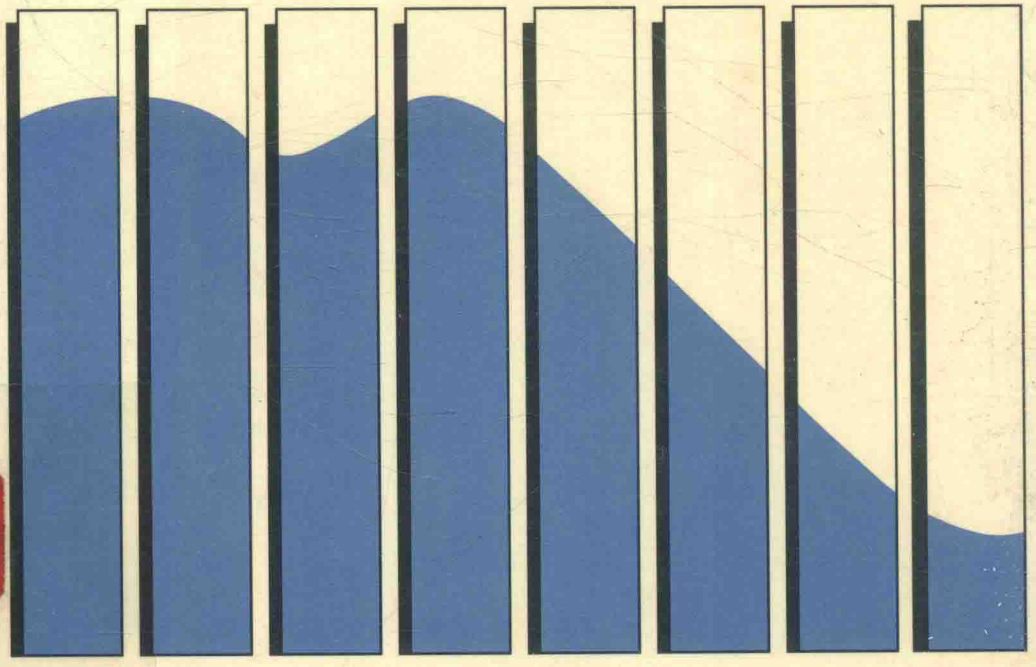
RELAPSE PREVENTION WITH SEX OFFENDERS



EDITED BY D. RICHARD LAWS

Relapse Prevention with Sex Offenders

Edited by

D. RICHARD LAWS
Florida Mental Health Institute
University of South Florida

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Contributors

CARMEN S. ANDERSON, M.A., Department of Law & Mental Health, Florida Mental Health Institute, University of South Florida, Tampa, Florida

KENNETH A. ANDERSON, M.A., Department of Law & Mental Health, Florida Mental Health Institute, University of South Florida, Tampa, Florida

JOHN ARMSTRONG, Burlington Probation and Parole, Burlington, Vermont

LINDA S. BEAL, M.S., Burlington Probation and Parole, Burlington, Vermont

CAROLYN H. CAREY, M.A., Child Sexual Abuse Treatment Services, Counseling Service of Addison County, Middlebury, Vermont

GEORGIA F. CUMMING, B.S., Vermont Treatment Program for Sexual Aggressors, South Burlington, Vermont

DAVID M. DAY, California State Department of Mental Health, Sacramento, California

WILLIAM H. GEORGE, Ph.D., Department of Psychology, State University of New York at Buffalo, Buffalo, New York

RODERICK L. HALL, Ph.D., Florida Department of Corrections, Tallahassee, Florida

DIANE HILDEBRAN, M.A., College Street Center for Psychotherapy, Burlington, Vermont

PAMELA JACKSON, Ph.D., Sex Offender Treatment and Evaluation Project, Atascadero State Hospital, Atascadero, California

KATURAH D. JENKINS-HALL, Ph.D., Department of Law & Mental Health, Florida Mental Health Institute, University of South Florida, Tampa, Florida

D. RICHARD LAWS, Ph.D., Department of Law & Mental Health, Florida Mental Health Institute, University of South Florida, Tampa, Florida

J. DAVID LONG, Ph.D., Rutland Mental Health Services, Rutland, Vermont

RITA K. MACDONALD, Vermont Treatment Program for Sexual Aggressors, South Burlington, Vermont

G. ALAN MARLATT, Ph.D., Department of Psychology, University of Washington, Seattle, Washington

JANICE K. MARQUES, Ph.D., California State Department of Mental Health, Sacramento, California

GARY R. MARTIN, M.S.W., College Street Center for Psychotherapy, Burlington, Vermont
ROBERT J. McGRATH, M.A., Adult Outpatient Services, Counseling Service of Addison County, Middlebury, Vermont
MICHAEL H. MINER, Ph.D., Sex Offender Treatment and Evaluation Project, Atascadero State Hospital, Atascadero, California
JOSEPH MURPHY, Sex Offender Treatment and Evaluation Project, Atascadero State Hospital, Atascadero, California
MARY K. NAFPAKTITIS, Office of the San Luis Obispo County Superintendent of Schools, San Luis Obispo, California
CRAIG NELSON, Ph.D., Sex Offender Treatment and Evaluation Project, Atascadero State Hospital, Atascadero, California
CANDICE A. OSBORN, M.A., Department of Law & Mental Health, Florida Mental Health Institute, University of South Florida, Tampa, Florida
JOHN PETTY, M.Ed., Brattleboro Center for a Safer Society, Brattleboro, Vermont
WILLIAM D. PITHERS, Ph.D., Vermont Treatment Program for Sexual Aggressors, South Burlington, Vermont
KABE RUSSEL, M.S.W., Sex Offender Treatment and Evaluation Project, Atascadero, California
GENELL G. SANDBERG, Ph.D., Parkview Psychological Services, Sioux City, Iowa
CAROL SHOCKLEY-SMITH, M.Ed., Department of Law & Mental Health, Florida Mental Health Institute, University of South Florida, Tampa, Florida
HELEN STEENMAN, Ph.D., Sex Offender Treatment and Evaluation Project, Atascadero State Hospital, Atascadero, California
V. HENLIE STURGEON, M.S., Sex Offender Treatment and Evaluation Project, Atascadero State Hospital, Atascadero, California
J. KEVIN THOMPSON, Ph.D., Department of Psychology, University of South Florida, Tampa, Florida
CARL R. VIESTI, JR., Ph.D., Sex Offender Treatment and Evaluation Project, Atascadero State Hospital, Atascadero, California
ALICIA WUESTHOFF, M.S.W., Vermont Treatment Program for Sexual Aggressors, South Burlington, Vermont

Preface

I had originally intended to write a fairly lengthy introduction to this volume. I was going to trace the origins of relapse prevention treatment, describe its history in the treatment of alcoholism and drug abuse, and describe some of its extensions to other problems, such as smoking, before arriving at the current application to sexual offending. In the course of this I planned to point out the differences between the earlier applications of RP and its use with sex offenders. However, Bill George and Alan Marlatt have relieved me of this responsibility by contributing the excellent Introduction that follows. Therefore, I will simply tell you something about this book and how it came to be the way you find it.

In 1978, a clinical psychology intern from the University of Washington named Janice Marques worked for me in the Sexual Behavior Laboratory at Atascadero State Hospital in California. During that period she showed me a prepublication manuscript by Alan Marlatt and Judith Gordon called "Determinants of Relapse." They had conceptualized a cognitive–behavioral treatment called relapse prevention, she told me, that might have application to sex offenders. In 1980, I requested a monograph from Marlatt that was one of the early statements of the rationale for the treatment. By 1981, I was at work on a grant application that incorporated many of those ideas as a central component of a proposed treatment. During these years Marques and another Atascadero intern, Bill Pithers, began formulating their own statements of this new treatment application.

When my grant application was approved in 1984, I hired Alan Marlatt and Bill George as consultants to prepare an RP treatment manual for use in the project. In the spring of 1987, Alan and Bill conducted training sessions with our therapists in Tampa. At the conclusion of these sessions I was talking to Alan and said, in what I thought was an offhand manner, "Someone ought to do a book on RP with sex offenders." He looked at me and said, "Why don't you do it?" Before I could say that I couldn't, that I had never done a book before, he scribbled a phone number on a business card and handed it to me. "Call Seymour Weingarten at Guilford," he said, "and tell him what you want to do." That's how we got here.

This is not the average edited volume. We deliberately set out to create a work that would appeal to both the specialist and the scholar, and especially to the practitioner. We decided not to prepare a volume with a small number of very long chapters on general aspects of treatment, followed by a few shorter chapters on application. This book is virtually *all* about applications. Instead we have a book of 26 chapters, 5 long ones and 21 short ones. The long ones are the Introduction, which provides an overview of RP as a treatment for sex offenders; 3 program descriptions—Marques's in California, Jenkins-Hall's in Florida, and Pithers's in Vermont; and a concluding chapter on RP outcome data. These lengthy chapters are intended to show RP in its full application within carefully conducted treatment programs. The shorter chapters deal with specific aspects of RP, the features that usually receive very brief treatment in the typical edited book. Here authors were requested to give something more than the flavor of what was done, to give the reader rather specific information on how some aspect of the treatment might be conducted. These shorter chapters deal, respectively, with sex offender problems viewed from an RP perspective, assessment of high-risk situations and coping skills, and treatment solutions to the problems in terms of both specific skills training and more global interventions.

This is intended to be a user-friendly text, but it is not a cookbook. When I was reviewing the chapters and communicating with the authors I told them: "Remember who your audience is. We're not writing this book for academic psychologists, although they will read it. We're writing primarily for the people in the hospitals, prisons, clinics, and private-practice offices who want to know how to do RP with sex offenders."

The book will not tell you specifically *how* to do RP. This is not a treatment manual. The authors are describing for you how they modified the original RP treatment to make it suitable for sex offenders. They are telling you what worked for *them* in *their* treatment setting. Those same procedures may or may not work in yours. You must remember that relapse prevention as a treatment procedure is in its infancy and that RP as applied to sex offenders is approximately postnatal.

In the Introduction George and Marlatt caution against using RP as an isolated treatment. Use that as your first principle. RP was developed as a maintenance strategy intended to preserve gains made in whatever treatment preceded it. A review of Part IV, "Programs," shows that the Marques's and Pithers's programs use RP as a sort of umbrella concept, under which a variety of activities are conducted. Jenkins-Hall's program, on the other hand, uses RP as one treatment component, then as a maintenance procedure in individual, long-term follow-up. These represent the two major uses of the treatment with sex offenders.

In order to *do* RP, I would suggest that readers closely examine all assessment and treatment procedures described in the book in order to decide which components will be best suited to your setting. Build your RP program

around what will work best for you in terms of what you are already doing. Although I said that this is not a cookbook, try out what the authors say worked for them. If they did something a particular way, try it and see if it works. If they used certain words, use those phrases and see what happens. Do not be concerned about making mistakes. Be imaginative and feel free to improvise on the guidelines suggested here.

A great many procedures, techniques, inventories, forms, tests, and so forth are described in this book. We had originally intended to develop an appendix to include the most important of these with instructions for their use. It soon became apparent that space considerations would not permit this. Rather than spend time reconceptualizing, developing, testing, and validating new assessment and treatment procedures, you might wish to contact the authors and request copies of their materials. The persons working in this field are quite approachable and willing to help.

Once again, let me call your attention to a caution raised by George and Marlatt. Simply because we have gathered together a great variety of apparently face-valid procedures in a book, offered some statistical analyses, and come to optimistic, if tentative conclusions, that in no way *proves* that RP is an effective treatment for sex offenders. There is *no* definitive evidence, here or anywhere else, that RP or any other treatment is effective over the long haul with this difficult clientele. Although sex offenders have been treated for decades it has only been in very recent years that treatment has begun to be carefully documented and follow-up carefully monitored. Sadly, too few have been carefully treated, and even fewer carefully followed for long periods, to warrant excessive optimism.

In the last 10 years the focus in treatment of sex offenders has narrowed considerably. That focus is now on a central core of behavioral and cognitive–behavioral treatments, supplemented by a wide variety of other interventions. RP is solidly in the mainstream of that movement. It is my belief, and I think that this book contributes to the conclusion, that we may at last be riding a winner.

A large number of people deserve thanks for assisting me in the preparation of this volume. I first want to thank those authors that I have never met who contributed so generously to this work. Alan Marlatt and Bill George have provided information and strong support since 1984, both for our research and for this book. Special thanks are due Janice Marques, Bill Pithers, and Katurah Jenkins-Hall, the central players in this piece, who helped organize the scheme of the book, then rallied their program staff to assist in writing the chapters. Jack Zusman, Max Dertke, and Dick Swanson of the Florida Mental Health Institute were supportive throughout. And, finally, thanks go to Seymour Weingarten, Editor-in-Chief of The Guilford Press, for believing that this was the right book at the right time.

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Introduction

WILLIAM H. GEORGE
G. ALAN MARLATT

With increasing notoriety and alarm, sexual offenses (such as rape and child molestation) have come to be recognized as frequent yet underreported crimes that exact a heavy toll on the physical and psychological well-being of victims and their families. There is also growing awareness of the plight of offenders, many of whom were earlier victims themselves, and their families. Though there is uncertainty about the true incidence of offenses, it is generally acknowledged that the available statistics underestimate the problem. The more important recognition is that the gravity and durability of negative sequelae associated with sexual offenses, as well as mounting public outrage, convey a clear sense of urgency about the need for solutions that will reduce the incidence of these offenses.

Amid disagreements about the causes of sexual offenses and the utility of offender treatment, one solution that has enjoyed wide consensus is detection and punishment of the offenders. A clear benefit of this solution is that it protects society; incarcerated offenders have less access to potential victims. Similarly, registration in criminal justice monitoring systems (probation and parole) provides modest mechanisms for tracking the offender's whereabouts, restricting his/her range of travel and access to potential victims, and enforcing participation in rehabilitative endeavors. However, recidivism rates, though variable, have suggested that for some offenders punishment alone has been an inadequate solution, perhaps serving only to forestall resumption of the offense pattern. Another solution has been the application of therapeutic interventions designed to alter the offender's sexual arousal patterns related to offending. Behavioral approaches have been especially prominent in this regard. Though short-term success in modifying sexual arousal patterns has been documented, long-term posttreatment success in reducing reoffense has been disappointing (Quinsey & Marshall, 1983).

The overall picture seems to be characterized by disturbing reoffense rates for both untreated and treated sexual offenders (Furby, Weinrott, & Blackshaw, 1989; Marques & Nelson, in press). This trend may be conceptualized, in part, as a *maintenance problem*. That is, there is frequent failure to maintain nonoffense patterns achieved as a consequence of adjudication, incarceration, and/or treatment. Relapse Prevention (RP) is a treatment approach, developed within the area of addictive disorders, that is specifically designed to address maintenance problems in the changing of behavior. This Introduction describes the RP approach and its application for reducing recidivism among sex offenders. Four specific aims are encompassed: (1) to describe the origins and basic assumptions of RP, (2) to summarize the RP conceptual framework, (3) to discuss the rationale, benefits, and limitations of applying RP to sex offenders, and (4) to outline how RP treatment procedures would be applied to sex offenders.

WHAT IS RELAPSE PREVENTION?

RP is a self-control program designed to teach individuals who are trying to change their behavior how to anticipate and cope with the problem of relapse. In very general terms, relapse refers to a breakdown or failure in a person's attempt to change or modify any target behavior. The RP program focuses on enabling the person to prevent relapse and thereby to maintain the newly adopted behavior pattern. Based on social cognitive principles, RP has a psychoeducational thrust that combines behavioral skill-training procedures with cognitive intervention techniques.

Origins from the Field of Addictive Disorders

The RP model was initially developed as a maintenance program for use in the treatment of such addictive behaviors as alcohol abuse, cigarette smoking, drug abuse, and overeating (Marlatt & Gordon, 1980). For the addictions, the typical goals of treatment are either to refrain totally from performing a target behavior (e.g., to abstain from drug use) or to impose regulatory limits on the occurrence of a behavior (e.g., to diet as a means of controlling food intake). The chief emphasis in this field has generally been on getting the "addicted" person to stop engaging in the problematic behavior. However, high relapse rates in addictions treatment show that "getting stopped" gives no assurance of "remaining stopped." All too often, posttreatment changes eventually give way to a return to the pretreatment addictive pattern. It was in this context that the RP program originated as a method for maintaining long-term freedom from addiction.

Scientific and Theoretical Underpinnings of Relapse Prevention

The underpinnings of the RP program derive from the broader social learning (Bandura, 1969, 1977a) approach to understanding human behavior, now referred to as social cognitive theory (Bandura, 1986). Based on empirical studies and hypothesis testing, the social cognitive approach has evolved from earlier behavioral theories and integrates principles from social cognition, observational learning, and behavior modification. As with other cognitive–behavioral research and treatment approaches that have been developed in recent years, the RP program combines behavioral and cognitive interventions. As a result of this heritage, the RP program makes certain critical assumptions about addictive disorders. First, addictive behavior patterns are viewed as multiply determined by past learning experiences, situational antecedent influences, prevailing reinforcement contingencies (both rewards and punishments), cognitive expectations or beliefs, and biological influences. Second, the target behavior can best be construed on a continuum between nonproblematic expression (e.g., social drinking) and addictive, or problematic, expression (e.g., alcoholism). Therefore, the same principles can be used to understand the acquisition and maintenance of nonaddictive as well as addictive behaviors. Finally, the addictive behavior can be conceptualized as a maladaptive response for coping with life stressors and dissatisfactions. An implication of this latter assumption is that more adaptive coping responses are not utilized by the individual and the addictive behavior has evolved as a habitual replacement response for this deficiency. Together, the foregoing assumptions reflect an ideology that is distinctive from the more predominant theoretical model in the addictions field, loosely known as the medical–disease model. The latter approach is predicated on the assumption that some, if not all, addictions (e.g., alcoholism) are best characterized as diseases. The RP program described here is not an outgrowth of the medical–disease model of addictions and thus does not define addictions as disease entities.

Another important feature of the RP program that stems from its social learning roots is an emphasis on self-management. As such, RP exemplifies the compensatory model of helping–coping, described by Brickman et al. (1982), in which clients are seen as responsible not for problem etiology but for problem solution. This stance eschews the traditional active-doctor/passive-patient relationship in favor of more active client collaboration and involvement. The client's resultant sense of ownership over the change process contributes to an internal locus of control and enduring behavior changes that are resistant to unsupportive environmental influences. By contrast, the medical–disease model, as described by Brickman et al. (1982), assigns the client no responsibility for either problem etiology or problem solution. Instead, the client is to accept the illness role, seek expert help, and comply with the expert's

prescriptions for problem solution. According to Brickman et al., interventions that minimize client responsibility for problem solution tend to foster dependency, undermine client feelings of personal competence, and generate improvements that are attributed to external forces and only temporarily maintained.

Stages of Change in the Addictions: Treatment versus Maintenance

In the addictions field, it has become increasingly useful to conceptualize habit change as a multistage process. The significance of this strategy lies in the possibility that the relative importance and applicability of various descriptive analyses, explanatory principles, and treatment approaches may shift as an addict moves from stage to stage. Individuals may be more amenable or receptive to particular intervention strategies at different stages of change. Perhaps the most thorough and empirically cogent multistage model of habit change is the five-stage model proposed by Prochaska and DiClemente (1982, 1983) based on their work with smokers.

It is sufficient for present heuristic purposes to consider a simpler two-stage model that merely distinguishes treatment from maintenance. The treatment phase traditionally has been the predominant focus in the addictions field. Because of this disproportionate allocation of attention and energy to treatment, much more is known about cessation (getting the person to stop the addictive behavior) than about maintenance (preventing relapse). Far too often these two aims were confused because of the tacit assumption that maintenance was merely an extension of cessation. Important distinctions between initial treatment and long-range maintenance were not made clear. The fact is that very little was known about procedures designed specifically to maintain behavior change following the initial cessation, or "quit date."

Ignorance about the maintenance stage was reflected in a number of unhelpful developments. First, addicts who had undergone extensive cessation-oriented treatments were usually being discharged with few maintenance-oriented strategies beyond appeals to internal fortitude, a list of the virtues of "staying clean" (and/or the catastrophic perils of the addictive behavior), and phone numbers for an ex-addict support network. Missing were specific guidelines for how to avoid relapse. Second, open discussion of relapse was generally discouraged in treatment because it presumably could weaken commitment to cessation or, worse yet, subtly encourage relapse itself. In effect, there was no sanctioned forum in which addicts could voice fears about the maintenance stage or plan safeguards. Third, maintenance failure (relapse) was seen as indicative of treatment failure. Therefore, the overarching response to the

relapse problem in the addictions field has been to strengthen initial treatment by building more comprehensive broad-spectrum or multimodel treatment packages that presumably would induce a more forceful cessation. The general idea was to create a treatment so powerful that it would be less prone to "wear off." The obvious drawback to this strategy, however, is that the addition of more techniques and procedures makes it more difficult for the client to comply with the treatment requirements (Hall, 1980). Finally, this approach included few precautionary measures reflecting the reality that, while initial treatment procedures were usually administered to the client by the therapist (e.g., aversion therapy or counseling), maintenance procedures ultimately had to be self-administered by the client. Clients were not being systematically taught to become their own therapists and to carry on the thrust of the treatment after the end of the formal therapeutic relationship.

In sum, prior to the advent of RP, there was little appreciation in the addictions field for distinguishing between the cessation and maintenance processes. Thus there was little recognition of the possibility that treatment and maintenance each might require qualitatively different analyses and intervention points. Many, if not all, of the intervention techniques were directed primarily toward initial behavior change rather than toward the long-term maintenance of this change. What was often overlooked during the treatment phase was that the maintenance of change, once it has been induced, may be governed by entirely different principles than those associated with initial cessation. RP, a system of maintenance-oriented principles and interventions, addresses this long-standing deficiency. Furthermore, since there appears to be some validity in distinguishing treatment from maintenance, another advantage of RP is that it may be applied regardless of the orientation or methods used during treatment.

Defining Relapse

The term *relapse* traditionally has been construed as an entirely negative event. Negative associations such as "treatment breakdown" and "return to addiction" reflect one of two definitions of relapse in *Webster's New Collegiate Dictionary*: "a recurrence of symptoms of a disease after a period of improvement" (1984, p. 994). This definition is clearly compatible with the medical–disease approach and thereby embodies certain implications. First, the relapse is a function of an underlying and ongoing disease entity that is internally driven by biological processes and is completely outside of the person's conscious control. Second, treatment outcome is a dichotomous all-or-none affair: One is either "cured" (or the symptoms are in remission) or one has relapsed (recidivism). Standard practice in the addictions field has been to view any return to the treated