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Relapse Prevention and Sexual Offenders

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Society expects for sexual offenders (SOs) to accept responsibility, just as the recovering drug addict, for the management of personal behaviors. Relapse prevention (RP) offers treatment providers a highly productive tool for treatment of sexual addiction or compulsivity. This approach provides an effective and efficient approach to treatment that addresses high risk situations, sexual addiction, and harm reduction. Though 90% of SO treatment providers use RP within treatment questions remain: Does SO treatment reduce recidivism? Does RP enhance treatment efficacy? The author provides as brief overview of RP with SOs, addresses outcome research on the effectiveness of RP with SOs, presents current criticisms of RP with SOs, and provides recommendations for future research and practitioners. Legal considerations are also discussed.

There are 522,109 registered sexual offenders (SO) that are publicly viewable in the official state registries in the United States (www.familywatchdog.us/OffenderCountByState.asp). Statistics of this magnitude suggest a need for appropriate counseling strategies to assist these individuals. Due to possible consequences to potential victims and the community, prevention of lapse and relapse has taken a leading role in SO treatment programs (Price, 1999; Ward & Hudson, 1996). Society expects for sexual offenders to accept responsibility, just as the recovering drug addict, for the management of personal behaviors. Relapse prevention (RP) offers treatment providers a highly productive tool for treatment of sexual addiction or compulsivity. This approach provides an effective and efficient approach to treatment that addresses high risk situations, sexual addiction, and harm reduction (Harnell, 1995). However, some SO programs do not explicitly attend to sexual addition or compulsivity issues.

Signs of dissatisfaction in the application of RP to the SO population have been appearing since the mid-1990s (Launay, 2001). Theorists continue to question the efficacy and merit of adding RP to SO programs. Academic disputes continue to surface about the interaction and language of fundamentals within the RP model. Moreover, research designed to measure the efficacy of RP with SOs (Marques, Day, Nelson, & West, 1994; Marques, Nelson, West & Day., 1994; Hanson, 2000; Marques, Nelson, Alarcón, & Day., 2000) has been unsatisfactory. Consequently, this paper will address outcome research on the effectiveness of RP with SOs. It is beyond the scope of this paper to present an exhaustive view of RP as it relates to SO. Therefore, we will briefly discuss fundamental concepts including the definitions of SO, applicable laws concerning this population, relapse and assault.

Defining Sexual Offending

A SO is any person who has committed a sex crime. Paradoxically, the definition of a sex crime differs across cultures and legal jurisdiction. Most, if not all, SOs can be classified within two categories; those having paraphilias and those with sexual aggression (Longo, personal communication, 2005). The Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV) identifies paraphilias as sexual disorders with a six month duration in which a person has either acted on or been distressed by urges and/or fantasies involving any of the following categories: (1) nonhuman objects; (2) nonconsenting others; or (3) real or simulated suffering or humiliation (APA, 2008). Paraphilias include fetishes which involve nonhuman objects, voyeurism and pedophilia which involve nonconsenting others and sadomasochism which involves suffering and humiliation. Sexual aggression, on the other hand, refers to any type of sexual activity performed against a person's will through force, argu-

ment, pressure, alcohol, drugs, or authority (Sue, Sue, & Sue, 2006).

Applicable Laws

Now that we have a better idea of what the label of SO means, let discuss the laws in affect to protect the community from this diverse population and vise versa. Many times sexual offenses include child sexual abuse, downloading child pornography, rape, and statutory rape (Human Rights Watch, 2007). In most jurisdictions, public urination, mooning, streaking, and the failure to prevent one's own children from engaging in otherwise consensual sexual activity are also considered sexual offences, requiring registration in publicly available lists.

Registration

SO registries have been a prime focus in policy development in criminal justice over the last several years. The goals for SO registries are to deter SOs from future offending, supply law enforcement with new tools and to protect public interests (Center for Sex Offender Management, 1999). These tools work under the supposition that by posting information about known sex offenders, their communities can safeguard themselves from this population and "shame" SOs, thereby deterring from recidivism. However, registration has not been the only legal ramification for the SO population.

Residency Restrictions

Over half of the United States has enacted sex offender residency restrictions since 1995. Most of the statutes and restrictions vary in terms of protected zones and an offender's required distance from those locations. Additionally, these mandates prohibit SO from living within a minimum of five hundred feet of a school or daycare facility, (White, 2008) even if the assailant's offence did not involve children. Various courts have endorsed the constitutionality of these constraints. Yet, more and more jurisdictions on both the state and city levels have adopted stricter constraints in order to avoid becoming dumping grounds for the SOs from neighboring jurisdictions. The result is that some of the statutes, by their massive scope, ban offenders from living in entire cities (Warren, 2006).

In 2006, California citizens passed Proposition 83, which bans all registered SOs from living within 2,000 feet of any school or park (Warren, 2006). Georgia also passed residency restrictions prohibiting all registered sex offenders from living within 1,000 feet of a school, childcare facility, church, school bus stop, or other place where minors congregate (GA. 42.1.15). These restrictions are making it almost impossible for some offenders to find a place to live. Some individuals have been left with only hotels as possible places to live. Many times rehabilitated and/or released SOs can have difficulty finding work upon release, cannot afford a hotel bill for long and are ultimately left homeless (Dewan, 2007)."

Many registered sexual offenders (RSOs) live in socially disorganized communities (Tewksbury & Mustaine, 2006; Walker, Golden & VanHouten, 2001). A hefty percentage of RSOs live in close to "negative community attributes," including liquor stores, vacant lots, abandoned/boarded up buildings, abandoned vehicles, and large amounts of litter. These negative community attributes are among the commonly identified indicators of social disorganization (Mustaine & Tewksbury, 2008). These findings show a need for continued advocacy and work with this population. Nonetheless, there continues to be debate on the effective treatment of sexual offenders.

Relapse Prevention and Sexual Offenders: A Snapshot

Since the mid-1980s relapse prevention (RP) models have been accepted in addictions treatment (Marlatt & Gordon, 1985) and with SOs (Carich, Gray, Rombouts, Stone, & Pithers, 2001; Hudson & Ward, 1996a; Laws, 1983, 1995; Pithers & Gray, 1996). RP was originally designed to help addicts sustain transformative gains in treatment (Marlatt & Gordon, 1980). Relapse prevention is a highly successful model for management of addictive disorders and has been applied to sexual offender treatment (George & Marlatt, 1989; Laws, 1983; Marlatt & Gordon, 1980; Marlatt & Gordon, 1985). The foundational work of Pithers and contemporaries applied the relapse prevention model to adult offenders in the early 80s (Pithers, Marques, Gibat, and Marlatt, 1983; Hunter & Longo, 2004). Pithers contended that sexual offending, like other addictive behaviors, reflects persistent and deliberate behavior preceded by a sequence of synergistic events. Pithers' seminal work highlighted a demarcation of the precursors to sexual offending including the role of fantasy and cognitive distortions.

The basis of relapse prevention is the cognitive behavioral model. The cognitive behavioral model allows clinicians to aid clients with the identification of thought sequences, feelings, environmental cues, and actions that represent problematic behavior. In this, behavioral management is integral to the client's achievement in treatment (Hunter & Longo, 2004). More specifically, the identification of high risk situations may be the first step in behavioral management.

High risk situations (instances that jeopardize a client's sense of control over deviant behavior) are conceptualized as factors that herald addictive or compulsive actions (Nelson & Jackson, 1989; Price, 1999). Pithers (1990) established that sexual offenders' re-

lapses are not isolated events, but are resultant from series of cognitions and actions that produce sexually deviant behaviors. Research has also verified that the sexual offender's relapse cycle is a compilation of several preliminary and distinct stages of reoffense (Ward, Louden, Hudson, & Marshall, 1995). This is referred to as the assault or relapse cycle. By addressing these concepts, RP can be used to initiate change and maintain treatment gains. Fixed in Adlerian concretization, (Watts & Critelli, 1997), cognitive orientation, self-determinism, and social interest are premier concepts in RP.

Relapse and Assault

Though developed in the 1970s, the concept of the assault cycle was not juxtaposed with RP models until the early-1990s (Carich & Stone, 2001; Freeman-Longo & Pithers, 1992). Pithers et al. (1983) conceptualized the relapse process as a linear function, while the assault cycle was a circular concept. The relapse process is defined by the set of behaviors and situations within an offender's offending pattern. As a result of human nature, the relapse and offending process may be best analyzed from a meta-recursive perspective (Carich, 1999).

For our purposes, linear is a causal concept following the organic model by which a variable causes a reaction of another variable (e.g. fantasy causes arousal). There are several models that promote lend to this view of linearity, including Pithers's (1990) traditional view and cognitive-behavioral chains (Nelson & Jackson, 1989). Pithers used a six-stage model that identified relapse as a single chain of events (Carich et al., 2001). For Nelson and Jackson (1989) the relapse process consisted of connecting chains comprised of thoughts and behaviors.

On the other hand, the assault cycle is based on circular notions by which variables cause reactions in one another (e.g. fantasy causes arousal and arousal causes fantasy). The cycle is defined as a set of relational configurations of behavior involved in offending, including pre-assault, assault, and post-assault behaviors. The assault cycle is based on the following suppositions by Carich (1999):

1. An offender does not have to be in a cycle at all times.
2. There are not time frames or cures (permanent abstinence).
3. There are multiple cycles, subcycles, etc. that interconnect with each other.
4. Cycles are choices at all levels and apply to all offenders.
5. Some offenses are precursors to other offenses.
6. Offenders may be fixated (staying in one stage), regressing (moving backwards), or progressing (moving forward) through the cycle.
7. There are multiple triggers or risk factors, cues, distortions, and defenses. (p. 250)

The quintessence of these assumptions revolves around the arbitrary establishment of general stages of progressive, inert, and regressive behaviors in tandem with explicit individual content differences for each stage (Carich & Stone, 2001).

Bay and Freeman-Longo (1990) developed a four stage model with interrelated cognitive, emotional, and behavioral aspects. The stages are a) build up (e.g., fantasy about pleasure, assault planning, and committing to the assault); b) acting out (e.g., the actual assault); c) justification (e.g., fear and guilt, rationalization, false resolve, covering up); and d) pretend normal (e.g., returning to daily routine).

Given the complexity of human behavior, the traditional RP model has undergone major revisions as professionals realized that there are multiple pathways to facilitate and learn self-management strategies (Hudson & Ward, 1996a, 1996b; Ward & Hudson, 1996). Freeman-Longo and Pithers (1992) combined the traditional RP model with the four-stage cycle. They integrated seemingly trivial decisions, maladaptive coping reactions, relapse cues, high-risk factors, lapses, and abstinence violation effects (states of self-gratification for violating abstinence rules followed by problems with immediate gratification) in the build-up stage. In a discussion of juvenile sex offenders (JSO), Hunter and Longo (2004) utilized this same four stage cycle. However, in the pretend normal stage youth often do not acknowledge problems situations that may lead to offending and in fact pretend that everything is normal. However, other cycles have been created to address persistent and advanced SO behaviors.

The composite three-cycle is constructed in the basic three-stage primary cycle, but it includes a composite picture of the offender's offending process (Carich et al., 2001). It was developed for chronic offenders or those with numerous victims and types of offenses. This model consists of the summary of all offending dynamics and behaviors placed in the following stages: (a) pre-assault, (b) assault, (c) post-assault. (See Figure 1.)

Outcome Research of Relapse Prevention with Sexual Offenders

According to Freeman-Longo, Bird, Stevenson, & Fiske (1995) 90% of SO treatment providers use RP within treatment. Nevertheless, two questions remain: Do SO treatments reduce recidivism? Does RP enhance treatment efficacy?

SO Treatment and Recidivism

To date there is but one completed meta-analysis of SO treatment outcomes (Hall, 1995). This research reported a small yet significant treatment effect. Unfortunately, reanalysis proved that the treatment effect could be entirely accounted for by studies that used dropouts/refusers as the comparison group (DeClue, 2002; Harris, Rice, & Quinsey, 1998). Hanson notes that studies have consistently reported lower recidivism rates for those who complete treatment than for those who drop out (Hanson & Bussiere, 1998), but that one cannot conclude from these studies that the treatment made the difference. Some of the same offenders who are at risk to sexually reoffend may also drop out of treatment due to a lack of motivation, impulsiveness, or general belligerence (DeClue, 2002). Hanson reports that there continues to be insufficient evidence to justify any unambiguous conclusions.

RP Treatment Efficacy with SOs

DeClue (2002) argues for alterations to methodological approaches to augment the treatment efficacy of RP with SOs. DeClue asserts that research on RP with SOs may benefit from random assignment of participants into treatment and non-treatment groups. Later the author warns of victim backlash if an SO reoffends while in the non-treatment group.

Marshall and Anderson (2000) cite two treatment programs without RP components which found no effects for treatment. They also studied six programs with RP components that all reported positive effects for treatment. However, none of these studies utilized a truly randomized design (Launay, 2001). Treatment participants were compared with a convenience sample of matched, contemporaneous untreated clients from the same setting.

The Sex Offender Treatment Evaluation Project (SOTEP; Marques, Nelson, Alarcón, & Day, 2000) is the only study of its type to use a randomized design (DeClue, 2002). Marques et al., concluded that "after 5 years at risk, the 167 subjects who completed treatment had a lower sex offense rate (10.8%) than did the 225 volunteer control subjects (13.8%) or the 220 non-volunteer controls (13.2%). This trend has not reached statistical significance. Another consistent finding over our years of follow-up was that 37 dropouts demonstrated the poorest outcomes of sexual reoffense (18.9%). Nonetheless, RP continues to gain much criticism from academics.

Critiques of RP with SOs

Marshal and Anderson suggest that SOTEP data do not show treatment effectiveness because the treatment program was too in-depth. They imply at this level of programming participants may feel that they are unable to avoid relapse with continued extensive help. They later promote caution elaborate and lengthy programs "for fear they may convey to clients that their problems are essentially beyond their capacity to manage on their own" (p. 52).

RP theory has been criticized both for a lack of originality and for being muddled with specialized language. Authors (Eccles & Marshall, 1999; Marshall & Anderson, 2000) have argued that the RP concepts and vocabulary are daunting to both therapists and participants and that the language may give impression to participants that stopping offending beyond their capability. On the other hand, some participants learn to use the terminology with great skill and may intellectualize the process thus losing much of its purpose (Launay, 2001; DeClue, 2002).

On the other hand, Ward and Hudson focused on problems with defining RP constructs and their interactions. These authors questioned whether the problem of immediate gratification (i.e. when an offender focuses on the short-term rewards associated with offending rather than the long-term negative consequences) assists in moving from a high-risk situation to a lapse or from lapse to relapse (Ward & Hudson, 1996); or if the abstinence violation effect (i.e. the effect of lapsing that causes the offender to see him/herself as a failure and ultimately gives up on avoiding offending) trails a lapse or relapse (Ward et al., 1994; Ward & Hudson, 1996; Launay, 2001). Ward and Hudson also attack the original RP model on the supposition that is neglects to address offenders who feel positive about offending and/or are unmotivated for change (Ward & Hudson, 1996). These authors go on to criticize the original RP model for suggesting that covert decision making (i.e., the rapist purposefully drinking to numb guilty feelings prior to raping) can be applied to internal states such as mood and high risk situations. Nevertheless, these academic debates hold little relevance for clinical work and in fact make little sense to practitioners (Launay, 2001) and have done little to dissuade the use of RP within SO treatment.

Discussion

One of the primary arguments about use of RP and SOs is the suitability of participants. Launay (2001) suggests that RP be specifically applied to offenders "who are free from pro-offending attitudes and motivated not to reoffend" (p. 48). This would cause some major changes in established programs such as the SOTEP (Marques et al., 2000). However, this may be necessary to ensure generalizable research results and results free of major outliers (i.e. drop-outs, non-motivated individuals, etc.) for which any treatment may be ineffective. Launay suggests that the SOTEP introduce a system to check for pro-offending

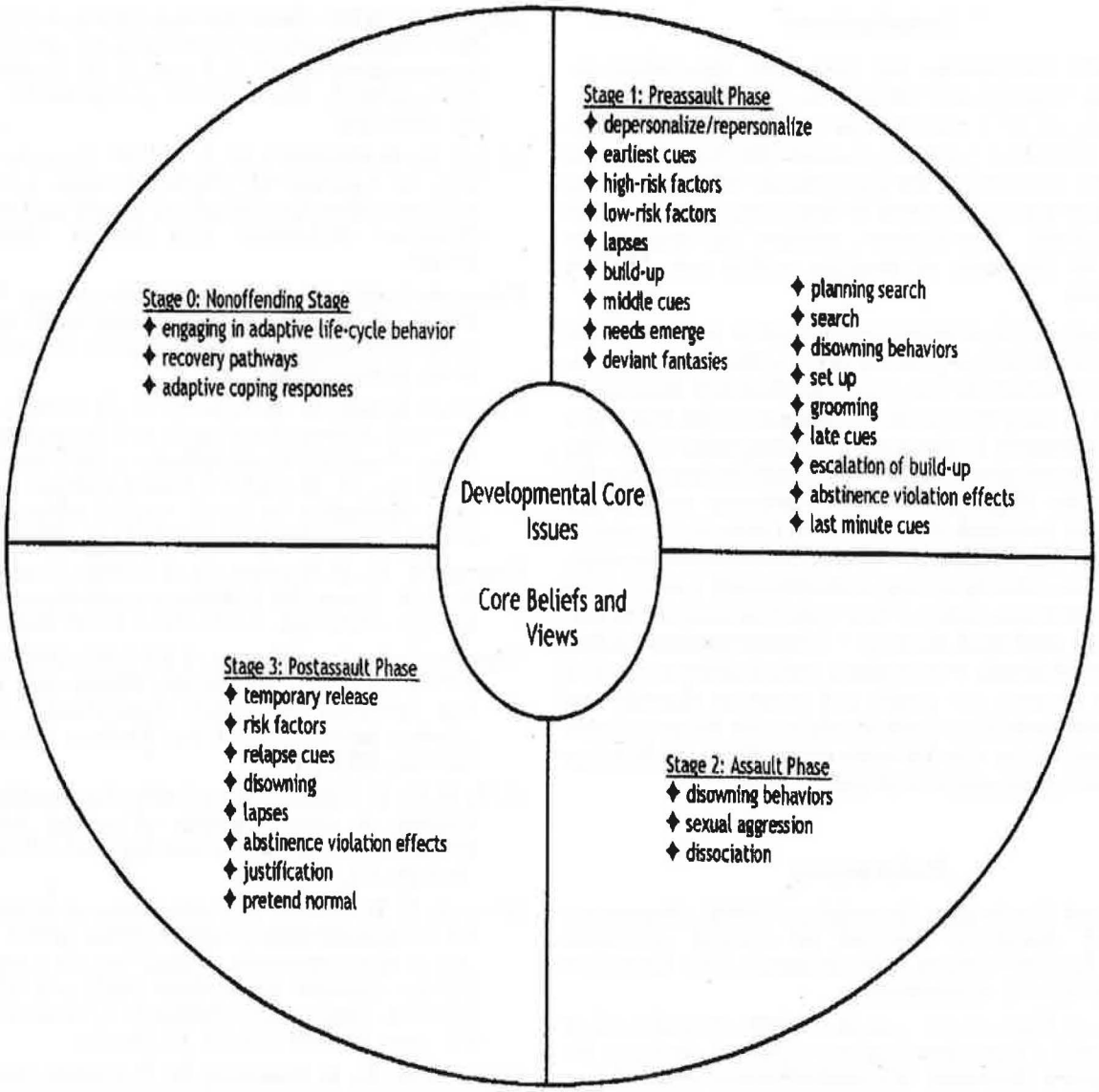

Figure 1. The Three-Stage Composite Assault Model (Carich, 1999).

and drop-out attitudes and to secondly allow facilitators assist participants according to progress.

Though many of the critiques of RP within SO treatment are justified, none are damning (Launay, 2001). However, there continues to be a lack of concrete and empirical evidence to complete support or avow the effectiveness of RP with SOs. Thus future research is needed to concretize efforts to continue of suspend the use of RP within SO treatment. Longitudinal and randomized studies will increase the breadth of knowledge we have on how to implement, revise, and properly test the limits of RP with SOs. This is a call to the field so that we may step out of the shadows of general acceptance of RP as a treatment without undeniable evidence of its effectiveness with the SO population. In the absence of strong evidence of positive or perfunctory treatment of the SO population, are the current legal mandates fair to the SO population.

At best these legal mandates have allowed society to feel more comfortable with the idea of SOs living amongst us. However, these individuals have been treated relatively harsh as compared to other identified criminals. Take murderers for example. There are no laws governing where released murderers may live. How about those that commit "white collar crimes?" there is no legal mandate that these individuals register nationally to be "shamed" for their misuses of power. So why is it that we regulate these types of directives for the SO population?

Conclusions

The main conclusions are, first, that theoretical debates on language and constructs yield little benefit to practitioners who continue to use relapse prevention for sex offenders. Secondly, though many critiques are based on sound evidence they provide little in the way of solid or pejorative proof to deny any positive treatment effects. Nonetheless, relapse prevention remains at the helm of practice within sex offender treatment.

Moreover, future research is imperative to the revision and development of a more acceptable version of relapse prevention for use with sex offenders that would support or deny its overall effectiveness with this population. Research is also needed to determine other viable treatment strategies for the rehabilitation of the SO population. Registration and residency restrictions need to be reviewed and revised to foster better understanding and acceptance of the SO population, especially those who have been rehabilitated. Lastly, if we plan to grow as a nation it is our duty as educators, parents, and professionals to gain a better understanding of the individuals that commit sexual offenses so that we can prepare our youth and peers to identify and help to redeem these individuals on the fringes of society. What better way for us to rehabilitate the SO population than to accept and assist them?

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