Treatment Readiness and Comprehensive Treatment Programming

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The process of personal change can be a frightening thing. When elements of our apple cart are upset, most of us become unnerved even under the best of circumstances. Old habits can be hard to break, particularly when the new ones we are trying to put in their place may not be as fun or interesting. Nonetheless, the process of human growth requires that we engage in a process of continuous quality improvement in which old, less useful ways of doing things are cast aside in favor of greater personal efficacy and efficiency.

Making lasting changes in one's personal life requires some engagement of a problem-solving rubric, whether formally or informally. Most schemes include a rough approximation of the following steps:

- Identify the problem (sometimes, this means simply acknowledging that a problem exists)
- Outline the components of the problem
- Devise and engage alternatives
- Evaluate outcomes
- Make revisions as necessary

It seems pretty simple, at least on paper. However, we know that some processes of the human psyche—like denial and minimization—often serve

to thwart this process. Indeed, even the seemingly simple task of acknowledging that we must change some part of our behavior can prove daunting.

So, what if we throw in a wild card, a really big wild card? What if your problem made you one of society's most reviled persons? What if there was some aspect of your makeup (and ultimately your behavior) that rendered you unwelcome in almost every community? Worse still, what if asking for help sometimes made matters worse for you? How quickly would you acknowledge that you had that problem? Yet, as a society, we continue to be angered when sexual offenders deny their offenses, or minimize the harm done to victims. Really, just for a moment, think about the sexual offender's predicament. Acknowledging that you took sexual advantage of a vulnerable person—perhaps, even a child—means that you will receive little positive consideration from anyone, anywhere. However, as a society, this declaration of guilt is what we expect sexual offenders to do. Ultimately, it is what they must do in order to meet society's expectations and have any hope of a life in the community.

One practitioner who trains volunteers to work with high-risk offenders released to the community uses an interesting exercise in the training process. He asks his volunteers to close their eyes and remember the last time they were sexually intimate. Once everyone opens their eyes, he asks to have one person share the particulars of the sexual encounter—in exacting detail. Of course, nobody volunteers. In fact, everyone shudders at the thought that they might be called on to recount such a private and personal event. Although sexuality is at the core of our being, it is something we guard ferociously and are hesitant to share with others—especially in a public forum.

When you think about it, this kind of public revelation of private matters is exactly what society expects sexual offenders to provide. The particularly difficult element of this process is that the sexual acts we demand that offenders share—in minute detail—are repugnant to most people, even to other offenders. Further, we often require that sexual offenders submit to a polygraph check of how truthful they are being, with deceptiveness frequently leading to negative consequences. Other negative consequences can result from being honest about a history of sexual offending. Being a sexual offender in an institutional setting can be dangerous to the offender's health because these offenders are often targets for violence by nonsexual offenders.

The twisted hierarchy normal to prisons puts murderers at the top of the food chain and homosexual child molesters at the bottom. Often, however, sexual offenders even find ways to vaunt themselves above others who have committed even "less acceptable" offenses.

Before I leave readers with the thought that sexual offenders are much maligned unfortunates worthy of our sympathy, let me say clearly that it is not my intention to suggest that we "go softer" on offenders. Rather, it is my intention to suggest that if we truly wish to eliminate sexual abuse of children and other vulnerable people, we need to better understand the dynamics of denial, minimization, and, ultimately, attitudinal and behavioral change. When we put the offenders' perspective and experience in terms described above, it is not so hard to see why so many offenders have a hard time coming clean about their offenses. A lot is at stake: personal reputation, social standing, access to love and support of family and friends, and personal freedom. Another factor is the oft-maligned concept of self-esteem. Generally, the research and treatment literature suggests that we should not focus on self-esteem when working with offenders, including those who commit sexual crimes (Andrews and Bonta 2006; orig. 1994). On the other hand, how could we possibly expect offenders not to have critical deficits in self-esteem that would ultimately impact their chances for successful personal change?

For some sexual offenders, a direct consequence of the hatred expressed by society is a sort of cognitive "shutting down." The once-popular relapse prevention model of treatment for sexual offenders has long been criticized for its negative focus (Yates 2005; 2007). This process of shutting down shares many elements in common with Seligman's (1975) concept of learned helplessness. Learned helplessness is described as a frame of mind in which an individual stops trying to change his/her circumstances because nothing he/she does appears to have any effect on the outcome. For instance, no matter how much insight a sexual offender gains regarding his deviant behavior, and no matter how much effort he puts into learning how to lead an offense-free life, a majority of citizens will still not trust him to be free. For some sexual offenders, this dynamic leads to hopelessness, depression, and a risk for self-harming behavior. The institutionalizing effects of long sentences, coupled with the threat (in some jurisdictions) of possible civil commitment and eventual difficulty establishing stability in the community,

give offenders little hope for the future. Ultimately, these processes of poor self-concept and poor self-esteem (shame, in particular) lead to denial and minimization. When combined with other familiar sexual offender tactics, such as victim blaming, projection, and a plethora of faulty thinking known as cognitive distortions, these are collectively known in the business as *ego defense mechanisms*.

In Freudian psychology, ego defense mechanisms are employed by the psyche when a person's self-concept is under threat. In fact, Freud listed a number of processes that we often find employed by persons who have done wrong—including each and every one of us, for things as simple as, "Who left the milk out?" However, for the purposes of this chapter, we are speaking specifically about those persons who have committed monumental wrongs, like sexual offenses. In 21st-century Western culture, it is a reasonably safe bet that most or all persons were raised with the same, basic Judeo-Christian morals, based loosely on the Ten Commandments and associated culture-specific amendments. This cultural influence applies just as much to offenders as to the rest of us. They know right from wrong just as well as we do. Yet, for some reason, offenders are able to either ignore or turn off this awareness of right and wrong to suit nefarious purposes. In 25 years of practice, I estimate that I have seen between eight and ten thousand sexual offenders. Most of these were men or boys, with only a handful being women or girls. I saw the majority of these persons either in assessment or for provision of counseling or other treatment services. Interestingly, excepting those who were particularly psychopathic, I have seen very, very few offenders who were happy with their sexually offensive behavior.

Again, why are we spending so much time outlining the dynamics of openness and honesty in sexual offenders regarding their deviant behavior? Because the process of being frankly able to recount one's wrongdoing, and taking full personal responsibility for the harm done to others, is exactly what we must expect of sexual offenders in treatment, especially if we want them to truly understand why the rest of us are so upset with them. To understand how best to get to the heart of why they do it, and how to stop them from doing it again, we have to accept and understand the particularly difficult task we give offenders when we ask them (or mandate them) to acknowledge their own behavior and to attend treatment.

Effective Interventions

The Andrews and Bonta (2006; orig. 1994) meta-analysis of the principles of effective correctional interventions was a seminal answer to Martinson's (1974; see also Furby, Weinrott, and Blackshaw 1989) damning assertion that "nothing works." Their research showed that, by following a small number of simple rules, treatment programs could dramatically increase correlations between participation and lowered recidivism. Their model has since come to be known as the "risk–need–responsivity" (RNR) model. In simple terms, this model decrees that programs will be more successful in decreasing problematic behavior if they 1) match intensity of intervention to level of assessed risk; 2) specifically target problem areas identified at assessment; and 3) make genuine attempts to respond to client characteristics and issues of motivation. While the majority of Andrews and Bonta's work has focused on offenders in general, Hanson (2006) recently demonstrated that these principles also apply to sexual offenders. In his study, Hanson found that adherence to the RNR principles was associated with reduced sexual recidivism, with the most significant effect found among treatment programs that adhered to all three principles. Accordingly, we have good reason to believe that applying sound social learning in a multidimensional, cognitive–behavioral framework will succeed every bit as much with sexual offenders as with offenders in general.

However, as influential as it has been, the RNR model is not without its critics. For example, proponents of the Good Lives Model (GLM) approach to the treatment of sexual offenders (Ward 2006; Ward and Gannon 2006; Ward, Melser, and Yates 2007) have suggested that the RNR model's focus on criminogenic needs is a necessary but not sufficient condition for effective treatment. Ward (2006) further suggests that it is "necessary to broaden the scope of correctional interventions to take into account the promotion of human goods." In the Good Lives Model, individuals are regarded as active, goal-seeking beings who seek to acquire fundamental, primary human goods—actions, experiences, and activities that are intrinsically beneficial to their individual well-being and that are sought for their own sake (Ward and Gannon 2006; Ward and Stewart 2003). Examples of primary human goods that all of us seek to attain include relatedness/intimacy, agency/autonomy, and emotional equilibrium (Ward 2002; Ward and Stewart 2003). In short,

human goods are associated with general well-being, and the sort of balanced, self-determinism argued in the life skills model (Curtiss and Warren 1973).

Although RNR provides a framework for the preparation and evaluation of "effective" programs, critics of the RNR model suggest that it does not necessarily assist clinicians in choosing intervention styles that best engage offenders in therapy. In particular, knowing or asserting that a focus on risk reduction is important does not necessarily ensure that offenders will be motivated to engage in treatment to that end. Given that lack of motivation is an important response factor in treatment (Barrett, Wilson, and Long 2003; Stirpe, Wilson, and Long 2001), and that research clearly indicates that individuals who do not complete treatment re-offend at higher rates than those who complete treatment (Hanson and Bussière 1998), it is obvious that practitioners cannot afford to ignore interventions that are better designed to address offender responsiveness concerns. Furthermore, research in various clinical domains clearly indicates that effective therapist characteristics and behaviors, such as empathy, respect, warmth, and the use of positive reinforcement, are essential to treatment effectiveness, and that they account for significant portions of the variance in outcome (Marshall, Anderson, and Fernandez 1999; Marshall, Fernandez, Serran, Mulloy, Thornton, Mann, and Anderson 2003; Marshall, Marshall, Serran, and Fernandez 2006; Marshall, Serran, Moulden, Mulloy, Fernandez, Mann, and Thornton 2002). Therefore, it is critical for treatment to go beyond the RNR approach, if it is to be maximally effective, because its principal focus on risk management does not provide therapists with sufficient tools to engage and work with offenders in therapy, nor does it provide offenders with sufficient motivation to engage in the treatment process (Mann, Webster, Schofield, and Marshall 2004). In short, we need to teach treatment providers how to "sell" offenders on the process of change, and we need to motivate offenders to "buy" what we are selling.

In a recent paper (Wilson and Yates 2009), Pamela Yates and I argued that the RNR and GLM are ultimately complementary and, when fused, provide a useful framework for the effective treatment of persons who sexually offend. The RNR's focus on ensuring adequate intensity and focus in treatment meshes nicely with the GLM's focus on human goods and the ensuring of sufficient motivation to change. The literature regarding treatment efficacy continues to offer conflicting messages (see Marques, Wiederanders, Day, Nelson, and van Ommeren 2005; Marshall and Marshall 2007; 2008; Seto, Marques, Harris, Chaffin, Lalumière, Miner, Berliner, Rice, Lieb, and Quinsey 2008); however, to paraphrase Abracen and Looman (2005), I believe we have long moved beyond the question of "What works?" and into the realm of "What works best?" We should always be compelled, however, to look for ways to maximize reductions in re-offending. It would seem that an integration of RNR and the GLM might help us to achieve those additional reductions in recidivism by focusing on problem areas and by offering interventions commensurate with risk and need, while ensuring consumer buy-in and attending to the overall well-being and pro-social functioning of offenders.

Comprehensive Treatment Programming for Persons Who Have Sexually Offended

In offering comprehensive treatment programming to persons who have sexually offended, we must take several considerations into account. First, more is at stake with regard to these clients and the risks they pose, in comparison to the risks posed by most other types of offenders. Sexual offenders released to the community are held to a much higher standard. Indeed, most citizens hold that even one sexual recidivist is too many. Consequently, society tends to advocate longer sentences and more stringent controls for sexual offenders. The literature (Hanson and Bussière 1998; Hanson and Morton-Bourgon 2004) is clear that sexual re-offending is the result of a complex interaction of offender-specific and environmental factors that span biological, psychological, and social realms. As such, simply focusing on issues of containment, without attending to offenders as whole beings, will ultimately fail to maximize reduction of risk to the community.

To truly address risk for sexual offending, we must attend to skill deficits and psychological needs in a number of domains. First, intensity of treatment must be in line with the level of risk posed by the offender (in keeping with the risk principle of RNR—see Abracen, Looman, Mailloux, Serin, and

Malcolm 2003; Hanson and Yates 2004; Mailloux, Abracen, Serin, Cousineau, Malcolm, and Looman 2003; Marshall and Yates 2005). Second, consistent with the needs principle, programming must specifically address the various lifestyle areas identified as contributing to risk during both assessment and ongoing intervention. We must remember that sexual offending is a multifaceted problem, with problematic behavior and attitudes existing in a number of domains. Thus, for example, simply focusing on inappropriate acquisition of intimacy is unlikely to truly address risk overall. In this, the concept of "sex-offender-specific" treatment is discarded in favor of a holistic approach inclusive of risk-increasing factors in a multitude of domains.

In keeping with the needs principle of the RNR model, our main concern in treating sexual offenders must continue to be the risk of future sexual offending, as that is the area that puts them most at odds with society. Current literature (Wilson and Yates 2009) strongly suggests that comprehensive approaches are likely to be the most effective in addressing the risks of reoffending. Indeed, the literature is replete with evidence that sexual offense risk is mediated by such concerns as alcohol and substance abuse, poor problem-solving skills, dysregulation of emotion, self-regulation deficits, mental health difficulties, and other treatment-complicating factors. In order to fully address the totality of risk, we must consider all of these areas, and do so in a manner that treats the whole person and aims to increase psychological well-being. In addition to paying attention to the two aspects of the RNR model that are traditionally emphasized—risk and need—it is clear that treatment programming must truly attend to issues of responsivity in attempting to maximize gains and overall reintegration potential. In offering effective interventions, consideration of treatment readiness (Cullen and Wilson 2003) is a necessity, as is attention to approaches that seek to engage clients, rather than ones that simply require that they "do what we want them to" (see Marshall, Thornton, Marshall, Fernandez, and Mann 2001). Further, it is clear that we must do more to engage those we want to change in the process of change, which will require a consistent effort to gauge how offenders are doing in treatment *as whole persons*. It is incumbent on treatment providers to remember that offenders in treatment must have something to work toward, in terms of future planning. As lofty a goal as it may be, treatment providers must assist offenders in recognizing not only their difficulties and problem areas but also their strengths and goals so that they can ultimately achieve well-being and the sort of balanced, self-determined lifestyle promoted by the Good Lives Model.

Problem Identification and Treatment Readiness

Aside from us telling them so, how are offenders to know what their problems are? The current zeitgeist in treatment programming for sexual offenders is the Good Lives Model, as described by Ward and others (Ward and Stewart 2003; Wilson and Yates 2009). What is a "good life"? It has been said (see Thornton 2002, as quoted by Schlank 2008) that many offenders come from backgrounds in which they were provided with very few of the typical aspects of what most successful people would call a "good life." When your developmental history is replete with abuse, poor parenting, poor nutrition, poor role modeling, and a host of other "poor" foundational elements, is it any wonder that many of our offenders are left scratching their heads when we suggest that they need to lead a "good life"? This proposal is a tall order for those without a realistic frame of reference.

In many ways, the recent push to provide treatment readiness programming for sexual offenders derives its origins from efforts to engage deniers in treatment. As a psychologist formerly providing sexual offender assessment and treatment services in the Correctional Service of Canada (CSC), I am mindful of how fortunate I was to work in that environment, arguably one of the most dynamic research and practice networks in the world. In the mid-1990s, sexual offender treatment pioneer Bill Marshall was tasked with finding a way to engage deniers in treatment. The reintegration heyday of CSC took place during the 1990s. In those years, great efforts were made to manage and treat lower-risk offenders in community settings in keeping with the (then) recent findings of Andrews and Bonta (2006; orig. 1994). Many sexual offenders—regardless of risk level—were being held in prison, simply because they refused to admit they had done anything wrong.

Interestingly, Hanson and Bussière (1998; see also Hanson and Morton-Bourgon 2004) published the first of two seminal meta-analyses of the predictors of sexual offender recidivism at about the same time that Marshall

was trying to work with deniers. The first meta-analysis was a major landmark in our understanding of the factors most related to risk for future offending but, surprising to most in the field, the researchers' data (later corroborated by the 2004 meta-analysis) strongly suggested that denial and minimization were unrelated to recidivism. The field exclaimed a collective, "How could this be?" Later research (e.g., Nunes, Hanson, Firestone, Moulden, Greenberg, and Bradford 2007) would refine our understanding of the Hanson findings, but it is still unclear whether denial or minimization constitutes a worthwhile factor to consider when attempting to determine who will and who will not reoffend. As with most elements of human behavior, the reasons behind recidivism seem to be more complex than any one single factor. We do know, however, that those who enter treatment and see it through to the end seem to reoffend at lower rates than those who drop out (Marshall, Marshall, Fernandez, Malcolm, and Moulden 2008). We also know that coordinating treatment, throughout the process (see Wilson and Eccles 1998), and beyond, of an offender's reintegration into the community (Wilson 1996), is also likely good clinical and risk-management practice.

To get back to Marshall, his efforts to engage deniers in treatment led to some important findings. Principally, we learned that once we take admission of guilt off the table, many deniers are willing to look at the sort of lifestyle management issues we now know to be important in building the sort of balanced, self-determined lifestyles (Curtiss and Warren 1973) that are incongruent with reoffending. Basically, the approach was like this: "Okay, let's say for the sake of argument that you are completely innocent, and that you did nothing wrong. Look at where you are. You're locked up in a federal penitentiary, facing a long sentence with little chance of early release because the parole board is unimpressed by offenders who fail to take responsibility for their actions. Do you think, just maybe, that there were things going on in your life that you might want to re-examine—maybe even change—so that you don't end up here, locked up unfairly, again?"

Surprisingly, many offenders could see the logic in these assertions and decided to give Dr. Marshall's program a chance. And as some of these men began to explore their lifestyle and interpersonal choices, they also began to share more and more about the poor sexual choices they had made—to the point that many ended up admitting to their offenses and, ultimately, moving into mainstream treatment for sexual offenders. In essence, programming for deniers targeted the sort of precontemplative issues identified by DiClemente and Prochaska (1998) in their transtheoretical stages of change model, roughly equivalent to the "problem identification" step outlined in the beginning of this chapter.

TRY: Treatment Readiness for You

As psychologists working in the Correctional Service of Canada, Murray Cullen and I were acutely aware of the groundbreaking work being done by Marshall and his associates. Dr. Cullen has had great success in helping men with anger and emotion difficulties come to terms with those problems and gain better control of their lives through his popular *Cage Your Rage* workbook series (see Cullen 1992). Together, we recognized that the sorts of issues highlighted by Marshall's efforts were not just applicable to deniers, but applied, as well, to most sexual offenders contemplating treatment. In fact, it occurred to us that any course of change takes some preparation and a certain easing into the process. Consider exercise as a means to lose weight. Do you start slowly and then gradually increase the intensity of your workout, or do you just jump in with both feet and start competing in 10K races?

In the beginning section of this chapter, I outlined reasons why many sexual offenders would have a difficult time agreeing to engage in therapy focusing on their sexually deviant behavior. These barriers to change—also called "treatment interfering factors" by psychologists and other professional sexual offender treatment providers—need to be overcome. In order to make successful lifestyle changes of the sort that will assist offenders in successfully avoiding situations of risk and reoffending, the course of treatment must be intelligently constructed and implemented. This necessary step is the often-overlooked "professional discretion" element of Andrews and Bonta's RNR model, in which well-considered design and in-process reflection are critical to successful behavioral change.

The literature on effective interventions stresses that all successful treatment endeavors must attend to issues of client responsivity. Simply put, all program components must take into account the personal attributes and skill

levels of each participant in order to ensure maximum treatment efficacy. Programs also need to ensure that prospective participants understand why they must engage in treatment, and they must believe that such engagement will assist them in making the changes necessary to achieve the sort of balanced, self-determined lifestyle that we promise them will help them to live better lives. Individuals slated for intensive psychotherapy must be ready for that experience. The curriculum in the workbook entitled *TRY—Treatment Readiness for You* (Cullen and Wilson 2003) assists participants who have experienced past behavioral difficulties to identify their own potential stumbling blocks as a natural part of the process of personal change.

TRY is a short-term group intervention aimed at identifying barriers to treatment and increasing motivation to change. As originally conceived, the program was intended to run for eight weeks and was to be offered principally in a group format. Through participation in TRY, clients were told they would

- confront reasons for being in their current life circumstances (i.e., being institutionalized, being required to attend treatment, etc.);
- be introduced to models of change as they apply to behavior;
- learn to deal with cognitive dissonance by confronting ambivalence;
- identify short- and long-term barriers to making pro-social lifestyle changes;
- establish a roadmap for change in future treatment groups; and
- develop hopefulness while decreasing hopelessness and helplessness.

Marshall and his associates (Marshall et al. 2008) published outcomes from the Rockwood Preparatory Program for Sexual Offenders showing clearly that involvement in treatment readiness programming can increase self-efficacy and hope for future success. Although the genesis of their program was related to dealing with deniers, they ultimately found that motivation was the more worthy treatment target, as I did in research completed with two of my graduate students (Barrett, Wilson, and Long 2003; Stirpe et al. 2001). However, of most interest, Marshall et al. (2008) found that offenders who did not complete their preparatory program ultimately received more treatment in higher security settings, had greater difficulty engaging in treatment, and spent more time in prison before release than their peers who completed the preparatory program. That is, offenders who completed treatment readiness programming were better prepared for the process of change, understood the material more quickly, and were more likely to achieve early release.

Comprehensive Treatment Programming that Emphasizes Treatment Readiness in a Civil Commitment Setting

Civil commitment is a somewhat uniquely American approach to long-term sexual offender risk management. Under Kansas's Sexually Violent Predator Act (see *Kansas v. Hendricks* 1997), any person who, due to "mental abnormality" or "personality disorder," is likely to engage in "predatory acts of sexual violence" can be indefinitely confined. In this landmark case, which essentially began the process of sexual offender civil commitment in the United States, Hendricks appealed the finding against him, but the Supreme Court ultimately upheld the decision. In doing so, the Supreme Court defined a "mental abnormality" as a "congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to commit sexually violent offenses." As such, persons eligible for confinement were limited to those "not able to control" their dangerousness.

In Florida, the Involuntary Civil Commitment for Sexually Violent Predators' Treatment and Care Act became effective on January 1, 1999. Under this act, inmates serving sentences with sexual offense histories (not necessarily for their latest offenses) are reviewed by the Department of Children and Families, prior to release, for possible referral for civil commitment trial. The court then decides who meets criteria for civil commitment as a sexually violent predator (SVP) based, in part, on expert testimony. Those offenders awaiting trial are detained in the same facility as those already civilly committed. Housing and treatment are offered at the Florida Civil Commitment Center (FCCC) in Arcadia, Florida.

The goal of the Florida Civil Commitment Center is to assist all residents in the development of a balanced, self-determined lifestyle. Arguably, the men referred to the FCCC are among the highest risk sexual offenders of all those in Florida who receive determinate sentences for sexual offenses. Consequently, and in keeping with the tenets of the risk principle, the program is long-term and intensive. The FCCC's Comprehensive Treatment Program (CTP) for persons who have sexually offended is a four-phase, multi-modal, holistic approach to identifying and addressing problematic cognitions and behaviors that lead to increased risk for future sexual violence. The program is modeled, with adaptation, on aspects of treatment and risk-management programming designed in part by David Thornton (formerly of Her Majesty's Prison Service in the United Kingdom—see Thornton 2002), Jim Haaven's "New Me Life Planning" model (Haaven, Little, and Petre-Miller 1990), and elements of the Correctional Service of Canada's National Sex Offender Programs model (see Wilson, Cortoni, Picheca, and Nunes 2007).

The traditional model of sexual offender treatment puts principal emphasis on identification of deviant sexual fantasies and high-risk situations, full disclosure of sexual offense histories, and development of new cognitions and behavior—sometimes with little or no attention to treatment readiness and motivation. The FCCC model puts considerable time and effort into the process of preparing treatment participants for change. We believe that this preparation is tantamount to laying the foundation on which all other treatment endeavors will rely for stability. Simply put, it is a lot like painting without priming: without adequate preparation for change many of the concepts we wish participants to incorporate into their new lives will not stick.

Phase I: Preparation for Change

Phase I of the CTP emphasizes identification of the participants' problems, poor methods of problem solving, and treatment-interfering factors (or, barriers to change). All program participants must complete three individual programming components before being advanced to Phase II. Participants begin with participation in Moral Reconation Therapy (MRT—see Little and Robinson, 1988; Little, Robinson, Burnette, and Swan 1999) then move on to Thinking for a Change (T4C—see Glick, Bush, and Taymans 1997). Participation in TRY—Treatment Readiness for You (Cullen and Wilson 2003) commences approximately halfway through T4C. Placement of TRY toward the end of Phase I is intentional, in that this is when CTP participants first begin to speak about lifestyle management issues, specifically as they relate to sexuality. Up to that point, sexual issues may be raised as examples, but they are not the primary focus of intervention.

Moral Reconation Therapy (MRT)

Moral Reconation Therapy is an evidence-based approach to increasing problem-solving and moral decision-making skills. In using exercises and tasks, MRT resembles what is usually described as "cognitive skills" educational programming. However, the skills training with MRT is intended to go beyond usual classroom methods of skills development. Recent literature has shown MRT to be effective in lowering recidivism rates in those who successfully complete the program. The seven parts of MRT are as follows:

1. *Confrontation and Assessment of Self:* Assesses residents' beliefs, attitudes, behaviors, and defense mechanisms
2. *Assessment of Current Relationships:* Includes planning to heal damaged relationships
3. *Reinforcement of Positive Behaviors and Habits:* Residents help others to raise their own awareness of moral responsibility to the community
4. *Positive Identity Formation:* Explores the inner self and the setting of goals
5. *Enhancement of Self-Concept:* Builds self-esteem and positive habits
6. *Increased Impulse Control:* Develops skills to delay gratification and manage their pleasure-seeking behavior
7. *Developing Higher Stages of Moral Reasoning:* Residents are encouraged to demonstrate greater concern for others and for social systems

Thinking for a Change (T4C)

Thinking for a Change consists of exercises that build problem-solving skills. Participants learn how good decisions are made and how to use those good decisions to get along better with their friends, families, and others. The goal

is for participants to quickly identify and appreciate how reevaluating their thinking, belief systems, personal and interpersonal values, and attitudes can help their lives. Participants begin organizing their thoughts using cognitive skills and methods, applying both in an objective and systematic way. T4C has the following goals:

1. Increase awareness of cognitive distortions related to events-thoughts-feelings-actions
2. Identify differences between physical and emotional feelings and examine how they guide behavior
3. Learn to identify high-risk thoughts and feelings
4. Identify unhealthy attitudes and beliefs that lead to unhealthy behaviors
5. Improve problem-solving skills and coping strategies through new thinking
6. Improve communication and listening skills to improve interpersonal relationships

TRY: Treatment Readiness for You

Earlier in this chapter, we discussed that before offenders can go into intensive treatment, they must be ready for that treatment. The Florida Civil Commitment Center is currently piloting the TRY curriculum described above as adapted to a civil commitment population. Because treatment interfering factors in this population are frequently coupled with higher than average degrees of antisociality and a deep anger at the civil commitment process, treatment readiness programming for CTP participants is an even bigger challenge than offering such programming to many sexual offender clients. In the FCCC adaptation, TRY programming helps residents to identify barriers to change as a natural part of the process of personal growth. Increasing motivation to change in this population, however, must also take into consideration entrenched antisocial values and attitudes (some of which can be profound), degrees of institutionalization, comorbid mental health issues, and systemic issues (i.e., civil commitment as a concept, ongoing litigation, and legislative difficulties).

TRY programming at the FCCC is offered in a group setting with two facilitators, ideally one of each gender. Group sizes average 15 participants, who meet weekly for 90 minutes over a 12-week period. The program closely follows the published curriculum; however, some elements (e.g., ambivalence) targeted for one session in the original configuration are extended because of an increased need for focus in this particular population. To date, we have run four cycles with approximately 80 FCCC residents having completed the program prior to advancement to Phase II. At present, no outcome data are available (program evaluation efforts are ongoing). Observations from receiving Phase II facilitators, however, have been that TRY participants appear to have an easier time in the disclosure portion (i.e., giving a complete account of one's sexual offending past).

Phase II: Awareness

In Phase II of the CTP, participants develop an agreed upon and comprehensive identification of the main factors that contributed to past offending. In disclosure, the goal is to completely disclose the entirety of one's history of deviant sexuality and behavior. This process is usually completed with the assistance of polygraph evaluations (although it is important to note that we use polygraph as a tool to assist participants in being honest; we do not use it as a pass/fail tool to aid or inhibit graduation to higher phases of treatment). Once the goals of disclosure are met, participants move into the discovery stage, where the goal is to provide opportunities to demonstrate insight into participants' current expressions of risk factors and to further identify continued barriers to personal balance and self-determinism.

Phase III: Healthy Alternative Behaviors

In Phase III of the CTP, we encourage residents to re-evaluate justifications and attitudes that supported their offending behavior. Ultimately this process leads to increased awareness of deficits in emotional coping and specific problematic emotions, acknowledgment of deviant sexual arousal/interest, reduction of deviant arousal, verbalization of events and behaviors that comprised sexual offenses, and the application of new coping strategies. In the development component of Phase III, the focus of treatment is to help residents reliably control their psychological risk factors. Residents use healthier, more prosocial strategies in situations where risk factors are more common.

This large task is accomplished by addressing the following objectives:

- Develop a representation of "old me"
- Develop a representation of "future me"
- Enact "future me" role plays
- Review a balanced, self-determined lifestyle
- Get to the "future me"

The relationship skills component of Phase III is designed to help residents understand how they relate to others. It helps residents see how they may wish to change patterns of relating. Finally, it enables residents to develop the attitudes and skills that promote healthier ways of relating to others. The development of relationship skills is important. Experiencing problems making and keeping emotionally intimate relationships with adults has a lot to do with reducing risk for sexual reoffending. Persons who commit sexual offenses and have problems with relationships sometimes avoid close relationships, seek but fail to establish close relationships, or enter relationships that are not meaningful.

The empathy and emotional awareness component of Phase III is designed to assist residents as they try to understand and share with others in a more empathic and emotionally healthy manner through

- developing a richer, better-differentiated emotional experience;
- increasing perspective-taking skills in general, and specifically in situations where problems exist in seeing how others might interpret the things we do and say;
- increasing one's ability to share and understand emotions with others in a healthy way;
- reducing unhelpful or unhealthy responses to others' distress (e.g., freezing, self-pity, rescue-ranger); and
- developing and exploring empathy skills in the context of close relationships.

Last, consolidation of treatment gains (i.e., organizing and making them more permanent) comes through ongoing development and supervised practice of self-control over behaviors, thoughts, and emotions. Interventions are defined as contributing to a model of behavior that stresses balance and self-determination. Therefore, consolidation is very helpful in learning how to maintain treatment gains, encourage prosocial behavior, feel better about oneself, make better decisions, and provide support and reinforcement to ensure residents use their newly learned behaviors.

Phase IV: Maintenance and Comprehensive Discharge Planning

Phase IV of the Comprehensive Treatment Program provides additional opportunity to evaluate behavioral change and skill development. Phase IV allows us to gauge to what extent each participant has both acquired and integrated, and is now demonstrating behaviorally the attitudes and skills critical to avoiding future sexual offending behavior. A key component of this last phase of treatment involves volunteering and providing mentoring to persons in earlier phases of treatment. Residents in Phase IV also make preparations for life in the community through structured vocational programming (in which they identify potential sources of employment and engage in practice job interviews); make connections with social supports (including family and friends) and community-based social service agencies (e.g., treatment providers, advocacy organizations, welfare); and identify legal and civic responsibilities (e.g., probation, sexual offender registration, etc.).

Sexual offender assessment, treatment, and risk management is serious business. The potential costs of not doing a good job are huge. The public expects that persons who pose a risk to others will either take whatever treatment is necessary to eliminate that risk or—if they cannot control themselves—will be removed from society, possibly forever. Couple this attitude with the reality that most citizens believe that even one recidivist is too many, and it is easy to see the daunting task facing sexual offender service providers, to say nothing of the tremendous challenges up against the offenders themselves.

In this chapter, I have framed the plight of the offender—who must face both the chilling reality of his own behavioral history and the absolute need to make substantial lifestyle changes, if he ever hopes to be free in the community. My intention was not to seek absolution for offenders, although my mentor (Kurt Freund) was always clear in his acknowledgment of the bitter

duality of sexual offenders—inherent dangerousness coupled with a social predicament worthy of compassion. Rather, I hope that readers have been able to acknowledge and identify some of the very real challenges we all face in getting offenders into treatment, having them stay there, and making sure that they actually learn (and incorporate into their core beings) better ways of living—offense free. Addressing barriers to change, treatment-interfering factors, and motivation are key components of any program that has the goal of successfully altering behavior, including the especially lofty objective of the development of a balanced, self-determined lifestyle. The same challenge is true of sexual offender treatment in general. However, traditional programming has done little to consider issues of offender responsivity. In fact, we often mandate sexual offenders to the sort of treatment we think they need, rather than taking the time to find out whether the offender also believes these targets and goals to be important. While I hesitate to suggest that we should leave curriculum development to the clients, there is a certain benefit in at least checking in with clients to see if we are hitting all the necessary targets. Interestingly, we are now seeing more "user satisfaction" data being reported regarding sexual offender treatment endeavors (see Levenson and Prescott 2009; Levenson, Macgowan, Morin, and Cotter 2009). I believe this process of checking in with clients to be a very important element of good clinical intervention.

Treatment readiness programming has been a long time coming in the sexual offender treatment realm. As we refine methods of intervention, we identify areas in need of further exploration. Unfortunately, little research has been published regarding motivation to change in sexual offenders—certainly not nearly as much as we have seen regarding risk assessment and risk management. Ward (2006), in his criticisms of the RNR model, emphasized the need to pay more than mere lip service to the concept of responsivity. Of the components of the RNR model, the one we consistently do most poorly is being responsive to clients' needs in the design and implementation of treatment models. The need to *prepare* and *motivate* clients for participation in treatment is essential. Critical to this foundation is an acknowledgment of how difficult it is to change, especially when we consider the environments in which the changes are to begin (i.e., prison, civil commitment center, etc.) and, second, where they will be implemented (i.e., community). Sanding the surface, keeping it clean, and applying a good coat of primer will help ensure success in any painting endeavor. The same principles apply here.

REFERENCES

Abracen, J., and J. Looman. 2005. Developments in the assessment and treatment of sexual offenders: Looking backward with a view to the future. *Journal of Interpersonal Violence* 20:12–19.

Abracen, J., J. Looman, D. L. Mailloux, R. Serin, and B. Malcolm. 2003. Clarification regarding Marshall and Yates's critique of "Dosage of treatment to sexual offenders: Are we overprescribing?" *International Journal of Offender Therapy and Comparative Criminology* 49:225–30.

Andrews, D. A., and J. Bonta. 1994. *The psychology of criminal conduct.* Cincinnati, OH: Anderson Publishing.

———. 2006. *The psychology of criminal conduct.* 4th Ed. Newark, NJ: Anderson Publishing.

Barrett, M., R. J. Wilson, and C. Long. 2003. Measuring motivation to change in sexual offenders from institutional intake to community treatment. *Sexual Abuse: A Journal of Research and Treatment* 15:269–83.

Cullen, M. C. 1992. *Cage your rage: An inmate's guide to anger control.* Lanham, MD: American Corrections Association.

Cullen, M. C., and R. J. Wilson. 2003. *TRY—Treatment readiness for you: A workbook for sexual offenders.* Lanham, MD: American Corrections Association.

Curtiss, P. R., and P. W. Warren. 1973. *The dynamics of life skills coaching.* Prince Albert, SK: Saskatchewan NewStart Inc. for the Training Research and Development Station, Department of Manpower and Immigration.

DiClemente, C. C., and J. O. Prochaska. 1998. Toward a comprehensive, transtheoretical model of change: Stages of change and addictive behaviors. In *Treating addictive behaviors: Applied clinical psychology,* W. R. Miller and N. Heather (2nd ed., pp. 3–24). New York: Plenum Press.

Furby, L., M. R. Weinrott, and L. Blackshaw. 1989. Sex offender recidivism: A review. *Psychological Bulletin* 105:3–30.

Glick, B., J. Bush, and J. Taymans. 1997. *Thinking for a change.* Washington, DC: National Institute of Corrections.

Haaven, J. L., R. Little, and D. Petre-Miller. 1990. *Treating intellectual disabled sex offenders: A model residential program.* Orwell, VT: Safer Society.

Hanson, R. K. 2006. *What works: The principles of effective interventions with offenders.* Presented at the 25th Annual Convention of the Association for the Treatment of Sexual Abusers, Chicago, IL.

Hanson, R. K., and M. T. Bussière. 1998. Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology* 66:348–62.

Hanson, R. K., and K. Morton-Bourgon. 2004. *Predictors of sexual recidivism: An updated meta-analysis.* User Report No. 2004–02. Ottawa, ON: Public Safety and Emergency Preparedness Canada.

Hanson, R. K., and P. M. Yates. 2004. Sexual violence: Risk factors and treatment. In Anthology on interventions against violent men, M. Eliasson (ed.), 151–66. *Acta Universitatis Upsaliensis, Uppsalla Women's Studies B: Women in the Humanities* 3. Uppsala, Sweden: Uppsala Universitet.

Kansas v. Hendricks. 1997. 521 U.S. 346.

Levenson, J. S., M. J. Macgowan, J. W. Morin, and L. P. Cotter. 2009. Perceptions of sex offenders about treatment: Satisfaction and engagement in group therapy. *Sexual Abuse: A Journal of Research & Treatment* 21:35–56.

Levenson, J. S., and D. S. Prescott. 2009. Treatment experiences of civilly committed sex offenders: A consumer satisfaction survey. *Sexual Abuse: A Journal of Research & Treatment* 21:6–20.

Little, G. L., and K. D. Robinson. 1988. Moral Reconation Therapy: A systematic step-by-step treatment system for treatment resistant clients. *Psychological Reports* 62:135–51.

Little, G. L., K. D. Robinson, K. D. Burnette, and S. Swan. 1999. Successful ten-year outcome data on MRT®-treated felony offenders: Treated offenders show significantly lower reincarceration in each year. *Cognitive-Behavioral Treatment Review* 5:1–3.

Mailloux, D. L., J. Abracen, R. Serin, C. Cousineau, B. Malcolm, and J. Looman. 2003. Dosage of treatment to sexual offenders: Are we overprescribing? *International Journal of Offender Therapy and Comparative Criminology* 47:171–84.

Mann, R. E., S. D. Webster, C. Schofield, and W. L. Marshall. 2004. Approach versus avoidance goals in relapse prevention with sexual offenders. *Sexual Abuse: A Journal of Research and Treatment* 16:65–75.

Marques, J. K., M. Wiederanders, D. M. Day, C. Nelson, and A. van Ommeren. 2005. Effects of a relapse prevention program on sexual recidivism: Final results from California's sex offender treatment and evaluation project (SOTEP). *Sexual Abuse: A Journal of Research of Research and Treatment* 17:79–107.

Marshall, W. L., D. Anderson, and Y. M. Fernandez. 1999. *Cognitive behavioural treatment of sexual offenders.* Toronto, ON: John Wiley & Sons.

Marshall, W. L., Y. M. Fernandez, G. A. Serran, R. Mulloy, D. Thornton, R. E. Mann, and D. Anderson. 2003. Process variables in the treatment of sexual offenders. *Aggression and Violent Behavior: A Review Journal* 8:205–34.

Marshall, W. L., and L. E. Marshall. 2007. The utility of the random controlled trial for evaluating sexual offender treatment: The gold standard or an inappropriate strategy? *Sexual Abuse: A Journal of Research and Treatment* 19:175–91.

———. 2008. Good clinical practice and the evaluation of treatment: A response to Seto et al. *Sexual Abuse: A Journal of Research and Treatment* 20:256–60.

Marshall, L. E., W. L. Marshall, Y. M. Fernandez, P. B. Malcolm, and H. M. Moulden. 2008. The Rockwood Preparatory Program for Sexual Offenders: Description and preliminary appraisal. *Sexual Abuse: A Journal of Research and Treatment* 20:25–42.

Marshall, W. L., L. E. Marshall, G. A. Serran, and Y. M. Fernandez. 2006. *Treating sexual offenders: An integrated approach.* New York, NY: Routledge.

Marshall, W. L., G. A. Serran, H. Moulden, R. Mulloy, Y. M. Fernandez, R. E. Mann, and D. Thornton. 2002. Therapist features in sexual offender treatment: Their reliable identification and influence on behaviour change. *Clinical Psychology and Psychotherapy* 9:395–405.

Marshall, W. L., D. Thornton, L. E. Marshall, Y. M. Fernandez, and R. Mann. 2001. Treatment of sexual offenders who are in categorical denial: A pilot project. *Sexual Abuse: A Journal of Research and Treatment* 13:205–15.

Marshall, W. L., and P. M. Yates. 2005. Comment on Mailloux et al.'s 2003 study "Dosage of treatment to sexual offenders: Are we overprescribing?" *International Journal of Offender Therapy and Comparative Criminology* 49:221–24.

Martinson, R. 1974. Nothing works: Questions and answers about prison reform. *The Public Interest* 35:22–54.

Nunes, K. L., R. K. Hanson, P. Firestone, H. M. Moulden, D. M. Greenberg, and J. M. Bradford. 2007. Denial predicts recidivism for some sexual offenders. *Sexual Abuse: A Journal of Research and Treatment* 19:91–105.

Schlank, A. 2008. The baby, the bathwater, and pendulum swings: The need to slow down and evaluate research critically. *ATSA Forum* 21:27–37.

Seligman, Martin E. P. 1975. *Helplessness: On depression, development, and death.* New York, NY: W H Freeman/Times Books/ Henry Holt & Co.

Seto, M. C., J. K. Marques, G. T. Harris, M. Chaffin, M. L. Lalumière, M. H. Miner, L. Berliner, M. E. Rice, R. Lieb, and V. L. Quinsey. 2008. Good science and progress in sex offender treatment are intertwined: A response to Marshall and Marshall (2007). *Sexual Abuse: A Journal of Research and Treatment* 20(3):247–55.

Simons, D., B. McCullar, and C. Tyler. 2008. Evaluation of the Good Lives model approach to treatment planning. Presented at the 27th Annual Research and Treatment Conference Association for the Treatment of Sexual Abusers, Atlanta, GA.

Stirpe, T., R. J. Wilson, and C. Long. 2001. Goal attainment scaling with sexual offenders: A measure of clinical impact at post treatment and at community follow-up. *Sexual Abuse: A Journal of Research and Treatment* 13:65–77.

Thornton, D. 2002. Constructing and testing a framework for dynamic risk assessment. *Sexual Abuse: A Journal of Research and Treatment* 14:139–53.

Ward, T. 2002. Good Lives and the rehabilitation of offenders: Promises and problems. *Aggression and Violent Behavior* 7:513–28.

———. 2006. Promoting human goods and reducing risk. *Beyond Retribution* 111–17.

Ward, T., and T. Gannon. 2006. Rehabilitation, etiology, and self-regulation: The Good Lives Model of sexual offender treatment. *Aggression and Violent Behavior* 11:77–94.

Ward, T., J. Melser, and P. M. Yates. 2007. Reconstructing the Risk Need Responsivity Model: A theoretical elaboration and evaluation. *Aggression and Violent Behavior* 12:208–28.

Ward, T., and C. A. Stewart. 2003. The treatment of sexual offenders: Risk management and good lives. *Professional Psychology: Research and Practice* 34:353–60.

Wilson, R. J. 1996. Catch-22: What psychological staff can (and cannot) do for offenders after their sentence expires. *Forum on Corrections Research* 8:27–29.

Wilson, R. J., F. Cortoni, J. E. Picheca, and K. Nunes. 2007. Community-based sexual offender maintenance treatment programming: An evaluation. *Research Report R-188.* Ottawa, ON: Correctional Service of Canada.

Wilson, R. J., and A. Eccles. 1998. Forging a link between institutional and community-based treatment services. *Forum on Corrections Research* 10:39–41.

Wilson, R. J., and P. M. Yates. 2009. Effective interventions and the Good Lives Model: Maximizing treatment gains for sexual offenders. *Aggression & Violent Behavior* 14:157–61.

Yates, P. M. 2005. Pathways to the treatment of sexual offenders: Rethinking intervention. *ATSA Forum* 18:1–9.

———. 2007. Taking the leap: Abandoning relapse prevention and applying the self-regulation model to the treatment of sexual offenders. In D. Prescott (ed.), *Applying knowledge to practice: The treatment and supervision of sexual abusers*, 143–74. Oklahoma City, OK: Wood'n'Barnes.

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foundation for facilitating meaningful change and risk management is therapeutic
gement. This book offers a long overdue voice highlighting why it is important for
ment providers and programs to consider and strategically attend to building therapeutic
ionships, motivating clients, and understanding issues and dynamics related to the
ess of change. These perspectives will enhance treatment efficacy and assist individuals
have engaged in sexually abusive behaviour to manage their risk and risk factors and to
healthier lives, realizing their potential."

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