Abstract:
A growing consensus has been developing over the past 10 years that relapse prevention may be "necessary but not sufficient" to successfully treat some sex offenders. This has led to the realization that many of the established principles of psychotherapy apply to sex offenders as much as to other client populations, and to renewed interest in the therapist-client relationship. Part of this interest stems from the increasing influence of attachment theory and research. "Intimacy deficits" are a major factor in sex offender recidivism, but attachment is a complex issue and we should be wary of taking short cuts, for example, using self-report, in our research. Given that negative mood has frequently been found to be associated with sex offender "lapses," the author suggests that more attention needs to be given to the causes and treatment of affect dysregulation, and in particular, to the role of shame in sexual offending. Concerns regarding the diagnosis of antisocial personality disorder and the use of the PCL-R are also discussed.

Expanding Sex Offender Treatment
by Jay Adams, Ph.D.

Sex Offender Treatment Re-discovers Psychotherapy Research

I've spent almost 30 years treating sex offenders, trying to understand why they do what they do, how they differ among themselves, and how they can be helped to stop. It is gratifying to see a rising current in the literature which is finally questioning the long-standing and widespread assumption that our sex offender clients are totally different from every other client population. This assumption has allowed us to violate a number of our own ethical standards (Glasser, 2003) and to disregard many of the established principles of psychotherapy. One of the unfortunate consequences of the widespread acceptance of Relapse Prevention is that it has fostered a "cook book" approach to sex offender treatment, which may have attracted individuals to the field who lack the qualities necessary for effective clinical practice. There has been no more consistent finding in psychotherapy research than that the quality of the therapeutic relationship accounts in large part for improvement, regardless of the therapeutic paradigm or technique used. This is acknowledged by some cognitive behavior therapists, such as Linehan (1993), who expresses it in reinforcement terms: "The relationship with the therapist is the primary reinforcer." This obvious fact has been largely ignored in sex offender treatment for the past 20 years, perhaps because some in the field feared being accused of "coddling" sex offenders or being "soft on crime."

Now some sex offender therapists are calling attention to the importance of the therapeutic alliance. In a recent article, Fernandez (2006) questions the value of confrontation in sex offender treatment, which has gone largely unchallenged until recently. She cites research from both the general psychotherapy literature and from sex offender treatment which found that confrontation was related to later non-compliance, lack of generalization beyond the therapy situation, lower self-esteem, increased levels of resistance, and deterring clients from making a commitment to treatment. Fernandez also notes the importance of instilling hope. "The failure of therapists to instill hope in treatment participants appears to result in clients believing that they do not have the ability to change and is related to a lack of motivation by clients to make the necessary changes in their lives" (p.192). The instillation of hope is a

factor cited by Yalom in what is widely regarded as the best book ever written on group psychotherapy. First published in 1970, Yalom's book delineated 11 therapeutic factors that he believed were what caused group therapy to be effective. Despite the fact that this book was written many years before the women's movement forced rape and child sexual abuse out of the closet, the factors Yalom thought were important have turned out to be very closely related to the long-term sequelae of childhood abuse, as delineated in the more recent literature.

Fernandez (2006) expresses concern that sex offender therapists should avoid a collusive approach, noting that "Collusive therapists tend to construe their clients as victims and, as a result, do not require offenders to take responsibility for their own behaviors" (p.190). This seems to me a completely artificial dichotomy, a straw man. While the victim-to-victimizer path is complex, it is closer to the rule than the exception. For example, Hanson (1999) reports that "in file reviews of 409 sexual offenders, we found that 75% had been victims of some form of child abuse—physical, sexual , or neglect" (pp.85-86). Validating a client's feelings about his own abuse does not mean not requiring him to take responsibility for his victimization of others. Such validation does not constitute an "excuse." It is in fact one of the most important things we can do to encourage him to take responsibility. It doesn't make much sense to be continually telling our clients how much their behavior harmed their victims while at the same time implying that whatever happened to them in childhood is of no consequence. Therapists who establish appropriate group norms and a strong sense of group cohesion will find that group members will not allow each other to make excuses. When a client makes what could be construed as an excuse ("I molested that kid because I was molested"), this is a great therapeutic opportunity to ask an open-ended question such as, "How do you see those things as being connected?"

In 2000, the Canadian National Sex Offender Treatment Program moved away from reliance on Relapse Prevention as its primary treatment modality to what they call "the self-regulation model" or "self-management." The Director of the Canadian program noted that the new model is less punitive, focuses more on the development of a strong therapeutic alliance, and is geared toward reducing resistance and client drop-out (Yates, December 19, 2003, personal communication). This appears to be one of many indications that we are moving away from the notion that treatment is something we impose on sex offenders and more toward an appreciation that sexual offending is an *interpersonal* problem. Some writers have even suggested that collaboration with our clients is an approach that could improve both treatment and risk assessment (Shingler & Mann, 2006). The view that therapy is a collaborative endeavor is quite consistent with the "phenomenological approach" used by many who work in the field of trauma treatment (see Briere, 2002; Courtois, 1999). There are a number of areas where what we have learned from trauma research could greatly enhance our work with sex offenders.

The re-focusing of attention on the importance of the therapeutic relationship is an encouraging development which is long over-due. There are other issues in sex offender research and treatment where we seem to be making little headway. This lack of progress is in many instances due to a failure to understand the findings of trauma research and how they apply to sex offenders. Several areas where trauma research could be more effectively applied to sex offenders are: the application of attachment theory to sex offenders based on self-report; the failure to understand the causes of affect dysregulation and the role that it plays in many sex offenses; the role of shame as a precipitant in many sex offenses,

rather than a consequence; the use of the PCL-R and the diagnosis of antisocial personality disorder with little or no reference to the offender's own abuse history; and the general failure of sex offender treatment to provide avenues for decreasing intimacy deficits.

Sex Offenders and Attachment Theory

The recent attention to the field of attachment theory is encouraging but the method of studying this rather complex subject is a source of concern. The literature on attachment clearly suggests that, in terms of potential dangerousness, we should be most concerned about the roughly 13% of individuals who have what is called "disorganized" attachment. The human infant explores its environment but returns to the "safe base" of the attachment figure when the novelty of the environment is too frightening. What happens when the primary attachment figure is herself the source of the fear? In order to get a true feeling for the bizarre behaviors of some parents of children who show disorganized attachment, one must read some of the observations made in the "Strange Situation" experiments by Ainsworth, Main, and others. "They [parents of disorganized offspring] are disruptive to an organized strategy because the infant cannot make sense of the internally generated and confusing parental responses. Furthermore, the child cannot use the parent to become soothed or oriented, because the parent is in fact the source of the fear or disorientation" (Siegal, 1999, p.108). "We suggest that disorganized/disoriented behavior is expectable *whenever an infant is markedly frightened by its primary haven(s) of safety, i.e., the attachment figure(s)...*then disorganized behavior should of course occur when an infant is maltreated by the parent" (Hesse & Main, 2004, p.1102). Indeed a number of studies have found that almost 80% of infants known to have been maltreated by their parents show disorganized attachment (Carlson et al, 1989; Lyons-Ruth, 1996). They account for a high percentage of those who commit violent crimes and/or are later diagnosed as having major mental illnesses. "Children with disorganized/disoriented attachment have been found to have the most difficulty later in life with emotional, social, and cognitive impairments...Studies have found that these children may become hostile and aggressive with their peers. They tend to develop a controlling style of interaction that makes social relationships difficult" (Siegal, 1999, p.109).

The descriptions of disorganized attachment in the literature are highly reminiscent of many of our sex offender clients, as will be seen below in the discussion of affect dysregulation. Thus it is of vital importance that we be able to identify individuals with disorganized attachment. Attachment is not something that anyone has conscious awareness of because it occurs so early in human development. The process of attachment is thought to begin as soon as the infant is able to differentiate one human face from another, and continue until about age 24 months. Yet much of the sex offender research which has focused on attachment is based on self-report. Experimental observations of mother-child interactions in the "Strange Situation" have been conducted over more than 4 decades and in numerous cultures. Main (2002) reports that this research involved 66 hours of observation *per dyad*. This is a large body of painstaking research which has to be respected for its thoroughness. I do not believe that it can be ignored and replaced by self-report instruments. Rather, in order to obtain valid and reliable information about attachment status, research should use the instrument developed and validated specifically for this purpose, the Adult Attachment Interview (George, Kaplan & Main, 1984,1986, 1996). Main cautions, "Self-reported relations to mother or parents show little or no relation to the

Adult Attachment Interview" (2000, p.24). Unfortunately this instrument requires specialized training to use. The sex offender literature often makes general reference to Bowlby (1969) but fails to cite the wealth of research that has grown out of his ideas. A notable exception to this is the work of Gail Ryan and her colleagues at the Kempe Center in Denver (Ryan et al., 1999). The importance of getting accurate information about the attachment status of sex offenders cannot be overestimated. In a recent article Laws and Ward note that the early uncritical acceptance of relapse prevention "resulted in the widespread implementation of a largely unproven treatment approach" (Laws & Ward, 2006, p.242). I fear that the failure of sex offender researchers to draw on the extensive and well-documented findings of developmental research may lead us down a similar erroneous path and result in wrong conclusions.

Affect dysregulation

There has been a fair amount of interest in the relationship between negative mood and sexual offending. Many sex offenders report stress and negative affect immediately prior to offending (Serran & Marshall, 2006) and Ward and Hudson (2000) found that the regulation of affect appears to be impaired in sex offenders. Serran & Marshall (2006) also concluded that "research examining the coping strategies of sexual offenders suggests that these offenders tend to choose ineffective strategies..." (p.112). They delineate coping strategies as generally falling within one of three categories. The most effective are described as *task-focused*, which occur when the individual has a sense of efficacy and believes that he can change the situation. The other two are described as either *emotion-focused* or *avoidance-focused*. The first involve ineffectively venting emotions, fantasizing, or self-preoccupation in the form of ruminating, becoming depressed, or wallowing in self-pity. The second are techniques to avoid the problem, such as substance abuse, watching T.V., eating or engaging in sex. All of these maladaptive "strategies" are also among the long-term effects of abuse.

I have argued elsewhere that the findings of Hanson and Harris (2000) regarding the stable dynamic factors related to recidivism support the contention that it is the offender's own untreated history of childhood abuse that makes him vulnerable to re-offend (Adams, 2003). In a more recent article, Hanson notes that "problems with sexual self-regulation form a core deficit associated with sexual offending" and goes on to suggest that "problems with sexual self-regulation can be understood within the larger context of general self-regulation problems and antisocial orientation" (Hanson,2006, p.24). Not coincidentally, "general self-regulation problems" are also a primary long-term consequence of early childhood abuse. "In fact, it has been suggested that affect dysregulation may be the core dysfunction that results from psychological trauma...Such individuals tend to overreact to minor stresses, become easily overwhelmed, appear to have extreme reactions to neutral or mild stimuli, have trouble calming themselves...They also typically have a great deal of trouble either expressing or modulating their anger...Further such individuals frequently exhibit suicidal preoccupation, either sexual preoccupation or difficulty modulating sexual impulses, and heightened risk-taking behavior" (Luxenberg et al., 2001, p.377).

An understanding of how the infant brain develops reveals how affect dysregulation comes about. One of the first functions to come "on line" after an infant is born is the "startle reaction." When an intrusive event occurs in the infant's immediate environment, such as parental yelling or fighting, breaking dishes

or furniture, or even loud noises on a nearby T.V, the startle response is triggered. The infant begins to cry and must rely on its caregiver to respond with comfort and protection. The brain develops in a "use-dependent" fashion (see Siegel, 1999; Perry, 1997). Each time the startle response is triggered, the connections in the brain which cause it are strengthened, increasing the likelihood that it will occur again. A "kindling effect" is established, so that as the brain connections are strengthened, it takes less and less to trigger the response. The result is a child who reacts strongly to even minor stress, becomes easily overwhelmed, and experiences his emotions more intensely than other children. Such children have trouble calming themselves once emotionally aroused. Prolonged hyperarousal while the brain is developing causes difficulties in affect regulation. This means that the individual becomes emotionally vulnerable.

A second major causal factor in affect dysregulation is how the mother or primary caregiver responds to the infant's emotional arousal. Research on attachment theory has established that a secure bond requires the mother to be acutely responsive to the emotional states of the infant. It is from the mother's attunement with the child and her appropriate response to his distress that the child learns how to self-soothe and how to be empathic. The ability to self-soothe is related to the child's later capacity to develop coping skills rather than becoming overwhelmed. A primary caregiver who has her own history of trauma can establish a secure attachment bond with her infant IF AND ONLY IF she can discuss her own trauma in a logical, coherent and emotionally connected way (Main, 2000). A mother is unlikely to be able to establish a secure attachment bond with her infant if she is being abused by her partner, if she is overwhelmed by the demands of numerous other very young children, if she is abusing drugs or alcohol, or if she has her own unresolved trauma issues. Thus events in the surrounding environment and the primary caregiver's own trauma history and ability to be acutely "tuned in" to the infant can interact in a variety of ways to lay the ground work for later difficulties in modulating emotions. In addition, the strength of early attachments plays a crucial role in how an individual copes with later trauma, such as being sexually abused.

Treatment outcomes with our most at-risk clients will not improve without an understanding of the etiologic role of attachment failure and abuse. Teaching such clients effective coping strategies and/or trying to increase their motivation are of little benefit, because many of our clients do not "choose ineffective [coping] strategies" (Serran & Marshall, 2006). Rather, they rely on the only coping skills that they have, which are the products of their early developmental deficits. It is essential to assess clients with respect to their impulsivity and difficulty modulating affect. Clients who are experiencing painful emotions and feel overwhelmed are likely to flee from treatment, to call upon familiar defenses that have worked in the past, or act out in a variety of ways as a distraction. Distraction behavior may include substance abuse, self-injury, and/or deviant sexual fantasy or behavior. Therefore it is important to provide such clients with treatment that can help them learn how to tolerate strong affect and modulate it BEFORE we expect them to approach areas that are scary and painful. Marsha Linehan's dialectical behavior therapy (DBT) has proven successful with severe borderlines, and her techniques should be equally applicable with many sex offender clients (Linehan, 1993). DBT should be the starting point in treatment for sex offenders whose history includes difficulty with impulse control. Linehan's extremely structured approach can give sex offenders the skills they need in order to deal effectively with the emotional arousal that is likely to occur when engaging in treatment assignments

such as Behavior Chains and Autobiographies. Providing offenders with the skills to manage the arousal of painful affect would go a long way in reducing "resistance" and treatment dropout.

The Role of Shame in Sex Offenses

Shame has recently become a focus of interest among researchers and clinicians seeking to understand sex offenses. Allen Schore, one of the most well respected and prolific attachment theorists, regards shame as the emotion evoked when a child's aroused state is not attuned to by the caregiver (Schore, 1994). Moreover, shame is one of the emotions most commonly experienced by children when they are abused, especially when the abuse is sexual (Briere, 1992). Shame is an excruciatingly painful emotion which strikes at the very core of the self. It is not something we did which is bad or worthless, but our very being. There are numerous practices which we routinely employ in sex offender treatment which are likely to elicit shame. Some examples are the preparation of a detailed autobiography, the processing of crimes in detail through the constructions of Behavior Chains, and phallometric assessment.

One of the most important developments in this area are the findings that shame interferes with empathy and is likely to increase the externalization of blame (Hanson, 1997; Bumby, 2000; Proeve & Howells, 1993). This consideration of shame in the literature has created awareness that the usual ways in which sex offender therapists attempt to induce victim empathy in clients may often be counterproductive. However, the emphasis continues to be on the offender's experience of shame after an offense or a lapse. In a recent article, Proeve and Howells (2006) discuss shame in terms of its possible evolutionary role in promoting conformity and prosocial behavior. This formulation fails to consider that humans are capable of experiencing shame long before they become capable of complicated reasoning. If Schore's ideas regarding the origins of shame are correct, it is likely that many sex offenders avoid treatment, flee from treatment, blame the victim, and in some cases commit their offenses because they are already overwhelmed with shame. In this formulation, shame is the cause rather than the effect of many sex offenses. In light of what is known about the effects of shame and the childhood abuse in the histories of many sex offenders, it seems logical that the most effective way to encourage victim empathy is to model it in relation to the client's own abuse. This means creating a therapy situation that is a safe place where the offender can feel comfortable to explore the relationship between his offenses and his own history. "It could be argued that unless the offender is heard as a victim in his own right, his capacity to develop victim empathy will be impaired" (Craissati et al., 2000, p.236).

ASPD/Psychopathy

Hanson (2006, p.24) lists general self-regulation problems as a factor under "Antisocial orientation." It seems somewhat contradictory that an antisocial orientation implies volitional control, yet some of the indications of such an orientation, such as problems with self-regulation, impulsivity, and irritability, clearly imply a lack of volitional control. On the one hand, we see such people as impulsive and unable to delay gratification, but at the same time, as crafty and manipulative. This seeming contradiction may stem from our failure to heed the following caveat from Hare: "The neglect and abuse of children can cause horrendous psychological damage. Children damaged in this way often have lower I.Q.s, and an increased risk of depression, suicide, acting out, and drug problems. They are more likely than others to

be violent and to be arrested as juveniles. Among preschool children, the abused and neglected are more likely than other children to get angry, refuse to follow directions and show a lack of enthusiasm. By the time they enter school they tend to be hyperactive, easily distracted, lacking in self-control, and not well liked by their peers. But these factors do not make them into psychopaths" (Hare, 1993, p.170).

Hare's early research on psychopathy was based on the theory that psychopaths are chronically under-aroused and that they engage in dangerous and risky behavior in an effort to bring their arousal level up to normal. This hypoarousal was theorized to be innate, or genetic. Psychopaths are also generally seen as engaging in instrumental aggression, i.e., aggression with a specific purpose, used to obtain a desired result. However, much of the violence seen in prison populations, including sex offenders, appears to be impulsive, and those who engage in it appear to be hyperaroused. The criteria for antisocial personality disorder are largely behavioral, and overlap substantially with Factor 2 of the PCL-R. Many of the symptoms in both the ASPD diagnosis and the PCL-R could be easily confused with the long-term sequelae of early childhood abuse. A few examples are: "impulsivity," "promiscuous sexual behavior," and "poor behavioral controls" may be caused by affect dysregulation as described above; "shallow affect," "lack of remorse," and "lack of empathy" could be due to the presence of dissociation, which is also a long-term effect of childhood abuse.

"Evidence of conduct disorder with onset before age 15" is another of the required criteria for diagnosing ASPD. In the discussion of the diagnostic features of conduct disorder, the text states, "Running away episodes that occur as a direct consequence of physical or sexual abuse do not typically qualify for this criterion...the Conduct Disorder diagnosis should be applied only when the behavior in question is symptomatic of an underlying dysfunction within the individual and not simply a reaction to the immediate social context" (DSM-IV-TR, p.94, p.96). The authors suggest that it would be helpful to consider the social and economic context of the behavior in making this diagnosis but this is rarely taken into account in forensic assessments. These are a few of the issues which may have led to a confounding of grown up abused children with true psychopaths. In light of the emphasis now placed on the PCL-R and the ASPD diagnosis in predicting risk, assessing motivation, and selecting treatment approaches with sex offender clients, the deleterious consequences of such confusion can be profound. It is essential, both clinically and ethically, that we exercise care in assigning these labels and that we know as much as we can about our clients' histories before we do so.

Intimacy Deficits

Research by Hanson and Harris (2000) identified intimacy deficits as one of the major variables that predict recidivism. However the Relapse Prevention paradigm, with its emphasis on cognitive factors and identifying offense triggers, provides no avenue for working on intimacy. How does an offender work on his intimacy deficits in treatment? Main (2002) noted that intimacy deficits are not as immutable as might be thought. One of her most important research findings has been that a relationship with a secure partner can transform insecure partners to secure partners in approximately 5 years. This is consistent with other brain research which has found that the prefrontal cortex retains some degree of plasticity through-out life and that the primitive portions of the right hemisphere will continue to re-organize IF the individual is exposed to a close relationship (Siegel, 1999).

Unfortunately many individuals who have a history of childhood abuse select partners who have also been abused, and therefore also have attachment deficits. For many of our clients, the only context in which they are likely to experience a relationship with a securely attached person is psychotherapy. Thus we have come full circle from the opening discussion of the importance of the therapeutic alliance. The exciting developments in neurobiology and attachment theory in the past 20 years have shed light on how crucial the therapeutic relationship is in effecting lasting change.

Now we have re-discovered what we already knew but with the important addition that we have a much better basis for understanding why and how psychotherapy works. We can also see more clearly why there are no "quick fixes." If we want our clients to undergo lasting change, we must be willing to accompany them on a journey which is likely to be painful and dark We must provide a safe place for this journey to take place and allow them to explore how their history has affected them. This must be followed by the learning of new skills and repeated opportunities to practice them. Deeper understanding can help us to deal more therapeutically with the frustration and counter-transference which our sex offender clients often engender.. Nicholas Groth, a pioneer in sex offender treatment, used to say that if you want sex offenders to come to treatment, you have to offer them something that feels like help. Our colleagues in neurobiology, developmental psychology and trauma treatment have provided us with valuable information. All we have to do is be willing to use it.

Implications for Policy and Practice

In the United States, public policy with respect to sex offenders has been headed in the wrong direction for almost 20 years. If the issues discussed in this article have any merit, it must be clear why isolation, punishment, and stigmatization are precisely the wrong way to deal with sex offenders. Many jurisdictions are increasingly experiencing problems caused by Draconian legal measures adopted in response to public hysteria. Some law enforcement officers and district attorneys are beginning to see that these measures don't work. In many cases, they actually make the problem worse by forcing sex offenders to live far away from jobs, therapy services, and family support, thereby increasing their likelihood of re-offense. We know from victim research that sex offenses are alarmingly common. Yet, as a society, we appear to be approaching a point where the public believes that all sex offenders should be locked up "for good," or have someone hired to watch them 24 hours a day. But neither of these "solutions" is affordable or legal.

Public policy decisions must be based more on science and focus more on the intelligent allocation of resources. Research has established that those who benefit most from intensive treatment are the most serious offenders. Such treatment is long-term and expensive, and should be reserved for those who most need it. Since such treatment is painful and stressful, it should be undertaken when offenders are in secure settings. It makes little sense to keep serious sex offenders in prison for many years, providing them with no treatment and exposing them to violence which makes them more dangerous, and then spend million of dollars evaluating and "treating" them as sexually violent predators. Many sex offenders can be safely treated in the community but recent laws have made this extremely difficult. At this point, it is virtually impossible to find residential substance abuse treatment for a registered sex

offender anywhere in the United States, due to residency restrictions. This is another problem which puts many of them at greater risk for re-offense.

Treating any forensic population, including sex offenders, is not something that is valued or considered worthy of equal remuneration within the field of forensic psychology/psychiatry. Few forensic professionals want to be bothered with treating this difficult group when assessment offers so much more financial reward. There has been a tendency to blame offenders and label them as "untreatable" rather than take responsibility for our own failures. The media and the passage of SVP laws have only exacerbated this situation.

We must make a concerted effort to correct the constant media refrain that "sex offenders are not treatable and they all re-offend." Those of us who support treatment must move beyond the superficial notion that sex offenders can be treated by anyone with a "work book" who gives assignments in a rote fashion and expects the offender to virtually treat himself. We must also move away from the lopsided emphasis on cognition, and appreciate the central role of affect in sexual offending. Emotions are messy, but no meaningful work with *any* client population is possible without them. This also means that the therapist's rapport with the client is a critical element in recovery. Finally, successful treatment of sex offenders requires training in the effects of early trauma and how to treat it. We must actively oppose the prevalent "abuse excuse" rhetoric and move to an understanding that, for the majority of sex offenders, abuse is the central problem, not an excuse.

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