemporary Advancements: Lessons Learned from Early Sexual Offender Treatment

The rise and fall of Relapse Prevention has paved the way for numerous advancements in the field of Sexual Offender Treatment. Notable advancements to theory and application include the Self-Regulation Model and its pathways to offending (Ward & Hudson, 2000), strengths based approaches such as the Good Lives Model (e.g., Ward, 2002), attachment informed approaches (e.g., Rich, 2005), motivational interviewing and the stages of change (e.g., Prescott, 2009), and integrated theories of sexual offending and advancements in our understanding and emphasis on the neurobiological factors (e.g. Ward & Hudson, 2005).

Perhaps the most encouraging finding to come about from the research on the efficacy of sexual offender treatment to date is that the Risk, Need, Responsivity (RNR) principles of effective general correctional programming also apply to sexual offender treatment (Hanson, Bourgon, Helmus & Hodgson, 2009). There is finally substantial conclusive data indicating that sexual offender treatment programs are effective at reducing sexual recidivism. The degree of success is proportional to the degree of adherence to the three guiding principles.

1. Risk Principle: The comprehensiveness, intensity, and duration of treatment provided to individual offenders should be proportionate to the degree of risk they present.
2. Need Principle: Treatment should be appropriately targeted at participant characteristics that contribute to their risk.
3. Responsivity Principle: Treatment should be delivered in a manner that strives to engage participants meaningfully and facilitate their learning.

■ Five Simple Ways to Improve the Efficacy of Sexual Offender Treatment

Having contemplated the general psychology, general criminality and sexual offense specific literature base, as well my personal experience having worked in the field of sexual abuse, especially during the post SOTEP years at Atascadero State Hospital, then at Coalinga State Hospital, the institution that replaced ASH as the catchment for California's civilly committed sexual offenders, it appeared to me that there are five important ways we can enhance the efficacy of sexual offender treatment. Essential to these lessons was my direct experience with the individuals who have ventured to the dark side of our shared humanity, the perpetrators of sexually abusive behavior, and also sometimes the victims as well, both of whom have become ensnared in our collective problem of abuse.

The five "ways" are more akin to guiding principles that require flexible individualized application, rather than a step-by-step method. Though convenient and comforting in their standardized approach to anxiety producing ailments, cook book like mechanistic techniques often do not generalize to out-of-treatment settings because "subjects" fail to derive meaning from them. In order to reliably encode and store information for use at a later time (such as a way to prevent abusive relating to children or women), memory requires the individual to ascribe meaning to events. Meaning requires full, willing, awareness. Much to the chagrin of researchers, meaning is not always linear, logical or language based.

Unlike standard RP techniques, the "Five Simple Ways" call for treatment that fits the individual rather than fitting the individual into pre-existing categories valued as having supreme knowledge. They are constructive, whole person focused suggestions that strive to overcome "the perception of offenders as bundles of risk factors rather than integrated, complex beings who are seeking to give value and meaning to their lives (Ward & Marshall 2004)." They attempt to bring balance to a field of treatment that has become dominated by problem-focused, deficit-based programming. The "five ways" underlie long-lasting change based on collaborative relating with others and are useful in working with abusive individuals regardless of setting or context.

The necessity of deriving meaning from treatment through collaborative relationships underlies what is talked about as The Responsibility Principle. Among the most salient lessons of contemporary research and surely an impending area for further study and development is the Responsibility Principle (Andrews & Bonta, 2006). Adherence to the Responsibility Principle means that treatment methods and delivery are adapted to meet the unique learning style of individual participants. In a sense, the Five Ways are an amplification of this principle.

1. Focus on the Client's Self First: Assess and Treat "Old Wounds"

It comes as no surprise that the prevalence of childhood trauma among adult offender populations is significantly higher than in the general population, with rates ranging from 30% to 70% in offender samples. Motivated by the awareness of harm offenders have proximally caused, programs are reluctant to address the distal wounds of these abusive individuals. While acknowledging the suffering of offenders has been interpreted by many as coddling that facilitates their abusive attitudes, a central idea of this principle is that treatment will not be effective if it does not address the wounds of offenders.

Unmet needs caused by trauma such as physical or psychological abuse, neglect, and accidents cause disruptions in development. These "wounds" are stored in various body systems and cause excessive self-focus and dysregulation, greatly impacting the structure and function of the brain (Siegel, 1999). Herein the seeds for a variety of mental illnesses involving impaired affective bonding and dysregulation of internal states are implanted. The unmet needs of childhood, including the fear, shame, confusion, and need for soothing of trauma, are fertile breeding grounds for problems of sexual abuse.

As often is the case, many years later the wounded self continues to behave as if the ongoing victim of early violations. The victim who could not contain, manage and integrate the abuse transforms it into aggression; the recipient becomes the abuser. The intolerable receptive state of fear is transformed to the reactive solution of aggression. This is the cycle of abuse in action. Early trauma that has not been adequately integrated manifests as excessive self-focus and deep-seated victim stancing that are typically labeled as a form of treatment resistance and aggressively challenged or otherwise not tolerated by treatment providers.

This principle calls upon treatment providers to initiate treatment at the place of the offender's wounds. We start with the offender's worldview, and assess for and empathically validate his woundedness. We receive rather than react. This fundamental acceptance of the offender as an ailing fellow human facilitates trust and reduces psychological defensiveness such as externalizing, avoidance, and denial.

As the offender begins to integrate the trauma at a neurobiological level, the embedded self-protections against being overwhelmed by it are no longer necessary. It is through the validating relationship with the therapist that the offender learns it is no longer necessary to avoid or fear his internal experience. With the self's wounds adequately tended to the offender can fearlessly set aside the self and attend to and receive the other. Often a wellspring of empathy for others occurs when this happens. With this new place for others to exist in the lives of offenders, internal motivation for non-abusiveness begins. The abuse he perpetrated is viewed through

this new other-oriented lens; real accountability occurs. To my supervisees I have called this strategy for preventing the abuse of others by focusing on the self-first, the "back door approach" to offender treatment.

2. Highlight Affective Factors

The second principle underlying long lasting change involves the significant contribution of affective factors upon human behavior. The emotion system plays an organizing role in human functioning. Strategies to prevent future abusiveness solely through cognitive processes, such as challenging the logic of distorted beliefs, identifying components of relapse cycles, and memorizing lists of risk factors and new coping strategies often fail to "sink in" to the deep preconscious memory systems that are accessed automatically in the context of high affective and physiological arousal. When the opportunity for future offending occurs, as it often does, in the context of high levels of arousal, rational decision-making is bypassed for responding that is evoked by subcortical levels of the brain – meaning, without thinking.

Several valuable treatment strategies emerge from this knowledge that explicit memory is typically bypassed in the context of high arousal. Do not yield to the convenient temptation to treat abusiveness solely through cognitive methods. Allow a place in treatment for participants to experience, identify, and process affect. Practice strategies to facilitate improved tolerance and modulation of affect. Value the "here and now" of therapy as opposed to using available treatment time to focus entirely on discussing what happened in the past and what will happen in the future. Underscore the value of non-verbal experience and assign emotionally rich "homework assignments," such as video and bibliotherapy. Prioritize creating a therapeutic landscape that is safe, supportive, reliable, and nurturing. Process offenders' affective reactions to other group members, family members, and therapists; rather than reactively punish, receptively explore offender client's attempts to ingratiate, devalue, bully, and/or seduce the treatment provider. Model strategies to avoid miscommunication such as direct, clear conversing with good eye contact and congruence between emotions and body language; ask for attention before making important statements and provide appropriate statements of your own feelings and beliefs.

3. Cultivate Empathy for the Abuser and a Landscape for Change

A fundamental challenge to treatment providers of abusive individuals is to do good work while being exposed to unpleasant, tragic, and harmful aspects of those in our care. Metaphorically, we are paid to psychologically swim in a dark, unpredictable pool of human behavior, where there are things no one wants to claim floating on the surface and who knows what dangerous things lie underneath. What is the best way to resolve this dilemma? One approach is to avoid jumping in altogether, to treat

from the outside looking down. Another approach is to close one's eyes, plug one's nose, dive in, and get the job done as quickly as possible and get out of there.

A third option is to invest in preparations and protective wear before immersing oneself in the job. While this option is more resource intensive than the previous options, it yields better results. The immersion into the dark pool is necessary. It can be frightening but with proper precautions the therapist's innermost self remains protected. Therapists that have proper training, a viable professional network, and ongoing supervision or professional consultation tend to derive more job satisfaction and less burnout than unprepared clinicians. Importantly, effective treatment requires meaningful engagement by the therapist. It is not only necessary to dive into the dark pool but to explore its murky contents with a sense that there is something rare and valuable to be found.

The central premise of this principle is that the therapist and the therapeutic landscape are essential features of effective treatment (Marshall, 2005). This means that "how" treatment is delivered is at least as important as "what" is delivered.

The relatively recent research finding that outcome in sexual offender treatment is strongly influenced by process is a welcome invitation to our field to put the "psychology" back into forensic psychology. Indeed, just as sexual offender treatment separated itself firmly from the field of general psychotherapy in carving out its identity, training programs in forensic psychology have become increasingly differentiated from their clinical psychology predecessor. It was not until the 1990's that psychology training programs began offering masters and doctoral degrees in forensic psychology. Some such programs have often sacrificed intensive clinical training for classes on legal knowledge and forensic application, such as evaluation and court testimony. The call to focus on therapy process with sexual offenders is also a call for our therapist training programs to better prepare forensic psychologists with solid psychotherapy skills.

Strategies to maximize participant response to treatment involve attending to the following: therapist attributes, style and behaviors, the nature and quality of the interactional processes among treatment participants and providers, the therapeutic climate and the degree of group cohesion, and indices of participant satisfaction. Therapist behaviors that encourage change are genuineness, respect, support, warmth, directiveness, flexibility, rewarding-ness, being encouraging emotional expression and active participation, moderate humor, imbuing confidence and hope, and foremost, empathy (Marshall, 2005).

Over fifty years ago, Carl Roger's identified the participant's experience of therapist empathy as the most essential ingredient for effective therapy.

To sense the client's private world as if it were your own, but without ever losing the "as if" quality —

this is empathy, and this seems essential to therapy. To sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it (is empathy). When the client's world is this clear to the therapist, and he moves about in it freely, then he can both communicate his understanding of what is clearly known to the client and can also voice meanings in the client's experience of which the client is scarcely aware (Rogers, 1957, p.99).

Offenders will not see themselves differently until we do. Ensnared in a criminal justice system with competing punitive and rehabilitative goals, sexual offender treatment all too often seems to get lured into the cycle of abuse. This is evident in deviancy and deficit focused treatment, inadequate focus on strengths and resiliencies, and aggressively confrontational, authoritative, punishing, rejecting, and disinterested behaviors toward offender participants by staff.

Good healers utilize a fine tuned empathic system. This means we can weave a rational thread through the confusion and discomfort that accompanies abuse. We strive to see the world from the offender's emotional and cognitive perspective. This empathy for the offender participant helps him feel understood, cared about and amenable to do the real work of therapy. It cultivates the development of the offender's empathy, internally motivating the attachment system, pro-social behavior and the inhibition of abusive impulses.

4. Embrace the Mystery of Wholeness

Like any effective change intervention, sexual offender treatment requires involvement from the past, present, and future totality of the offender client, in all senses of body, mind, emotion, and spirit. It seems a merciless case of the "izes" has unfortunately befallen contemporary sexual offender treatment - "standardize programming, manualize the treatment, categorize the offenders, analyze the data, sterilize the subject matter, etc." There is a strong pull to create cookbook approaches to offender treatment that are inflexible to individual characteristics. This certainly simplifies clinician training and program evaluation, but it also devalues the dynamic individuality of participants and the unique psychological atmosphere that emerges when therapy happens. Relevant criminogenic needs can be targeted in a way that is responsive to the unique learning style of individual participants. The reminder to embrace the mystery of wholeness in sexual offender interventions does not mean to discard psychological science in favor of unguided clinical judgment. It means to consider the cost when we remove consideration of the individual offender client from the treatment process.

We all have moments when we experience a sense of integration or wholeness within ourselves; the difficulty is that this state is not typically accompanied by logical comprehension. An essential distinguishing feature of humans compared to mammals earlier on the evolutionary chain is our

capacity for meta-cognition, to think about thinking. A unique human urge is to know, most often through logic and language, but there are other ways to experience something as true. Embracing the aspects of the human condition that are not scientifically proven, or perhaps even rationally known, is challenging but valuable.

Embracing that which is not known means to acknowledge the operation of intrapsychic motivations beyond conscious awareness. States of disease often occur when there is an incompatibility between conscious rational desire and outward behavior. This suggests the behavior may be motivated unconscious irrational processes. An example of this is an offender who feels, thinks, and articulates that he does not want to create another victim, yet for reasons not known to him he continually places himself in situations that increase the likelihood for re-offense. Some would conceptualize this as a type of dissonance or disagreement between two competing beliefs. This principle suggests that competing drives, desires, fantasies, etc. are not ignored or chastised but identified and processed in an effort to continually strive to know and integrate. It means striving to make conscious the strong forces that lie beneath awareness.

This principle acknowledges the power of those aspects of life and living we have not figured out yet. It acknowledges the influence of the preconscious, the unconscious, the unknown, and the irrational. It calls us to value the experiential, the affective, the non-linear, and the non-verbal dimensions wherein clients can derive that essential sense of meaning necessary for internal change. This holistic approach is multimodal and values creative pursuits, work, play, somatic methods, spiritual, and meditative efforts, and the cathartic experience of art, storytelling, music, and drama as ripe opportunities for offender clients to transform destabilizing internal states and shore up resiliencies. These experiences are reminders of a universal connection with all of humanity.

Embracing the Mystery of Wholeness involves valuing that activity of willing awareness of whatever emerges in offender clients' inner and external world. Prioritizing the goal of being fully present and attentive to experience the full scope of activities of living facilitates mindful behavioral choices that can counteract affective and behavioral dysregulation and impulsivity. As an antidote to program features involving heavy emphasis on deviancy, self-control, and self-restraint, this principle calls upon the need for constructive approaches that build up resiliencies, replace deficits with strengths, and facilitate offender clients' connection to the universal commonalities of humanity.

5. Care for the Therapist

For many treatment providers, a tendency to empathize with the pain of others was part of a professional calling to the field of forensic mental health. Unfortunately, the empathy that brought us to this work and which is necessary to do the work well

can also be a genuine job hazard that contributes to dissatisfaction, burn-out, vicarious traumatization (Pearlman & Saakvitne, 1995), and impaired work performance. We immerse ourselves into the dark aspects of humanity, where real pain predominates. We contain distress. We continually intervene against abusiveness. We foster health. These efforts have positive and negative impact upon us as therapists.

Appropriate care for the therapists who, on a daily basis, vicariously experience traumatic events through empathic engagement with offender clients is a necessary component of effective Sexual Offender Treatment. Absent such care, therapists are vulnerable to personal distress and other trauma symptoms that tempt participation in the cycle of abuse. There are numerous ways that program administrators, supervisors and therapists can achieve adequate care for therapists.

At the administrative level, clinical staff should be selected in part on the skills and traits that are responsive to participants' unique learning styles and abilities; for example, genuineness, warmth, empathy, and directiveness. Such traits and skills often reflect a personal commitment to self-awareness, personal growth, compassion, and a desire to ally with others to evoke change. Staff that can communicate effectively, are open to feedback and can think and act flexibly tend to demonstrate resiliency to the difficult nature of the work. Respect for the professional boundary between staff and offender clients is essential.

Administrative strategies that promote the well-being of staff include allowing flexible work schedules (e.g., a 4 day, 10 hour work week), on grounds staff exercise facility and break areas, in-service trainings involving staff care, and staff celebratory events. Staff retention, work satisfaction, and work quality are enhanced by providing ample time for professional development, allowing staff time to pursue and develop areas of expertise, and creating opportunities for position advancements and shifting duties. It is essential that programs ensure appropriate resources for supervisory staff and procedures and communicate to treatment staff that their contributions make a difference.

Given the unusual, taxing and high stakes nature of the work, it is not surprising there is a good deal of therapist turnover in the field of Sexual Offender Treatment. The goal of staff-retention is served by promoting awareness of counter-therapeutic pulls and its effects. Staff are educated about the signs and symptoms of burn-out, vicarious traumatization, and boundary violation. Some treatment providers may ultimately find working with abusive individuals too difficult or the emotional and psychological toll too great; for these staff a job change

may be in the best interest of both the treatment consumers and the treatment provider.

Therapists can engage in a number of strategies to avoid negative impact. Expect counter-transference and negative reactions to the work. Continually assess personal signs of burnout. Practice the kind of therapy that we espouse to offender clients on one's own self. Utilize mindfulness techniques. Strive to incorporate your best qualities in your work. Promote a well-rounded lifestyle but prioritize your personal life above work. Develop a passion in your professional life. Allow ourselves some kind of personal therapy. Utilize debriefing, supervision, and consultation, and foster connections with other professionals in the field.

■ Final Word/Conclusion

The field of Sexual Offender Treatment has developed markedly since its initial establishment in the 1980's and the days of Relapse Prevention. Through a historical and personal reflection, five simple strategies have emerged as ways to enhance the efficacy of Sexual Offender Treatment: Focus on the Client's Self-First: Assess and Treat Old Wounds. Highlight Affective Factors. Cultivate Empathy for the Abuser and a Landscape for Change. Embrace the Mystery of Wholeness. Care for the Therapist.

Commonalities that underlie these strategies include a focus on participant response to treatment delivery, the impact of the therapist upon outcome, and an encouragement to return basic principles of general psychotherapy to the application of Sexual Offender Treatment. It is hoped these strategies will take on meaning to individual therapists and program developers and assist the forward progress of the field of Sexual Offender Treatment.

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