

MODELS OF TREATMENT FOR OFFENDERS WHO ABUSE CHILDREN

OVERVIEW

Treatment for sexual offenders has changed drastically over the past half-century (Laws and Marshall, 2003). Even though earlier non-behavioral treatment approaches were important in establishing that child sex offenders could be engaged in treatment, John B. Watson and Alfred Kinsey were prominent in the development of behavioral treatment approaches in the early to mid-20th century. Kurt Freund developed penile plethysmography (PPG) in 1957 in response to the sexual preference hypothesis. Despite many criticisms of the PPG, it remains popular and continues to be widely used.

The earliest behavioral approaches to treatment reflected the view that deviant sexual behavior was a distorted manifestation for pedophilia and other paraphilias. Exhibitionists and child molesters were treated with electrical aversion; the modification of sexual fantasies was the target of efforts applied to sadists and voyeurs. However, limited information existed about the long-term effects on overt behavior of these techniques.

A combination of behavioral and cognitive behavioral treatments began to emerge in the late 1960s. This decade is also noted for the further development of phallometric evaluations in assessment and the associated focus on modifying sexual preferences, introduction of cognitive processes and the first description of more comprehensive treatment programs. In the early 1970s, cognitive psychology began to penetrate the field of treating child sex offenders – social skills training, assertiveness, sexual dysfunctions and gender role behavior. The first conference, at which sexual offender issues were discussed from a behavioral or cognitive behavioral perspective, was in 1975-this subsequently became known as the Association for the Treatment of Sexual Abuse (ATSA). The most significant innovation of the 1980s was the adaptation of the relapse

prevention model from an addictions perspective, as well as formulating social learning theories of sexual offending behavior. Further, a wide variety of programs described targets such as sexual preferences, sex education, victim empathy, social skills, self-esteem, substance abuse, anger management and relapse prevention.

Contemporary sex offender treatment programs (both in the U.S. and internationally) employ a multidimensional approach that includes cognitive-behavioral techniques, relapse prevention strategies and psychopharmacology to treat child sex offenders. Although there is no “cure” for individuals who sexually molest children, the above treatment approaches appear to be successful with regard to reducing recidivism rates (Barbaree & Marshall, 1991; Eccles & Walker, 1998; Fisher & Beech, 1999; Wood et al., 2000; Aytes et al., 2001).

COGNITIVE-BEHAVIORAL TREATMENT AND RELAPSE PREVENTION

Cognitive-behavioral treatment has emerged as the principal type of treatment used to modify deviant sexual arousal, increase appropriate sexual desires, modify cognitive distortions and improve interpersonal coping skills. As a comprehensive structured treatment approach, cognitive-behavioral treatment integrates cognitive restructuring methods and behavioral techniques. According to Nicholaichuk and Yates (2002), this treatment approach is based on the premise that “cognitive and affective processes and behavior are linked, and that cognitions, affect, and behavior are mutually influential.” Therefore, treatment typically includes targeting the following: (1) deviant sexual behavior and interests, (2) a wide range of social skills/relational deficits and (3) cognitive distortions, which permit the offender to justify, rationalize and/or minimize the offending behavior (Marshall & Barbaree, 1990; McGrath et al., 1998).

DEVIANT SEXUAL BEHAVIOR AND INTERESTS

Combinations of behavioral approaches are frequently used in an attempt to address deviant sexual behavior/interests. These approaches include covert sensitization, aversion therapy and masturbatory satiation. The objective of these approaches is to reduce deviant sexual behavior/fantasy while maintaining and/or increasing sexual arousal to appropriate stimuli (Abel et al, 1992; Becker, 1994; Marshall & Barbaree, 1990; Quinsey & Earls, 1990; McGrath et al., 1998).

Covert sensitization involves the pairing of a negative consequence (aversive event) with the sexual arousal stimulus. An example of this technique would consist of having the offender imagine a paraphilic event in order to elicit arousal, and at that point, imagine the humiliation of getting arrested for the event while at work or at home with his family.

Aversion therapy is similar to covert sensitization; however, the sexual arousal stimulus is paired with an aversive event (i.e., mild electric shock, sniffing a noxious odor such as ammonia, sniffing rotting meat or tissue or boredom/fatigue). The goal of both of these approaches is to teach the offender to associate negative consequences/events with sexually deviant arousal/thoughts.

Masturbatory satiation requires the offender to masturbate to ejaculation while verbalizing an appropriate sexual fantasy. The offender then continues to masturbate for 50-120 minutes while verbalizing deviant sexual fantasies. Since masturbation is unlikely to result in orgasm during the given time period, it is hoped that the offender will learn to associate deviant fantasy with unsatisfactory sexual activity. Furthermore, sexual gratification becomes associated with appropriate sexual behavior.

SOCIAL SKILLS/RELATIONAL DEFICITS

Cognitive-behavioral treatment seeks to enhance the offender's interpersonal functioning, which includes enhancing relationship skills, appropriate social interaction and empathy (Marshall, 1989; McFall, 1990; Seidman et al., 1994; Marshall et al., 1999). Social problem solving, conversational skills, managing social anxiety, assertiveness, conflict reso-

lution, empathy and intimacy, anger management, self-confidence and the use of intoxicants are targeted (Laws & Marshall, 2003). Educational modules, which include role-playing of specific types of social interactions, behavioral assignments and presentations on various aspects of social skills are the techniques utilized to address these social difficulties.

The inclusion of empathy-enhancement in treatment is based on the belief that the attitudes of sexual offenders toward their victims will change if they understand how the victim feels. The subsequent development of empathy will inhibit future sexual abuse since empathy is something that people learn, rather than an instinct. This is achieved in treatment through utilization of audiovisual methods and materials to demonstrate the pain associated with victimization. These methods include writing assignments, wherein the offender describes his sexual assault from the victim's view point, and the use of role-play wherein the offender plays the role of himself confronted by a peer as well as the role of his victim, respectively (Mulloy & Marshall, 1999).

COGNITIVE DISTORTIONS

Cognitive restructuring is an integral part of cognitive-behavioral treatment. As mentioned previously, child sex offenders construct internal rationalizations, excuses and cognitive distortions in order to maintain their sexually deviant behavior. Therefore, it is paramount that an offender's cognitive distortions are challenged so that he can comprehend his faulty thinking and recognize its distorted, self-serving nature (Marshall & Barbaree, 1990). Additionally, the clinician will present more socially appropriate and adaptive views, and the benefits of accepting such views are identified. This is achieved by examining the role of rationalizations, excuses and cognitive distortions from a non-sexual approach in the lives of average people, thereby normalizing the process while showing its hazards. Role-play is also utilized in which the therapist plays the role of the offender, elaborating on the cognitive distortions elicited throughout the offense process, while the offender plays various roles, including that of a victim's parent and/or an old friend, who supports his taking responsibility for his behavior and admitting his distortions.

THE RELAPSE PROCESS

The classical relapse prevention treatment approach was initially developed in response to the clinical difficulties associated with the treatment of addictive behaviors, such as alcoholism and drug dependency. This approach was subsequently altered for use in the treatment of sex offenders (Eccles & Marshall, 1999; Laws, 1999; Laws et al., 2000). In the classical model of relapse prevention, a lapse, which is perceived as a momentary indulgence but not a relapse, involved an actual reindulgence in the problem behavior (i.e., drinking). However, in the sex offender model of relapse prevention, a lapse is defined as "offense precursor activities such as deviant fantasies, purchasing pornography or cruising for potential victims," and perceived as a relapse (Laws et al., 2000). Therefore, in the treatment of sex offenders, the relapse prevention approach pays considerable attention to behaviors that might lead to sex offending as opposed to the actual reindulgence in the aberrant behavior. Relapses are regarded as the culmination of a series of events and situations through which the offender proceeds prior to offending (Eccles & Marshall, 1999).

The relapse process (sometimes called a cycle or a chain) is based on the offender's capacity to cope with high-risk situations. These situations are defined as a set of circumstances that threaten the offender's sense of self-control. In treatment, the relapse process begins with the offender declaring his intent to abstain from the deviant behavior. Self-management skills and the anticipation of adaptive coping mechanisms are reinforced. As the offender encounters high-risk situations, his self-management skills and coping mechanisms are challenged. Should the offender successfully cope with this situation, his sense of self-management survives and abstinence remains intact. Conversely, should the offender fail to successfully cope with the situation, his sense of self-management decreases, and a tendency to passively yield to the temptation of the next high-risk situation ensues. Each time the offender fails to cope with a high-risk situation, he will engage in one of the behaviors involved in his relapse process (i.e., deviant fantasy, the purchase of pornography). However, at this stage, these behaviors are considered lapses as opposed to a relapse. Several factors, subsumed by a concept

referred to as the "Abstinence Violation Effect" (AVE), determine whether a lapse becomes a relapse. A major aspect of the AVE is a conflict between the offender's definition of himself as an abstainer and his recent indulgence in a behavior that is part of his relapse process (e.g., self-deprecation, the expectation to fail, his need for immediate gratification). At this stage, if the offender does not use treatment effectively to cope with his beliefs and/or urges, and to regain his confidence in self-management, a relapse is inevitable (Pithers et al., 1983; Pithers et al., 1983; Pithers, 1990; Eccles & Marshall, 1999; Marques et al., 2000; Launay, 2001). Ward and Hudson's (2000) self-regulation model expanded the original relapse prevention process to incorporate more comprehensive cognitive, affective and behavioral factors. Further, within Ward and Hudson's model, post offense factors are considered.

The self-regulation model of relapse prevention contains nine phases (life event, desire for deviant sex or activity, offense-related goals established, strategy selected, high-risk situation entered, lapse, sexual offense, post offense evaluation and attitude toward future offending) and four pathways (avoidant-passive, avoidant-active, approach-automatic and approach-explicit). According to Ward and Hudson, an important aspect of this model is that the offender can "exit the relapse process at any time by implementing appropriate coping strategies . . . move back and forth between different points in the offense chain. . . [and] remain at specific phases for a relatively long time before moving on to the next phase."

In 2002, Bickley and Beech evaluated the ability of the self-regulation model to classify sexual offenders. The sample consisted of 87 child abusers who ranged in age from 21 to 75. The majority of the participants (62%) had offended outside the family, 15% had offended inside the family, and 23% had offended both inside and outside the family. Of the participants, 36% had offended against boys, 33% against girls, and 31% had offended against both sexes. Fifty-three percent of the sample had a previous conviction for a sexual offense. The participants were classified as belonging to one of the four pathway groups identified by Ward and Hudson's self-regulation model of sexual offense process.

Results indicated that the profile of the “fixated” child molester is consistent with the self-regulation model’s description of an approach pathway. In contrast, the “regressed” offender is consistent with Ward and Hudson’s description of an avoidant pathway. Bickley and Beech concluded that the self-regulation model could be reliably employed in the classification of child molesters, with inter-rater agreement found in more than 80% of the sample. Furthermore, differences across the two group distinctions (i.e., avoidant vs. approach, active vs. passive) in both the psychometric and offense demographic data provided objective support for the validity of the framework.

TREATMENT EFFICACY STUDIES

Most studies conducted on treatment efficacy focus on the rate of recidivism among offenders. In studying recidivism rates, researchers compare sex offenders who have participated in treatment to those who have not. Further, they consider specific variables such as the type of treatment implemented and whether or not an offender completed the treatment process.

In a follow-up study conducted on 89 sex offenders in Ontario, Looman et al. (2000) found that those offenders who participated in treatment had a sexual recidivism rate of 23.6%, whereas the those offenders who did not participate in treatment had a sexual recidivism rate of 51.7%. Similarly, when 296 treated and 283 untreated offenders were followed for a six-year period, Nicholaichuk et al. (2002) found that convictions for new sexual offenses among treated sex offenders were 14.5% versus 33.2% for untreated offenders. Further, during the follow-up period, 48% of treated offenders remained out of prison as compared to 28.3% of untreated offenders. Time series comparisons of treated offenders and comparison samples also showed that treated offenders reoffended at significantly lower rates after ten years.

In reviewing studies pertaining to the efficacy of a particular type of treatment, there is significant evidence that cognitive-behavioral treatment has emerged as the principle type of sex offender treatment targeting deviant arousal, increasing appro-

priate sexual desires, modifying distorted thinking and improving interpersonal coping skills (Marshall & Barbaree, 1990; Marshall & Eccles, 1999; Marshall & Pithers, 1994; Becker, 1994; Hall, 1995; Abracen & Looman, 2001; Burdon et al., 2002; Nicholaichuk et al., 2002; Craig, 2003). Further, Marshall and Anderson (2000) found that cognitive-behavioral treatment programs that have an internal self-management relapse prevention component appear to be the most successful in reducing recidivism rates.

Studies of the effects of treatment completion on recidivism have also supported the effectiveness of treatment (Hall, 1995; Hanson & Bussière; Hanson, 2002). A retrospective study, conducted by McGrath et al. (2003), found that the reduction in the sexual recidivism rate among those offenders who participated in treatment was statistically, as well as clinically, significant. Treatment completers were almost six times less likely to be charged with a new sexual offense than were offenders who refused, dropped out or were terminated from treatment.

PHARMACOLOGICAL INTERVENTIONS

Physiologically, the androgen (hormone) testosterone is the major activator element of sexual desire, fantasies and behavior, and basically controls the frequency, duration and magnitude of spontaneous erections. Given this, medications used to treat deviant sexual behavior are aimed at the reduction of testosterone and/or totally suppressing testosterone action at the levels of the receptor (Rösler & Witztum, 2000). These medications include antiandrogens such as Cyproterone Acetate (CPA), Medroxyprogesterone (MPA or Depo-Provera) and Long-Acting Analogues of Gonadotropin-Releasing Hormone (GnRH) (Berlin, 1983; Bradford, 1990; Grubin, 2000; Rösler & Witztum, 2000).

Further, given the compulsive nature of pedophilic behavior, benefits with regard to the containment of such behavior have been seen through treatment with selective serotonin reuptake inhibitors (SSRIs) such as Sertraline, Fluoxetine, Fluvoxamine, Desipramine and Clomipramine.

Even though there are a number of studies on the efficacy of the above medications with regard to the treatment of sexually deviant behavior, most studies conclude that a combination of medical and psychological treatment has proven to be the most beneficial.

SEX OFFENDER TREATMENT FOR PREISTS

In 1993, Loftus and Camargo published a study evaluating their Southdown Treatment Center for clergy offenders. They found that the majority of the patients were diocesan priests; between the ages of 49 and 60 when they were first referred for treatment; ministered in parishes and educational settings; had no criminal or psychiatric history; and had no history of substance abuse. The offense data illustrates that the abuse occurred frequently (four or more times) and the ages of the victims varied. In evaluating their treatment, the authors urge that clerics should be treated no differently from other sex offenders. There has been some evidence in favor of the utilization of non-verbal psychotherapies because the patients provided evidence that there appears to be a sense of alienation from the body. Recidivism is discussed with caution since only 40 out of the 111 men in the sample are accounted for in the study. With that issue taken

into account, there appears to be a recidivism rate of 10%.

The 1996 article by Warberg, Abel, and Osborn explored the uses of cognitive behavioral therapy with clergy through analyzation of case studies. Through various measures, therapists are able to teach clergy that the behavior is anything but impulsive and can be interrupted early in the process. Failure to appreciate the power differentiation between minister and parishioner, naivety about sexual issues/minimal training in transference/counter transference, and desensitization of the intimacy of the minister/laity relationship all combine to affect victim empathy. Paraphilias must also be evaluated when assessing treatment needs in order to render a comprehensive plan. The authors assert that 20% of professional sexual misconduct cases were found to have a history of prior paraphilias. It is stressed that interpersonal and emotional factors (anxiety, stress, depression, deficits in social/assertive skills, alcohol/drug abuse, personality disorders/intrapsychic conflicts) play a role in the development of professional sexual misconduct. In order to ensure the safety of the minister and congregation, those who have engaged in sexual misconduct must be thoroughly evaluated and placed under constant surveillance by staff members.