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Cognitive-Behavioral Therapy in the Treatment and Management of Sex Offenders

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In this article, current methods of conceptualizing and treating adult sexual offending are reviewed. First, the Risk-Needs-Responsivity (RNR) approach to sex offender management is presented and critiqued. Then, the newer Good Lives Model is discussed and contrasted with the aforementioned RNR approach. The discussion of these approaches to sex offender management and rehabilitation is followed by a review of those cognitive-behavioral therapy (CBT) techniques used to treat risk factors associated with sex offending, as such techniques are employed in both paradigms. Finally, research regarding the efficacy of using CBT techniques to treat sex offending behavior is presented, and future directions for sex offender treatment and management are discussed.

Keywords: sex offender management; cognitive-behavioral therapy; sex offender treatment; Good Lives Model

As of 2001, approximately 386,000 sex offenders were registered in the United States (Bureau of Justice Statistics [BJS], 2002). Although the public often demands that strategies for managing perpetrators of sexual crimes focus on confinement, the majority of convicted sex offenders spend the greatest portion of their lives in the community (BJS, 2002). Further, despite public demand for strict management of sex offenders, recent studies have shown better outcomes, such as lower recidivism rates, are realized when sex offender management includes a treatment component (e.g., Center for Sexual Offender Management [CSOM], 2006; Hanson et al., 2002; Hall, 1995).

Accordingly, the purpose of this article is to provide an overview of current practices in the treatment and management of sex offenders. First, the Risk-Need-Responsivity (RNR) approach to sex offender management is detailed and contrasted with the Good Lives Model (GLM). Next, an overview of CBT for sex offenders, which may be provided under either an RNR approach or

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the GLM, is detailed. Finally, implications for policy and future research directions for sex offender treatment are delineated.

Management Frameworks and Theoretical Underpinnings

For the past 40 years, sex offender management has been based upon an RNR approach (Andrews & Bonta, 1998). Under this paradigm, offenders' risk level, their criminogenic needs, and responsivity factors are targeted in an effort to reduce sexual recidivism. That is, programs following this model are tailored to offenders' risk level such that offenders who are at higher risk for reoffending, as compared to those who are at a lower risk for reoffending, participate in more intensive management programs. Under the need principle, management focuses on remediating behavioral deficits and dynamic risk factors related to offending behavior. Finally, the responsivity principle stipulates that management should match the offender's learning style, level of motivation, and cultural background (Andrews & Bonta, 1998; Hanson & Morton-Bourgon, 2004; Whitehead, Ward, & Collie, 2007). In practice, rehabilitation programs developed in an RNR model utilize cognitive-behavioral therapy (CBT) techniques to address risk factors that have been empirically associated with reoffending (such as interpersonal skills deficits, cognitive distortions, and a lack of victim empathy), as cognitive and behavioral techniques are well suited to address these risk factors (Hanson & Morton-Bourgon, 2004). Enhancing an offender's quality of life or helping him or her reach certain goals is not a focus in this management model (Ward & Stewart, 2003).

In addition to RNR, most sex offender management programs, at least since the 1980s (Pithers, Marques, Gibat, & Marlatt, 1983), have included an element of relapse prevention (RP; Birgden, Owen, & Raymond, 2003). RP provides a framework for facilitating self-management among sex offenders post-treatment. That is, treatment under an RP framework does not aim to change any of those risk factors conceptualized to contribute to sex offending behavior. Rather, the goal of RP is to teach offenders to recognize those situations in which they are likely to reoffend and to use coping strategies (e.g., skills learned in treatment) in such situations (Marlatt, 1985; Marshall, Anderson, Fernandez, 1999; Roth & Fonagy, 2005; Ward & Hudson, 1998). In other words, RP is focused primarily on identifying the offender's specific dynamic risk factors for reoffending. Therefore, this approach can be subsumed under the needs principle of an RNR approach to sex offender management (Barnett & Wood, 2008). In fact, there is ambiguity as to whether RP alone can provide a treatment or management framework for sex offenders or whether such ideas, and associated techniques, are better incorporated into a more comprehensive CBT treatment package provided under an RNR management framework (Birgden et al., 2003; Laws, 1989).

While modest empirical support for sex offender management programs based on RNR and/or RP frameworks has emerged (Hanson & Morton-Bourgon, 2004; Kirsch & Becker, 2006; Marques, Day, Nelson, & Minder, 1989), these approaches have been criticized for, among other things, their focus on criminogenic risk factors to the exclusion of other variables that may help sex offenders lead more productive, prosocial, and fulfilling lives. Such frameworks, thus, create necessary but insufficient conditions for effective treatment (Lindsay, Ward, Morgan, & Wilson, 2007; Ward & Gannon, 2006).

More recently, in part due to the acknowledgement of such limits to the RNR model, the GLM has been developed as an alternate model of sex offending behavior and sex offender rehabilitation (Lindsay et al., 2007; Whitehead et al., 2007). Under this framework practitioners are directed to not only consider those criminogenic or dynamic risk factors that contribute to sex offending, but also to understand each offender's unique values, life position, and goals when conceptualizing management strategies and/or treatment. According to the GLM, such understanding and consideration throughout the rehabilitation process provides a motivational force for change.

The GLM is based on the understanding that each individual has basic or primary needs, such as relatedness, competence, autonomy, happiness, and health (Deci & Ryan, 2000; Emmons, 1999; Thakkar, Ward, & Tidmarsh, 2006), that he or she instinctually strives to meet (Kekes, 1989) and that offending represents a maladaptive but effective way to meet these needs. From this conceptualization, it follows that offending may be curbed if an offender's unique needs are understood and if more adaptive means of achieving these primary needs are found (Ward & Stewart, 2003).

In other words, where treatment directed by an RNR strategy aims solely to reduce an offender's risk of reoffending by addressing criminogenic needs or dynamic risk factors for reoffending, treatment in a GLM framework considers an offender's personal goals or needs as a means of motivating and enabling behavior change. Dynamic risk factors for reoffending are addressed when they impede an individual from fulfilling his primary needs in a prosocial manner (Ward & Stewart, 2003).

Comparison of the RNR Approach and the GLM

While there are certain similarities between the GLM and the RNR approach to sex offender management and treatment (Thakkar et al., 2006), there are also some notable differences between these two approaches. The divergent aims of the two approaches represent one primary difference between the two frameworks. Treatment and management under the GLM aims to help offenders find prosocial means of achieving fulfilling lives, as achievement of such lives is posited to reduce reoffense rates among offenders. Meanwhile, in an RNR framework, reducing reoffending behavior by ameliorating dynamic risk factors for reoffending is the sole aim. Additionally, it has been argued that treatment informed by a GLM approach, as compared to treatment under an RNR approach, is better at motivating offenders to participate in treatment, remain in treatment, and to make changes to their lives. In fact, one study found that treatment adhering to the GLM resulted in significantly higher rates of treatment completion, motivation, engagement, and within-treatment change as well as lower attrition rates compared to treatment based upon a RP framework (Simons, McCullar, & Tyler, 2008).

While the debate regarding which theoretical framework should be applied in the management and rehabilitation of sex offenders continues (Thakkar et al., 2006), a consensus regarding which techniques should be used to change dynamic risk factors for reoffending in sex offenders has seemingly been reached. CBT techniques, and not other types of treatment techniques, have been found to be effective tools for realizing behavior change and promoting prosocial behavior among sex offenders (Losel & Schmucker, 2005). As a result, in day-to-day practice, treatment informed by the different management approaches may appear similar and is most often cognitive behavioral in nature (Losel & Schmucker, 2005).

Cognitive-Behavioral Therapy for Sexual Offenders

Current Practices and Outcomes

CBT as a treatment for sex offenders has enjoyed a long history. Attempts at treating sexually deviant behavior have been documented since the late 19th century, when ideas about sexual deviance and its treatment emerged from both the psychoanalytic and behaviorist schools (Laws & Marshall, 2003). Today, though some treatment programs still use psychoanalytic techniques (e.g., insight-oriented approaches; Losel & Schmucker, 2005), CBT has become the most commonly used therapeutic modality in the treatment of sexual offenders (Losel & Schmucker, 2005).

Despite long-term interest in sexually deviant behavior and its treatment, robust information supporting the efficacy and effectiveness of psychosocial treatments for sexual offenders is

just beginning to emerge. In fact, until the last decade, a number of influential papers (e.g., Furby, Weinrott, & Blackshaw, 1989; Martison, 1974; White, Bradley, Ferriter, & Hatzipetrou, 1998) suggested that sex offender treatment did not work. More recently, however, researchers have found that sex offender treatment reduces recidivism (Hanson et al., 2002; Looman, Dickie, & Abracen, 2005; Losel & Schmucker, 2005; Scalora & Garbin, 2003). Perhaps, most notably, the two most recent meta-analytic reviews of the sex offender treatment outcome literature show that providing treatment, and specifically comprehensive CBT, to sex offenders reduces recidivism (Hanson et al., 2002; Losel & Schmucker, 2005). Furthermore, additional evidence has been garnered suggesting that CBT reduces reoffending behavior over the long-term and that CBT proves a cost-effective means of curbing reoffending behavior (Maletsky & Steinhauser, 2002; Prentsky & Burgess, 1990). Thus, in light of these data, CBT enjoys support and is currently the most commonly used psychosocial treatment for sex offenders (Losel & Schmucker, 2005).

Specific Risk Factors and Associated Cognitive Techniques

Below, some of the most common treatment targets among sex offender treatment programs are outlined, and cognitive and behavioral techniques used to address these targets are explained (McGrath, Cumming, & Bruchard, 2003). Additionally, empirical information supporting the use of these techniques in the treatment of sex offenders is provided. In current practice, regardless of whether a program's stated overarching approach to sex offender management is the GLM or RNR approach, programs utilize some combination of the following techniques to address risk factors for sexual reoffending (Lindsay et al., 2007; McGrath et al., 2003).

Cognitive Distortions and Schemas. Among sex offenders, cognitive distortions refer to the inaccurate thoughts and thought processes that support offending behavior, and schemas refer to the beliefs that support these problematic cognitions and thought processes (Marshall et al., 1999). A variety of schemas, including beliefs that children are sexual beings, that individuals are entitled to sex, that sexual activity does not harm children, that society's rules and norms may be disregarded, and that women are game-playing, deceitful, and/or hurtful individuals, have been linked, either theoretically and/or empirically, to sex offending (Hanson & Morton-Bourgon, 2004; Malamuth, Sockloskie, Koss, & Tanaka, 1991; Mann & Beech, 2003). Much like cognitive conceptualizations of other disorders, these schemas are believed to develop in childhood and to contribute to sex offending behavior via their effects on individuals' perceptions and interpretations of life events (Mann & Beech, 2003). Meanwhile, specific cognitions and thinking errors that have been associated with sex offending schemas, and hence, have been directly linked to sex offending behavior, include mistaken beliefs that a victim desires sex, minimization of one's own responsibility for the act, mind reading, and victim blaming errors (Barriga & Gibbs, 1996; Beck, 2002; Beckett, Beech, Fisher, & Fordham, 1994; Blumenthal, Gudjonsson, & Burns, 1999; Hall, 1996; Happel & Auffrey, 1995; Hudson et al., 1993; Lipton, McDonel, & McFall, 1987).

The use of cognitive therapy techniques to change cognitive distortions and maladaptive beliefs in sex offenders has received empirical support (Hall, 1996; Marshall et al., 1999). Specifically, the following techniques have been found to be effective in changing maladaptive cognitions, and hence, in reducing recidivism among sex offenders: completion of daily thought records to identify those distortions that contribute to deviant sexual behaviors, labeling of maladaptive thoughts, and the generation of more adaptive thoughts in a group setting (Murphy, 1990). For example, in practice, a pedophile may endorse the belief that a child who sits on his or her lap is interested in his or her sexual advances. To address this belief, a clinician could present the belief to the offender or a group of offenders for discussion. Alternate hypotheses could be generated to explain why a child may want to sit on an adult's lap. Then, each of these alternate explanations could be discussed in light of the original cognitive distortion. In essence, the

therapist could work with the pedophile to help him or her arrive at the conclusion that there are other plausible explanations for a child wanting to sit on his or her lap.

More recently, techniques from Young's Schema Therapy (1999), such as role playing, have also been adapted for use with sex offenders with promising results. In practice, for example, sex offenders are sometimes enlisted to take the role of the victim. Such an exercise encourages the sex offender to think about the victim's perspective, an event which in turn is hoped to lead him or her to challenge his or her cognitive distortions around the impact of his or her sex offending behavior. In fact, results indicate that schema therapy may reduce offending-related cognitions in offenders who have not responded to more traditional cognitive therapy interventions (Perkins, Hammond, Coles, & Bishopp, 1998).

Emotion Dysregulation. Emotion dysregulation, which may be defined as a propensity to experience negative affect, a slow return to baseline after emotional arousal, and/or non-normative emotional reactions to stimuli (Linehan, 1993; Thompson, 1994), has been associated with maladaptive behavior, including sexual offending behavior (Linehan, 1993; Hanson & Morton-Bourgon, 2004; Ward, Hudson, & Keenan, 1998). Due to this understanding, emotion regulation, for example, improved management of anger and other emotions (Johnston & Ward, 1996), has been increasingly targeted in sex offender treatment programs (Howells, Day, & Wright, 2004; Yates, 2003).

Techniques suggested in the treatment of emotion dysregulation among sex offenders include emotional labeling and psychoeducation about the experience and purpose of emotions (Moster, Wnuk, & Jeglic, 2008). More recently, acceptance-based techniques, such as mindfulness and willingness, have also been suggested for use with sex offenders who avoid emotions or who are unaware of their emotions (Day, 2009; Quayle, Vaughan, & Taylor, 2006). Other techniques aimed at uncovering the antecedents of offending behavior may also be utilized to aid the offender in determining which emotions, if any, precipitate or maintain his or her offending behavior. These may include techniques such as behavioral chain analyses whereby an offender is asked to draw a chain of the thoughts, feelings, and emotions that immediately precede his or her sexual offending behavior.

While the efficacy of teaching sex offenders emotion regulation skills has not been well studied (Yates, 2003), support for the additive utility of such a module within cognitively based treatments for some disorders, for example, Borderline Personality Disorder, continues to grow (Linehan, 1993). Further, some authors (e.g., Day, 2009; Quayle et al., 2006) have recently argued that teaching emotion regulation skills to sexual offenders makes sense because emotional arousal, including dysphoria and/or anger, occurs in certain offenders' offense chains. In sum, the provision of emotion regulation skills is likely an important component in successful treatment of sex offenders (Moster et al., 2008), though empirical understanding of the additive effectiveness of this component in the treatment of sex offenders awaits further study (Day, 2009; Quayle et al., 2006).

Interpersonal Skills Deficits. Interpersonal deficits, including a lack of social support and problems with intimacy and maintaining nonconflictual interpersonal relationships, have been associated with sex offending behavior (Hudson & Ward, 2000). Those elements of sex offender therapy aimed at enhancing offenders' interpersonal skills are similar to the elements employed in CBT for disorders such as social phobia and may include techniques such as communication and assertiveness training and role-playing (Hudson & Ward, 2000; Marshall et al., 1999). Psychoeducation around intimacy and healthy relationships may also be included if it is determined that the offender has deficits in these areas (Correctional Services of Canada, 1995; Marshall et al., 1999). For example, in practice, sex offenders may be taught about healthy adult relationships and how to foster them in a group setting. Specific discussion topics may include how to make age-appropriate friends and how to develop topics of conversation and shared interests with potential age-appropriate and consenting romantic partners.

Though the efficacy of using cognitive and behavioral techniques to treat social skills deficits in sex offenders remains unknown, the efficacy of employing these techniques to treat social skills deficits among other populations has long been established (Heimberg, 2001). Therefore, social skills training is likely an efficacious treatment technique for reducing social skills deficits among sex offenders.

Deviant Sexual Behavior. Deviant sexual behavior, including deviant sexual preoccupations, preferences, and arousal, has long been associated with sexual offending behavior. Further, offenders with more deviant patterns of arousal have been found to be at higher risk for reoffending sexually (Hanson & Morton-Bourgon, 2004; Kafka, 1997; Kanin, 1967). Accordingly, such behaviors continue to be highlighted as treatment targets in many programs (Kafka, 1997).

Treatments aimed at reducing deviant sexual behavior are most often behavioral and include techniques such as covert sensitization, masturbatory satiation, and verbal satiation (see Dougher, 1996, for a review). Addressing deviant sexual arousal by employing behavioral techniques has been found to be an effective means of reducing deviant sexual behavior, and in turn, reducing recidivism (Barbaree & Marshall, 1988).

Empathy Deficits. A lack of empathy, or ability to take another's perspective or experience his or her emotions (Mahrer, Boulet, & Fairweather, 1994), has long been posited as a contributing factor to sexual offending. Empirical data supporting the importance of empathy deficits in sex offending, however, is lacking (Hanson & Scott, 1995; Polaschek, 2003). Despite the limited empirical evidence, due to the intuitive appeal of linking empathy deficits to sex offending, empathy training has remained an often included component of sex offender treatment (Polaschek, 2003).

Usually undertaken in a group setting, empathy training programs involve activities that aim to enable an offender to understand the victim's perspective and experience of the crime. Specific interventions may include showing videos of victim impact statements to offenders, requiring an offender to write a letter of regret and remorse to the victim, and/or a requirement that offenders share letters received from their victims with the group (Carich, Metzger, Baig, & Harper, 2003; Freeman-Longo & Pithers, 1992; Marshall et al., 1999). As alluded to earlier, robust support that empathy training improves an offender's ability to take the victim's perspective and therefore prevents future offending is lacking (Williams & Khanna, 1990).

Conclusion and Implications

Broadly defined, the aim of sex offender management is to reduce the risk that a sex offender will reoffend, and therefore, to protect society. To achieve this goal in today's society in which sex offenders are often managed in the community, the provision of efficacious treatment to offenders has become an increasingly important and necessary task.

In this article, two approaches to sex offender management and rehabilitation, that is, the RNR approach and the GLM, have been reviewed. While these approaches differ theoretically, treatments under both utilize CBT techniques to train sex offenders to manage those dynamic risk factors that contribute to sex offending. In fact, though treatment in a GLM framework seemingly requires that offenders' motivations, values, and goals be understood and attended to throughout treatment, in practice, the majority of programs, even those that employ a GLM orientation, seem to focus on employing specific CBT techniques to address dynamic risk factors for sexual offending. This may be the case because very little information exists detailing how treatment might proceed under the GLM. That is, few published reports provide specific information on which therapeutic techniques may work to, for instance, facilitate the discovery of an offender's primary needs or aid the therapist and client in understanding different, realistic ways the client may meet his or her needs.

In our view, the information provided in this article has numerous policy implications. First, in the United States, treatment is not mandated for all offenders, and treatment that is conducted is not required to be CBT-based. Instead, many states have "best practice" policy guidelines. Thus, as research support for programs using CBT techniques (either following an RNR or GLM framework) continues to grow, this therapeutic modality should be considered "best practice" for the treatment of sex offenders. Second, a large part of the literature on the GLM has been theoretical in nature, or in other words, few empirically based studies have examined treatment outcomes using this theoretical framework (Lindsay et al., 2007). Therefore, it is important for programs based upon the GLM to pool their outcome data so researchers may examine whether working under this framework produces better results for both offenders and society than adherence to other approaches, for example, an RNR approach. Further, as alluded to above, more practical information regarding those techniques and practices that may facilitate work in a GLM is needed. That is, little practical information is available to clinicians who wish to provide treatment in a GLM framework. Finally, the GLM represents a new way of thinking about correctional programming. Many still view prison as a place for punishment and penance. Unanimous public support does not yet exist for treatment of individuals in the criminal justice system. Thus, developing treatment programs based upon a model aimed at improving offenders' qualities of life and helping them to achieve their personal goals may meet with some resistance. Consequently, public education detailing the benefits of having offenders focus upon their own personal growth may be needed.

Future Directions

In the last decade, proponents of the GLM have suggested that motivating sex offenders by facilitating their discovery of a meaningful life and prosocial means of achieving that life is a necessary component of treatment. Yet, practically, little information is available detailing how such aims may be achieved. We propose, for the reasons detailed below, that Dialectical Behavior Therapy (DBT) may be an available and appropriate treatment for this pursuit.

There appears to be significant overlap between the GLM approach to offender rehabilitation and DBT, a well-structured cognitive-behavioral treatment originally designed to treat individuals with Borderline Personality Disorder who self-injure (Linehan, 1993). For instance, in DBT, the patient is assumed to be doing the best he or she can, yet he or she is also assumed to want and to need to do better (Linehan, 1993). Consequently, maladaptive behavior is viewed as an individual's best current solution to his or her difficulties (Linehan, 1993). Similarly, in a GLM framework, individuals are assumed to offend because they cannot meet their needs or obtain their desired outcomes in a more prosocial manner (Ward & Gannon, 2006). Thus, skills building to reach prosocial goals becomes a primary target in treatment informed by the GLM as it is in DBT treatment. Another similarity between the two approaches is their mutual foci on helping individuals build a meaningful life or a "life worth living" (Linehan, 1993; Ward & Gannon, 2006). The authors of both approaches suggest that having such an ultimate goal provides both motivation throughout the process of behavior change and ensures maintenance of more adaptive functioning (e.g., less antisocial behavior) once initial treatment goals are reached (Linehan, 1993; Ward & Gannon, 2006; Ward, Mann, & Gannon, 2007).

One other author (Shingler, 2004) has also noted the consistency between the GLM approach to offender management and DBT. Shingler (2004) highlights similarities in the conceptualizations of problematic behaviors in the two approaches. Considering the overlap between aspects of DBT and the GLM, DBT may provide a feasible, detailed treatment approach to sex offending behavior that is consistent with the GLM approach to offender rehabilitation.

In fact, recently, DBT has been adapted to treat individuals within the criminal justice system. Preliminary data suggest that using DBT with forensic inpatients significantly improved their global functioning and adaptive coping abilities and significantly decreased their hostility and depression (McCann & Ball, 2000). Additionally, preliminary findings from a study evaluating DBT for stalking offenders sentenced to probation are also promising: individuals who completed the DBT program were significantly less likely to recidivate than those who dropped out (Rosenfeld et al., 2007). While no DBT program has been specifically developed and evaluated for the treatment of sex offenders (Berzins & Trestman, 2004), these initial findings suggest DBT may prove useful in the treatment of sex offenders.

A few others seemingly agree. One group (Gordon & Hover, 1998) has added DBT skills training to a more traditional CBT treatment program for sex offenders, with promising results (Berzins & Trestman, 2004). Meanwhile, another group is currently developing "corrections-modified DBT (DBT-CM)" and will test their treatment on a sample of male sex offenders (Berzins & Trestman, 2004).

While the field awaits results from the DBT-CM trial, it seems prudent and potentially informative for researchers to empirically investigate the fit between components of DBT and sex offending behavior and its treatment. For instance, the appropriateness and utility of conceptualizing sex offending behavior as a manifestation of emotion dysregulation should be further explored. In DBT, emotion dysregulation is conceptualized as the core difficulty in Borderline Personality Disorder (BPD) (Linehan, 1993). Thus, for standard DBT to work with sex offenders, offending behavior should result from emotion dysregulation. If sex offending does not or does not always result from emotion dysregulation, as suggested by Ward and colleagues (1998), then treatment modifications are needed. Similarly, in DBT, the biosocial theory is used to explain the development and maintenance of BPD (Linehan, 1993). However, whether a biological sensitivity to emotional stimuli and a proneness to experience intense emotions coupled with an invalidating environment (i.e., biosocial theory) explains the development of sex offending behavior remains to be determined (Day, 2009). In fact, McCann, Ball, and Ivanoff (2000) have proposed that biosocial theory be modified to include environments that positively reinforce antisocial behavior when the theory is used to explain Antisocial Personality Disorder. Finally, a better understanding of the applicability and effectiveness of using acceptance strategies with sex offenders is needed to support the use of DBT with sex offenders. In DBT, acceptance, whether manifested as reciprocal communication, validation, or environmental intervention, is one of two core treatment strategies. In other words, acceptance is a large part of the theory, practice, and arguably, the success, of DBT. To date, however, no empirical study has investigated the efficacy of using acceptance-based therapeutic techniques with sex offenders (Quayle et al., 2006). Furthermore, to our knowledge, the applicability of acceptance-based strategies to sex offenders has not been established. Quayle and colleagues (2006) have, however, argued that the trajectory to sex offending behavior includes dysphoria for some offenders, and thus, that acceptance-based therapeutic techniques may prove useful for certain sex offenders. In sum, a clearer understanding of the applicability of certain core DBT assumptions, strategies, and therapeutic techniques to sex offending behavior can inform the use of DBT in sex offender treatment.

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