

TRAUMA RESOLUTION TREATMENT AS AN ADJUNCT TO STANDARD
TREATMENT FOR SEXUAL OFFENDERS

by

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Dissertation proposal submitted to the Faculty of the
Virginia Polytechnic Institute and State University
In partial fulfillment of the requirements for the degree of
Doctor of Philosophy
In
Human Development

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May 6, 2004
Blacksburg, Virginia

Keywords: trauma resolution; sex offender; EMDR; treatment

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Abstract

This study explored the use of adding trauma resolution therapy to standard cognitive-behavioral relapse prevention therapy for sex offenders. Ten adjudicated sex offenders with sexual abuse histories were treated with eye movement desensitization and reprocessing as an adjunct to standard outpatient sex offender treatment. Data points include self-report, other-report, assessment instruments, session transcripts, research journals, and physiological measures. Systematic treatment research and development methods (Bischoff, McKeel, Moon, & Sprenkle, 1996) resulted in a proposed treatment protocol. Emergent themes from a cross-case, grounded theory data analysis are presented. The data suggests the adjunct treatment provided some benefit both to participants and to the goals of standard sex offender-specific treatment. Implications for treatment providers, marriage and family therapy, and future research are discussed.

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CHAPTER I: INTRODUCTION

Statement of the Problem

Sexual abuse is a social problem that has come to the forefront of attention in both the public and the professional community within the last 20 years. Sensational media coverage of highly publicized cases has brought this issue out of the shadows into public awareness. In response, prevention efforts in schools and communities have been increased (Roberts, Alexander, & Fanurik, 1990). This growing interest has been demonstrated in a proliferation of books and films focused on this issue aimed at the general public, and texts, workshops, and training seminars targeted to the mental health professional community. This increased attention may be responsible, in part, for the increase in reports of sexual assault and the resulting increase in the prison population of sexual offenders (Number of Sex Offenders, 1991).

The perpetrators of these sexual crimes have received less widespread attention. The little attention sexual offenders do receive often creates myths and misconceptions (Federoff & Moran, 1997). In the minds of most, including many mental health professionals, sexual offenders are considered depraved and dangerous monsters. In Scotland they are called “beasts,” in other parts of the United Kingdom they are known as “snappers.” In fact, most societies have their own colloquial slurs for this population.

This perception may be partially responsible for the slow progress the professional and judicial communities have made in their efforts to treat and rehabilitate these men and women. This is understandable considering the physical and emotional pain and suffering sexual perpetrators cause their victims. Incidence of child sexual abuse, for example, was originally estimated at 19% in females and 9% in males in a sample of college students (Finkelhor, 1979). College students, however, may not be representative of the general population. A study of

random door-to-door sampling showed prevalence rates of 38% in females (Russell, 1984).

Other studies using broader definitions of sexual abuse yielded rates as high as 62% in females and 31% in males (Peters, Wyatt, & Finkelhor, 1986).

Data collected on the average number of victims per offender varies significantly as well.

In a study conducted by Renshaw (1994) exploring the relationship between one's own victimization and the number of victims, the average number of victims per perpetrator ranged from 1.25 for offenders not reporting sexual abuse in childhood to 3.45 for those who acknowledge childhood sexual abuse. Abel, Becker, Murphy, and Flanagan (1981) reported the mean number of victims per offender from a sample of sex deviates ranged from 2.1 for heterosexual incest to 582.8 for frottage (touching or rubbing against a non-consenting person). A more alarming figure was reported in a study by the New York State Psychiatric Institute wherein 232 child molesters who were guaranteed confidentiality admitted they had attempted 55,250 acts of child molestation with successful completion of over 38,000 (Abel, Mittelman, & Becker, 1985).

Whether one accepts the more conservative figures, undoubtedly hampered by denial and fear of retribution, or the more startling figures reported by Abel et al. (1985), the systemic implications of this problem on the individual, familial, and societal levels are apparent. Considering the phenomenon of the intergenerational hypothesis of sexual abuse (Faller, 1989), it becomes a problem of exponential perpetuation. There is an ongoing call in the mental health field for treatment models that are both effective and durable in helping to alleviate this socially, emotionally, and financially pernicious problem (Burton & Smith-Darden, 2000; Furby, Weinrott, & Blackshaw, 1989; Hanson, Steffy, & Gauthier, 1993; Polizzi, MacKenzie, & Hickman, 1999). Despite some evidence that treatment can reduce recidivism rates (Hanson,

2000), there remains considerable room for refining theory and improving interventions to reduce re-offending and the considerable suffering it causes (Marshall & Laws, 2003).

Purpose of the Study

My purpose in this study was to use collective case study and grounded theory method research to develop and improve therapeutic interventions for sexual offenders. Improving treatment effectiveness has both emotional and financial benefits to society. McGraths's (1994) cost-benefit analysis of outpatient sex offender treatment showed that as little as a 1% decrease in sexual offense recidivism offset Vermont's investment in those programs. This small percentage decrease would also undoubtedly spare the potential anguish of victimization to tens of thousands of survivors.

My systematic research strategy follows research and development methods (Williams, 1991) detailed by Bischoff, McKeel, Moon, and Sprenkle (1996). The four stages of this methodology are: 1) identifying the consumer and determining need, 2) generating ideas for meeting the perceived needs, 3) developing, field testing, and revising the preliminary model by (a) developing a tentative model, (b) implementing the model, (c) collecting and analyzing data, and (d) organizing the results into a revised model of therapeutic intervention, and 4) finalizing the model. I intended to explore the impact of adding a treatment component for resolving disturbing traumatic memories on sexual offenders who are concurrently undergoing cognitive behavioral/relapse prevention (CBT-RP) group treatment. There is a call toward exploring expanded treatment approaches to address a broader spectrum of disturbances and behaviors in sexual offending (Knopp, 1994; Schwartz, 1994), perpetrating (Shapiro, 1995, 2002), and conduct-disordered clients (Greenwald, 2002b; Soberman, Greenwald, & Rule, 2002).

In this study I reviewed the literature on: (a) trauma sequelae and treatment, where sequelae refer to the pathological after-effects of trauma; (b) etiology of sexually aggressive behaviors; (c) and currently used treatment programs and their effectiveness or efficacy. I discuss the gap between theories of origin and treatment practice. It is proposed that a history of childhood trauma in some offenders is a prevalent predisposing factor in etiological theory and research, and that trauma resolution can address at least part of that gap between theory and current practice.

I reviewed the theory and research on bilateral stimulation or eye movement desensitization and reprocessing (EMDR) to explore its appropriateness as a treatment intervention for resolving trauma in sexual offenders. Finally, I performed a collective and cross-case study grounded theory analysis on a sample of adult and adolescent cases involving trauma resolution treatment provided to sexual offenders.

Theoretical Frameworks

Trauma Sequelae

My theoretical underpinnings for this treatment augmentation are based on Finkelhor's (1986, 1988; Finkelhor & Browne, 1985) Traumagenic Dynamics of Sexual Abuse model, Finkelhor's (1984) four-factor theory of child sexual abuse, and Rasmussen's, Burton's and Christopherson's (1992) Trauma Outcome Process model. The Traumagenic Dynamics of Sexual Abuse model, and the Trauma Outcome Process model each describe at least one potential outcome in the trauma sequelae to be that of externalized aggressive behavior. Trauma sequelae are said to include disengagement, dissociation, isolation, criminal involvement, mistrust, depression, dependency, impaired social skills, decreased self-esteem, decreased sense of control, and identification with the aggressor among other dynamics. Sexual trauma often

leads to confusion about sexual norms, confusion of sex with love and care-giving, sexual preoccupation, fetishism of sexual parts, bonding of sexual activity with negative emotions and memories, and sexual dysfunction (Finkelhor, 1986). Many of these same characteristics are prevalent in profiles of sexual offenders.

While these dynamics are the primary focus of treatment in sexual abuse survivors, they are rarely addressed in the treatment of sexual offenders despite their presentation (Knopp, 1994). It is my theory, therefore, that addressing these issues with offenders may be beneficial to their progress in treatment for such recalcitrant target goals as reducing denial and externalized aggression, and increasing empathy and treatment participation.

Finkelhor's (1984) four-factor theory of child sexual abuse addresses (a) characteristics of the offender, (b) disinhibitors, (c) the environment, and (d) the victim. Characteristics of the offender involve the basic motivators driving the behavior. Social and emotional congruency with children is thought to be one motivator, while deviant arousal, at times the result of the offender's own victimization, is thought to be another. Finkelhor holds that any salient feature of a sexualized event, be it pain, pleasure, guilt, or anger, provides a basis for making it a point of fixation. Consequently, reenactment may be a part of the sequelae in an effort to master the trauma or recreate the physical or emotional stimulation caused by it. Fixation on material paired with fantasy and masturbation become self-reinforcing, thus developing deviant sexual arousal patterns. These patterns may respond best to behavioral techniques designed to alter arousal response (e.g., covert sensitization, arousal reconditioning, satiation therapy). The sequelae of reenactment involve the repetitive effort of the offender to identify with the aggressor in an attempt to gain control or mastery over his victimization.

In part, an offender's motivation to abuse may be linked to trauma echoes (Gray, 1989; Rasmussen et al., 1992), imprinting (Eisenman, 2000; Eisenman & Kristsonis, 1995; Hess, 1959; Lorenz, 1927) and trauma-bonded triggers which may be visual (Bartone & Wright, 1990), auditory (Johnston, 1993), olfactory (Cella, Perry, Kulchychy, & Goodwin, 1988), gustatory (Croq, Macher, Barros-Beck, Rosenberg, & Duval, 1993) or tactile (Lindberg & Distad, 1985). It is possible that survivors-offenders may not be cognizant of internal triggers (VanOyen Witvliet, 1997). Intrusive memories, images, or behavioral disturbances may occur shortly after trauma (McFarlane, 1993), months after the trauma (Shalev, 1992), or even decades post trauma (Harel, Kahana, & Wilson, 1993).

Schwartz and Masters (1994) developed a theory of sexual compulsivity (including rape and child molestation) that combines psychodynamic, trauma-based theories with cognitive-behavioral and addiction models. The theory postulates that sexual compulsivity is rooted in early traumas maintained through cognitive distortions and behavioral reinforcements. Schwartz and Masters discuss the trauma resolution portion of their integrative treatment approach in the following:

Trauma-based approaches to treatment, including abreaction, catharsis, and cognitive restructuring are then useful in resolving the original issues for which the compulsion symptoms had served as functional distorted survival strategies, and which keep the individual from having overwhelming intrusion of memory and cognition. By blending therapeutic approaches, treatment efficacy improves dramatically (pp. 73-74).

Perhaps support for this idea can be found in the preliminary results of the Sex Offender

Treatment Evaluation Program (Marques, 1999). The results showed that sexual offenders who did not have a history of childhood physical abuse responded better to CBT-RP treatment.

Seghorn, Prentky, and Boucher (1987) examined the incidence of childhood physical and sexual abuse in a sample of incarcerated child molesters ($N = 54$), and found that the incidence of childhood sexual assault in child molesters was almost six times higher than figures reported in the literature. Examining the broader definition of abuse to include neglect yielded an incidence rate of 81%.

Further support for this idea can be found in an unpublished study conducted by Datta and Wallace (1996). They investigated their hypothesis that addressing childhood trauma in the treatment of sex offenders would reduce anxiety and increase victim empathy, thus facilitating a break in the offense cycle. Ten incarcerated adolescents with histories of sexual abuse were given three sessions of EMDR. Pre- and post-measures revealed a statistically significant reduction in anxiety and an increase in victim empathy as measured by a scale designed for the study. Due to a weak design, the results did not prove, but do tend to support further investigation of this theory.

Finally, following the work of Dr. Clifton Wolf, McMulin (1994, 1998) proposes a blend of psychodynamic and relapse prevention techniques by incorporating Trauma Incident Reduction (French, 1991) and EMDR into a RP program. McMulin holds that the internal cueing of unresolved childhood trauma could lead to maladaptive, compulsive and addictive behaviors.

Trauma Resolution Theory

Most of the attention in the field of treating sexual abuse has been directed at female survivors. This may be best evidenced by the work of two of the field's leading authors. The opening line in the acknowledgements of Herman's (1992) book entitled *Trauma and Recovery*,

reads, "This book owes its existence to the women's liberation movement" (ix). This contrasts with the telling title of Hunter's (1990) book entitled *Abused Boys: The Neglected Victims of Sexual Abuse*. Sexual abuse has historically been perceived as a crime on a female committed by a male (Freeman-Longo, 1989). The sexual abuse of males has gained more attention in recent years, as has general trauma for males, undoubtedly fueled by the recognition of post-traumatic stress disorder (PTSD) symptomatology in returning Viet Nam veterans. Prevalence rates of sexual abuse by gender vary significantly (Badgley, 1984; Finkelhor, 1979, 1984; Fromuth, 1983; Sorrenti-Little, Bagley, & Robertson, 1984), though figures invariably indicate higher rates for females (Freeman-Longo, 1986). Geffner (1992) reports often-cited prevalence rates for childhood sexual abuse to be 20% to 45% for women and 18% for men in North America. Many believe numbers of male victims are under-reported (Hunter, 1990; Mathews, 1996), naming shame induced by societal views of male autonomy and independence as a primary deterrent for males to come forward (Draucker & Petrovic, 1996; Gill & Tutty, 1997, 1999).

Treatment protocols are largely based on research done with female survivors (Herman, 1992). A symptom approach to understanding childhood sexual abuse has spawned a lengthy list of associative symptoms in an effort to categorize and quantify the trauma sequelae (Courtois, 1988; Perry, 1998; Russell, 1986), which become the primary targets of treatment. Stages of recovery include forming a healing relationship, safety, remembrance and mourning, and reconnection (Herman, 1992). Healing stages for males are similar, although there is generally a focus on reclaiming one's "manhood" (Hunter, 1990) as a means of overcoming societal shame and stigmatization.

More recently, researchers have turned their attention to neurophysiological systems as a basis for understanding trauma and developing treatment (Aston-Jones, Valentino, Bockstaele, &

Myerson, 1994; Friedman, 1993; Sapolsky, 1992; van der Kolk, 1996). VanOyen Witvliet (1997) reviewed the literature on emotional memory phenomenon, integrating findings and theories from the research areas of psychobiology, pharmacology, and physiology. She concluded that intrusive imagery is driven and sustained by high-arousal affect and physiological reactivity. She suggested that cognitive-behavioral therapies of exposure aimed at reducing affective arousal and autonomic activation should reduce intrusive imagery in trauma survivors. Empirical studies have shown EMDR to be equal or superior to exposure therapies for this goal (Ironson, Freund, Strauss, & Williams, 2002; Lee, Gavriel, Drummond, Richards, & Greenwald, 2002; Van Etten & Taylor, 1998)

Eye Movement Desensitization and Reprocessing (EMDR)

EMDR is a psychological treatment method developed by Francine Shapiro (1989a, 1989b, 1995), which has received much attention and mixed reaction by the scientific and professional communities. This eight-phase treatment protocol uses bilateral stimulation to allow clients to work through traumatic events with the goal of desensitizing and reprocessing memories to reduce PTSD symptomatology (Shapiro, 1995; 2001). During the desensitization and reprocessing phases of treatment, the therapist asks clients to focus on a traumatic or disturbing memory as well as the accompanying cognitions and emotions. The therapist provides bilateral stimulation in the form of visual tracking, auditory stimulus, or tactile stimulation. The therapist gauges treatment progress by client-report scaling measures of subjective units of disturbance (SUDS) and validity of cognition (VOC; Shapiro, 1995). Once the memory has been desensitized, as indicated by client report, the therapist guides the client in reprocessing the accompanying negative cognitions, replacing them with client-generated positive cognitions.

Initial use of EMDR looked promising, and EMDR became an “effective” treatment, and received an A/B rating from the Treatment Guidelines Committee of the International Society of Traumatic Stress Studies (ISTSS; Chemtob, Tolin, van der Kolk, & Pitman, 2000). This designation came just two years after Chambless and colleagues (1998) reviewed studies of empirically validated treatments and reported there were no well-established treatments for PTSD. More recently the Department of Veterans Affairs and Department of Defense (2004) in its clinical practice guidelines listed EMDR as one of four therapies to be given the highest level of evidence and was recommended for treatment of PTSD.

Some researchers suggest that EMDR may be a more efficient treatment than previous exposure therapies (Ironson et al., 2002; Lee et al., 2002; Van Etten & Taylor, 1998) with which it is often erroneously compared (Rogers & Silver, 2002). Two comparison studies of EMDR that combined exposure and stress management treatments yielded opposing results. One showed EMDR to be more effective (Lee et al., 2002) while the other showed EMDR to be less effective (Devilly & Spence, 1999). Much of the debate appears to be in trying to determine the necessity of the eye-movement component of the treatment (Herbert et al., 2000; Lohr, Tolin, & Lilienfeld, 1998; McNally, 1999; Rosen Lohr, McNally, & Herbert,, 1998), or from attempts to define EMDR as an exposure procedure (Devilly, 2001; Dyck, 1993; Herbert et al., 2000; MacCulloch & Feldman, 1996; McNally, 1999) for which its techniques violate much of the theory (Boudewyns & Hyer, 1996). Insufficient treatment fidelity has been cited as a criticism of research studies (Maxfield & Hyer, 2002; Perkins & Rouanzoin, 2002, Rogers & Silver, 2002; Shapiro, 1999). Perkins and Rouanzoin (2002) review and clarify much of the “historical misinformation, slurs, and charges of ‘pseudoscience’” (p. 88). They note that acceptance of ideas that challenge tradition are often met with resistance, and that the resulting tension is an

important component of carrying the “process of scientific investigation forward” (p. 93). Their review addressed points of confusion in substantive scientific issues raised by several researchers and attempts to clarify each individually in table format.

Maxfield and Hyer (2002) conducted a review of EMDR studies completed in 1999 (with one in press) investigating efficacy in the treatment of PTSD. Their purpose was to investigate the relationship between efficacy and methodology in those studies. Their findings indicate a significant correlation between methodology and outcome, with trained and reliable assessor and treatment fidelity showing the highest bivariate correlations at .54 and .79 respectively. Their review was grounded in Foa’s and Meadows’ (1997) Gold Standard Scale. The three studies they reviewed showing EMDR to be non-effective or minimally effective (Devilly & Spence, 1999; Devilly et al., 1998; Jensen, 1994) were below the Gold Standard mean of 5.42 at 3.5, 3.5, and 4.0 respectively. The remainder of the studies reviewed was above the Gold Standard mean, and showed positive effect sizes ranging from .46 to 2.85.

Despite skepticism from a few in the research community (Devilly, 2000; Herbert et al., 2000a; Jensen, 1994; Lohr et al., 1998; McNally, 1999; Rosen, 1999), hundreds of positive individual case studies have been published by practitioners who have reportedly expanded the application of EMDR to address a variety of presenting issues such as major depression, anxiety, phobia, and personality disorders. (e.g., Feske & Goldstein, 1997; Forbes, Creamer, & Rycroft, 1994; Lohr, Kleinknect, Tolin, & Barrett, 1995; Manfield, 1998; Marcus, Marquis, & Sakai, 1997; Protinsky, Sparks, & Flemke, 2001; Rothbaum, 1997; Shapiro, 1996; Shapiro & Forrest, 1997; Wilson, Silver, Covi, & Foster, 1996; Wilson, Becker, & Tinker, 1997; Whisman, 1996).

The underlying theory behind EMDR utilizes the components of neuro networks, bilateral stimulation and accelerated information processing (Shapiro, 1995). Some theorize that

traumatic memory may become mired in the brain's hippocampus and related limbic brain structures as disturbing sensory images and physical sensations, without having access to the neocortex. The information fails to move from the hippocampus and integrate into the neocortex, whereby the individual fails to learn from or make sense of the event (Stickgold, 2002). Through the use of bilateral stimulation such as oscillating eye movement, touch, or auditory reports, the information is moved through the corpus callosum from the right hemisphere of the brain to the left hemisphere. Perry (1998) states that these memories need to be processed through both brain hemispheres for appropriate processing to occur.

Preliminary brain imaging studies show that this type of bilateral stimulation transfers information from one hemisphere to the other (van der Kolk, 1998). Martin Teicher and his associates (1997) analyzed brain function in subjects both with and without childhood sexual abuse. When asked to recall memories of abuse, those persons with abuse histories showed activation in only the right brain hemisphere, and not in the left-brain hemisphere. During bilateral stimulation, increased blood flow to both brain hemispheres has been evident during MRI and PET brain scans, and new neuronal connections are made in the memory network (Cassese, 2000). Levin, Lazrove, and van der Kolk (1999) conducted a neuroimaging study using Single Photon Emission Computed Tomography (SPECT). Subject brains were imaged at baseline, prior to EMDR treatment, while recalling traumatic memory, and following standard protocol EMDR treatment. They reported increased activity of the anterior cingulate gyrus and left frontal lobe following EMDR treatment. These results lend support to this brain region hypothesis.

Shapiro (1995) proposed that directed eye movement mimics the saccades of rapid eye movement (REM), the sleep cycle during which episodic memories are integrated into the

neocortex. In line with that theory, Stickgold (2002) of Harvard Medical School's Department of Psychiatry proposed the theory that the "repetitive redirecting of attention in EMDR induces a neurobiological state, similar to that of REM sleep, which is optimally configured to support the cortical integration of traumatic memories into general semantic networks" (p. 61). It is suggested that the bilateral stimulation sponsored by EMDR can work better for memory integration than can REM sleep since, unlike during sleep, the client can select material to hold in their mind, thereby the material to be processed. There are other models which attempt to explain the orienting response in EMDR (Armstrong & Vaughn, 1996; Bergman, 1998; Lipke, 1995, 2000; Servan-Schreiber, 2000), and though somewhat different, all focus on the ability of EMDR to alter the mind's state to a point where effective processing of traumatic memories is possible.

Treatment for Sexual Offending

Treatment of sexual offenders began with the pioneering work of the American psychiatrist, Gene Abel, in the 1960s and 1970s. Abel introduced the concept of applying behavioral and cognitive behavioral therapy (CBT) approaches to the treatment of sexual offenders. Also during this decade came the application of phallometric procedures initially used by Freund to assess gender preferences, and later modified to evaluate child molesters (Freund, 1965). This procedure created increased interest in behavioral approaches to treatment to include aversive therapies (Abel, Levis, & Clancy, 1970; Laws, Meyer, & Holmen, 1978; Marshall, 1973), covert sensitization (Callahan & Leitenberg, 1973; Maletzky, 1973), and shame aversion therapy (Serber, 1970; Wickramasekera, 1976). Cognitive process gained attention following the work of Neisser (1976) and was incorporated into offender treatment by way of cognitive self-control (Cautela, 1967, 1970, 1971). Abel's and Blanchard's (1974) work on deviant fantasies

firmly bridged behavioral and cognitive models, and CBT became the accepted method of treatment. By the end of the decade, CBT approaches were being broadened to include social skill deficit training (Becker, Abel, Blanchard, Murphy, & Coleman, 1978) and empathic skill enhancement (Murphy, Abel, & Becker, 1980).

The following decade saw the revolutionary introduction of relapse prevention (RP), based on Marlatt's (1982) model developed for treating substance addictions. Pithers, Marques, Gibat, and Marlatt (1983) adapted the model to treat sexual offenders as a means of offering clients a way of combating risks and temptations beyond formal treatment. The expanded CBT-RP model was introduced in Vermont (Pithers, Kashima, Cumming, Beal, & Buell, 1988) and California (Marques, 1982), and it was widely studied (Marques, 1988; Marques, Day, Nelson, & Miner, 1989; Marques, Day, Nelson, & West, 1993, 1994; Marques, Nelson, Alarcon, & Day, 2000; Marques, Nelson, West, & Day, 1994;). Despite continued work on theories of etiology including social learning theory (Bandura, 1977), feminist theory (Bart, 1983; Bart & O'Brien, 1985; Brownmiller, 1975; Burt, 1980; Darke, 1990; Herman, 1981, 1990; Kelly, 1988; MacLeod & Saraga, 1988; Russell, 1984, 1988), biomedical theory (Berlin, 1983, 1988), biological theory (Ellis, 1989), pre-conditioning theory (Araji & Finkelor, 1985, 1986; Finkelhor, 1984, 1986), attachment theory (Marshall 1989, 1993), courtship disorder theory (Freund, 1988, 1990; Freund, Scher, & Hucker, 1983, 1984), and trauma-organized system theory (Bentovim 1996), CBT-RP remains largely intact as the basic structure for 90% (Freeman-Longo, Bird, Stevenson, & Fiske, 1995) of treatment programs.

Ward, Keenan, and Hudson (2000) have examined ideas about development and described the relationship between cognitions, emotions, and intimacy in sexual offenders. They have also considered the theoretical tenants of relapse prevention. They revised the concept of

the abstinence violation effect (Hudson, Ward, & Marshall, 1992) and provided a variation of the offense chain (Ward, Louden, Hudson, & Marshall, 1995), offering a “self-regulation” model of the offense process (Ward & Hudson, 1998b, 2000). During this same period, preliminary results from the California Sex Offender Treatment Evaluation Project (SOTEP) study (Marques et al., 1994) using RP were revealed, and the results were not favorable. In response, Hanson et al. (2002) undertook a meta-analytic analysis of 42 worldwide treatment studies involving 9,454 participants. Their results showed a clear effect for current methods of CBT treatment and small effect from older forms of treatment in use prior to 1980.

Research Questions

Despite a growing body of literature, there remains a gap in our understanding of the etiology and of the treatment process for sexual offending. I intend to add to the knowledge base by exploring the systematic application of an exploratory treatment augmentation. By adding the component of trauma resolution treatment to the commonly employed CBT-RP treatment model, I hope to investigate the following questions:

1. How might trauma-focused EMDR treatment augment CBT-RP group treatment for sexual offenders?
2. How do sexual offenders experience trauma-focused EMDR treatment?
3. What implications might this enhanced treatment model have for clients and their families?

Operational Definitions of Key Terms and Concepts

Trauma-focused EMDR refers to the process of using bilateral stimulation treatment protocol developed by Shapiro (1991, 1995) to desensitize disturbing memories, thoughts, and/or images (trauma), and to install client-preferred positive cognitions. EMDR is an eight-phase

treatment model consisting of a) client history, b) preparation, c) assessment, d) desensitization, e) installation, f) body scan, g) closure, and h) reevaluation. The standard protocol has three prongs in which memory or cognitions are targeted. The prongs consist of a) past experiences that led to the current dysfunction, b) present triggers of the dysfunctional material, and c) a future template of preferred cognition (Shapiro, 1990).

CBT-RP treatment refers to the treatment program commonly accepted as the standard form of treatment of sexual offenders (Freeman-Longo, Bird, Stevenson, & Fiske, 1994). The model is generally described as a comprehensive treatment designed to help clients maintain behavioral changes via increased self-awareness. Understanding for the offender of his own thinking, affective, and behavioral reactions is intended to allow the offender to cope more adaptively (Lane, 1997).

Sexual offender refers to individuals who commit sexual acts for their immediate gratification that are considered contrary to the prevailing sexual mores of the society in which they live, and are thereby punishable by law (Gebhard, Gagnon, Pomeroy, & Christenson, 1964).

Past or historical trauma refers to a history of childhood maltreatment that might include sexual, physical, emotional abuse, or neglect or abandonment.

The offending cycle refers to a three-phase pattern of: a) thoughts, feelings, events, and activities preceding thinking about committing an offensive sexual act, b) thoughts, fantasies, victim selection and planning for the offensive sexual act, and c) committing the offensive sexual act.

Families refer to the person or persons who may or may not be blood-related to the sexual offender, but who cohabit with him or serve as his primary social contact or support network.

Delimiters and Assumptions of the Study

I drew participants for this study from a pool of sexual offenders being treated in an outpatient setting in rural Southeast United States. The majority of participants are court ordered to attend treatment under the conditions of probation or parole. This subject pool was selected for several reasons. First, I felt this most closely replicated the clinical setting as when participants are not in treatment, they are integrated within their communities, living relatively free and normal lives. Second, incarcerated offenders are under more pressure to participate in treatment, and I felt this might affect their decision to participate in the study. Finally, incarcerated offenders represent a special class of persons for which approval from Institutional Review Boards can be problematic. This is, again, due to the lack of agency incarcerated offenders may perceive. Given these restrictions, generalizability of findings beyond this population is not defensible.

The assumption I hold in undertaking this project is that sexual offenders can be rehabilitated, and can go on to live healthy and productive lives. I hold the bias that sexual offenders have the same right to treatment as any other client, not only for the benefit of his potential victims, but also for his own benefit in being allowed the opportunity for recovery. This assumption does not bring with it any level of naiveté, and I believe that life-long vigilance, both internal and external, is prudent with rehabilitated sex offenders.

The treatment method proposed in this study may undoubtedly meet with some resistance from the sex offender treatment community. Practitioners frequently encounter denial of accusations from sexual offenders, often despite substantial evidence to the contrary. Minimization and blame shifting are also frequently evident, even among those offenders who readily admit their guilt. Sexual offenders sometimes blame a personal childhood history of

sexual victimization for their own offending behaviors (Ward, Hudson, & Marshall, 1995). For this reason, many treatment providers intentionally avoid addressing the offender's trauma history, fearing it will provide the offender with an excuse from responsibility. The assumption behind this study, however, is that a balance can be struck between acknowledging past victimization while not allowing that to reduce accountability and responsibility for actions. In fact, I propose that not acknowledging and addressing the offender's history may further entrench his empathic deficits, fueled perhaps by his perception of inequity (e.g., "why should I care about my victims when no one cares about what happened to me?"). Similarly, ignoring the offender's history of victimization can leave in place the internal emotional cueing, which can affectively trigger the offender's deviant cycle. Thus, the tools learned in CBT-RP treatment may be ignored as internal cues and urges become overwhelming.

CHAPTER II: LITERATURE REVIEW

Researchers have attempted to explore a variety of etiological factors of sexual offending (Lanyon, 1991; Marshall & Barbaree, 1989; Schwartz, 1995). Thus far, there is not an all-inclusive theory (Ward & Hudson, 1998) with the recommended epistemic strategy being that of theoretical pluralism (Hooker, 1987). Ward and Hudson (1998) attempt to forward this effort with their development of a metatheoretical framework utilizing Kalmar and Sternberg's (1988) concept of "theory knitting." Their theory construction process involves distinction between distal (predispositional) and proximal (triggering) causal factors, with level II theory development focusing more on the former. The following is a review of some extant theories of sexual offending etiology focused at this level.

Social Learning Theory

Social learning theory (Bandura, 1977) holds that behavior is learned and maintained by processes of observation, experimentation, and positive and negative reinforcement. Under this model, the victimized child may learn through experiential and observational means that adults can and do sexually interact with children (Freeman-Longo, 1986; Howells, 1981). Victims may be externally rewarded for their participation and may also experience rewards in the form of physical or emotional pleasure. Related to this theory are those of differential association theory (Sutherland & Cressey, 1978) and social control theory (Hirschi, 1969). The latter assumes that inherent propensity for deviant behavior is controlled by close association with others, while the former assumes that deviant behavior is the product of socialization into a deviant lifestyle.

Conditioning Theory

Howells (1981) has proposed that conditioning may be a means by which some adults eventually come to molest children. McGuire, Carlisle, and Young (1965) hypothesize that when

a child is engaged in sexual behavior by an adult, he or she may engage in masturbatory fantasies centered on the abuse. Classical conditioning pairs the fantasy with emotional or physical pleasure (conditioned and unconditioned stimulus respectively) so that the conditioned stimulus becomes increasingly more arousing. This model coincides with one aspect of the abused-abuser hypothesis.

Abused-Abuser Hypothesis

Much has been written about the victim to victimizer hypothesis grounded in the original theory outlined by Groth and Burgess (1977). Inherent problems with testing this theory lie in the observations that most abused persons never become offenders (Becker, 1988; Freund & Kuban, 1994). Offenders may over-report prior abuse possibly to garner sympathy (Hanson & Slater, 1993), or may under-report abuse (Finkelhor, 1984; Freeman-Longo, 1986) perhaps due to shame, despair, or a lack of a trusting therapeutic relationship (Becker, 1988; Kahn & Lafond, 1988). The first time an adolescent or adult male obtains any help with his own victimization is often when he comes to the attention of the legal system because of his own offending behaviors (Sepler, 1990). Much of the literature focusing on the developmental effects of trauma on youths have resulted in theories such as the “vampire syndrome” which entails a reenactment of the abuse (Longo, 1982; McCormack, Rokous, Hazelwood, & Burgess, 1992), efforts at achieving mastery over prior abuse (Watkins & Betovim, 1992), or a conditioning of sexual arousal (Hunter & Becker, 1994).

An early study by Groth (1979) led to the assertion that, with regard to child molesters, later offenses often duplicate the offender’s own victimization with correspondences between the age of the victim and the nature of the offensive act. Developmental theories of abusive behavior have been widely hypothesized and researched (Barbaree, Marshall, & McCormick, 1998;

Bentovim, 1996; Bischof & Rosen, 1997; Freeman-Longo, 1989; Greenwald, 2002a; Hodges, Lanyado, & Andreou, 1994; Johnson & Knight, 2000; Skuse, Bentovim, Hodges, Williams, New, Andreou, et al., 1996; Smallbone & McCabe, 2003; Worling, 1995), although they remain non-definitive due to the phenomenon's multivariate determinism. For example, studies finding no evidence to support the abused-abuser theory focus solely on past sexual traumatization (Federoff & Pinkus, 1996; Hanson & Slater, 1988). Others apply a broader definition of trauma (Bentovim, 1996) and report 78% - 83% of perpetrators experienced or were exposed to violence compared to 39% to 43% of non-perpetrators. Craissati, McClurg, and Browne (2002) found rates of 46% of sexual victimization within an urban sample of 178 convicted sexual offenders. Of the total sample, 82% reported some history of childhood abuse, and the entire sample reported high levels of childhood disturbance and maltreatment. Freund and Kuban (1990, 1994) employed phallometric testing to explore the abused-abuser hypothesis, and they discovered a "close connection between pedophilia and a self-report on childhood seduction" (p. 562).

Veneziano, Veneziano, and LeGrand (2000) conducted a study with 68 perpetrators who had been sexually abused (92% of the original sample of 74) to explore the hypothesis that adolescent sexual offenders would repeat the behaviors they had experienced in victimization. The results supported their hypothesis ($X^2 = 8.0, p < .01$).

Feminist Theory

A feminist analysis of sexual assault posits it to be a phenomenon engendered by any system of male supremacy (Herman, 1990). Feminists hold that, in patriarchal societies, sexuality becomes defined by male dominance and female submission so that sexual conquest by males is nothing more than an exaggerated outcome of that definition (Bart, 1983; Bart & O'Brien, 1985; Herman, 1981, 1990). Brownmiller (1975) sees sexual dominance by men as a

means of preserving the patriarchy through terror, thus benefiting all men in the society. The feminist contention is that sexually aggressive and coercive men are merely demonstrating the normal state of these societies, and that they and their non-offending brothers are in collusion, if not overtly, then at least covertly.

Otterbein (1979) looked at prevalence of rape for 43 primitive societies and found higher incidences in societies where fraternities run by and for men are a part of the structure and where feuding were common. Sanday (1981) conducted cross-cultural studies and concluded that rape is most common in societies where only a male deity is worshipped, women hold little political or economic power, the sexes are segregated, and childcare is considered an inferior occupation. Both of these studies also found societal acceptance of violence to be influential in rape-prone cultures, which brings into question the cause-effect premise of male dominance and rape. An example is the Hutterites; a male dominated society without ideological machismo or common interpersonal violence. Baron, Strauss, and Jafee (1988) looked at the violence-rape association in a well controlled study in the United States and concluded that cultural support for violence has a direct association with the incidence of rape. They also found that states with higher percentages of divorced males had higher incidence of rape. They interpreted this as a generalized anger and hostility towards women, though evidence did not support this. Baron and Strauss (1984) also explored the relationship between pornography use and rape in the United States. They found them to be highly correlated, although these findings were refuted by a systematic research review by Murrin and Laws (1990). The relationship between societal views on sexuality and prevalence of sexual aggression remains unclear. Another theory is that societal restriction of sexual intercourse may promote rape due to frustration of the rejected male (Chappell, 1976). This may speak more loudly to societal promotion of male entitlement, though.

In a similar vein, a view in societies where pedophilia is commonly accepted is that of permissive rather than causal cultural attitudes (Grubin, 1990). Societies where pedophilia is common, such as Melanesia and ancient Greece, are both said to be male dominated and ideologically machismo, with women held in low status, segregation practiced, and where heterosexual activity was restricted. Where pedophilia is more commonly accepted, proscription against sexual activity with children involved only male children, while sexual activity with young girls was widely accepted (Quinsey, 1986). Finkelhor and Lewis (1988) credit male socialization as more important than psychosexual characteristics where pedophilia is involved. They site men's association of sexuality and subordination, and their general attitudes about children in those cultures as the cognitive framework allowing for the sexualization of young children.

Early views about intrafamilial sexual abuse held the non-offending adult accountable (Lustig et al., 1966). Later research by Mian, Wehrspann, Klanher-Diamond, LeBaron, and Winder (1986) found that 67% of children reporting intrafamilial abuse occurred after separation or divorce, compared with 27% reporting incest in intact families. A study by Perrott et al. (1998) suggested that women who were sexually abused in childhood, and who used reframing (adopting an alternate perception which may include justification or rationalization) as a coping skill to deal with that history, were more likely to have children who were sexually abused. Mothers who used reframing are thought to minimize or deny the reality of their own abuse, and are therefore ill-equipped to be on the alert for dangerous situations for their own children. These findings coincide with those of Morrow and Smith (1995) who constructed a grounded theory approach to highlight coping strategies employed by survivors as: (a) creating resistance strategies, (b) reframing abuse to create an illusion of control or power, (c) attempting to master

trauma, (d) attempting to control other areas of life besides the abuse, (e) seeking confirmation from others, or (f) rejecting power altogether. Similarly, a study of coping defenses in women abused sexually as children conducted by Romans et al. (1999) concluded that those with a history of childhood sexual abuse use less mature defenses, with a gradation with more severe forms of childhood sexual abuse correlating with the least mature defense styles. A study conducted by Bentovim (1996) revealed one key risk factor for boys to become sexual perpetrators was having a mother who had been a victim of sexual abuse. Unfortunately, these findings and theories have led to a practice of “mother-blaming” in cases where children are sexually molested and/or go on to become sexual offenders. Ryan (1991) contends that it was not until the 1980's that the blame and responsibility for incest was placed solely on the offender.

Feminist researcher Hooper (1995) offers an alternate view. She undertook the task of calling into question the received view of the “cycle of abuse” (p. 349). Hooper interviewed 15 women survivors whose children had been sexually abused. The interviews were a means to deconstruct and reconstruct currently held beliefs that a woman’s history of childhood victimization accounts for the frequent occurrence of victimization of her children. She describes this view as pathologizing and blaming of mothers. Her interviews revealed more common themes of *current* household physical and sexual abuse as the connection the women made to their children’s sexual abuse. The participants cited distraction and disempowerment resulting from current household violence as more relevant to the phenomenon of their child’s abuse than was their own childhood history. In keeping with critical theory objectives, Hooper suggests that we abandon the current view of the cycle of abuse, which not only pathologizes and revictimizes mothers, but also masks the presence of current family violence. This view has undoubtedly influenced more systemic treatment models, although there is a recent movement towards

incorporating a more ecological approach to sexual offender treatment, particularly in the case of adolescents.

Trauma-Organized System Theory

Bentovim (1996) considers the roles of the perpetrator, victim, non-protective parent/caregiver, and society in his theory of trauma-organized systems. His theory holds that deletion and minimization are systemic factors as is neutralization of the protective parent. Drawing on etiological theories of abuse, he holds that the victimizer is overwhelmed beyond control by impulses emerging from his own experiences. Cultural influences of male dominance and belief in “see, hear, speak, think no evil” tend to place blame on the victim and minimize the realities of the trauma. Bentovim draws on Finkelhor’s (1987) traumagenic dynamic responses (described previously herein) to account for victim response, and results of his own 1996 study to the non-protective parental (mother) response. He concludes that a characteristic of trauma-organized systems is that there is no confiding person to counter stressful effects. Emergent risk factors for boys to become abusers included (a) exposure to a climate of violence in the home, (b) experience of physical violence, (c) discontinuity of care, (d) feelings of rejection, and (e) the mother having been a victim of sexual abuse herself. He cites a study by Sroufe, Jacobvitz, Mangelsdorf, DeAngeleo, and Ward (1985) as finding that women who suffered sexual abuse as children tended to behave in seductive, sexualized ways as a means of controlling their young male children. In her exploration of the hypothesis of intergenerational sexual abuse, Faller (1989) found support for history of parental abuse in parents of both genders, though the father’s abuse history was more closely related when the perpetrator was a biological father in an intact family.

Attachment Theory

Bowlby (1969, 1973, 1980) developed attachment theory with later theoretical contributions made by Ainsworth (Ainsworth, 1989; Ainsworth & Bowlby, 1991). The core of this complex theory is that, through repetitive response (or non-response) from a caregiver, the individual develops an internal working model about relationships. The idea that internal working models of relationship are somehow related to early attachment experiences remains the received view. Research examined infant attachment and how it corresponds to adult attachment (Hazan & Shaver, 1987), and how that may affect well being (Fehr & Pehrman, 1985) and bonding in couple relationships (Bass & Davis, 1988). Research on sexual offenders has found evidence of intimacy deficits and sexual offending (Marshall, 1989, 1993; Seidman, Marshall, Hudson, & Robertson, 1994), and it has begun to consider the effects of attachment style on interpersonal skill deficits, emotional loneliness, coping styles, and sexual offending (Marshall, Serran, & Cortoni, 2000).

An etiological model of the onset and maintenance of sex offending and the relation with insecure attachment was developed by Marshall (1989, 1993). Ward, Hudson, and Marshall (1996) conducted a study with 147 heterogeneous sexual offenders and found significant relationships between sexual offenders and insecure attachment styles in adult relationships, though this was not unique to sexual offenders and was evident in the entire criminal sample. They also found evidence of differentiated attachment styles between offender types. Child molesters are more likely to have fearful or preoccupied attachment styles, consistent with research showing evidence of social anxiety and poor social skills in this population (McFall, 1990). Rapists tended to have dismissive attachment styles, consistent with findings of high levels of interpersonal aggression related to dismissive attachment (Bartholomew & Horowotz

1991). Smallbone and Dadds (1998) found similar results in their study with 48 incarcerated sexual offenders of insecure childhood attachment related to sexual offending and attachment style significantly related to offense type.

More recently, attachment is being considered from a neurobiological perspective (see Solomon & Siegel, 2003), studying the links between attachment, aggression, empathy, and the human brain. Empathy has been found to rely on the right cortex of the orbital prefrontal region, which is the brain region linked to the understanding the emotional states of others, or empathy (Schore, 1994). Schore (2003) forwards that “empathy is...a moral emotion, and so attachment experiences thus directly impact the neurobiological substrate of moral development” (p. 122). The findings that EMDR alters brain activity (van der Kolk, 1998) suggest that EMDR may have important implications in affecting aggressive tendencies, empathic skills, and attachment styles in offenders.

Mikulincer, Florian, and Weller (1993) looked at attachment theory in relation to how people cope with the impact of traumatic events. They conducted a study conducted with 147 undergraduate students exposed to an Iraqi missile attack on Israel during the Gulf War. Results supported significantly different responses to trauma when comparing persons with profiles consistent with secure, ambivalent, and avoidant attachment styles. The results support their hypothesis that those with avoidant attachment styles may not be able to recognize themselves as depressed or anxious, and their maladjustment to trauma may be manifested in heightened hostility and anger.

EMDR: A Review of Empirical Studies

Hertlein and Ricci (in press) reviewed all empirical studies of EMDR client outcomes focused on treatment of PTSD. We focused on studies involving trauma given EMDR's origins

as a treatment of traumatic memory (Shapiro, 1989a). We limited the review to those studies published in the English literature between 1997 and April of 2003, which follows from DeBell's and Jones' (1997) review.

PsychINFO, MEDLINE, ScienceDIRECT.com, and Family and Society Studies Worldwide were the databases utilized to conduct this research synthesis. However, we were aware of other articles that were not listed in the databases. As a result, we augmented our search with David Baldwin's Trauma Pages, at <http://www.trauma-pages.com>. This site is periodically updated and intends to provide an exhaustive EMDR bibliography by the year of publication. It is my belief that we have located all of the published EMDR studies within these parameters. Our search located 16 controlled studies of EMDR outcomes. The Macklin et al. (2000) study was excluded , as it was a follow-up study inconsistent with the inclusion criteria.

Korn and Leeds (2002) conducted an AB design using the self-report TSI and SCL-90 as outcome measures (for a list of assessment inventories and abbreviations, see Appendix). Assessment was not blind as the treating therapist was the assessor. The target symptoms were clearly defined with both participants meeting PTSD criteria. Treatment procedure employed Resource Development and Installation (RDI) as opposed to standard EMDR. RDI was described as similar to EMDR, though uses fewer eye movements per set. Test power is considered limited by almost any standard by the small sample size ($N = 2$). RDI was effective and researchers suggest RDI has promise in increasing stability for clients with a history of trauma, but the results must be interpreted with caution due to research design limitations.

Lytle, Hazlett-Stevens, and Borkovec (2002) examined the effectiveness of EMDR using past stressful life experiences as the identified target of treatment. Their controlled study used a randomized design to compare EMDR to a fixed eye condition (ED) and a non-directive therapy

condition (ND). Researchers employed a series of reliable and valid instruments, although all instruments relied on self-report and were administered by a treating therapist. Another weakness was the level of therapist training. Two of the therapists underwent Level I EMDR training, and they trained the third therapist in the procedure. The participants ($N = 48$) were from a sample of college students. Diagnosis was unclear with only partial criteria for PTSD met. Treatment was one session, thus not following the protocol established by Shapiro (1995). Their results indicated EMDR was not significantly better over the comparative treatment methods. ED showed the best performance overall. The Penn State Worry Questionnaire (PSWQ) was significantly associated with poorer outcomes on both EMD and ED, but not with ND.

Devilly and Spence (1999) performed a stratified random comparison of cognitive-behavioral treatment with EMDR targeting PTSD symptoms. The researchers used the STAI-Y2, SCL-90R, BDI, PPD, CMS, PSS-SR, CEQ, DEVS-T, SUD, and IES, all reliable and valid measures of change, but all self-report (see Appendix for list of inventories). The assignment of participants to two treatment conditions was random. The symptoms for treatment were specific. The treating therapists were Level II trained and treatment adherence was independently assessed by videotape and reported as adequate. The EMDR procedure followed the typical protocol outlined by Shapiro (1995). However, Maxfield and Hyer (2002) critiqued the description of the EMDR technique, stating it did not conform to standard procedures. Some of these deviations included inaccurate instructions and repeating the negative cognition during treatment. Additionally, an independent rater was present to assure that the research was following the EMDR protocol, but assessment was not blind. Confounding conditions were present with half of their sample ($n = 23$) receiving concurrent psychopharmacological treatment. The researchers

concluded that not only was TTP more effective initially in the treatment of PTSD, but also was more durable with the effects of EMDR dissipating over time.

In a study by Marcus, Marquis, and Sakai (1997), EMDR was compared to standard care for PTSD. Standard care (SC), however, included a variety of treatment models and was not clearly defined. The 67 participants were randomly assigned to each treatment condition. Measures include several reliable and valid measures such as the IES, MPTSD, BDI, STAI-I, STAI-S, SUD, GAF, SCL-90, GSI, and SCL-90, and PSD (see Appendix for list of inventories). Assessment was not blind, evidenced by the statement, "...it was not possible to keep the independent evaluator blind to treatment condition..." (p. 309). The authors describe adherence to Shapiro's eight steps in the protocol, although this was not independently monitored via videotape or live supervision. EMDR performed significantly better than the SC group for the specific scales for PTSD (i.e., IES, MPTSD, STAI-T, portions of the STAI-S, and SUD). The authors also reported that EMDR participants required statistically fewer sessions, but the mean number of total sessions for each is unclear. For example, after three sessions, half of the participants in the EMDR group did not meet the criteria for PTSD, which was true for only 20% of the participants in the SC group. At post-treatment, about three-fourths of the EMDR group (77%) no longer met the criteria for PTSD, true for only half (50%) of the SC group. The power of this test surpasses the majority of others under review with its sample size of 67.

Rogers et al. (1999) examined the effectiveness of EMDR with a small sample ($n = 12$) of Vietnam veterans diagnosed with PTSD. Dependent measures were subjective (IES and SUD), but the study was unique in including physiological measures such as heart rate and blood pressure. Participants were randomly assigned to conditions (EMDR vs. relaxation condition), and treatment providers were blind to the assessment data. Additionally, the authors described

the treatment protocol in specific detail, which strictly adheres to standard EMDR protocol (Shapiro, 1995). Sessions were videotaped to check for treatment fidelity, but fidelity checks were not included in the present study. The length of treatment was limited to one session. There was a significant difference in the SUD from pre- to post-assessment. Again, the study relied on a small sample of 12 participants, generating limited test power. No indication of the level of therapist training was provided. Additionally, all but one participant was taking antidepressant medication, which may confound results with controls unclear. EMDR was more effective than the exposure group for reducing the severity of the intrusive memory.

Cusack and Spates (1999) compared EMDR and eye-movement desensitization (EMD) as treatment methods for PTSD symptoms ($N = 27$). EMD is described as being similar to EMDR but without the cognitive aspects which define EMDR. The strengths of this study were the random assignment to conditions as well as use of reliable and valid measures. Another unique feature was that this study employed a more comprehensive assessment using the BASA (a behavioral assessment), and an interview (SI- PTSD) in addition to self-report measures. Blind observation assessed treatment fidelity, but typical treatment protocol was not followed. Length of treatment was one to three 90-minute sessions. The study did not report control of confounding variables, nor was it a requirement for inclusion to meet criteria for PTSD. The results indicated both EMDR and EMD were effective in reducing PTSD symptoms.

Lazrove, Triffleman, Kite, McGlashan, and Rounsaville (1998) conducted a pre-pilot AB design study of eight participants diagnosed with chronic PTSD. Strengths of this study include treatment fidelity by monitored, Level II trained therapists. Reliable and valid self-report and interview measures were used to assess the target symptomatology of chronic PTSD. Despite the power limitations of the small sample size ($N = 8$), results were clinically significant in that none

of the seven participants completing the three-session treatment met criteria for current PTSD based on a post-treatment structured interview. Depressive symptoms also improved significantly, which appeared to be a secondary effect. A robust treatment effect was observed in only three sessions, indicating EMDR as a unique form of therapy rather than an alternative to exposure therapies. Favorable results from this pilot study were such that the researchers moved ahead with a controlled trial to assess EMDR treatment for PTSD more precisely.

Devilly, Spence, and Rapee (1998) compared EMDR to two groups: EMDR minus the eye movement component group (REDDR) and a psychiatric support control group (SPS). The purpose of the study was to determine the necessity of the eye movement component of EMDR. In a mixed group design, 51 veterans with PTSD symptomatology completed several self-report measures. This study accounts for physiological measures such as heart rate and blood pressure. The scales used were reliable and valid. Another strength of this study was that treating therapists were all Level II trained. Though 51 participants appears to be a large sample, it was divided over three conditions resulting in a sample size of 14 in the EMDR group, 16 in the REDDR group, and 16 in the SPS group. In this sense, the sample sizes were small in each condition. Assignment was also not completely random, but instead followed a block design. There were no fidelity checks reported in this study, so it is difficult to determine the extent to which the standard EMDR protocol was followed. Additionally, the number of sessions was limited and might not provide an adequate judgment of effectiveness. The researchers found that all groups reported a decrease in symptoms, but at follow-up there were no lasting effects for the treatment groups. The authors concluded that eye movements were not likely a mechanism for change.

Lee, Gavriel, Drummond, Richards, and Greenwald (2002) randomly assigned 24 participants (12 in each group) to one of two conditions: EMDR, or Stress Inoculation Training with Prolonged Exposure (SITPE). Participants were recruited from hospital psychology clinics and sexual assault referral centers, and each served as his own control. Measures to assess change included SI-PTSD, MMPI-K, IES, and BDI, all reliable and valid, but all self-report measures (see Appendix for list of inventories). Participants received seven, 60-minute sessions of treatment and were assessed at pre-treatment, post-treatment, and three-month follow up. The researchers used behaviorally trained assessors and Level II trained clinicians in the study, both strengths. Another strength was the monitoring of treatment fidelity via videotape. However, the study did not provide for a blind or independent assessor. There was also evidence of extra-therapeutic factors (e.g., potential for concurrent psychotherapy and/or medications). Though both EMDR and SITPE were effective, EMDR was superior to SITPE in the measurement of intrusion. The authors noted that participants in the EMDR condition required less homework than the SITPE condition.

Edmond, Rubin, and Wambach (1999) conducted a randomized experimental evaluation with 59 women recruited from newspaper advertisements and flyers to agencies and clinicians in Texas. Volunteers with reported history of childhood sexual abuse were screened for inclusion, however, neither PTSD nor any other diagnosis was used as a prerequisite. Pretest scores did reveal symptomatology consistent with a clinical population. Participants were randomly assigned to EMDR treatment ($n = 20$), routine individual treatment ($n = 20$) and wait list control ($n = 19$). The random assignment to treatment, control, and comparison groups were strengths of this study, as was the training level and verified treatment protocol of treating clinicians. Although the standardized outcome measures used (i.e., STAI, IES, BDI) demonstrate adequate

reliability and validity, they are all self-report measures that were administered by the primary researcher. Other outcomes (i.e., SUD, VOC) are subjective measures that are part of EMDR treatment protocol. This procedure warrants caution in interpreting results given the possibility of relational artifacts and researcher bias. The sample size of 59 may be perceived favorably relative to other studies reviewed; however it still leaves a fairly large risk of a Type II error. The researchers report large composite effect sizes between the EMDR and routine treatment groups of 1.46 at posttest and 1.08 at three-month follow-up. Furthermore, EMDR-treated individuals did not show clinically significant levels of trauma-specific anxiety or depression while the comparison group exhibited above average symptomatology. Researchers concluded that EMDR was more effective than routine individual treatment at maintaining therapeutic gains. Stable to larger effect sizes at follow up is consistent with the findings of a meta-analysis conducted by Van Etten and Taylor (1998).

Scheck, Schaeffer, and Gillette (1998) studied the efficacy of EMDR with a sample of 60 traumatized women, ages 16 to 25. Though a PTSD diagnosis was not a prerequisite for inclusion, participants met criteria of at least two of eight dysfunctional behavior patterns (e.g., truancy, sexual promiscuity). Participants were randomly assigned to an EMDR treatment group or an active listening (AL) treatment group. This was a well-designed study. Assessors were trained, supervised, and blind to conditions. Therapists were Level II trained and followed specific treatment protocol, although this was determined by self-monitoring only. The major weakness in this design was the arguably inadequate two-session treatment regime. It is possible that this shortened treatment model disadvantaged the AL treatment given EMDR's claims of efficiency. There was also no mention of control for extra-therapeutic factors (e.g., concurrent treatment) that must be considered when interpreting the results. At post-treatment assessment,

the EMDR participants were within one standard deviation of normal group means. The AL group was within one standard deviation on only one measure (STATE). Three-month follow up was hampered both by unavailability of many participants and the confound of subsequent treatment by a number of participants, therefore statistical comparisons were not made. Overall, the general pattern of outcome measures showed improvement for both groups, though EMDR showed pre-post-effect sizes approximately double those of the AL group. The authors recognized and reported a significant limitation of study with this “unstable” (p. 37), untrusting population. The participants might “represent a more stable, more trusting, less resistant subpopulation of the high risk-population we targeted” (p. 37). However, their caveat speaks not to interpretation of a between-group comparison, but rather to the generalization of results to those in crisis situations who have not yet been stabilized.

Soberman, Greenwald, and Rule (2002) conducted a study based on their hypothesis that the development and persistence of conduct problems may originate, in part, from a history of trauma. They selected EMDR as a means of testing this hypothesis due to its promise as a “considerably more efficient” (p. 219) trauma treatment. Twenty-nine boys ages 10 to 16 who exhibited acting-out behaviors severe enough to result in residential or day treatment placement participated. Data sources included six self- or other-report measures of behaviors, symptoms, and distress (i.e., SUD, IES-8, CROPS, PROPS, PRS and BRS). The BRS was an existing, system-wide rating of behaviors from which clients earn privileges. Participants were randomly assigned to treatment or control groups, with both groups continuing in standard milieu treatment. Standard treatment included individual, group and family therapy, psychopharmacology, behavior modification, and special education services. Random assignment to a therapist was not accomplished as only one Level II trained clinician provided

all treatment, thus weakening external validity. Furthermore, although treatment in this study did follow standardized EMDR protocol (Shapiro, 1995), the three sessions provided are considered inadequate by our review standards. Also, the procedures were not independently monitored. Results showed statistical significance at post-treatment on two measures (i.e., SUDS, PRS), however two-month follow up results favored EMDR on all measures except the IES which showed a change from clinical to non-clinical levels for both groups. Other results included trends favoring EMDR over control groups. Strengths of this study were the random and controlled design with a homogeneous group of boys. However, a significant weakness recognized by the authors was that the centralized treatment center from which participants were drawn created a system-wide interest in trauma, possibly influencing the milieu thus affecting non-participants as well. They also discussed the small sample size and truncated treatment design as limitations to yielding statistically significant changes across all measures. The authors concluded that the treatment holds promise, particularly in view of the continuing improvements made by the treatment group, which echoes findings in similar research studies (e.g., Greenwald, 1994; Scheck, Scheffer, & Gillette, 1998). They suspected the treatment reduced reactivity in the EMDR group, thereby allowing the boys to take advantage of their ongoing treatment milieu.

Ironson, Freund, Strauss, and Williams (2002) conducted a pilot study with 22 individuals with some history of trauma, meeting *DSM III-R* criterion for trauma. Participants agreed to three preliminary sessions and one active treatment session of either EMDR or prolonged exposure (PE). PE treatment followed instructions for Foa's and Rothbaum's (1998, as cited in Ironson et al., 2002) imaginal exposure. EMDR followed the eight-phase protocol per Shapiro (1995). The therapists were doctoral students who had received at least Level I training for EMDR, and were supervised by clinicians with Level II training. Therapists were trained in

the PE technique by Freund (second author). Both treatments were manualized and fidelity checks and supervision were applied throughout. Measures were self-report (SUDS, BDI, DES, PSS-SR). Results suggest that EMDR and PE were equally effective in reducing PTSD symptoms. Results were maintained at three-month follow up with 12 participants who could be located.

Power et al. (2002) conducted one of the most methodologically sound studies in this review. Patients who met criteria for PTSD ($N = 105$) were randomly assigned to EMDR ($n = 39$), exposure plus cognitive restructuring (E + CR) ($n = 37$) and wait list ($n = 29$) groups. A maximum of 10 treatment sessions were allowed, although treating clinicians felt results had been achieved in fewer sessions. In that regard, the EMDR group showed subjectively measured efficiency requiring a mean of 4.2 sessions ($SD = 2.5$) compared to a mean of 6.4 ($SD = 3.2$) sessions for the E + CR group. Areas ranked in the mid-range were lack of blind assessment and use of multi-modal assessment measures. Assessor reliability was not reported, thereby registering no score on that criterion. EMDR and E + CR performed equally well across all measures, with both showing statistical significance compared to the wait list group. EMDR performed better on one measure of depression (HADS), with 81% of EMDR patients achieving clinically significant reductions in symptoms compared to 43% of the E + CR participants ($p < .05$). The other measure revealing significance was the SDS with 70% versus 38% respectively. However, gains in both of these measures were lost at a 15-month follow up. The authors concluded that while each experimental treatment out-performed the wait list, the majority of patients do not achieve clinically significant long-term gains without additional treatment. The researchers concluded that EMDR and E + CR are effective in treatment of PTSD, however EMDR required fewer treatment sessions to achieve these results.

Carlson, Chemtob, Rusnak, Hedlund, and Muraoka (1998) used a sample of 35 male veterans diagnosed with PTSD to explore EMDR effectiveness. The participants were randomly assigned to one of three conditions: EMDR, biofeedback-assisted relaxation, or routine clinical care. Reliable and valid measures used included the CAPS-1, CMS, IES, PTSD-SR, BDI, STAI, clinical scales of the MMPI-2, and the MAC-R subscale (see Appendix for list of inventories). Participants were assessed at pre-treatment, treatment, post-treatment, and follow-up. The assessors were independent, but not blind to the interview process. A design strength was the inclusion of psychophysiological measures in the assessment. Another strength was the length of treatment (12 sessions). While the treating therapists were “formerly trained in the EMDR method” (p. 8), the training level (Level I or Level II) is unclear. Also unclear was the potential for confounding conditions. At the three-month follow up, EMDR was effective when compared to the other groups. Participants in the EMDR group had statistically significantly lower scores on self-report measures of PTSD symptoms than did the biofeedback or routine care group.

Taylor, Thordarson and Maxfield et al.(2003) compared the three treatment methods of prolonged exposure therapy, relaxation training, and EMDR for efficacy, speed, and incidence of symptom worsening for PTSD. Their study design intended to avoid the methodological limitations of prior studies examining this issue. Consequently, they followed and met all of Foa and Meadows' (1997) GS for sound treatment outcome research. Inclusion criteria were a diagnosis of PTSD according to *DSM-IV-TR* standards, legal ability to consent to treatment, and willingness to suspend any concomitant psychological treatment and also maintain entry levels of psychotropic medication over the course of the study. Qualifying participants (N = 60) were randomly assigned to one of the three treatment groups, each providing eight 90-minute individual sessions. Treatment protocols followed detailed manuals. Two female clinicians were

randomly assigned to participants. Clinician qualifications and experience are clearly outlined, as are the three treatment protocols. Blind assessors administered the SCID-IV and CAPS interviews. Interview outcomes and symptom assessment were independently rated and showed satisfactory levels of inter-rater reliability (i.e. .80 - .93). Self-report questionnaires were completed by participants before, during and after treatment. The authors conclude that "Compared with EMDR and relaxation training, exposure therapy (a) produced significantly larger reductions in avoidance and reexperiencing symptoms, (b) tended to be faster at reducing avoidance, and (c) tended to yield a greater proportion of participants who no longer met criteria for PTSD after treatment. EMDR and relaxation did not differ from one another in speed or efficacy." (p. 330).

This review of current EMDR research continues to lend support to its current designation by the Treatment Guidelines Committee of the International Society of Traumatic Stress Studies (ISTSS) (cited in Chemtob et al., 2000) as an effective treatment for PTSD. Ten of the 16 studies reviewed in this research synthesis report that EMDR was more effective than comparison treatments, and another five report it performed as least as well as comparison treatments. Only one study (Devilly & Spence, 1999) reports EMDR was ineffective as compared to another treatment for PTSD.

Efforts to dismantle and classify EMDR as a treatment type will undoubtedly continue. Whether EMDR fits theoretically in the cognitive-behavioral sub-groups of exposure, implosion, flooding or systematic desensitization treatment, or as the information processing therapy that Shapiro suggests, its efficacy and efficiency are evidenced by the empirical research literature.

Sex Offender Treatment: Standard Treatment Models

Treatment for the extinction of sexual offending has remained fairly static since 1983. Treatment of sexual offenders was originally based on psychoanalysis and psychodynamics (Becker & Murphy, 1998), which were typically the treatment approaches for any and all presenting problems. Viewed as sexual perversion, offending behaviors were believed to be fixations at stages of psychosexual development. Discovery through interpretation and development through transference were thought to be the means to reconstructing personality and behavior. These methods are said to have had poor results with this population (Crawford, 1981).

Currently, the most accepted form of treatment is CBT within a relapse prevention model (Pithers et al., 1983; Pithers, 1990; Murphy & Smith, 1996; Salter, 1988). This model is a revised version of Marlatt's (1982) relapse prevention model designed for the treatment of addictions. A 1994 survey revealed that close to 90% of North American treatment programs for sexual offenders report the use of relapse prevention (Freeman-Longo et al., 1994). A more recent national survey of treatment providers continues to find the large majority of all respondents chose cognitive-behavioral/relapse prevention as the theory that most closely described their work (Burton, & Smith-Darden, 2000). These models are generally described as a comprehensive treatment designed to help clients maintain behavioral changes through their understanding of the sexual abuse cycle and relapse process. The idea here is that offender awareness of the sex abuse cycle, along with his/her thinking, affective reactions, and behavioral reactions, will allow the offender to cope differently (Lane, 1997). Generally accepted phases of this treatment model as it applies to sexual offenders include reducing denial, correcting cognitive distortions or minimalizations, identifying internal and external risk factors,

identification and revision of arousal patterns, social competence training, assertiveness training, problem solving, and victim empathy (Becker & Murphy, 1998; Pithers, 1990; Salter, 1988).

Outcome research indicates relapse prevention appears to be effective with sexual offenders (Alexander, 1999; Maletzky, 1991; Marshall & Barbaree, 1988, 1990; Marshall, Jones, Ward, Johnson, & Barbaree, 1991; Pithers & Cumming, 1989; Prentky & Burgess, 1990), although some longer-term studies continue to question treatment outcome effectiveness (e.g., Hanson et al., 1993). Some researchers feel that the field of sexual offender treatment may be too new to adequately measure treatment efficacy (Alexander, 1999), while others point to research design flaws as the primary hurdle to efficacy measurement (McConaghy, 1999). Marques (1999) suggests that the question “does sex offender treatment work?” needs to be looked at through a lens of more specific and useful questions and by offender typology. Fisher, Beech, and Browne (2000) conclude from their efficacy study of relapse prevention that it should “only be undertaken as part of an extensive treatment program covering all areas of offending behavior” (p. 181). In any case, the call remains for identifying interventions that improve outcomes (Becker, Kaplan, & Kavoussi, 1988; Bourdin, Henggeler, Blaske, & Stein, 1990; Dwyer, 1997; Launay, 2001; Maletzky, 1993; Marshall & Anderson, 1996; Marques, 1999; McGuire, 2000; Polizzi, MacKenzie, & Hickman, 1999; Pollock, 1996; Ruddijs & Timmerman, 2000) and enhance the abuser’s motivation to apply this approach in daily life (Pithers & Gray, 1996).

Sex Offender Treatment: Expanded Treatment Models

Recently, some researchers are focusing attention on theories of etiology and are expanding this accepted standard treatment model. Schwartz (1994), for instance, draws on the Masters and Johnson treatment program for sex offenders, suggesting a move beyond

mechanistic reductionism to augment the elements of typical relapse prevention programs with the inclusion of empathy and trauma resolution. In this program model, the theory is that the survivor of trauma is left with unprocessed rage, which he/she may direct internally and/or externally. Trauma in the form of sexual abuse may cause the offender to repeat the behavior on others. Garland and Dougher (1990) labeled this the abused abuser hypothesis (see also Groth & Burgess, 1977). This compulsive behavior becomes a means of self-medicating in the face of feeling. Additionally, sexuality becomes trauma-bonded which perpetuates this link for the offender. This idea of trauma-bonded sexuality is similar to Finkelhor's (1986) concept of traumatic sexualization--one of four traumagenic dynamics of the impact of childhood sexual abuse.

This inclusion of trauma treatment mimics the more balanced treatment model, which is typically found primarily in children's treatment programs (Gray & Pithers, 1993). Along similar lines, Dewhurst and Nielsen (1999) have recently proposed a balanced treatment model, which they call a resiliency-based approach that integrates the transtheoretical model of change (Prochaska et al., 1994), the Aboriginal medicine wheel, resiliency, and the narrative approach forwarded by Michael White and others. Anechiarico (1998) proposes a model, which integrates development of the interpersonal dimension into the relapse prevention model on the theory, that sex offending "is not only a behavior disorder but also a relational disorder. It is an extortion of intimacy in an attempt to restore damaged self-esteem" (p. 18) which she suggests is fragile and unstable. Warren's and Green's (1995) Southwest Sexual Compulsivity Program holds the belief that, with the inclusion of self-development and trauma resolution to more standard practices of cognitive behavioral treatment, offenders and sexual compulsives can experience personality transformation. These models all have in common the idea that focusing on negative traits and

behaviors alone can further diminish the self-esteem of the offender, thereby perpetuating the patterns of abuse. In addition, the offender may lack motivation for change unless he or she feels a “bigger payoff” for the work of developing and maintaining a new lifestyle. This idea fits not only with Prochaska’s (1994) change model, but also that of Vroom’s (1964) Expectancy Theory wherein motivation is said to be the product of the multiplicands of valence, instrumentality and expectancy.

Sex Offender Treatment: A Review of Empirical Studies

The following review of CBT-RP outcome studies is confined to those studies conducted in the United States and published in the English literature between 1993 and March 2003. I have excluded studies focused on special populations (e.g., females, children, persons with developmental delays). Studies were obtained by searching the PsychINFO, MEDLINE, ScienceDIRECT.com, Family and Society Studies Worldwide databases. Further studies were located from the reference sections of the literature located through those sources. The search yielded only eight studies fitting all criteria. Although it did fit criteria, the Barnes and Peterson (1997) study was unavailable in print, and was therefore omitted from the review.

Berliner, Schram, Miller, and Milloy (1995) conducted a study of sexual offenders ($N = 613$), comparing rates of recidivism between those who elected standard punishment in lieu of receiving treatment ($n = 300$) and those who underwent the Special Sex Offender Sentencing Alternative (SSOSA) of treatment and supervision ($n = 313$). Recidivism was determined by tracking arrest and conviction records from the sentencing date through to December, 1990. Offenders were primarily White (85%), male, (98%), and educated through high school or beyond (66%). Ages of offenders ranged from 22 to 40 years (62%) with 47% reporting that they were married. Results were significant between groups for all reoffense categories except sexual

offenses, which were almost identical for both groups. Characteristics for both groups associated with reoffense, significant at the $p < .05$ level, were: age of offender, history of sexual victimization, history of violence, prior adult conviction, other offenses, and frequency of contact. Felony rearrest (including felony sexual offense) was significantly associated with: ethnicity, age, marital status, employment status, history of sexual victimization, history of violence, prior convictions, level of coercion used, age of the victim, number of victims, frequency of contact, and admittance to prior sexual charges. The authors note that this was not designed to be a treatment outcome study, and there was not a standard treatment approach used on the sample. Regardless, results did not support effectiveness of treatment and community supervision over no treatment and maximum sentencing.

A treatment outcome study conducted by Aytes, Olsen, Zakrajsek, Murray, and Ironson (2001) involved 395 sexual offenders who were supervised and treated in the Jackson County (Oregon) Community Corrections facility, 89 sexual offenders from nearby Linn County who were supervised but untreated, and 231 nonsexual offenders. The sample represented offenders convicted between 1985 and 1995. The treatment group was separated into three subgroups delineated by successful ($n = 170$), unsuccessful ($n = 157$), and incomplete ($n = 68$) treatment. The remainder of the Jackson County sexual offenders ($n = 149$) did not participate in treatment and were thereby omitted. Recidivism rates were compared for the three groups. A chi-square test of recidivism rates among the three subgroups was statistically significant ($X^2 = 25.12$, $df = 3$, $p < .01$). Comparisons of Jackson County sexual offenders in treatment for more than one year ($n = 373$), Linn County untreated offenders ($n = 343$), and Jackson County nonsexual offenders ($n = 173$) showed slightly lower rates of recidivism for treated sexual offenders over untreated sexual offenders. They also found substantially lower rates of recidivism for treated sexual

offenders over nonsexual offenders at three-year and five-year follow-up. When these figures were controlled for treatment that lasted less than one year, however, treated offender rates of recidivism were 40% lower than Linn County untreated sexual offenders. Strengths of this study include protracted follow-up time, adequate sample size, and control for treatment length. The program under review offers closely supervised a CBT-RP methodology, which indicates treatment fidelity. This study suffers from the use of dichotomous outcome measures of recidivism, however, which may be an incomplete or inadequate measure at best. Additionally, limited information is provided concerning between-group demographics and criminal history, which could easily confound results. Statistically and clinically significant results do empirically support benefits of CBT-RP treatment for sexual offenders, if only under these comprehensive treatment conditions.

Dwyer (1997) did a 17- year follow-up study of 180 male sexual offender treatment completers and almost-completers. Participant demographics showed that 47.3% were married, 25.7% were single, and 10.8% were divorced. Approximately 40% of the participants had at least some college while 31% were postgraduates or professionals. The mean age was 48.2 years, and 62% reported membership in a church or temple. Average treatment time was 31 months. Sexual identity was reported as 70% heterosexual, 15% homosexual, and the remaining reported a bisexual orientation. The majority of the sample was pedophiles (64.1%) and nearly 21% were incest fathers. Treatment was voluntary and used the physiological measure of phallometrics and clinical scales including MMPI, MCMI-II, and MSI. Follow-up data consisted of interviews, anonymous questionnaires, and criminal records from the home city of Minneapolis, MN and surrounding areas (including parts of Canada). One hundred and eight participants presented for follow-up interviews and were assessed for attachment, involvement, commitment, and existing

problems. Results of this research revealed that 17 men had sexually reoffended while an additional five had criminally recidivated. Fifty-three percent of the sexual re-offenders were in the almost-completed group, while the majority of non-sexual re-offenses were in the graduated group. Nine percent of the sexual re-offenders were from those classified as pedophiles, 21% from those originally convicted for incest, 30% from those classified as exhibitionists, and 100% ($n = 3$) from those originally convicted for rape. Indicators showed significantly improved self-view after treatment and the ability to utilize skills learned during treatment into their daily lives. Sexual recidivism rates were .06 for treated men versus .16 for comparison group members. These results yielded an odds ratio of .35, meaning for every 100 untreated sexual offenders who will recidivate, 35 treated offenders will also recidivate. Results of this study may have been confounded by pharmacotherapy as an extra-therapeutic factor. Follow-up data may also be questionable as the researchers relied primarily on self-report measures to assess self-esteem, behaviors, etc. Criminal records, although concrete, are subject to the vagaries of the law, and re-offense does not necessarily result in re-arrest.

Maletzky and Steinhauser (2002) conducted a 25-year follow up of cognitive behavioral therapy with 7,275 sexual offenders. Their method was a retrospective chart review of all males over the age of 18 from the files of a metropolitan outpatient clinic in the northwestern United States. Subjects were divided into six cohorts according to type of offense (i.e., child molester of females, child molester of males, heterosexual pedophile, homosexual pedophile, exhibitionist, rapist). Data from the charts included plethysmograph tests, self-report questionnaires, polygraph examination results, and criminal records. Treatment failure was determined by criminal records and self-report. When possible, verification via physiological measures (i.e., plethysmograph, polygraph) was done. Respective recidivism rates for those completing treatment versus those

terminating were: .24% vs. 1.7% for child molesters of females; .58% vs. 2% for child molesters of males; .47% vs. 7.5% for heterosexual pedophiles; 1.8% vs. 17.1% for homosexual pedophiles; .73% vs. 8% for exhibitionists; and 9.8% vs. 74.5% for rapists. The authors concluded that treatment for most offenders appeared effective when provided in individual and group therapy, with dropouts showing higher risk to re-offend. Treatment results varied by cohort, with predatory (e.g., rapists) or preferential (e.g., homosexual pedophile) offenders showing 2 to 2½ times the overall failure rate of child molesters. Results also show that failure rates increase over time with best results obtained in the first six to twelve months post-treatment, with a continued rise in failure rates until the 8th or 10th year when the numbers stabilize.

The longevity of this study allowed researchers to conclude that treatment techniques have improved over the past 25 years, with rates of treatment failure showing an indirect correlation with time (Maletzky & Steinhauser, 2002). The exception to this trend in improved outcomes was the rapist cohort. There are many factors that must be considered when interpreting the results of this study. The retrospective review design is subject to lost, inaccurate, or missing data. Similarly, the length of the study resulted in high numbers of subjects who were lost to contact and unavailable for follow-up. This was somewhat mitigated by a search of criminal records. As might be expected, very few participants agreed to plethysmograph or polygraph tests at follow-up, so results rely mainly on self-report. Confounding conditions (e.g., life-events, substance use, subsequent treatment) were not controlled for in the follow-up data. Data collection methods precluded absolute statements regarding treatment success or failure. Finally, each cohort served as its own control due to the ethical considerations disallowing assignation of motivated sexual offenders to a control group.

Marques (1999) headed a longitudinal study mandated by the California state legislature entitled California Sex Offender Treatment and Evaluation Project (SOTEP). The clinical research study began in 1984 with the dual goals of reducing recidivism for released offenders and providing legislators with outcome data on which to base future public policy. The study design was rare for this population in that it had a volunteer control group of imprisoned sex offenders who volunteered, but were not matched-pair, randomly selected for treatment. It also had a non-volunteer control group of prisoners who qualified for the project but refused treatment. Treatment was the CBT-RP based largely on Marlatt's (1982) addiction design. Participants received three weekly 90-minute core RP group sessions in addition to any number of special groups (e.g., substance abuse, anger management) and individual treatment components (e.g., behavior therapy to alter arousal patterns). Participants also received a one-year aftercare program once released into the community.

Preliminary results do not yet show a significant treatment effect, although dropouts maintain a higher relapse rates even over both control groups. No statistically significant differences are evident thus far between the treatment group and volunteer and non-volunteer control groups. Self-report and physiological measures do show trends in increased sense of personal responsibility, decrease in deviant sexual interest, and understanding of and ability to apply RP principles. The study also found that offenders responded better to treatment if (a) they are married, (b) they did not have a history of childhood physical abuse, and (c) they were unemployed at the time of their offenses. This is a well-designed research project, particularly in view of the uniqueness of using control groups. Multi-modal measures were available to researchers as were criminal records that included not only arrest but also charges of re-offense. While this study is making substantial contributions to the knowledge base about sexual

offenders and treatment, the results thus far are not favorable to support current models of treatment. This is particularly meaningful when one considers the full range of services (e.g., special groups, after-care) available to the subjects of this study.

McGrath, Hoke, and Vojtisek (1998) found significantly better treatment results than in their study of 122 low- to moderate-risk sexual offenders receiving specialized outpatient CBT-RP treatment. The sample included 43 molesters of females, 8 molesters of males, 4 molesters of both genders, 36 incest offenders, 23 rapists, and 8 hands-off offenders (e.g., exhibitionism). Mean age of participants was 37.4 years, and 60.5% had 12 or more years of education. The study included a retrospective comparison group ($n = 32$) comprised of sexual offenders who received less-specialized services within the same geographical area of Vermont, and a control group ($n = 19$) of treatment refusers. Less-specialized treatment was considered that which did not follow the comprehensive CBT-RP program developed within this rural Vermont county, and if treatment providers had minimal experience in treating this population.

Between treatment group comparisons revealed no statistically significant differences in risk factors of prior convictions, and time-at-risk. Differences were prevalent in the area of offense type, wherein the specialized treatment group contained 35.2% incest offenders compared to 18.8% in the less specialized group. Incest offenders typically have the lowest rate of sexual reoffense among sexual offenders (McGrath, 1991) and this large percentage difference may have affected outcome results. Outcome measures relied on the one year follow-up of recidivism and probation violation data which showed significant main effect across treatment groups, $X^2 (2, N = 122) = 10.7, p > .01$, with no differences found between the less-specialized and no-treatment groups. Comparison tests between treatment groups showed statistical significance on the dependent measures of sexual reoffenses ($z = 3.50, p < .01$), but not on non-

sexual or non-violent reoffenses. The researchers concluded the evidence from this study supports previous research findings on the efficacy of CBT-RP treatment approaches with sex offenders. The study had low test-power due to limited per-cell sample sizes, and was not able to control for participant bias due to motivation. Additionally, random assignment was not possible. Follow-up data was confined to a one-year post-treatment period. These are common limitations in studies with this population and are often cited as hurdles to gauging effectiveness (Barbaree, 1997; McConaghy, 1999). For example, the literature shows recidivism rates do not tend to level off until between eight and ten years post-treatment (Maletzky & Steinhauser, 2002), thus shorter follow-up may deceive results. This study also lacks a true manualized treatment protocol as methods “evolved somewhat” (p. 209), thereby making unavailable the specific components of treatment, which may have had effect. Nonetheless, the study adds to the limited knowledge base by adding support for the benefits of a systematic treatment program for sex offenders.

McGuire (2000) conducted an ex-post facto study of sexual offenders incarcerated in a medium security Wisconsin prison between 1994 and 1996. His study intentionally focused on the appropriateness of outcome measures, attempting to address criticisms in the literature of prior studies. Specifically, he utilized lapse indicators as an outcome measure. Lapse indicators are described as behavioral changes demonstrated by the offender prior to committing another sexual offense. As a result, the study did not rely on the dichotomous measure of recidivism rates, which suffer from shortfalls discussed previously. In addition to charged offenses, this study also considered lapse behaviors of: (a) substance usage, (b) non-sexual criminal activity, (c) failure to attend aftercare treatment, and (d) deviant sexual behavior falling short of criminal charges. Parole agents’ reports of behaviors were the data as were computer-tracking systems used to monitor offenders. A comparison group was developed from treatment refusers and non-

completers. Results were presented by offender typology of rapists with adult victims, statutory rapists, and child offenders. Adult and statutory rapists showed higher lapse behaviors of impulsive type, as compared to child molesters whose lapse behaviors were centered around non-compliance with aftercare and planned contact with children and former victims. There were overall positive differences in treated versus non-treated offenders, with the former showing significantly fewer non-sex-related charges and supervision revocations. However significance was not reached between groups regarding sex-related offenses and absconded status. Despite the effort at improving outcome measures, the small sample size of this study limits external reliability. Results add important information to the knowledge base about lapse behaviors by offender typology and may guide supervising agents in their task of monitoring parolees. Limited information is provided by this study concerning treatment effectiveness, however. Given the study's focus, limited information was provided about treatment protocol other than to mention it was based on a CBT-RP model. This study does represent an alternative to commonly used dichotomous outcome measures.

Miner and Dwyer (1995) conducted a sixteen-year study of 173 sexual offenders in outpatient treatment. The purpose of the study was twofold: to look at demographics and characteristics of non-completers of the program, and to look at comparative recidivism rates between those who completed treatment, and those considered as non-completers. Measures used were the MMPI and the Tennessee Self-Concept Scale, both of which are self-report, valid and reliable instruments. Outcome was also determined by a review of arrest records from a wide geographical surrounding area. State laws hampered arrest records data for Iowa and South Dakota, which did not allow for record release. In an effort to mitigate the insensitive measure of using re-arrest records, researchers applied a "very liberal definition of re-offense" (p. 91).

Results indicated that premature termination of treatment is problematic, with fewer subjects completing treatment when compared to non-completers. The researchers were interested in this statistic, given the tendency for many outcome studies to ignore non-completers in their method. Non-completers tended to show lower self-esteem, rigidity, lack of awareness or concern about the impact of their behaviors on others, and very conventional attitudes. Yet despite this profile, these factors account for only a small proportion of the variability and are only marginally predictive. Re-offending data showed that non-completers are at greater risk for reoffending than are treatment completers. However, the authors caution that this speaks less to treatment effectiveness, and more to characteristics of dropouts. Results also show no significant differences in sexual reoffenses between the two groups.

The studies reviewed were somewhat mixed in their results of treatment effectiveness. Five of the eight concluded CBT-RP treatment was effective (Aytes et al., 2001; Maletzky et al., 2002; McGrath et al., 1998; McGuire, 2000; Miner et al., 1995), although sexual reoffense versus non-sexual reoffense was not always as clear (e.g., McGuire). Undoubtedly one of the most rigorous studies (Marques, 1999) preliminarily shows no statistical significance between treated and untreated offenders.

Differing research goals and methods make cross-study comparisons difficult. For example Berliner's and associates' study (1995) did not support treatment effectiveness, yet was admittedly not designed to be an outcome study with a standard treatment approach. Additionally, methodological limitations are prevalent in studies with this population. For example, Quinsey, Haris, Rice, and Lalumiere (1993) point out the negligence of many studies to address treatment dropouts when considering recidivism, thus producing misleading results. Outcome measures are also difficult to ascertain in treatment studies of this nature. Recidivism is

the primary outcome measure used to assess effectiveness of treatment for sexual offenders in five of the studies reviewed (Aytes et al., 2001; Berliner et al., 1995; Maletzky & Steinhauser, 2002; McGrath et al., 1998). Recidivism is a measure with inherent problems. Marshall and Barbaree (1988) conducted a study comparing information regarding reoffenses from social service agencies with records of actual criminal conviction. They estimate that there are approximately 2.4 reoffenses for each one officially noted. Groth and Longo (1982) conducted a similar study using anonymous questionnaires with 83 rapists and 54 child abusers. Their results showed 14 undetected victims for each rapist, and 11 undetected victims for each child molester. Abel, Becker, Mittelman, et al. (1987) found similarly high rates of undetected crimes in a study that provided confidentiality without retribution by the federal government. Relying on recidivism rates as a sole outcome measure does not appear to be a reliable, and efforts to develop multi-modal assessment should continue. However, funding for high quality research of treatment effectiveness has been scarce (Furby et al., 1989). Self-funded projects, such as program evaluation by staff, may be prone to researcher bias (Steele, 1995).

Study limitations reviewed by Furby, Weinrott, and Blackshaw (1989) continue to be evident in research designs. This is undoubtedly due to the difficulty in addressing longevity, dropouts, outcome measures, and self-report confounds. They suggest that “as yet no evidence that clinical treatment reduces rates of sex offenses in general . . .” (p. 27) is available.

The mixed results from this review of the literature indicate the need for continued research. It is beyond the scope of my study to rectify the methodological concerns hindering this research process with sex offenders. However, I believe much can be learned by seeking the emic view of treatment and participant experience, which will serve to guide not only future research, but also future methods of treatment.

CHAPTER III: METHODOLOGY

This study aimed to explore the benefits of adding trauma resolution treatment to currently used treatment models for sexual offending. This study investigated how EMDR might enhance CBT-RP treatment, and how sexual offenders would experience this added treatment component. The study also considered the systemic implications of incorporating individually based intervention (EMDR) into a group focused treatment model with divergent philosophies.

Independent interviewers conducted post-treatment interviews inquiring as to participants' reactions to treatment, any perceived benefits, and any perceived negative responses. The interviewer also inquired about any changes in interpersonal relationships including family, group members, and interpersonal relationships. The research questions for this study were used as a guide as opposed to a hypothesis. The exploratory nature of the study lends itself to the use of grounded theory methodology in which theory can emerge inductively from the data, with efforts to set aside preconceptions and bias.

The use of assessment instruments was intended to provide information about individual cases, not to draw generalizable statistical conclusions. It was my intention to add to the literature of what we know about sexual offenders and their treatment. It remains my hope that the emergent data and theory will have positive implications not only for sexual offenders, their families, and their victims, but also for the mental health fields including Marriage and Family Therapy.

Participants

Ten participants were included in this study. Participants were identified and/or adjudicated sexual offenders currently undergoing CBT-RP group treatment at the referring

treatment agency. Participants were drawn from satellite locations in Southwest Virginia. The target agency receives referrals from the Department of Corrections (probation cases), courts (Juvenile Circuit & General District), Department of Social Services, and Juvenile Probation. The agency serves individuals who have perpetrated some type of sexual act or sexual assault, both contact (e.g., child molestation, rape) and non-contact (e.g., voyeurism, obscene phone calls, inappropriate exposure) offenses. The facilities primarily serve adult and adolescent offenders, often assessing and treating sexually reactive and sexually aggressive youth. The clients range from 11 to 86 years of age, with an average client base of 37.5 years old. The vast majority of clients identify themselves as Caucasian (96%) with a minority of clients identifying as African American (3%) or other (1%). While no specific socioeconomic data is readily available, clients range from professionals with substantial incomes to individuals meeting poverty criterion. Client criminal records reveal that the mean number of contact and non-contact offenses per individual receiving treatment is 100, with 33% of the clients having participated in previous services for their sexual offenses. While 15% of the clients are receiving medication for diagnosed mental health issues, less than 1% is receiving medication prescribed to directly address the problems of sexual offending and deviant sexual arousal. Clients complete a Specialized Sexual Offender Risk Assessment and must demonstrate acknowledgment of their offense(s) within the first 90 days to remain in treatment. The average length of treatment is 3.5 years with additional 3-year follow-up period after the treatment has been terminated.

Research Tools

Trauma Scale Inventory (TSI)

John Briere (1995) developed the TSI for use in the “evaluation of acute and chronic traumatic symptomatology” (p. 1). It is designed at a fifth- to seventh-grade reading level. The

TSI is a 100-item paper-and-pencil test describing trauma related symptoms. These symptoms are rated on a “four point scale of frequency over the preceding six months” (Fernandez, 1995). Overall, the TSI assesses symptoms based on 10 clinical domains: anxious arousal (jumpiness, tension), dissociation behavior (depersonalization, numbing), depression (sadness, hopelessness), sexual concerns (dissatisfaction, unwanted sexual thoughts), anger or irritability (angry cognitions and behavior), dysfunction sexual behavior (promiscuity, harmful sexual behavior), intrusive experiences (flashbacks, nightmares), impaired self-reference (identity confusion, low self-esteem), defensive avoidance (cognitive and behavioral), and tension reduction (self mutilation, manipulative behaviors) (Gebart-Eaglemont, 1995). The TSI also has three built-in validity scales to detect under- or over-endorsement, and inconsistent responses. This assessment has shown high reliability (mean $\alpha = .86$) and reasonable convergent, predictive, and incremental ($p < .012$ relative to Impact of Event Scale, Symptom Checklist, and Brief Symptom Inventory) validity. Construct validity measured in the normative sample were significantly associated with elevated TSI scores as follows: a) adult interpersonal violence $\chi^2(12) = 137.39$, $p < .001$, b) childhood interpersonal violence, $\chi^2(12) = 135.90$, $p < .001$, c) adult disaster, $\chi^2(12) = 46.35$, $p < .001$, and d) childhood disaster, $\chi^2(12) = 25.33$, $p < .014$ (Briere, 1995). It should be noted that the TSI was normed on male and female adult populations. It is now identified as a measure for ages 18 and older, being appropriate for all adult sex-by-age combinations (Psychological Assessment Resources, 2002).

Trauma Symptom Checklist for Children (TSCC)

The TSCC is a 54-item assessment inventory designed to evaluate levels of PTSD and related psychological symptoms in children, generally taking 15 to 20 minutes to complete (Briere, 1996). This inventory specifically targets traumatic events such as physical and sexual

abuse, victimization by peers (e.g., physical or sexual assault), major losses, the witnessing of violence done to others, and natural disasters experienced during childhood. The items on the TSCC are based on a four-point scale allowing children age 8 through 16 to indicate how often the specific occurrence happens to them (i.e., never, sometimes, lots of times, almost all of the time). Post-hoc tests have suggested that 17-year-olds can be given the TSCC and appropriately compared to adolescent norms, albeit with a slight (2-point) downward adjustment of the Anger Scale for Females. The TSCC generates: two validity scales of under-response and hyper-response; six clinical scales of anxiety, depression, anger, posttraumatic stress, dissociation, sexual concerns; and eight critical items. The TSCC was normed on boys (47%) and girls (53%) representing racial diversity (44% Caucasian, 27% Black, and 22% Hispanic). Several studies have supported satisfactory reliability (Elliott & Briere, 1994; Friedrich, 1991; Lanktree & Briere, 1995) with the standardization sample yielding coefficients of the two validity scales at .85 and .66 and the clinical scales at .82, .86, .89, .87, .83, and .77 respectively (Briere & Lanktree, 1995).

Construct validity was supported in a study by Diaz (1994, as cited in Briere, 1996) showing subscales measuring PTSD, anxiety, and depression to be significant discriminators of abuse history, with PTSD and depression scales being more powerful discriminators than Achenbach's and Edelbrock's (1979, as cited in Briere, 1996) Child Behavioral Checklist for Children (CBCL) and Rosenberg's (1965, as cited in Briere, 1996) Self-Esteem Scale. Further studies supported scale scores being: a) higher in samples of children with trauma histories (Elliott, McNeil, Cox, & Bauman, 1995, as cited in Briere, 1996), b) increased in the presence of more severe trauma (Smith, Swenson, Hanson, & Saunders, 1994, as cited in Briere, 1996), and c) decreased in response to therapeutic interventions aimed at resolving trauma-related distress

(Cohen & Mannarino, 1992, as cited in Briere, 1996).

Sex Offender Treatment Rating Scale (SOTRS)

“The SOTRS (Anderson, Gibeau, & D’Amora, 1995) is designed to assess both process and outcome measures for cognitive/behavioral sex offender treatment. The scale consists of six clinical rating dimensions, defined by behavior. These include “insight (understanding of offense), deviant thoughts (offense related impulses), awareness of situational risks (challenges the capacity for self-control), motivation (as for personal change through treatment), victim empathy (emotional impact of sexual offenses), and offense disclosure” (p. 223-224). These ratings are combined for one progress score.

Subjective Units of Distress Scale (SUDS)

Shapiro (1995) adopted the use of the SUDS scale from Joseph Wolpe, M.D. (1982), which he developed for use in behavioral therapy. This is an 11-point, self-report scale using 10 as the highest level of distress and 0 as the lowest. Throughout treatment, clients are asked to assess their level of distress at the target memory. The goal is to have the client report reduced SUDS to low levels (e.g., 0 - 2) before beginning the next phase of treatment. Reduced reactivity to traumatic memory is considered an indication of recovery (Horowitz, 1986).

Penile Plethysmography or Phallometry

Plethysmography is the use of an instrument for “determining and registering variations in the size of an organ or limb” (Gove et al., 1971, p. 1740). This is achieved for sexual offenders by technology that measures erectile responses in males (Rosen & Keefe, 1978), by attaching an electronic sensor called a penile transducer (Bancroft, Jones, & Pullan, 1966; Barlow, Becker, Leitenberg, & Agras, 1970; Laws, 1977). The instrument detects changes in tumescence in

response to erotic stimuli, usually in the form of slides or audiotapes. Many researchers consider erectile response a useful measure for purposes of assessment and treatment (Abel, Becker, Murphy, & Flanagan, 1981; Avery-Clark & Laws, 1984; Card & Dibble, 1994; Laws , 1989; Marshall & Christie, 1981). Penile tumescence is said to be the most reliable of the physiological measures (Rosen & Keefe) and the only physiological response specific to sexual arousal in men. Evaluative research has shown that properly administered penile plethysmography possesses psychometric properties equal to or exceeding those shown for traditional measurement techniques (Murphy & Barbaree, 1988). Test-retest reliability coefficient for baseline measurement of penile circumference is reported to be 0.94 (Farkas et al., 1979). Deviant sexual arousal has been show to be one of the best predictors of recidivism (Hanson & Bussiere, 1998).

Polygraph

Sexual offenders in treatment at the referring agency are administered bi-annual polygraph examinations by a state-certified administrator. These maintenance examinations are used to monitor treatment and probation guideline adherence as well as to detect recidivism. Maintenance questions inquire as to any sexual contact or attempted sexual contact with minors since the participant's last examination. For the purposes of this study, polygraph examination results will only be concerned with recidivism.

Post-Treatment Interview Guide

The following questions were used to guide a semi-structured interview with the participant by an independent interviewer. The interview questions are designed to flow from the purpose of the study questions. Primary questions may be accompanied by extemporaneous probing questions. The primary questions are as follows:

- 1) What was your first reaction to hearing about EMDR?
- 2) What influenced you to decide to try EMDR?
- 3) Describe your first experience when the clinician used EMDR with you?
- 4) What benefits, if any, did you get from the use of EMDR?
- 5) What drawbacks, if any, would you describe from the use of EMDR?
- 6) Has EMDR treatment affected your feelings or thoughts about other people?
- 7) Since engaging in EMDR treatment what general changes, if any, might you describe about yourself when considering feelings or behaviors you might link with your own history of trauma?
- 8) If you consider impulse control a problem for you, how, if at all, has EMDR affected your ability to manage your impulses?
- 9) Remember, you only need to discuss or to be as specific as you feel comfortable with. Many offenders struggle with sexual arousal considered deviant by self or by others. Have you noticed any changes in your own arousal thoughts or patterns since engaging in this EMDR treatment?
- 10) Since engaging in EMDR treatment, have you noticed any differences in the way you feel, respond to, or engage:
 - a. with others in your treatment program?
 - b. with the work you are asked to do in your treatment program?
 - c. with your family?

Procedure

This research project received full approval from the Institutional Review Board of Virginia Polytechnic Institute and State University before data collection began. The procedure was coordinated with the clinical director and the service director of the referring agency. Both

are State Certified Sex Offender Treatment Providers and were responsible for my supervision during this project. Information concerning treatment was openly shared with agency staff and the larger treatment team with full knowledge and consent of participants.

Participants considered for inclusion in this study were referred from a team of licensed mental health professionals specializing in the treatment of sex offenders. All referred clients were drawn from a pool of sex offenders being treated in a CBT-RP outpatient treatment program. The treatment team selected clients they assessed had dynamics consistent with the purpose of this treatment model. The referred clients therefore had the ability to contribute to the purpose of the study (Creswell, 1998). Potential participants were screened by this writer in an individual or family session. The topic of the initial session was that of the exclusion criteria, rationale for the experimental treatment, and a question-and-answer period. Exclusion criteria included active psychosis, current suicidal or homicidal ideation, epilepsy, medical instability, or inability to recall or identify a memory of childhood abuse. There was no incentive offered for participation and no penalty for declining to participate. The concepts, procedures, and possible risks of EMDR treatment were described to potential participants. All clients who were approached chose to participate in the study. Participants were presented with informed consent information and offered an opportunity to ask any additional questions. Informed assent was obtained from the participants who were under 18 years of age. This was supported by an informed consent form signed by his legal guardian.

Participants were advised that trauma work has the potential risk of bringing unpleasant memories or thoughts to the forefront and may cause emotional discomfort for some clients. It was explained that while EMDR is believed to minimize the duration of this discomfort, this potential risk does exist and can be increased if a participant chooses to stop treatment before

completion. Participants were advised that in the event emotional discomfort occurs, they had access to supportive counseling by their primary clinician. No participant requested this additional service.

Multiple sources of data were used in an effort to give the case studies a holistic characteristic (Bogdan & Biklen, 1998). Prior to beginning treatment, all participants completed either the Trauma Symptom Inventory (TSI) or the Trauma Symptom Checklist for Children (TSCC) depending on his age. Participants completed these same assessment instruments at the end of treatment. Results of phallometric and polygraph assessments were recorded both pre- and post-treatment when available. A senior treating clinician completed the SOTRS for all participants before the onset and upon the completion of treatment. SUDS and VOCS were obtained intermittently as a part of the EMDR treatment protocol. I recorded research notes and memorandums in a journal that became part of the data. The EMDR trauma treatment was added as an adjunct to participants' ongoing group treatment. Participants underwent treatment-as-usual, plus trauma-focused EMDR sessions. I conducted all EMDR sessions. Treatment sessions were audio taped and transcribed verbatim for content analysis. Treatment was considered complete when SUDs reach levels of 0 - 3 (on the 0 - 10 scale) and positive cognition scales reach levels of 5 - 7 (on the 1 - 7 VOC scale). These treatment assessment measures are those specified by Shapiro (1995).

To enhance treatment fidelity, EMDR sessions adhered to basic level-two EMDR protocol as outlined by Shapiro (1995). I have been trained under the aegis of The EMDR Institute. The EMDR protocol "refers both to basic, standard procedure and to an expanded repertoire to intervention options guided by a set of decision-making principles" (Greenwald, 1996, p. 69).

Two independent researchers conducted post-treatment, semi-structured interviews with participants until both the interviewer and the interviewee believed the data had reached saturation. Interviews ranged from approximately one to two hours. The interviewers were instructed to use the interview questions as a guide, and to probe for further information where indicated to strive for clarity (Gilligan, 1982). The interviewers were instructed to avoid the use of leading questions. The goal was to allow the interviewee the opportunity to fully express his thoughts, feelings, ideas about, and experience of the treatment and research process.

Research Methods

Grounded Theory Inquiry Method

Grounded theory is a methodology that is primarily attributed to Strauss and Glaser in their seminal work entitled *The Discovery of Grounded Theory* (1967). Glaser and Strauss position grounded theory as that which would “[close] the embarrassing gap between theory and empirical research” (p. vii). Grounded theory methodology suggests a systematic gathering and analyzing of data by the processes of constant comparison, coding, and thematic or axial coding. The latter is primarily used when the researcher intends to develop theory. It includes methods of conceptualizing how the substantive codes interrelate, thereby suggesting a hypothesis or proposition which emerges from the data (Creswell, 1998; Strauss & Corbin, 1994). Constant comparison is the process of comparing information from data collection to emerging categories. These categories emerge through the process of open coding, and are further reassembled via thematic or axial coding as previously described (Creswell, 1998).

Given the strong procedural component to this methodology, which is as applicable to quantitative data as it is qualitative, it often (but not always) lends itself to a post-positivist or even (loosely) positivist inquiry paradigm. Along these positivist/post-positivist lines, extant

theory may be considered for elaboration or modification, although more commonly new theory is generated inductively from the data (Strauss & Corbin in Denzin & Lincoln, 1994, p. 273). In either case, theory evolves from the research through interaction between data collection and data analysis. Grounded theorists seem to rely on the ontological assumption that knowledge and reality are apprehendable, albeit imperfectly. They strive to provide for the development and verification of hypotheses and propositions. Structured or semi-structured interviews of participants, and participant observation, tend to keep researchers behind the metaphorical one-way mirror (Creswell, 1998; Morse, 1994).

Case Study Method

Case studies have a long history of use in the social science research. While they originated in the fields of political science, sociology (Creswell, 1998) and anthropology (Hamel, 1993), their single-subject and collective subject formats have made them a popular method of data collection and presentation for psychology, social work, law, medicine, and marriage and family therapy.

The focus of all three types of case studies (i.e., intrinsic, instrumental; and collective) is to develop and present an in-depth analysis of a case or cases. A case is considered that which is a system bounded by time and place (Creswell, 1998). Intrinsic case studies are generally used when the researcher feels there is some uniqueness to a case that deserves to be studied, and presents an in-depth look at a single subject. Collective case studies are typically used when the researcher is attempting to establish some generalizability (Glesne & Peshkin, 1992) by looking at common features and/or outcomes of a series of cases. The instrumental case study makes use of a case or cases to illustrate an issue or phenomenon. Instrumental case studies may also be employed to refine theory (Stake, 1995). The case is of secondary importance to the issue being

studied and serves merely as a means of insight. Instrumental case studies can be of single or collective samples and can be drawn from single or multiple sites (Yin, 1989). Purposeful sampling is recommended and data is typically drawn from several sources in an attempt to triangulate data for the purpose of clarifying meaning and providing different ways in which the phenomenon is being seen (Flick, 1992). Sources of information may include but are not limited to observations, interviews, audio-visual material, documents, and reports (Creswell, 1998).

Data Analysis

This research design incorporated an instrumental and collective case study method, a cross-case grounded theory analysis. Assessment data included self-report, observational clinical report, session transcripts and interview data, research journals, and physiological measures. Both methods triangulation and a triangulation of sources (Patton, 2002) were employed to inspect the consistency of data and findings. Upon completion of treatment participants were interviewed regarding their experiences with EMDR. Independent researchers who did not provide EMDR treatment conducted these interviews. I chose interviewers who had no formal training in EMDR in an effort to minimize interviewer biases. I instructed the interviewers to use the interview questions as a guide toward asking participants open-ended questions related to EMDR exposure, treatment, benefits, and drawbacks. I designed the questions bearing in mind that the emergent themes should be those that are meaningful for the participants. “The basic tenet of this method is that analysis is inductive rather than deductive, and that theory must emerge from the data” (Strauss & Corbin, 1990, p. 23).

Qualitative data was analyzed for emergent substantive themes developed via open and axial coding in accordance with Glaser’s and Strauss’ grounded theory methodology (1967). Content data from taped sessions, interviews, and a research journal were coded and thematically

analyzed using the constant comparative method (Glaser & Strauss, 1967). Data were analyzed as it was collected, then again as it was compared against newly collected data. Multi-modal data points, also known as triangulation of sources, provided for a process of recursive data analysis ensuring the analysis is well grounded in the data (Denzin & Lincoln 1994). This process helps ensure the credibility of emerging patterns, categories, and themes. Discoveries and insights were used to inform subsequent treatment and interviews. A line – by - line, paragraph – by - paragraph, and document – by - document comparison was done in an effort to identify and name concepts that described or explained phenomena (Strauss & Corbin, 1994). Data were reviewed for evidence of emergent patterns cutting across the greater part of the data (Taylor & Bogdan, 1984). Concepts were compared to each other and those pertaining to the same phenomena were grouped in categories using encompassing themes. Themes were examined for properties, context, interaction, and consequences of interactions of the phenomena within each theme (Glaser & Strauss, 1967). Member checks were conducted with several participants to verify their input and experiences as represented by the resulting themes and conceptualizations.

Results of assessment instruments (i.e., SOTRS, TSI, TSCC), physiological measures (i.e., penile plethysmograph, polygraph), and self-report scales (i.e., SUDS, VOC) were used for description as opposed to interpretation. Given the small number of participants, data was not statistically analyzed but rather served as pre- post- informational indicators for individual case reports presented as results. The scores on these measures were merely reported as part of each case to thicken case description. The TSI, TSCC, and SOTRS were scored, evaluated, and verified by me and also by an independent rater. A competent and/or certified technician conducted the polygraph and phallometric assessments.

Confidentiality/Anonymity

Results from this research do not contain participants' real names. The referring treatment agency's name has been omitted to protect participants' identities. Participants' clinical records have been maintained within the standards of confidentiality outlined by the American Association of Marriage and Family Therapists Code of Ethics (AAMFT, 2001). Participants agreed to have sessions videotaped by way of a signed consent form. Participants were fully aware when audio-taping and/or videotaping occurred. Participants' personal information was not divulged to others outside of the research project without participants' written consent, except when specifically required by law. There are times when clinicians may be legally or ethically required to divulge information against the participant's wishes. Clinicians are required by professional ethics and law to report evidence or suspicion of child or adult abuse or neglect, with or without client consent, including evidence or suspicions formed in the course of treatment. Clinicians are required to report any threat of physical harm made by the participant, the participant's companions, or the participant's family. Finally, the clinician is legally obligated to break confidentiality when ordered to testify by a court of law. I adhered to these ethical and legal principles over the course of this research project.

CHAPTER IV: CASE SUMMARIES

This chapter provides a brief background on each participant as well as an overall summary of his treatment. Samuel was the initial participant who engaged in the EMDR treatment as an adjunct to his treatment-as-usual CBT-RP program. Treatment protocol was adjusted in response to Samuel's case in accordance with the recursive treatment development procedure outlined by Bischoff, McKeel, and Sprenkle (1996). In view of this, Samuel's treatment process (Ricci, *in press*) is outlined in depth. This is followed by a series of several issues that were noted and addressed in subsequent applications of the treatment protocol. Similarly, subsequent treatment plans beyond that were adjusted in response to preceding treatment experiences.

Samuel

Samuel is a Caucasian male in his early 40s who identifies himself as heterosexual. He is of average height and weight and appears his stated age. He reports no history of mental illness and is oriented in all spheres. There are no abnormalities noted in gait, posture or facial expression. Samuel appears to be of average intelligence and his memory recall is within normal range. He reports no past or current use of psychotropic medication. Samuel has been involved in CBT-RP group sex offender treatment for approximately seven years, beginning during his incarceration for the incestuous sexual offending of his pre-adolescent daughter. When I met Samuel he had been involved in his current group treatment for approximately 18 months. His treatment team was concerned that Samuel was not progressing in his treatment, despite what appeared to be commitment to and motivation for the process. Despite repeated attempts, Samuel was unable to complete his victim impact statement: a necessary component of his treatment program. Thus was the reason for the referral to EMDR. Samuel reported that each time he

approached the material he was overcome with memories and flashbacks of his own abuse and was unable to stay focused on his work.

Samuel is the youngest of eight children. Samuel grew up on a midwestern farm operated by his mother and father. Samuel's father died when he was eight years old, leaving his mother struggling to raise her six children on a limited income. Samuel's oldest brother assumed the father's role in the family, and it was with this brother that Samuel was closest until the brother left for the armed services when Samuel was approximately ten years old. His leaving was a significant loss for Samuel, as was the death of his father. At the first interview, Samuel reported that sexual molestation by his older brother, the second oldest brother, had begun shortly before his father's death, when Samuel was approximately age seven. However, as treatment progressed Samuel began recalling memories of much earlier abuse. Samuel recalled that he and his three older brothers shared a bed, and he was often fondled and encouraged to fondle his older brother while two other brothers slept nearby. After the death of their father, the abuse became more overt. Samuel recalls that this abuse continued for several years with increasing frequency until Samuel turned 13. At that time, his older brother brutally penetrated Samuel causing tremendous physical pain and confusion. Samuel became angry and sullen, and told his brother that was the last time he was willing to comply. After that, Samuel recalls that his older brother became aggressive and verbally abusive to him. Samuel remembers clearly that it was the day of the rape that he made up his mind to "become bigger than all of them so they can't hurt me anymore." Samuel began to binge eat until in his mid teens he reached a weight in excess of three hundred-fifty pounds, with a waist size of 56 inches. It was also during this time that Samuel became involved in illegal drugs, and recalls being "high" during most of his adolescence.

Samuel married his first girlfriend shortly after high school graduation. He describes their

relationship as “loveless, and primarily sex-based.” Samuel became a frequent user of pornography. Samuel describes this period as “out of control” with addictions to drugs and sex. This ended when he was arrested for molesting his biological daughter and was sent to prison for five years. The age of Samuel’s daughter at the onset of sexual abuse was seven: the same age he initially recalled the first abuse by his perpetrating brother. Samuel reports that the “grooming” process he used with his daughter was similar to that used on him by his older brother. His offense bore markings of isomorphic reenactment as described by Finkelhor and Browne (1985), Finkelhor (1986, 1988) and Haapasalo, et al. (1999).

Figure 1 depicts Samuel’s TSI scores. His pre-treatment scores represent clinical elevations in the sub-scales of Intrusive Experience (IE) and Defensive Avoidant (DA). Elevated IE scores indicate intrusive posttraumatic reactions and symptoms including nightmares, flashbacks, unpleasant memories easily triggered by current events and repetitive thoughts of unpleasant experiences. High IE scores typically reflect distress states. High IE scores are “often, if not implicitly, linked to a previous experience of psychological trauma” (Briere, 1995, p.13). Elevated DA scale endorsers frequently attempt to eliminate painful thoughts or memories by stopping thoughts or pushing unpleasant thoughts out of their minds. They also often attempt to avoid events or stimuli that might trigger such thoughts. Respondents with this profile do not necessarily dissociate as much as make a conscious effort to control cognitive and behavioral responses as a means of managing post-traumatic stress. Clinical elevations on these subscales reflect a classic posttraumatic presentation, showing both the intrusive and avoidant components of PTSD. Samuel’s TSI profile also showed mid-range elevations on subscales of dissociation and impaired self-reference. Individuals showing these scores in the clinical range often have an uncertain sense of identity, and may have a difficult time understanding or expressing their

feelings. "This results in a limited ability to predict his reactions to certain circumstances" (p.15).

Samuel's TSI showed elevated Response Level (RL) measures, which bring into question the validity of the results. The RL subscale is a measure of the ten items that are least likely to receive zero ratings in the normative scale, indicating denial of thoughts, behaviors, and feelings that most respondents would report. "Those with very high scores on this scale are likely to be especially defensive or avoidant, oppositional regarding test-taking, or otherwise unwilling to endorse commonly endorsed items" (p.12). This profile supports both Samuel's and his therapist's description of his blocking and avoiding behaviors in his treatment program.

Sessions 1, 2 and 3

Tolerating Emotions

I began treatment with a relaxation/resource installation designed to develop internalized resources the client can access in times of stress (Shapiro, 1995). We then targeted an abuse experience. We established the SUDS to be between 8 and 9 (on a 0-10 scale, with 10 being the most disturbing), the negative cognition to be focused around shame, and the positive cognition VOC scale to be between 1 and 2 (on a 1 - 7 scale with 7 being completely believable). As we began the eye movements, Samuel identified a "sad" feeling, but quickly "blocked it out." This happened repeatedly. Samuel described the feeling being like a hand that started at his head, and passed over his entire body washing away the feelings. The result was having "absolutely no feelings." Despite periodic episodes of tearfulness, Samuel was unable to maintain a feeling state for any length of time. Intermittently, however, he identified feelings of "sad," "mad," "disgusted," and "confused." He also "heard" the words "it isn't fair." Towards the end of the session (35th eye movement set), he stated, "My mind is just wanting to destroy [my brother]." I spent this session doing very little verbal processing with Samuel, relying instead on forty-two

eye movement sets averaging forty to fifty passes each. (A pass is defined as one complete back and forth movement of the arm/fingers, which the client follows with his eyes). Revisiting the resource and restoring a sense of “okay” in Samuel ended the session. He described the experience as “opening so many doors. I open one and there’s a scene, then another, then another...”

For session three I switched to a bilateral hand-tapping technique as opposed to eye movements. My hope was that by allowing Samuel to close his eyes, and by being able to perform extended sets (tapping is easier on the arms than finger movements), that he would be able to maintain a feeling state longer. He reported a week of dreams of doors opening - with scenes behind each door. He also recalled earlier abuse, beginning around age five or six. The goals of phase I of treatment had been achieved: Samuel had formed a working therapeutic relationship with me and was able to maintain feeling states for extended periods of time.

Sessions 4 and 5

The “Knot” Between Self and Brother

Samuel acknowledged the “knot” in his thinking wherein he was equating himself with his brother. This presented significant hurdles for Samuel, in that he was unable to accept full responsibility (accountability) for his actions, given his belief that he had been “imprinted” by his brother’s sexual abuse. His own feelings about his abuse and thoughts about his brother were clouding his ability to clarify his thoughts and feelings about his offense, as well as his victim’s right to have her thoughts/feelings about him and what he had done to her. During the initial tapping set in session four Samuel developed an image of himself as an adult, standing next to his brother as an adult, and facing his victim at age 7, while his brother faced-off with Samuel as a small child of age 7. This image seemed to represent the tangle of feelings and thoughts

Samuel carried about his abuse and his offense. I encouraged him to allow the four people (two of which were himself) to have conversations with each other as we did tapping sets. Though he heard apologies “all around,” he (as a child) was unwilling to believe that his brother’s apology was sincere. This resulted in feelings of “fear” and “anger,” and also revealed the first evidence that there were some parts of the relationship with his brother that he enjoyed. This admission was a source of shame, and would become the focus of the next phase of treatment. Samuel’s images then flashed to a series of times during which he was being repeatedly molested (“it became more severe and more often after my father passed”), to a final image wherein Samuel was “doing the same thing to my daughter.”

Samuel seemed to hit a blockade in treatment at this point. He took this idea of parallelism to his process group, and perceived he was being criticized for having these “cognitive distortions.” This was the first treatment hurdle created by the philosophical differences between EMDR and CBT-RP protocol. EMDR conceptualizes that cognitive balance will be restored naturally as the brain/mind processes its way through cognitive distortions and negative cognitions. Oftentimes, this processing take circuitous and arcane route as the mind unravels beliefs that have been accumulated without the benefit of the “rational” or left orbitofrontal hemisphere of the brain. However, Samuel perceived a proscription from his group to entertain these ideas long enough to allow processing to occur. Consequently, each time these beliefs would arise, he actively attempted to suppress or alter them as he was taught in his CBT-RP work. I addressed this difficulty with his primary clinician, explaining the conceptual model of cognitive reprocessing outlined by EMDR protocol. We agreed that with careful monitoring we would give Samuel “permission” to entertain whatever thoughts and feelings arose.

Samuel’s thinking seemed to flow more freely after our conversation. He explored the

ideas of needing the attention from his brother, and of the confusion about why no one noticed what was happening to him (“people who care notice things about kids. My wife noticed stuff about my daughter...if you’re in touch with your kids...”). He also recalled earlier incidents of abuse, possibly starting at age three. He stated, “I feel like my mind has been opened up. My mind can sweep across it without skipping that part.”

Sessions 6 and 7

Isolation, Neglect, Loss

Treatment moved ahead rapidly at this point. For the first time, Samuel was able to visualize the memories from the perspective of himself as a child. In addition, he was able to tolerate the idea that there were parts of the relationship that he liked, and although at this point he felt a lot of “shame” and “disgust” about this, he was able to admit and explore it. He began to acknowledge the sexualization he felt at his experience. This freedom Samuel now felt to allow his thoughts to move without judgment allowed him to venture more deeply into his tangled feelings. He acknowledged some physical and emotional pleasure from the abuse (“...he asks does it feel good. I said ‘yes’. I told him I didn’t want to do it anymore, but it does feel good”). He was able to stay in touch with the mixture of feelings he was experiencing (“confused, excited, mad, and the hurt - the hurt is always there”). Samuel was able to tolerate revisiting the image of a painful rape he experienced from his brother. The episode of penetration was significant in that it marked the end of approximately ten to eleven years of ongoing sexual abuse. During tapping sets Samuel recalled through many of his senses the painful experience (“I heard him say ‘roll over’. I could hear the sheets rustle. I felt the pain - then coldness all over. The pain was unbelievable, and I can feel it right here, in this room, more than I want to feel it”). This episode was significant in two ways. First, it was this day that Samuel stood up to his

brother and told him he would never go with him again. While he was able to garner some sense of power and control from this, he also came to recognize that it established a deep sense of guilt and shame, believing that perhaps he had had the power to stop the abuse all along (“I’m bad. Why didn’t I tell him no before I did?”). Second, by being able to tolerate the memory he identified feelings of isolation (I can’t trust anyone. I don’t have anyone who loves me”) and neglect (“...there were so many warning signs. Nobody paid attention. I had bowel problems, blood. [The doctor] said I had hemorrhoids. My teacher said ‘you’re awfully young for that’. That was all like a running tape, I just saw it all”), and loss (“I [felt that way] the day they told me my father died. Now I remember the first time [my brother] touched me”; “...it seemed I lost everything the day of the rape”; “I have this feeling he’s hurting me so he doesn’t love me anymore”).

The permission Samuel felt to freely have his thoughts, without judgment, was crucial to allowing memories and feelings to flow freely. He was unraveling cognitive distortions and resulting negative cognitions he had carried for over thirty-five years.

Sessions 8 and 9

No One Would Have Believed Me

Samuel reported that during the week he had many memories of his abuse, but “it didn’t really upset or aggravate me or make me mad. It was just a review.” He described them “...like frames, like a slideshow. And the memories weren’t all just of me being abused. There was also some good stuff. And usually, before, my memories would go right to the abuse.”

Samuel described a recurring image. He saw himself as a very small child sitting on a tricycle in his boyhood farmyard. The image made him feel “aggravation.” As we used EMDR to process this he was overcome with a sense of loneliness. He recalled he was home from school

with a severe headache from being punched by a schoolyard bully. He recalled that his mother did not believe that his head really hurt, or that he had been hit. Despite the pain, he didn't cry because "I wasn't much allowed to cry. My brothers would say 'boys don't cry, I'll give you something to cry on'." He then saw the perpetrating brother "walking around the side of the house, grinning at me. I knew something sexual was gonna happen." Samuel did not believe the memory was accurate, yet the thoughts hung together in his mind. "Then right behind that, there's this fear. This dread, I am getting a picture of the day he raped me." As this session ended, Samuel came to the idea that "no one believed me." He was referring to the incident of the headache, but it was also the beginning of his being able to make sense of why he never told anyone about the sexual abuse.

Throughout this and the next session, Samuel began to understand his loneliness, and his need for the attention he received from the perpetrating brother. Between the sessions he was overcome with strong senses of loneliness that "engulfed my whole being. I was starving for attention."

Sessions 10, 11, 12

I am not him. He is not me. Sex is not Love.

Samuel began to explore the anger he feels towards his brother. My sense was that this was possibly the last part of the glue that was holding the thinking knot together. His thoughts at this point remained tangled ("...how can I hate him, be angry at him, when I'm no better"). In talking about his feelings of anger, they were consistently focused on the memory of being penetrated. Samuel was willing, and believed he was able, to target this memory again with the goal of getting in touch with the feelings of anger he believed he had. He did express some reservation about this, however. "Yeah, if I be open and find my anger - I do want to, I have so

much. But I know what my anger has done. Can do.” He recalled an incident where he became angry and tore the door off of a pick-up truck. “That scares me. To think about that. I’ve tried to do that since. It can’t be done.” Yet I felt that, despite his concerns, we would be able to manage whatever anger may surface during the tapping process. Samuel was able to revisit the rape scene. He approached feelings of anger, but they quickly turned to extreme sadness. Furthermore, he was seeing himself as an adult instead of a child, which “makes me feel safer.”

His memory would not allow the rape to happen. “My mind just shrieks. It’s unreal, right there I can just see everything like an explosion. It blows my fuses and everything disconnects right there. It just goes to black.” This remained the outcome despite several attempts at processing the memory. A new thought began to surface, however, which was that “he is just using me for his pleasure. He doesn’t care about me at all” While this was important progress, it still felt as if the anger was being blocked. He explained to me that his anger scared him. That he was unable to access it. “That scares me. I’ve been in prison. I have to shove the hate down cause once I let it out....” Despite my assurance that thoughts are not actions, Samuel was clearly blocked from his anger.

Over the next week, I discussed this situation with Samuel’s primary clinician. She joined us briefly in session and assured him that he could (and should) make use of the group for support when feelings such as this became too difficult for him to manage. Samuel’s face relaxed, and he seemed to have a renewed sense of determination to proceed with our work.

Samuel was finally able to face his anger. We began to process the rape incident. He was able to experience fully the confusion, the pain, the hurt and the anger. As is common with EMDR, Samuel continued to process during the two weeks between this and our next session. When he returned, he stated that he had been able to face the anger several times over the two

weeks, and that it had lost much of its power. He postulated that perhaps the real reason he had not wanted to face the anger was not so much fear of acting on it, as the idea that he wanted to maintain it (“...maybe I didn’t want to go there because I don’t want [the anger] to go away. I don’t want to forgive him”). Samuel seemed able to separate the anger he feels towards his brother from the anger he feels towards himself, and that which his victim must feel towards him. The knot was unraveling.

We spent the balance of the session processing these ideas using bilateral tapping. Samuel’s mind flowed to ideas of being a survivor rather than a victim. He also came to recognize and feel the love he had from his mother and his oldest brother, and was able to distinguish that from the attention he received from his perpetrating brother (“It’s a trick. He don’t want me on the tractor, he just wants me for sexual reasons.”), and to clarify love in his mind (“...there were people who loved me. You can’t feel or touch love. You just got to believe it”). These ideas were checked using the VOC scales, and Samuel stated he was able to believe these things fully, differently than he had before. (“It feels different. I know my thoughts are right. I felt the sadness come up in my throat, then it went right down. I wasn’t shoving nothing away - it just went down on its own”).

At the end of treatment Samuel’s scores on the TSI were all in the sub-clinical range as shown in Figure 1.

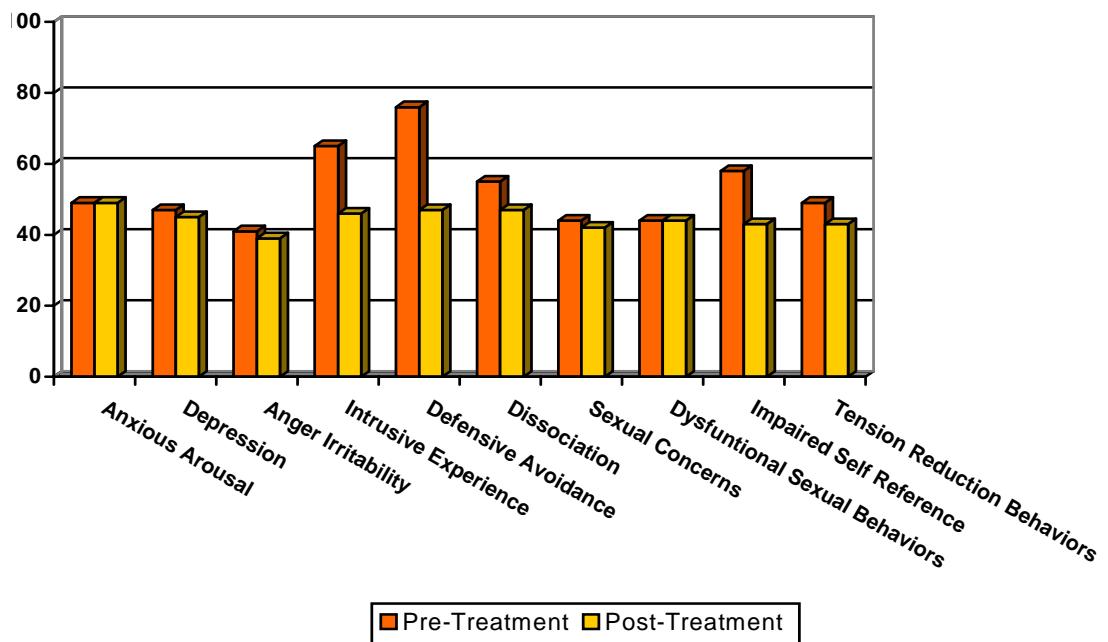


Figure 1. Samuel - Trauma Scale Inventory (Briere,1995)

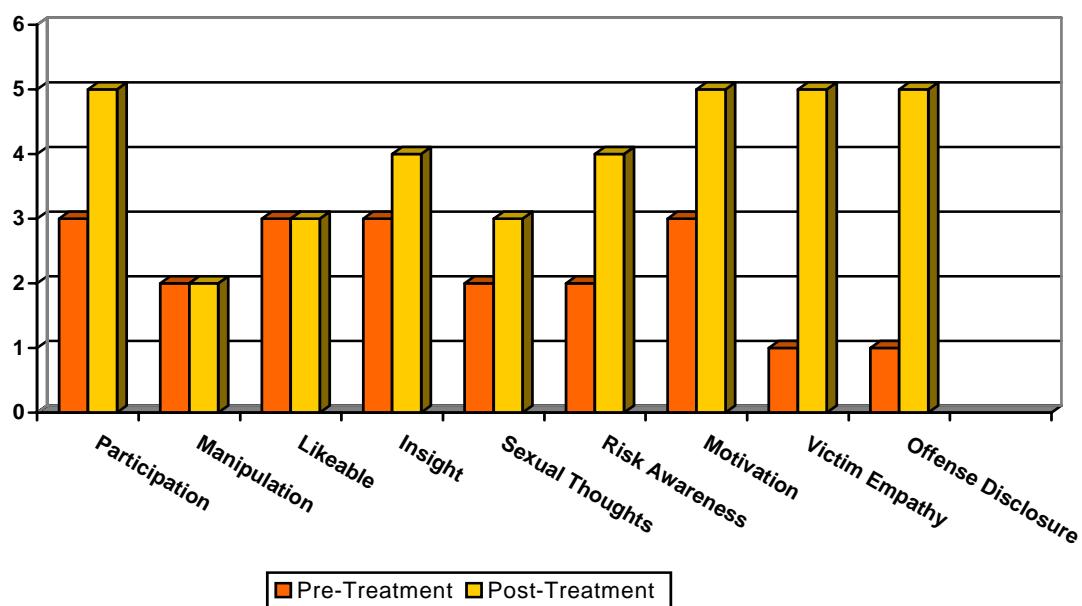


Figure 2. Samuel – Sex Offender Treatment Rating Scale (Anderson, Gibeau, & D'Amora,1995)

Samuel's primary clinician assessed improvement on seven of the nine ratings on the SOTRS (i.e., participation, insight, sexual thoughts, risk awareness, motivation, victim empathy, and offense disclosure). The most significant changes were noted in the latter two (see Figure 2).

The exit interview, conducted by an independent researcher, depicts a favorable response to EMDR trauma treatment. Samuel acknowledged his initial reservations, with periodic thoughts of abandoning the treatment.

"...there was [a time] in there that I didn't want to show up cause I knew where I was going and what I had to do...until I started getting those good feelings...after I struggled then I knew that, hey this is working."

However, he stated that the intensity of the treatment was cleansing.

"I can't remember which session it was but it was several into it that I was in here almost an hour and a half and I think I did cry the whole [time]. I stayed focused, I never lost the images, the thoughts, the feelings and all was just right there. And I know that next week I felt like I had been washed or something. I just felt better."

Samuel also acknowledged the change he experienced in terms of his previous defensive/avoidant stance:

"I couldn't be talking to you right now. There's no way I could talk to you, just these few things I've said..now that I can talk about my thoughts. It's amazed me..."

In talking specifically about the benefits Samuel said:

"There's so many things. Ah, just everyday life. ...I get up and go to work and my past doesn't haunt me [like] before...now it's more like a passing thought...it helped me with my thought process because now I've got it kind of put in its place and I can get on with the rest of my life."

And in talking specifically about his offending he states:

"I wanted to blame everybody about it and even take me being abused and blame what I had done, my mistakes, on all of that."

Samuel's post-treatment plethysmograph readings showed significant improvement.

Figure 3 illustrates that deviant arousal was clinically reduced overall, with the largest changes noted in arousal response to very young male children and grammar aged female children. The former category coincides with Samuel's age at the onset of his own abuse, while the latter is representative of his victim of conviction. Deviant arousal to children has been concluded to be the best predictor of re-offense risk (Hanson & Bussiere, 1998).

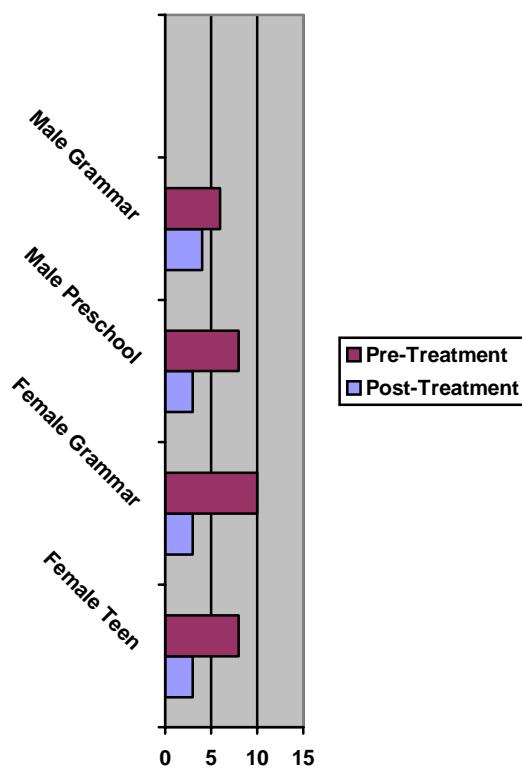


Figure 3. Samuel – Penile plethysmograph assessment results of deviant arousal responses.

In most ways, I applied EMDR in this case much the same way it would be used with any childhood sexual trauma victim. However, there were several differences that demanded close attention as treatment development proceeded. First, the client has acted out sexually against someone else. This must be considered at every step of treatment. Dissimilar to work with trauma victims who internalize their trauma (e.g., depression, anxiety, self-abuse), or externalize their trauma in other ways (e.g., violence, rage), the primary goal with a sexual offender needs to remain focused on community safety.

The second issue is the close coordination required between the EMDR provider and the primary clinician and treatment team to manage the philosophical differences between the two treatment modalities. In Samuel's case the primary clinician was willing to allow some flexibility (temporarily at least) in allowing Samuel to entertain and process some of his cognitive distortions. Evident in the transcripts is that without this cooperation (and permission to Samuel), the "thinking knots" may not have unraveled, and he may not have moved forward. This is no small hurdle to overcome. Undoubtedly, there are many CBT- RP treatment providers who would be unwilling to take this risk with their clients.

Another important feature in this case was that Samuel's offending behaviors were isomorphic to his own victimization. His victim was his relative, as he was to his brother. His victim was age seven, the same age he initially believed he was at the onset of his sexual abuse. He identified similar patterns of grooming and offending between those used on him and those he used. While these patterns may have contributed heavily to the thinking "knot" Samuel was experiencing (e.g., "I can't hate him. I'm just like him"), it also may account for (some of) the dynamics which made this a successful intervention with Samuel. This isomorphic dynamic would need to be monitored in future applications of this treatment.

Finally, it became evident that without Samuel's high level of motivation to progress in his CBT-RP treatment, he undoubtedly would have chosen to withdraw from this difficult work. In his exit interview he stated this several times, and named the combination of ease he felt with the treating clinician and support he perceived by his treatment team as the main factors which encouraged him to continue.

Alex

Alex is a Caucasian male in his early forties who identifies himself as heterosexual. He is of above average height and slender build, appearing somewhat younger than his stated age. He appears to be of average intelligence and is oriented in all spheres. His memory recall appears to be within normal limits. There are no abnormalities of posture, gait or facial expression noted. He reports a significant history of drug and alcohol abuse, a criminal history including Drunk In Public and Armed Robbery in addition to his charges for Aggravated Sexual Battery. Alex was imprisoned for five years for this latter crime. He reports no history of mental illness and no past or current use of psychotropic medication. He reports a medical diagnosis of Hepatitis C, which he attributes to his history of drug use and sexual promiscuity.

Alex had attended group CBT-RP treatment for approximately one year. Alex's victim of conviction is his niece who was six years old at the time he offended her. He disclosed seven female victims ranging in ages from six to 19 years old with the total number of offenses in excess of 100. Four of his victims are his relatives. His offenses include both child molestation and rape. Similar to Samuel, Alex was struggling with the task of presenting his victim impact statement, which entails demonstration of empathy for one's victim(s). As a result, the treatment team felt Alex was not progressing in treatment at a rate congruent with his apparent level of motivation.

Alex's initial TSI assessment showed clinical elevations on the measure of Intrusive Experiences as illustrated in Figure 4. This scale indicates posttraumatic reactions and symptoms including nightmares, flashbacks and upsetting memories easily triggered by current events. These symptoms are perceived by respondents as ego-dystonic and reflect a profile consistent with a *DSM-IV* diagnosis of PTSD and/or Acute Stress Disorder (ASD). Alex also showed elevated scores on the measure of dissociation.

Alex is the youngest of five siblings with a six-year age difference between him and his next oldest sibling. He was raised by both parents along with a brother twelve years his senior, a sister ten years his senior, a brother eight years his senior, and a sister six years his senior. He describes a childhood of impoverished conditions and frequent relocations, some due to his father's encounters with law enforcement. His childhood history includes family violence, drug addiction, incest, and suspicion of murder.

Alex was unclear about the details of his childhood sexual abuse; however had memories of a teenaged male friend of his oldest brother abusing him. Alex's initial recall of his sexual abuse was that it took place in a church rectory during a church-sponsored picnic. The abuse took place when he was six years old. He recalled being taken to the rectory by his oldest brother who was approximately eighteen years old at the time. Alex could recall images of the room and the abuse including the dark stairway leading to the rectory, the long, stringy black hair of his offender, laughter by his brother, and the presence of another boy similar in age to Alex. He describes being blindfolded at one point during the abuse. He recalls returning to his mother's side after the abuse, but being fearful of telling her what had happened. As Alex processed the memories of his abuse, he came to report that his brother was also involved in sexually abusing him as well as the other small boy. He also reported earlier incidents of fondling by this same

brother in his bed. This was a difficult admission for him to make as he had spent many years idolizing this particular brother who he recalled as leading a life replete with alcohol, drugs and frequent sexual encounters. He also recalls this brother telling him that he molested several of their nieces and cousins. His perception was that his older brother was popular and “cool.” Since completing treatment, Alex has talked to his mother about this brother who is now deceased. His mother reports that this brother was reported to engage in sexually deviant behavior and was implicated in a series of ax murders. Alex describes his relationship with his father as physically abusive. Alex believes his father is responsible for two murders including an older brother who argued with him. Alex was physically afraid of his father. Alex describes an unremarkable childhood relationship with his mother whom he describes as removed. He now believes she may have been intimidated by her husband, Alex’s father.

Alex’s pre-treatment TSI profile, shown in Figure 4, was similar to Samuel’s with the exception of a higher score for dissociation. From my experience with Samuel I anticipated that Alex would have a difficult time tolerating emotions. However, I decided to attempt the standard protocol of eye movements. I also decided it was important to use a resource installation on the first session to give him some internal support to tolerate difficult feelings. Given Alex’s fairly recent history of substance abuse, a considerable amount of time was spent developing a safety plan and establishing a support network before processing began.

Processing was attempted in the third session and Alex was quickly able to get in touch with memories of the abuse. However, as anticipated, he was unable to tolerate the memories for useful periods of time. As feelings would begin to occur Alex would experience a “shut off” of feelings similar to Samuel’s process. I switched from the bilateral visual technique to bilateral hand tapping. This method allowed Alex was to sustain an intense emotional state for

increasingly longer periods of time. Alex did much of his cognitive processing between sessions. A stumbling block in his EMDR treatment was that after the fourth session, Alex admitted that he had a strong urge to purchase alcohol on his way home from the session. It was during this session that Alex had come to the awareness that his brother was, in fact, not only present for the sexual abuse, but also participated. He also recalled other occurrences of abuse by this brother. He reported that about halfway home he became so overwhelmed with sadness that he was unable to stop crying. He was able to resist the urge to purchase alcohol by contacting his girlfriend as we had planned, however it became evident that a slower pace may be indicated. I was unaware of the intense emotional state that Alex had left the previous session in. Recall Alex's elevated TSI responses to defensive avoidance. Persons with avoidant attachment styles may not be able to recognize themselves as depressed or anxious (Mikulincer, Florian, & Weller, 1993). I made note to be aware of this for future sessions and also for future clients. It has been my experience that sexual offenders can be skilled at concealing their emotions, and extra vigilance is warranted when doing trauma work with this population.

Alex was able to complete his EMDR treatment in eight sessions. Similar to Samuel, Alex went through a series of cognitions and feelings both about his abuser(s) and himself. The most difficult hurdle for Alex was to recognize that the brother whom he grew up idolizing was in fact using Alex for his own pleasure, much as he was using many of his other victims. Once Alex was able to accept the reality of the type of person his brother was, the feelings of guilt and shame he felt about being abused turned to feelings of anger and sadness. As Alex processed these feelings, his thoughts oftentimes moved towards his own victims and he was experiencing the anger and sadness they must have felt towards him as he felt towards his perpetrators.

Alex completed the TSI post-treatment and his profile showed mixed results as illustrated

in Figure 4.

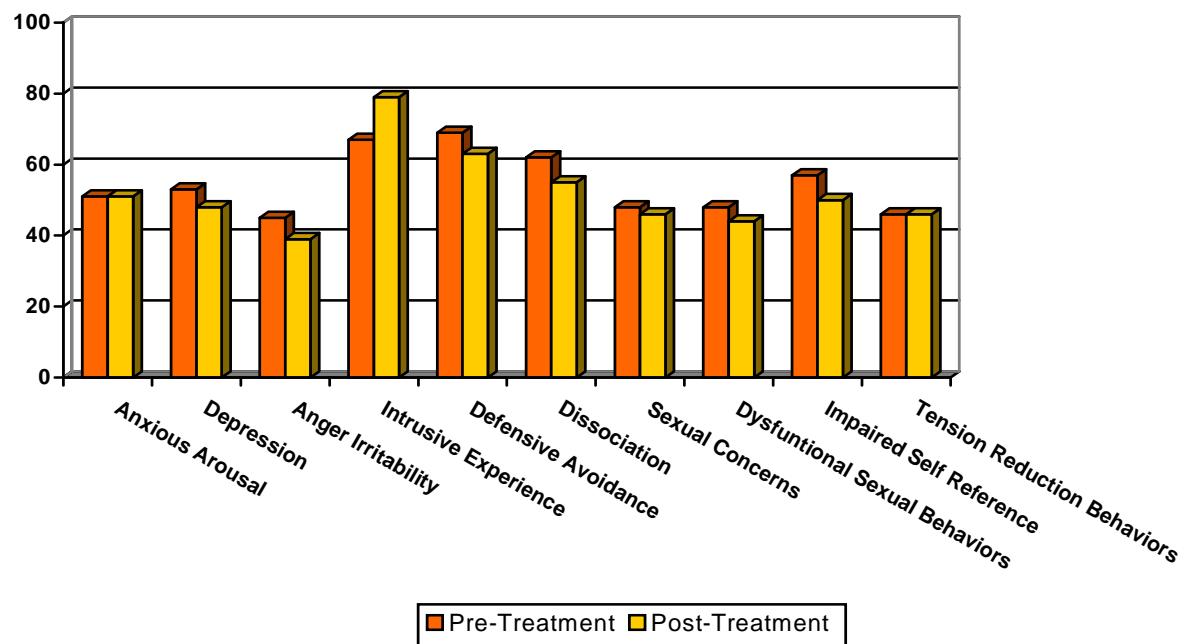


Figure 4. Alex – Trauma Scale Inventory (Briere, 1995)

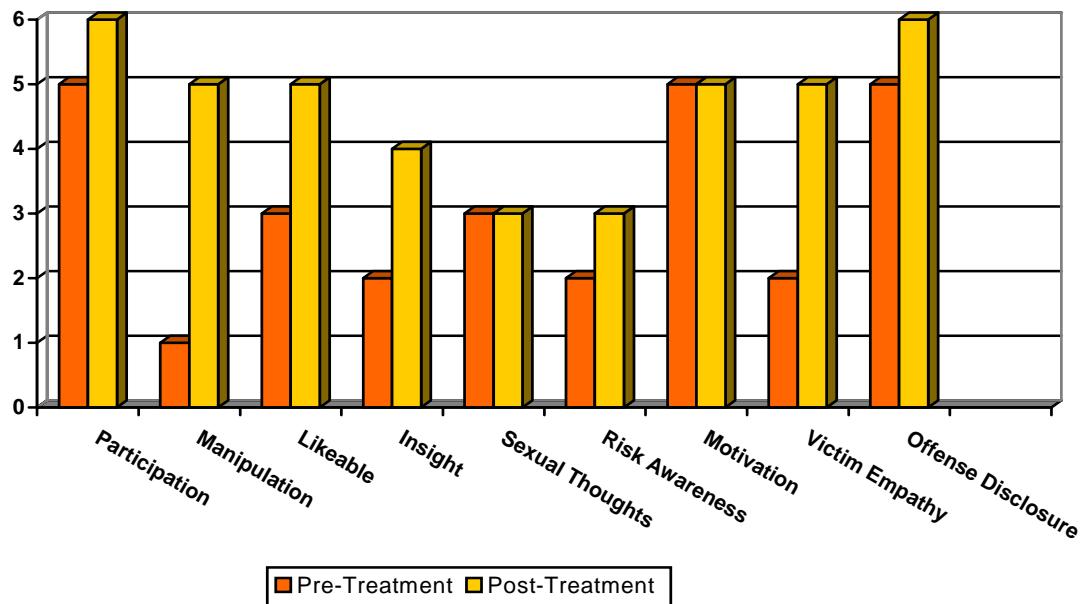


Figure 5. Alex – Sex Offender Treatment Rating Scale (Anderson., Gibeau, & D'Amora, 1995)

His score for defensive avoidance dropped below the clinical range, as did his score on dissociation. Of some concern was the increased score in intrusive experience. It is possible that while EMDR was focused specifically on his sexual abuse, the process of therapy brought up many other memories of violence within his family. These issues were not addressed in the treatment. I made notes to look for evidence of this phenomenon in his post-treatment interview.

Figure 5 illustrates Alex's primary clinician's assessment of SOTRS measures. It depicts improvement on almost all measures, with the largest gains evident on measures of manipulation, victim empathy and insight. His primary clinician reported that post-treatment Alex was able to successfully complete the tasks of a victim impact statement and a victim role play – areas Alex had struggled with previously.

Alex also showed mixed results when comparing his pre- and post-treatment penile plethysmograph assessments evidenced in Figure 6. Alex showed a clinically significant

decrease in arousal to depictions of sexual coercion with very young males. This corresponds to the age Alex was when his teenaged brother and his friend sexually molested him. The category of teenaged males also decreased slightly. It is common for victims of abuse to respond physiologically to stimuli depicting the ages and gender of themselves and their abusers at the time of the offense. Clinically significant decreases were also noted in the area of teenaged females as were slight decreases in the category of grammar aged females. These categories are congruent with the ages and genders of Alex's victims. Though remaining below the range of clinical significance, slight increases were evidenced in areas of pre-school aged females. This category coincides with the age and gender of Alex's victim of conviction.

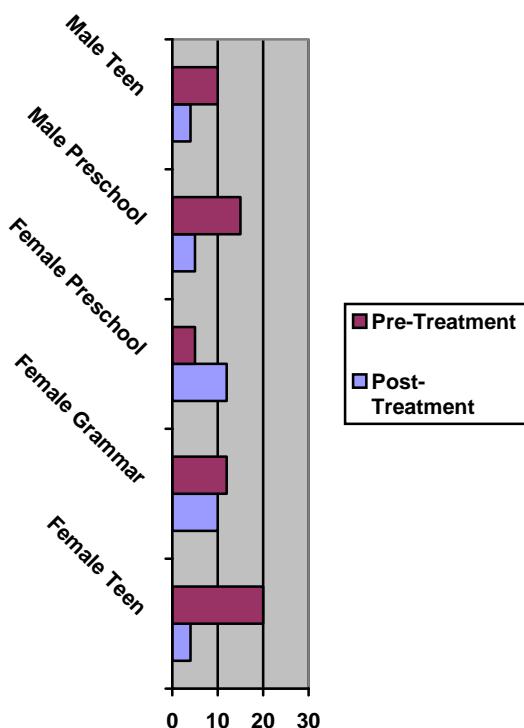


Figure 6. Alex – Penile plethysmograph assessment results of deviant arousal responses.

At time of the plethysmograph assessment Alex had begun work on his victim relationship concerning his victim of conviction. The early stage of this treatment task often raises the details of the molestation to the forefront of consciousness, thereby creating a conditioned physiological response.

Richard

Richard is a Caucasian male in his late forties who appears his stated age. He is of average height and overweight. He appears to be of average intelligence and is oriented in all spheres. Richard reports some struggles with memory recall, although it appears to be within normal limits. Richard worked as a long-haul truck driver until he became physically disabled with back injuries. He identifies himself as heterosexual and has been married two times. He reports infidelity in both marriages. He reports no significant history of alcohol or drug use. He has no history of criminal charges outside of the sexual molestation of his eleven-year-old stepdaughter. He also identifies his younger brother as one of his victims as well as several under-aged prostitutes he procured at truck stops over many years. Richard was diagnosed with major depressive disorder for which he received psychotherapy briefly several years ago. He reports no current use of psychotropic medication.

His treatment team referred Richard after he disclosed that as a child he was sodomized by some older neighbor boys over the course of a summer he spent living with his grandparents. He was twelve years old at the time of the abuse. At the time of referral Richard was working on his sexual autobiography in his group treatment program. He was reportedly struggling with the task insofar as he was unable to present the material in a clear and understandable manner. His initial TSI assessment, shown as Figure 7, indicated no clinical elevations indicative of post-traumatic symptomatology. Initially, Richard denied any disturbing memories of his childhood

sexual abuse.

Richard is the older of two boys who were raised by both parents. Financial struggles were apparent throughout Richard's childhood and in part resulted in his staying with his grandparents for long periods of time. He reports an unremarkable relationship history with his parents other than to state his father used corporal punishment liberally. Richard does not consider himself to have been physically abused as a child. He describes his attachment to his mother as secure, but cannot explain why he was not willing/able to tell her about the sexual abuse he was enduring. Richard maintains an adult relationship with his mother who was not aware of his childhood abuse at the time of intake. Richard's father is deceased.

In view of the apparent lack of immediate risks, no support network development was done with Richard before EMDR processing of the sexual abuse began. Richard was able to tolerate emotion so the bilateral eye movement technique was used. Richard got in touch with vivid images of the sexual abuse that took place in a shed on his grandparents' property. As he processed the abuse, he was able to experience the sights, sounds, and smells of the shed. A turning point in his treatment occurred in the second week when he recalled a person walking by the barn while he was being abused. This image brought to the forefront the loneliness and isolation Richard was feeling as a child, and allowed him to make sense of the reason he was "allowing" these older boys to perpetrate him – for the attention they were giving him. This was a particularly difficult session for Richard, however once he fully processed this, his thoughts turned to his own victims, including his younger brother. He began to talk about the hurt that his victims must have experienced. He also began to have images of other hurts he caused; for example the hurt look on his wife's face when she discovered his infidelity.

Richard's treatment was three sessions. Although he may have benefited from further

treatment, his SUDS had reached an acceptable level of two, while his VOC scales were reported at five to six. Figure 7 illustrates that Richard's post-treatment TSI scores either remained constant, or were slightly reduced from their previously sub-clinical levels. Figure 8 illustrates results of the SOTRS completed pre and post-treatment. Measures indicate improvement in all categories, with the largest changes showing in the areas of offense disclosure and victim empathy. Richard was reported to have done an excellent job of presenting his victim relationship history shortly after EMDR treatment ended. This task includes providing details of the offense(s). Richard was reported to have struggled with this task prior to EMDR treatment and had been receiving negative feedback from his group peers.

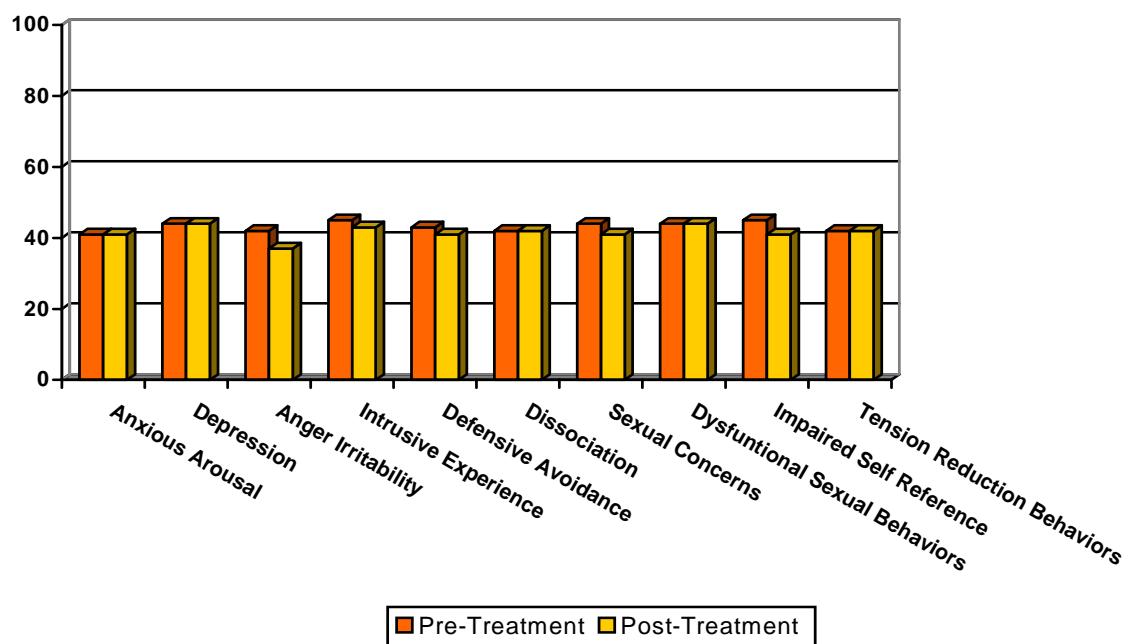


Figure 7. Richard – Trauma Scale Inventory (Briere, 1995)

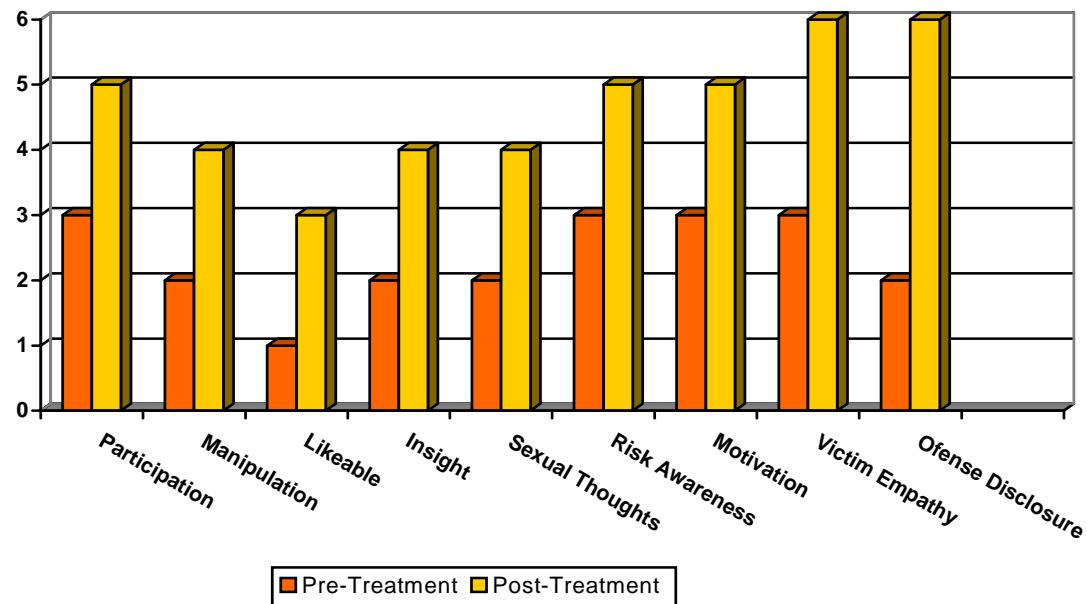


Figure 8. Richard – Sex Offender Treatment Rating Scale (Anderson, Gibeau, & D'Amora, 1995)

Of further interest are the significant reductions in deviant arousal evidenced on Richard's plethysmograph assessment after EMDR trauma treatment as shown in Figure 9. Before treatment, Richard showed deviant arousal to grammar aged and teenaged children of both genders above the significance score of 15 units of change. These elevated responses are consistent with Richard's clinical history. Richard sexually offended both grammar aged and teenaged females. Furthermore teenaged males sexually offended Richard when he was grammar aged. This is a typical profile for someone with Richard's history as both sexual perpetration and sexual victimization often create these types of conditioned arousal responses. His post-treatment penile plethysmograph shows no clinical levels of deviant arousal.

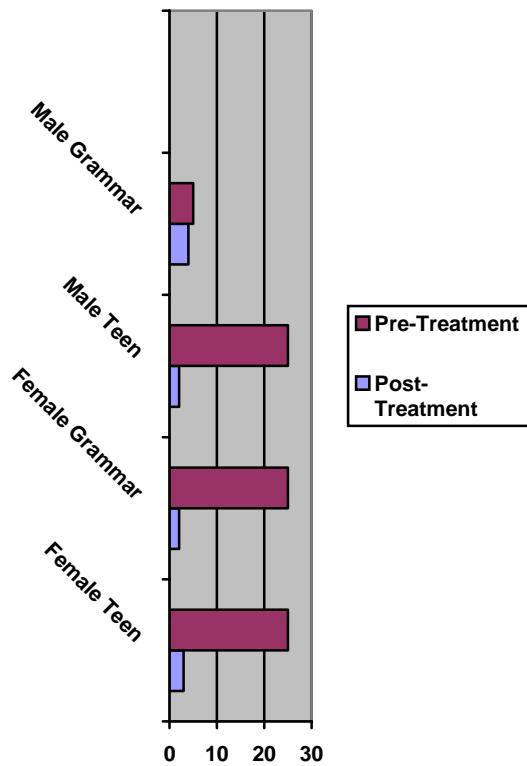


Figure 9. Richard – Penile plethysmograph assessment results of deviant arousal responses.

Randy

Randy is a 49-year-old Caucasian male of average height and obese stature. Randy is of low-average intelligence. He has been diagnosed with Recurrent Major Depressive Disorder with psychotic features. He is currently under a psychiatrist's care and is treated with anti-depressant and anti-psychotic medications. Clinical coordination with Randy's primary case manager was effected before he was accepted for EMDR treatment. His case manager felt that Randy had been stable for an acceptable period of time, with no evidence of active psychosis. Randy was accepted for EMDR treatment with caution.

Randy has a limited work history and is currently disabled due to his psychiatric condition. Randy completed the TSI before beginning treatment. Figure 10 shows his clinical

range scores on the following measures: anxious arousal, depression, intrusive experiences, defensive avoidance, dissociative depression, sexual concerns, tension reduction behaviors (maladaptive coping responses, e.g., self-mutilation), and impaired self-reference. This profile is indicative of a posttraumatic presentation in that the individual is reporting both the intrusive and avoidant components of PTSD. His symptom presentation and his inability to fully engage with treatment material are the reasons cited by his treatment team for recommending him for this EMDR treatment procedure.

Randy is the oldest of five siblings who were raised in an intact family by both parents. He reports his father was physically abusive and alcoholic. His father died approximately two years prior to this intake from lung and alcohol-related diseases. Randy currently resides with his mother and three adult siblings, one of whom is mentally retarded and one who is an alcoholic. Randy reports a history of drug and alcohol addiction from which he has been sober since his release from prison four years ago. Randy was imprisoned twice, once for assaulting a neighbor with a tire iron, and a second time for sexually molesting his pre-pubescent daughter. Randy also reports he sexually molested two of his sisters when he was in his early twenties. Randy's own history of sexual victimization began at approximately age six when he was forced to fondle his aunt's breasts and vagina while she slept with him. His next occurrence was at age twelve when an adult friend of the family took him into the barn and anally penetrated him. Finally, during his first incarceration at age 19 he was gang-raped in addition to being repeatedly forced to submit to sodomy by his cellmate. Prior to beginning this treatment, Randy had not disclosed any of these incidents to anyone.

Randy's EMDR treatment was interrupted by a suicide attempt for which he was hospitalized for 11 days. Randy also began using illegally obtained prescription opiates,

presumably in an effort to regulate his emotions. His primary care case manager requested that Randy resume EMDR treatment upon his release from the hospital. While Randy was able to successfully complete the EMDR treatment (as determined by acceptable SUDS and VOC levels), it affirmed my original protocol to exclude participants with psychiatric histories of psychosis.

Following EMDR treatment of 10 sessions, Randy was administered the TSI. All categories showed clinically significant decreases to below clinical range (see Figure 10). Of some concern in this profile was the elevated score on the measure of inconsistent responses. Such inconsistency may be due to “random responding, poor attention or concentration, dissociative phenomena, or reading difficulties” (Briere, 1995, p. 12). Given Randy’s intelligence level, the latter was suspected and he verified that he had a difficult time comprehending some questions. However, Randy is prone to placating which makes assessment difficult. He also reports periodic auditory hallucinations and it is difficult to accurately determine when these are active.

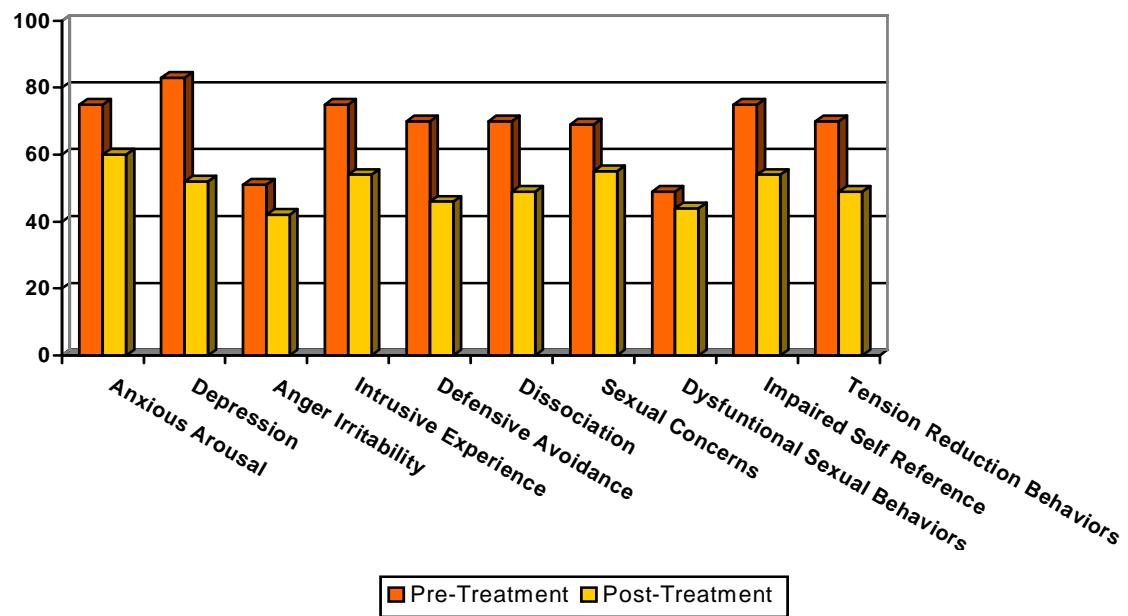


Figure 10. Randy – Trauma Scale Inventory (Briere, 1995)

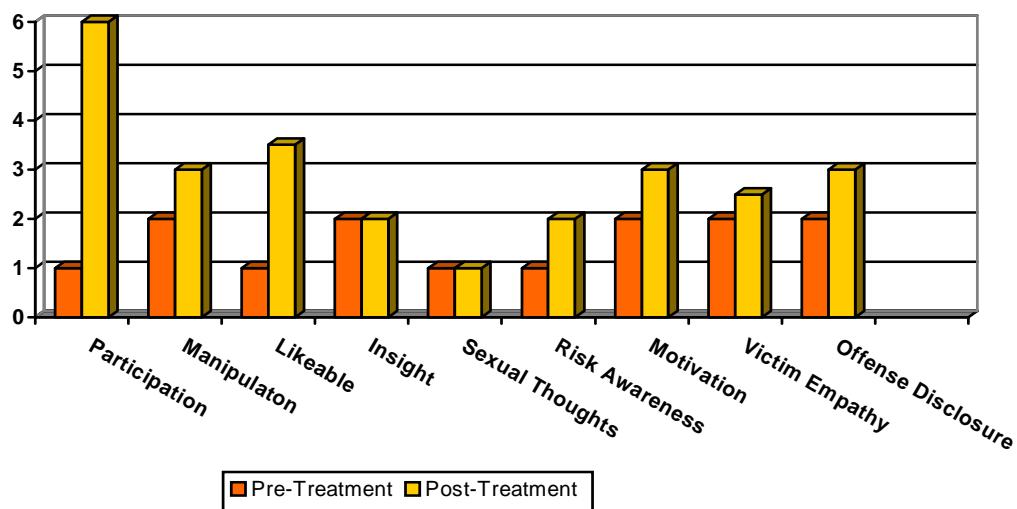


Figure 11. Randy – Sex Offender Treatment Rating Scale (Anderson, Gibeau, & D'Amora, 1995)

Randy's primary clinician registered overall improvement in measures of treatment progress, as depicted in Figure 11. She noted the largest gains to be in the area of participation,

reporting that Randy had “opened up” and had become an active group member. Other group members were also reported to have noticed considerable changes in Randy, complimenting the higher quality of his treatment work, and commenting on the clarity with which he presented his material.

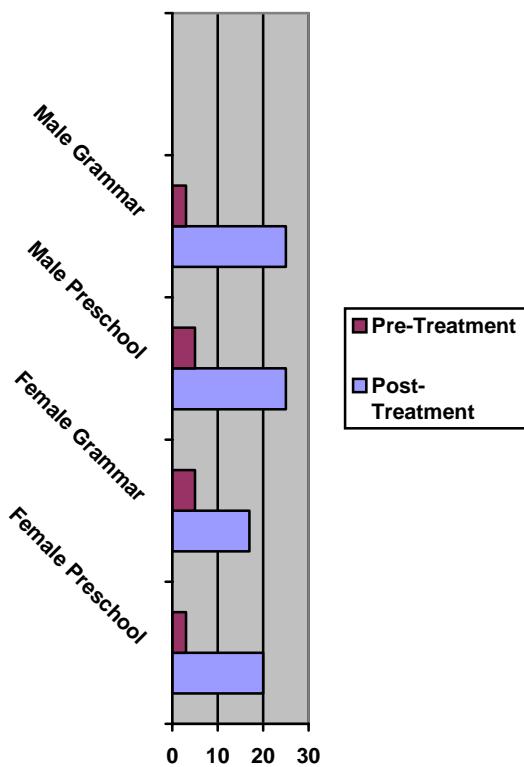


Figure 12. Randy – Penile plethysmograph assessment results of deviant arousal responses.

Of serious concern were the post-treatment results of Randy’s plethysmograph assessment shown in Figure 12. Results indicated significant increases in deviant arousal. It is possible that revisiting his sexual victimization served to increase triggers of arousal response. Another possibility given Randy’s psychiatric history is that he may have developed a secondary depression as a result of identifying with his own offender(s), with accompanying feelings of

toxic shame. This shame can act as a triggering effect on the offender's deviant cycle. Randy was referred for ongoing supportive counseling following EMDR treatment. His increased deviant arousal became a focus of his CBT-RP treatment program. Psychiatric care was intensified and Randy underwent several medication changes. Randy was hospitalized again approximately five months after EMDR treatment ended due to another suicide attempt. However upon his return to treatment his primary clinician continued to report sustained improvement in his participation and interpersonal behaviors.

Kyle

Kyle is a 37-year-old Caucasian male who appears younger than his stated age. He is of average height and slender build. Kyle initially identified himself as bisexual, but has since come to use the term homosexual when describing his sexual orientation. Kyle presents as below average intelligence, and reports having graduated high school through a special education program. Kyle's speech is pressured and perseverative under stress. Kyle is oriented in all spheres and shows no abnormalities of gait or facial expression. He reports a history positive for drug and alcohol abuse. His offense history involves molesting three teenaged males ranging in ages 13 to 17 over a period of seven years, including one offense that occurred following his initial arrest and release from prison.

Kyle completed the TSI before the onset of EMDR treatment (see Figure 13). His profile indicated clinical elevations to the following: depression, intrusive experiences, defensive avoidance, dissociative depression, sexual concerns, dysfunctional sexual behavior, and impaired self-reference. This symptom profile is consistent with a *DSM-IV* diagnosis of PTSD. His treatment team who reported the difficulty he was having presenting his sexual autobiography referred Kyle for EMDR treatment. Kyle reportedly became emotionally overwhelmed each time

he presented his work, and was unable to complete the task.

His mother raised Kyle with two older brothers and a younger sister. He reports his father left the family to be with another woman when he was very young. Financial difficulties resulted in Kyle leaving home as a young teen to live with another family. Kyle's history of sexual abuse began at approximately age five by his maternal grandfather. Kyle was often left in his grandfather's care and would be forced to submit to sodomy. Kyle recalls trying to tell his mother but was not believed. This abuse reportedly continued for a period of two years until his mother stopped leaving Kyle in his grandfather's care. Kyle also reports being sexually molested by an older brother with whom he shared a bed. The latter occurred during his early teen years and is isomorphic to his own offending patterns (Finkelhor & Browne 1985, 1986, 1988).

Kyle's EMDR treatment consisted of seven sessions. Kyle's process was both to desensitize to the sexual abuse he experienced as well as to accept his sexual orientation. Prior to treatment, Kyle struggled with the cognitive distortion that his offending was the fault of his grandfather who had offended him. He also believed that his homosexual tendencies were a direct result of his victimization. As Kyle processed the information, he came to accept responsibility for his offending behaviors, and also gained a level of comfort about his sexual orientation. Figure 13 illustrates post-treatment scores on the TSI that are all below clinical range. The greatest reduction is evident on the measure of impaired self-reference.

Figure 14 represents pre and post-treatment SOTRS scores assessed by Kyle's primary clinician. There was either consistency or improvement on all categories. The most important areas of gain for Kyle were that of participation and motivation. Kyle also showed improvement in insight and victim empathy. It was reported that his group work evidenced that as he came to understand the reality of his own abuse, he was better able to grasp the seriousness of the

offenses he committed.

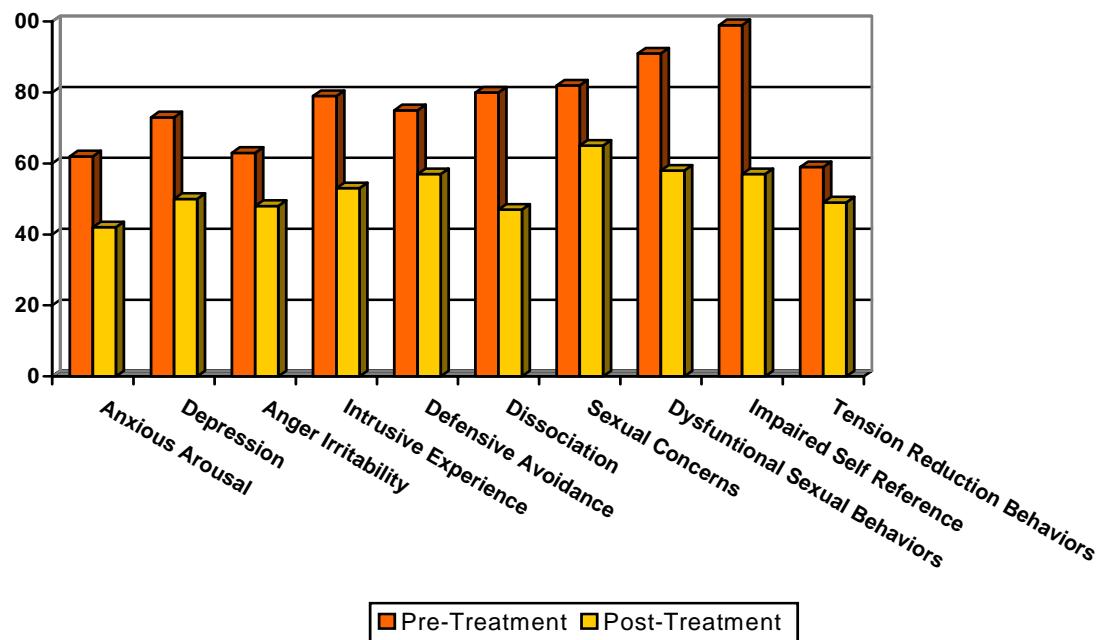


Figure 13. Kyle – Trauma Scale Inventory (Briere, 1995)

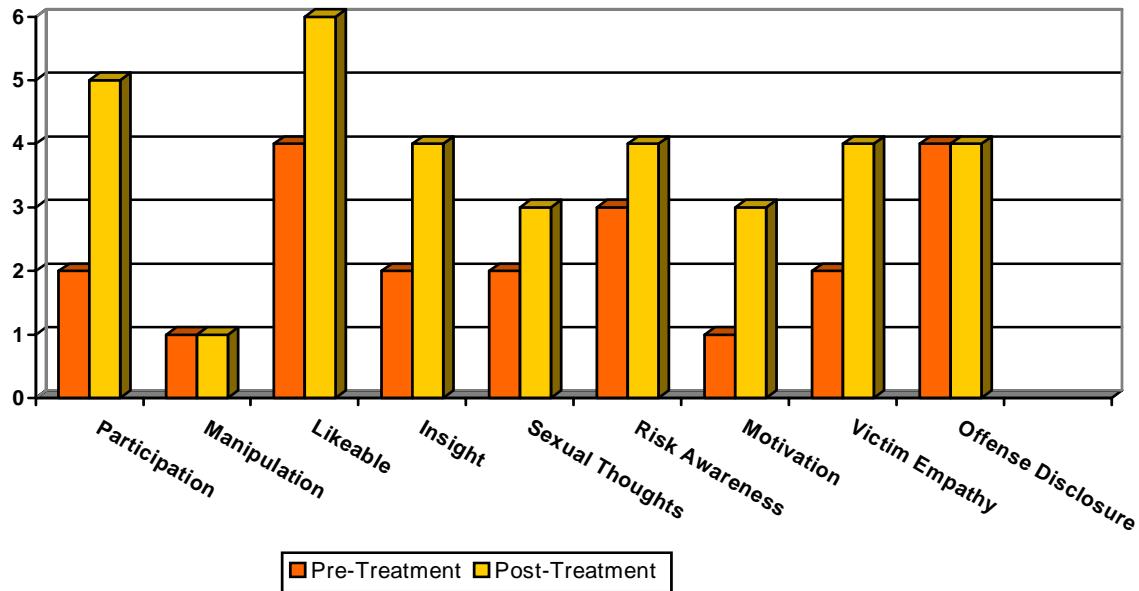


Figure 14. Kyle – Sex Offender Treatment Rating Scale (Anderson, Gibeau, & D'Amora, 1995)

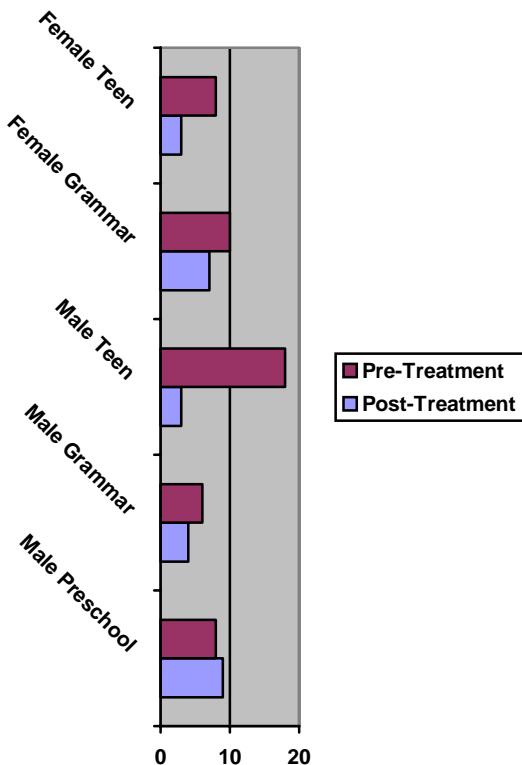


Figure 15. Kyle – Penile plethysmograph assessment results of deviant arousal responses.

Kyle's plethysmograph assessment was administered near the completion of EMDR treatment. As shown in Figure 15, arousal responses were decreased to all categories with the exception of male preschool aged children, although this remained below the range of clinical significance. This age category corresponds with the age Kyle was when his grandfather was offending him. The most significant decrease was demonstrated in response to teenaged males. This category represents the age range of Kyle's victims.

Mark

Mark is a 17-year-old Caucasian male of above average height and slender build. He appears of average intelligence and is fully oriented. He reports no significant medical history, no personal or family history of mental health problems, and takes no medication. His own history is positive for drug and alcohol abuse, as are the histories for both parents. Mark identifies himself as heterosexual and has had a series of peer-aged girlfriends with whom he has been sexually active. Mark admits to struggling with fear about his sexual orientation for several years given that his perpetrator was a male. Mark's mother left the family when he was approximately eight years old. His father and stepmother raised him along with two young stepsisters. The family resides in a mobile home in a rural setting. Mark reports feeling abandoned by his mother, and struggles with feelings that his father prefers his "new" family to him. Mark's history of childhood sexual abuse began at approximately age 11 and continued over the course of several years. Mark's perpetrator was an adult male family friend who spent a considerable amount of time with Mark and his family, often spending the night in Mark's bedroom. The perpetrator took Mark many places including weekend camping trips. Mark states he did not tell his father about the abuse for two reasons: first, he believed that the man would no

longer be allowed to take him places, and second he perceived his father as extremely homophobic and believed he would reject him for having had same-sex contact.

Mark completed the TSCC before treatment began and all scales were sub-clinical as shown in Figure 16. His highest scores were on measures of anxiety, overt dissociation, and PTSD symptomatology. His next level of elevated scores was on the measures of dissociation and anger. Mark's probation officer reports a significant history of angry, violent outbursts. The low score in this area may be indicative of underreporting on his part, or may be due to his two years of group treatment. Mark was recommended for EMDR by his treatment team given his inability to discuss his history of sexual victimization and patterns of offending without outbursts of anger. As a result, he was unable to complete the treatment tasks of presenting his sexual autobiography or his sexual offending behaviors without becoming aggressive to group facilitators or other group members. His treatment team felt that Mark was not progressing at a satisfactory rate in treatment as he was stalled on these objectives. Mark was resistant to the EMDR treatment and engaged at the encouragement of his father.

Mark sexually offended four victims ranging in age from eight to 10 years old. Two of his victims were females and his offense was genital touching and digital penetration. Two of his victims were males and involved manipulating them into performing oral sex in a pattern similar to that which was done to him. All of his victims were either relatives or close family friends.

Mark's EMDR treatment consisted of four sessions. Mark was prone to dissociation so the tactile (hand-tapping) technique was used. Mark was able to get in touch with the feelings of shame and despair he had while being offended. He also processed his fears that he may be homosexual, undoubtedly exacerbated by his father's overt homophobia. In addition to his report of acceptable SUDS and VOC scales, it was evident that Mark was able to discuss his sexual

victimization without the extreme emotional responses he had shown previously. Mark was also able to discuss his sexual perpetration and successfully completed his victim impact and victim relationship treatment tasks.

Given Mark's age, penile plethysmography is not a part of his treatment program. Mark's TSCC scores on his post-treatment assessment were decreased, with the largest changes showing on measures of overt dissociation, anxiety, anger, and PTSD symptomatology (see Figure 16). Figure 17 illustrates Mark's pre-treatment and post-treatment SOTRS scores. Mark showed the most improvement on the measure of offense disclosure. His clinician attributed this primarily to his ability to discuss the details of his offense without outbursts. He also showed gains in the areas of participation, insight, risk awareness and sexual thoughts. Mark's SOTRS shows regression on the score of manipulation. His primary clinician explained this trait has become more apparent recently in view of his life circumstances.

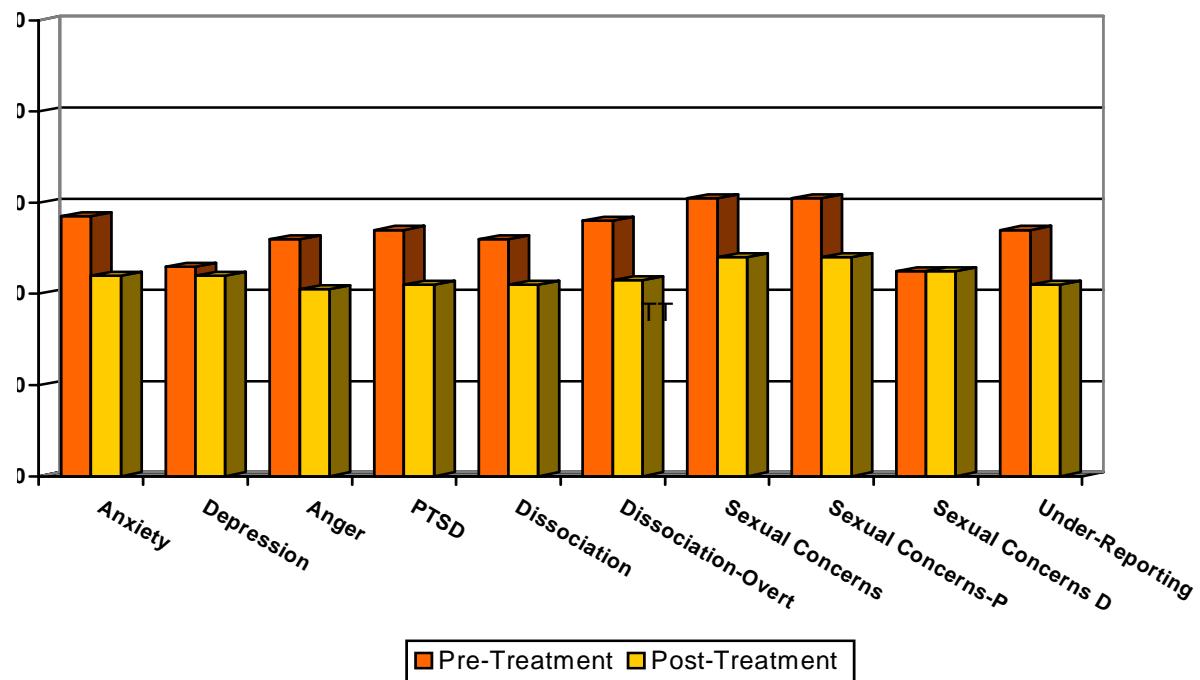


Figure 16. Mark – Trauma Symptom Checklist for Children (Briere, 1996)

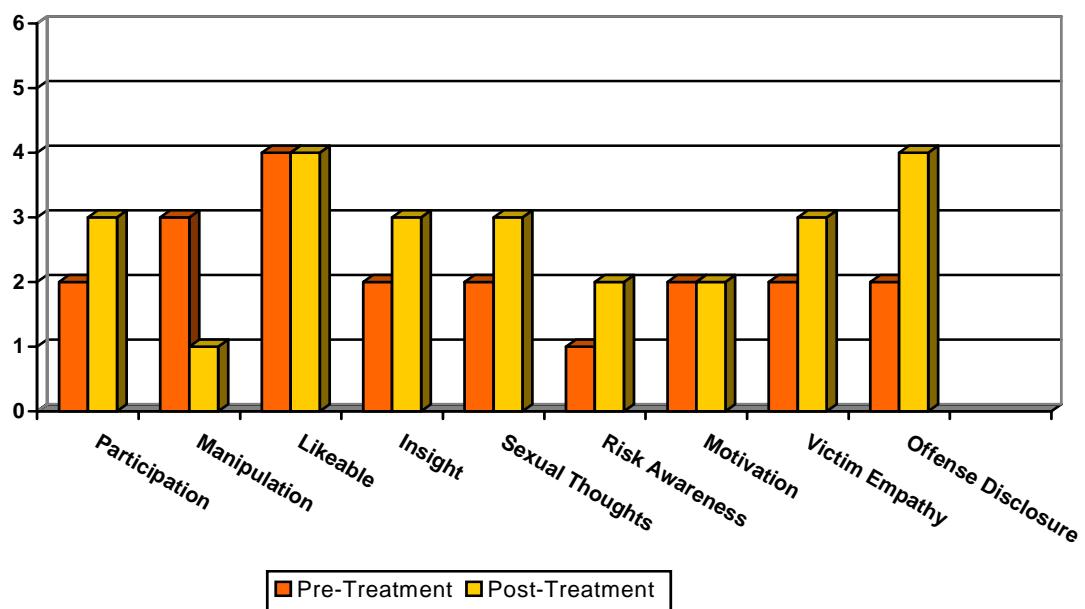


Figure 17. Mark – Sex Offender Treatment Rating Scale (Anderson, Gibeau, & D'Amora, 1995)

Following treatment, Mark was able to discuss his sexual victimization in his adolescent treatment group. According to his primary therapist, Mark also discussed his victimization with his father and his stepmother for the first time in a family therapy session. Mark also began and successfully completed his four victim impact statements, which were a hurdle in his treatment progress prior to the trauma treatment. He came to recognize, and was able to process, that he used many of the same manipulative techniques and language with his victims that his perpetrator had used on him. His primary therapist reported that when Mark came to this realization he became overtly emotional in his group session. She reports that he was able to regain his composure and continue processing the material successfully. In Mark's exit interview, he attributed his ability to tolerate the emotions to the EMDR trauma treatment.

Bill

Bill is a 17-year-old Caucasian male who attends an adolescent treatment group. He is of below average height and slight build. Bill exhibits no abnormalities of gait, posture, or facial expression. His memory recall appears to be within normal limits and he appears to function at an average level of intelligence. Bill has a significant history of illegal drug and alcohol use. He also has an extensive criminal history and has spent most of his adolescence in a juvenile residential facility. His presenting affect is indicative of depression, although he does not carry that diagnosis. Bill takes no medication.

Both parents raised Bill along with his younger brother whom he sexually perpetrated. Bill's offense of his younger brother, five years his junior, includes forcing him to perform fellatio and anally penetrating him. This occurred several times until his brother reported the offenses to his guidance counselor. Bill was removed from the home and placed in a residential

facility, however has since returned to live with his family against recommendations by his current treatment team.

An uncle sexually victimized Bill when he was 11 years old – the same age of his victim. Bill and some peer-aged cousins were reportedly locked in separate rooms of a camper. The official investigation states that the uncle anally sodomized each of the boys separately. Bill's cousins reported the offenses, while Bill denied that it occurred. Bill eventually agreed to testify in court against his uncle, however refused to do so during the trial.

His treatment team referred Bill for EMDR treatment with the concern that he was unwilling to engage in treatment. Bill admitted to offending his brother, but was unwilling to discuss the details of his offense. Similarly, Bill refused to discuss the specifics of his own victimization, and became verbally and physically aggressive when questioned.

Bill came to the screening session with his father who encouraged him to participate. Bill was mildly cooperative, but stated repeatedly he was unwilling to discuss his sexual victimization. He complied with completing the TSCC which showed elevated scores on measures of PTSD and dissociation. His lowest score was on the measure of anger, which contrasted with reports and clinical observations. It appeared Bill was underreporting on the TSCC inventory.

Bill underwent two EMDR sessions. He was uncooperative with the process and repeatedly refused to talk about what he was thinking or feeling. He did agree to a second session, however the results were similar. Bill told me that he was intentionally blocking any emotional response that came up during EMDR as he was fearful that he would become angry to the point of losing control. While it is possible that Bill was merely using this as an excuse not to participate, his primary treatment provider and I decided to cease the EMDR treatment. In large

part, this decision was based on the fact that Bill had a detached relationship with his parents and virtually no support network outside of group treatment. Should his emotions become overwhelming, it was unlikely he would receive outside support. It was equally unlikely that he access his treatment providers.

After termination of individual sessions, Bill only sporadically attended his group sessions. Bill turned eighteen years old and was referred to adult probation. He was made aware that continued non-compliance would result in a probation revocation hearing. Bill agreed to comply; however his attendance at his group sessions remained sporadic. At last report, Bill had resumed illegal drug use and was arrested for Armed Robbery. Bill was incarcerated in an adult correctional facility.

Derek

Derek was referred by his treatment team due to difficulty he seemed to be having demonstrating empathy for his victims. Derek was in the final stages of his treatment at the time of referral. Derek had been engaged in group CBT-RP treatment in excess of seven years. The assessment by his treatment team was that while he was presenting his treatment work well intellectually, he was unable to experience it on an emotional level. Derek acknowledged being sexually molested as a young teenager by an older male friend of his brother. However, he was adamant in stating that he did not mind, and even enjoyed, the sexual contact. Derek identifies himself as homosexual, but feels certain this is not related to his sexual abuse. He is not open about his sexual orientation with friends or family, and has not had an adult homosexual relationship. His offending history involves 27 teenaged male victims, and six teenaged female victims. He also has one female infant victim whom he perpetrated when he was a teenager. He identifies his number of offenses as being well in excess of 300. His pattern of offending is to

befriend his victim and persuade them to engage in sexual contact over long periods of time. Similar to many of the participants in this study, his offending pattern replicates the manner in which he was sexually offended as a child, using attention and privileges to persuade the victim to be sexual.

Although Derek is in his late forties, he adopts the clothes, jewelry and hairstyle of a teenager. He describes himself as having been a youthful looking teenager, and often states he does not consider age when looking at people. Derek is of average height and build, and appears to be of average intelligence. He has a stable, blue-collar employment history. Prior to being arrested for his offending he worked as a martial arts instructor, which afforded him access to several of his victims. Derek reports no significant history of mental illness, either in himself or his family. He has a significant history of drug and alcohol abuse that continued until the time of his arrest.

Derek was raised as the second oldest of seven children in an intact family. His older brother, four years his senior, was best friends with Derek's perpetrator. Derek describes his father as distant, and his mother as caring but overwhelmed raising seven children. Derek's father worked the third shift of a blue-collar job, thereby allowing little time for contact with his children. Derek does state that his father often spent time on weekends with Derek's older brother, but that Derek did not get along with his father so there was minimal contact between them. As a result, Derek states he often "nagged" and "begged" his older brother to let him spend time with him and his best friend.

Derek's EMDR treatment was six sessions, at which time he reported acceptable SUDS and VOCS. The primary cognitive change for Derek was an understanding that he submitted to his sexual molestation to satisfy his need for attention from an older male. He made the

connection between this reality for himself, and an understanding that his victims undoubtedly were experiencing the same thing. This insight was evident in his post-treatment interview, in his session transcripts, and also in his discussions with his treatment group. Derek reportedly became emotional in a group meeting while he was presenting the victim selection and grooming portions of his offense pattern. He stated to his group that it suddenly “hit him” that his victims were simply doing what they needed to do to get attention. He seemed to understand that this made them vulnerable as opposed to consenting participants as he had previously viewed them. He purposefully selected potential victims who did not receive adequate attention from their families. This realization was a big step forward for Derek in helping him to be clear on portions of his offense cycle about which he had been ambiguous.

Figure 18 shows Derek’s TSI scores both before and after EMDR treatment. Although his highest pre-treatment score was on the measure of sexual concerns, no score registered in the clinical range. This is consistent with his perception that his molestation was not in any way traumatic to him. Interestingly, his post-treatment scores all increased with the exception of sexual concerns. Scores on sexual concerns and dysfunctional sexual behavior both decreased.

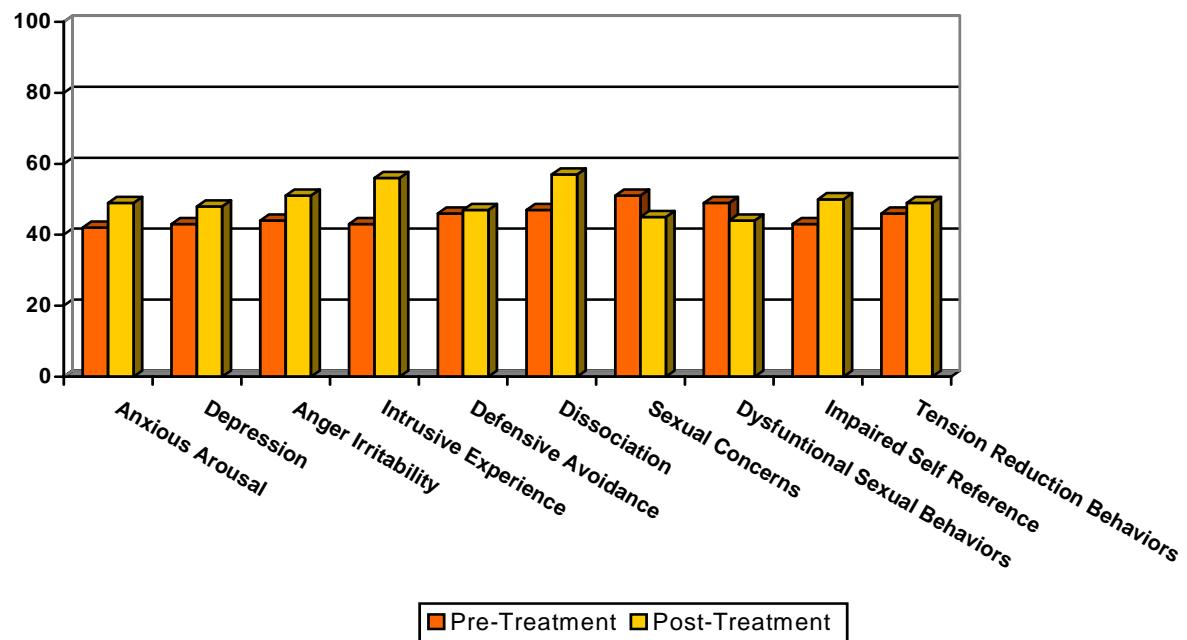


Figure 18. Derek – Trauma Scale Inventory (Briere, 1995)

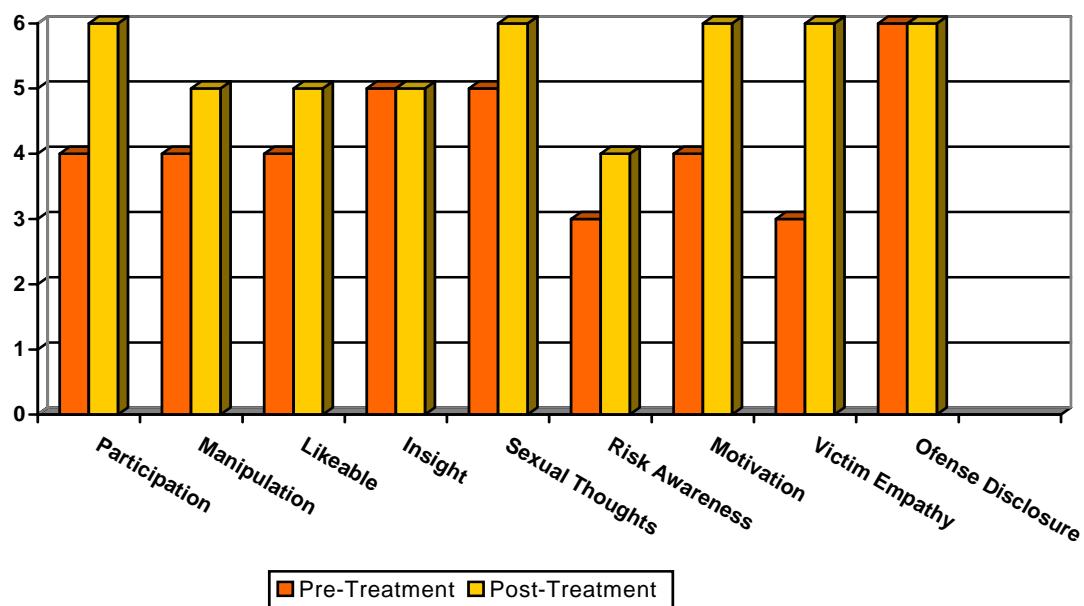


Figure 19. Derek – Sex Offender Treatment Rating Scale (Anderson, Gibeau, & D'Amora, 1995)

It is noteworthy that the built-in reliability scales of atypical responses and response levels improved significantly as well, which could indicate a more open and honest response set. Derek never did consider his victimization as traumatic, however through EMDR he states he came to an awareness of the harm that had been done to him. These increased scores, all of which remain below clinical significance, perhaps indicate this increased awareness.

Figure 19 illustrates Derek's improvement in seven of nine measures of the SOTRS, with the largest improvement on the measure of victim empathy. This is consistent with his report of understanding the reality of his offenses and his victims' motivation to continue to engage with him. At follow-up, Derek was reported to have successfully completed the "planning" and "grooming" portions of his sexual offense pattern. He is also reportedly involved in his first adult relationship. Derek reports that while he still struggles with arousal to teenagers, he finds these fantasies much less prevalent than in the past. He attributes this to his recent acceptance of his homosexuality, and his ability to comfortably access fantasies of adults.

Derek completed a plethysmograph assessment at the end of EMDR treatment. Primary changes, as shown in Figure 20, were in the areas of sexual arousal to males. Deviant arousal to underage males decreased while arousal to adult males, his stated preference, increased. Derek reported to his group that as he had become more comfortable entertaining his sexual interest in adult males, his arousal to male children was, while still present, easier to manage. Derek also felt the confidence to engage in his first adult homosexual relationship.

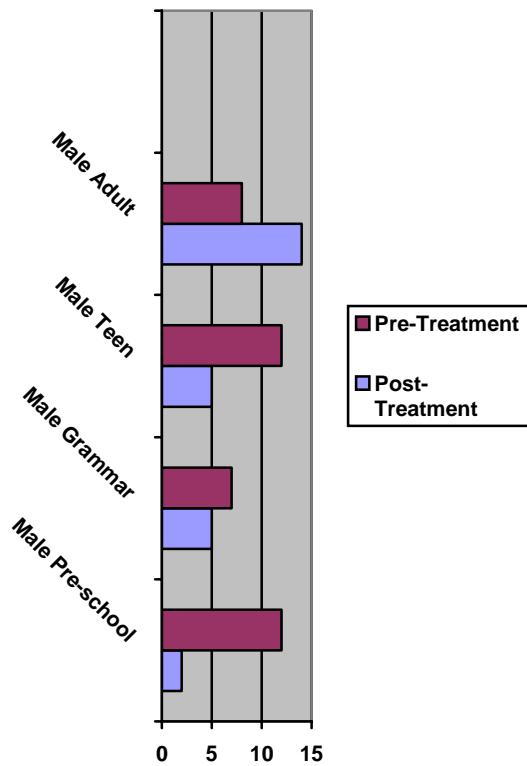


Figure 20. Derek – Penile plethysmograph assessment results of deviant arousal responses.

Jake

Jake is a 33-year-old Caucasian male who appears slightly younger than his chronological age. He is of average height and weight, and shows no abnormalities of gait, posture, or facial expression. Jake appears to be of average intelligence. He describes himself as heterosexual, although consistently registers arousal patterns to males on his plethysmograph assessments. Jake reports no history of drug or alcohol abuse outside of what he considers normal experimentation by teenagers. He reports neither a history of mental health counseling nor any psychotropic medication use. He reports an episode of depression when he first learned he was to be incarcerated. He reportedly attempted suicide by sleeping pills. He describes this as an attempt to garner sympathy and is clear in stating he planned the event so that he would be

discovered in time to save his life. He currently reports vague suicidal ideation with no plan or intention.

Jake was raised in an intact family with two younger sisters. His mother was a full time homemaker while his father worked a series of blue-collar jobs outside of the family home. He describes a good relationship with both parents and states “Dad tried to whip me to keep me in line, but it didn’t work.” He describes his mother as nurturing, and his father as distant.

Jake’s sexual offense history involves molesting a 10 year old male beginning when Jake was 20 years old. The molestation continued for several years until the boy reported it. Jake describes his sexual behaviors with the boy as fondling, masturbation, oral sex, and anal sodomy. As the boy became older and started to resist, Jake became threatening and aggressive with the boy, often using force and violence.

An adult male friend of Jake’s family began to sexually abuse Jake at age 13. Jake describes the man paying a great deal of attention to him, often buying him gifts including a bicycle. He often had Jake stay over at his house. Jake states he was not very close to his father and enjoyed the attention from an adult male figure. The sexual behaviors perpetrated on Jake were the similar to those he perpetrated on his own victim. The abuse reportedly stopped when Jake’s mother walked in on the man and Jake in bed. Jake’s mother told Jake they needed to keep the “secret” from Jake’s father. As a result, the man began to visit the family again about a year later, when Jake was 16, and again made a sexual overture at him. At that point, however, Jake reports he fought with the man and drove off in his car. Jake currently states that he enjoyed the sexual contact by the man, wanted it to happen, and in fact wanted it to resume when the man returned. He states he only pretended to act angry as by that point he was struggling with fears of homosexuality, and also didn’t want to put his mother through another “ordeal.”

His treatment team referred Jake for EMDR due to his inability to recognize his own victimization, as well as his inability to develop any level of empathy for his victim. Jake completed a pre-treatment TSI showing clinical elevation on the scale of intrusive experiences (see Figure 21). His second highest measure was that of defensive avoidance. This profile is consistent with the intrusive and avoidant components of PTSD. Given Jake's denial of harm this profile is rather surprising. However, it is possible that Jake's denial is merely an ineffective effort to restore an ego-syntonic state. Chronic PTSD often results in response to an event or events from the distant past and symptoms become integrated into the individual's personality (Briere, 1995).

Jake's treatment involved five sessions of EMDR. Initially, Jake was steadfast in his position that the abuse was his fault. He was focused on the fact that he was interested in his perpetrator sexually, and that he was fully aware of his perpetrator's intentions for buying him things and showing him attention. As he processed the material, he began to recognize that in some ways it was his mother's reaction to the discovery of the abuse that solidified this thinking for him. He entertained his current thinking that his mother's effort to keep the "secret" from his father and her apparent disappointment in him ("how could you let him do that to you") solidified his feeling of responsibility. At the end of five sessions, he labeled the VOC scale countering this belief at six out of seven. He stated "I never thought I would believe this I really didn't. But I can see it now. I can feel it." From that point, Jake was quickly able to make the connection to the idea that his own victim was similarly not responsible for the abuse Jake perpetrated on him. Prior to EMDR treatment Jake described his victim as "effeminate", and held the distortion that his victim, although only 10 years old, was inviting the sexual contact. Following treatment, Jake reportedly presented a clear representation to his group of how he

manipulated the boy.

Figure 21 represents Jake's pre and post-treatment TSI scores. All areas were slightly reduced, with intrusive experiences going from pre-treatment clinical levels to sub-clinical levels after treatment. Intrusive experience was Jakes' only clinical area at the onset of treatment. Although Jake never considered the abuse traumatic, he reported that prior to treatment it oftentimes "bothered" him and occupied much of his thinking – particularly before falling asleep at night. Jake also reported that after treatment he discussed the situation surrounding his abuse with his mother for the first time. Although his perception was that it made her uncomfortable, he was able to pursue the topic to a point where he was beginning to feel some resolution. He also told his mother that he was interested in having a family discussion about the abuse to include his father. It was Jake's plan to schedule a family therapy session with his primary clinician.

Figure 25 illustrates post-treatment changes in measures on the SOTRS. While Jake showed less gain than other participants, he was assessed to have improved on five of nine of the measures. Jake's treatment team was most concerned about his inability to give an accurate account of his offending behavior, and the lack of feeling he demonstrated when he attempted to do so. It is positive, then, that these are two of the areas in which Jake made some progress.

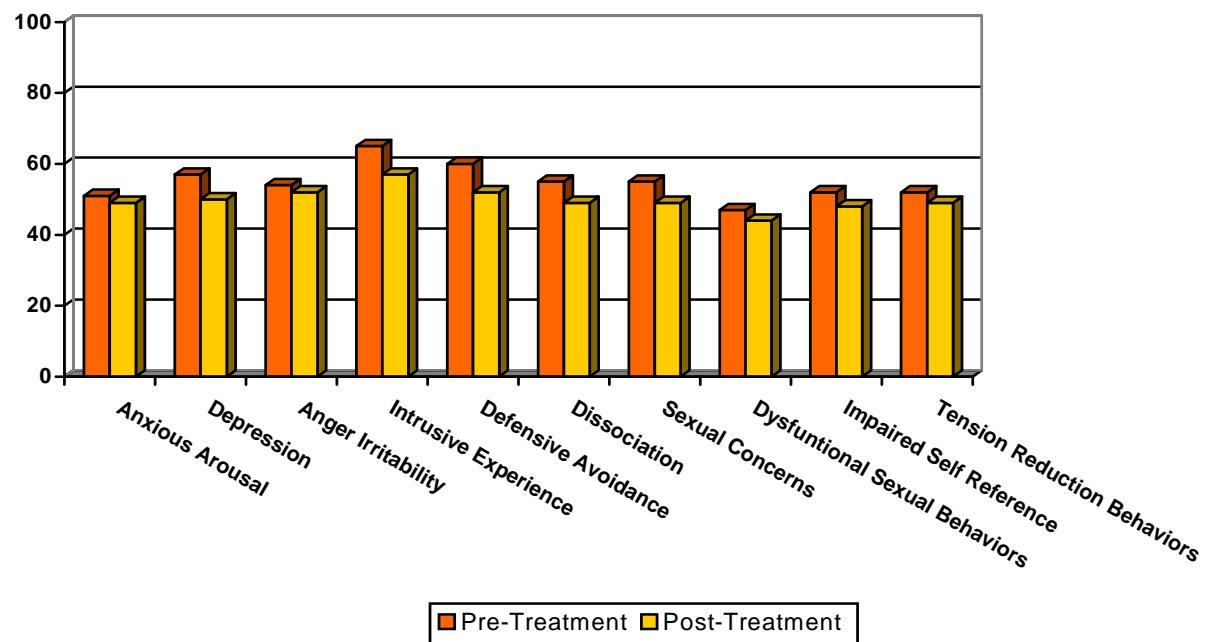


Figure 21. Jake – Trauma Scale Inventory (Briere, 1995)

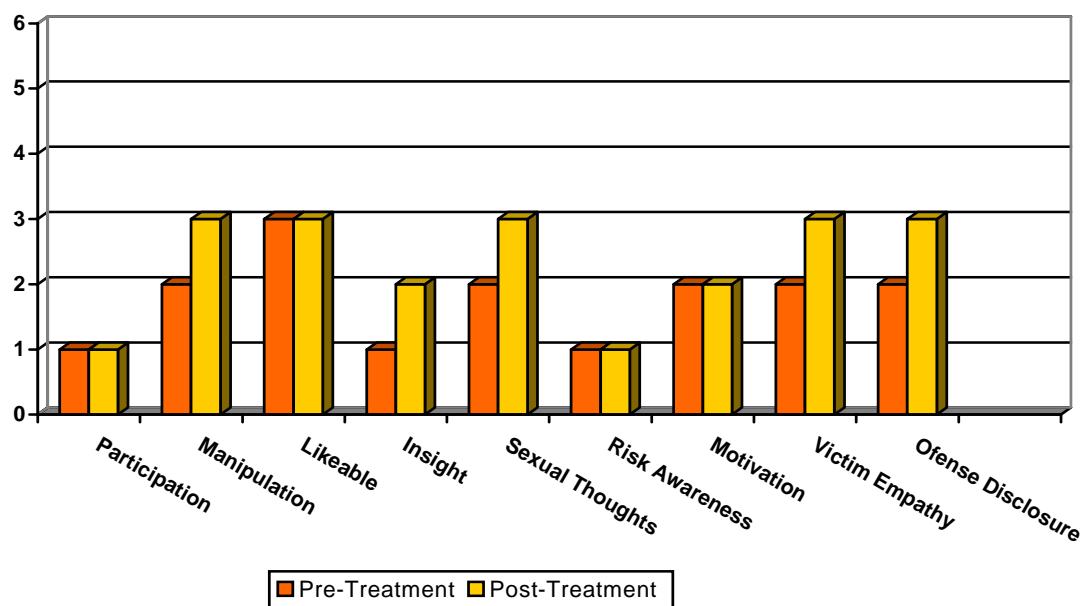


Figure 22. Jake – Sex Offender Treatment Rating Scale (Anderson, Gibeau, & D'Amora, 1995)

Ryan

Ryan is a 28-year-old Caucasian male who appears slightly younger than his stated age. He is below average in height and of small build, with no noted abnormalities of gait, posture, or facial expression. His memory recall appears to be within normal limits. Ryan reports no history of mental or physical illness and no use of prescription medication or illegal substances. He appears to be of average to above average intelligence and holds a bachelor's degree from an accredited university. Ryan is the only child of an intact family unit. He lived with his parents until recently. Ryan describes a very close and supportive relationship with his parents. However, he also acknowledges that when he was a young boy he often felt neglected by his parents whose focus was on other children for whom they provided daycare.

Before his arrest Ryan worked in a children's home, which is where he gained access to his victims. His offenses span several years and involve seven males ranging in ages from 10 to 14. His offensive behaviors include performing genital fondling and fellatio on his victims, several of whom he believed to be asleep at the time. Ryan's offending began in his early 20s, however he admits he considered offending earlier than that but was without opportunity. Ryan meets criteria typology of a pedophile, meaning his sexual preference is to children over adults. Ryan has recently come to admit his homosexual orientation, although he struggles with this given the proscription of homosexuality by his church.

An older male cousin offended Ryan when he was approximately 12 years old. This cousin reportedly fondled Ryan's genitals several times under the guise of wrestling. Ryan reports that he eventually told his father of the behavior. His father minimized the offense, telling Ryan that many boys go through same-sex exploration, and asked Ryan if he had sexual feelings

for males. This response by his father left Ryan feeling confused and uncertain about appropriate boundaries and behaviors. Ryan also reports that his father frequently lay in his bed as he fell asleep and rubbed his body. He recalls several times when his father rubbed his pubic area beneath his pajamas. Ryan does not consider himself to have been sexually abused by his cousin nor by his father.

As treatment progressed, Ryan began to perceive that he had been sexually offended, although he remained conflicted about responsibility. He continued to hold himself accountable, believing that his homosexual tendencies were a factor. He also did not see it as problematic. It was evident that this was not to be a significant area of change for Ryan, so we collaborated on an alternate treatment target. The primary focus of his treatment was to process the feelings of abandonment and neglect he felt by his parents. Another focus was to process the distortions he held about masculinity, resulting from a childhood of hiding and struggling with his sexual orientation. Ryan began to separate the concept of sexual orientation from that of masculinity. As a result, he improved self-acceptance. This gain is evident both in his session and interview data, as well as on the decreased score of impaired self reference on the TSI to sub-clinical levels as shown in Figure 22. Figure 23 represents pre- and post-treatment scores on the SOTRS. Ryan's largest gains were on measures of participation and sexual thoughts. Ryan's increased self-confidence was reportedly noticeable to his other group members. Ryan cites his largest treatment gain to be in the area of self-acceptance, to which he attributes his increased engagement and openness in treatment.

Ryan would benefit from further treatment. It is of concern that he maintains responsibility for his abuse, attributing it to his homosexuality desires. This belief lays the groundwork for Ryan to maintain distorted thinking about his victims' culpability – particularly

those who may be homosexual as well. This may account, in part, for his lack of progress on the measure of victim empathy as illustrated in Figure 23. Despite improved self-acceptance, he struggles with the realities of his homosexuality which conflicts with his religious beliefs. This increased his negative perception of masturbatory (tension reduction) behaviors, sexual concerns, and dysfunctional sexual behaviors as evidenced by self report and TSI results. Tension reduction behaviors and sexual concerns remain at or increased to clinical levels post-treatment. All other measures remained or fell below clinical significance post-treatment.

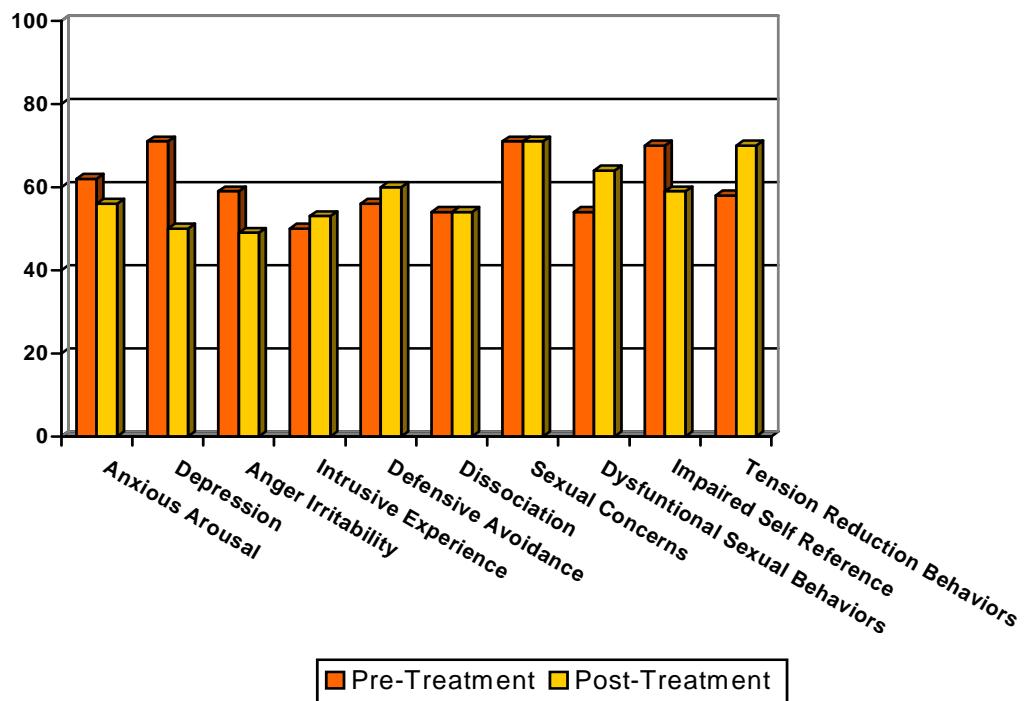


Figure 23. Ryan – Trauma Scale Inventory (Briere, 1995)

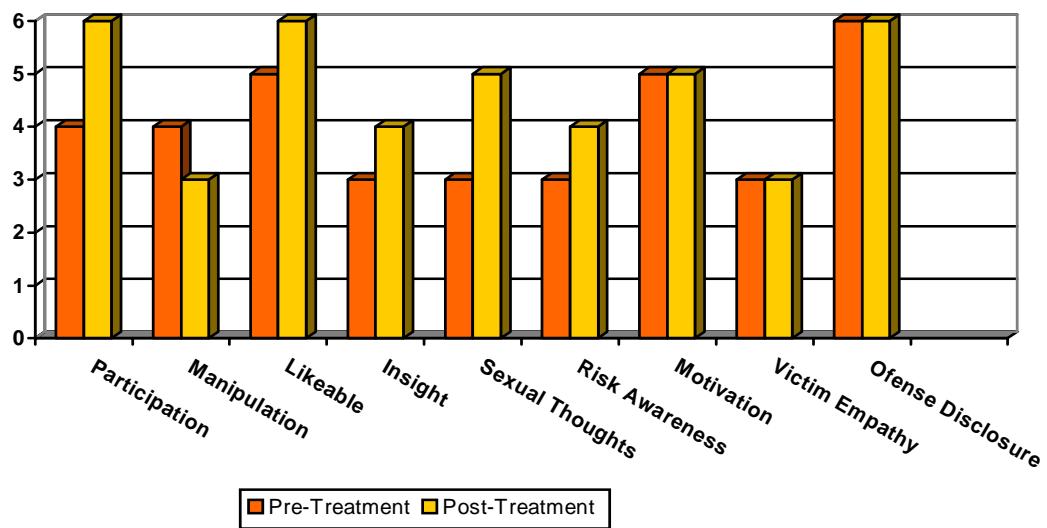


Figure 24. Ryan – Sex Offender Treatment Rating Scale (Anderson, Gibeau, & D'Amora, 1995)

CHAPTER V: FINDINGS

This chapter outlines the themes emerging from the grounded theory data analysis. The Coding Scheme is presented in Appendix B. In accordance with step 3c of Bischoff's, McKeel's, Moon's, and Sprenkle's (1996) model I first present themes related to the development of treatment protocol. Next I present themes generated from the data that relate to the original research questions. I also present findings that were not specifically part of the original research questions, but rather emerged from the data (Strauss & Corbin, 1990).

Themes and Sub-themes That Inform Treatment Protocol

Client's Perception of Trauma

This theme was derived primarily from data generated in my research journal and from the initial client interview. Two profiles emerged for clients who were referred for EMDR treatment by their primary clinicians.

Disturbed by the memory

The first was clients who acknowledged their history of sexual abuse, and were clear in recognizing the negative impact it was having on their current lives. These clients typically showed elevated responses to measures on the TSI. They also demonstrated emotional responses when topics surrounding their own abuse, or their sexual perpetration, were broached. The following journal entries and quotation illustrate this profile:

“[Client] demonstrated tearfulness and halted speech during initial meeting as he attempted to describe what he recalls of his childhood sexual abuse by [his perpetrator].”

“[Clinician] reports that [client] has frequent anger outbursts in group and has threatened violence when asked to discuss either the details of his offending, or the details of the sexual abuse he experienced by [his perpetrator].”

"I can't do what they, how they're asking. It tears up my insides, all over. It ain't that I don't want to. I do. I know what I done was wrong. I, I, it just makes me keep seeing him. And what he done to me."

Unaffected by the memory

The second profile was that of clients who remembered their childhood sexual abuse, yet felt strongly that it neither bothered them nor affected their current lives or functioning. Approximately half of the clients referred for EMDR treatment fit this profile.

"[Client] doesn't see the need to engage in EMDR treatment despite [clinician's] recommendation. He believes that he was fully aware of what [perpetrator] wanted and was doing, and that he was a consenting participant. He also believes it made him a stronger person."

"I guess to where it was so long ago it just don't bother me. I mean, I remember it and everything like that, but...but it didn't hurt me. I think maybe if he had hurt me, you know, like [another client's] offender....but he didn't, you know. And it give me the opportunity to go places with him...where as I wouldn't probably have got to."

The evidence of these dissimilar profiles informs the way in which clients were encouraged to engage in treatment. As with most therapies, the client must be able to see some potential need for, or benefit from, engaging in treatment. With this population, additional caution needed to be used given the fact they are adjudicated to CBT-RP treatment as a condition of their probation or parole. It was important to make clear to potential participants that this adjunct treatment was not required. Additional themes emerged that imply effective methods of engaging the client in trauma resolution treatment.

Client's Caution and Fear about Engaging in Treatment

A theme that emerged was that of caution and fear on the part of participants when

thinking of engaging in the EMDR treatment protocol.

“My first reaction was kind of I was cautious about it. I wasn’t exactly too sure what it meant. And then, uh, I was a little scared.”

Although I used the same explanation for these clients as I have for many years with other clients with whom I suggest EMDR, these participants had an overall sense of hesitancy. One possible explanation is that this population is fearful about treatment overall since it is tied to their probation and parole guidelines. Non-compliance with treatment guidelines can result in a parole revocation and a return to incarceration. Similarly, clients are acutely aware that any disclosures of previously unrecognized offenses are reportable and could result in additional legal charges. Although these explanations were not evident in the data it is possible that these clients would not verbalize these fears. Instead, they described fears about having to deal with the memories and emotions of their past:

“Real scared, because I would have to bring up the past. I hadn’t never talked about it. I hadn’t never talked about my granddaddy”.

Therapeutic Relationship

A related theme emerging from the data was the importance of the therapeutic relationship. Clients overwhelmingly reported that it was the comfort they felt with the treating clinician that encouraged them to engage in the treatment, despite their fears. Some representative quotes are as follows:

“The comfort with [EMDR clinician]. He, uh, he made me feel like, uh, I could talk to him. I could tell him anything. It wouldn’t shock him.”

“If I get pressured, see, I’ll shut down...it was, [EMDR clinician] was nice, and I mean he’s just very comfortable with me. Very comfortable with me.”

One client's report indicates he perceived the therapeutic relationship as more important than the EMDR process:

"Well, I think the main benefits that I got was it finally let me discuss being molested, with somebody that I could really talk to, and that I felt comfortable talking to."

Therapeutic relationship has often been cited as a primary component of treatment outcome (e.g., Horvath & Symonds, 1991; Lambert & Bergin, 1994; Lambert, DeJulio, & Stein, 1978). However in this study it appeared that not only was it possibly a component of outcome, but also a key element in the client's decision to engage. Sex offender clients may be distrustful, hyper vigilant, and may have experienced serious ruptures in attachment. A necessary element of treatment protocol, therefore, is the development of a solid working therapeutic relationship before the implementation of EMDR begins.

Perceived Benefit to Self

In terms of treatment protocol, a strong theme of self-help emerged which indicates an approach the treating clinician might take to encourage a client to engage. Some quotes representing this theme are as follows:

"...I figured if it...makes that more clear, maybe it can give me some insight into what, where all this started with me, and why I went in that direction."

"I thought maybe it would help me with my past. And, uh, and show me when I was offended. And what happened to me when I was molested."

"I want[ed] to get my life straight. I want[ed] to be as normal a human being as I can."

Leading and Pacing

Another theme that was prevalent was that of clinical leading and pacing, which clients identified as instrumental in keeping them engaged in a difficult process:

“...there was this little area there that I didn’t want to show up (for EMDR sessions) because I knew where I was going and what I had to do...it worked good because he would sit down and say ‘okay, are you ready?’ If he was to give me any leeway on that some days I would have refused to get into it. He didn’t give me any door or I wouldn’t have.”

Safety Plan

A skill that many in this client population seem to lack is the ability to manage their emotions without using maladaptive coping responses (e.g., substance abuse, sexual offending). It is thereby indicated that extra precaution be taken with this population when preparing them to engage them in the EMDR process. Use of Shapiro’s (1995) installation resource protocol is warranted. Additionally, developing a safety plan relying on an outside support network is prudent practice with this population, particularly in cases where high risk factors such as addiction exist.

High Risk Factors

“...on the way home (from a session) I just pulled off on the side of the road and cried right there. I thought, I don’t really want to do this. And to be honest right there, I come close, I would have went and bought a six-pack except I didn’t have no money on me”.

One high-risk client described his use of the coping mechanisms we had put in place as follows:

“I think in the beginning...it was hard to keep me focused because it was just a whirlwind. And I’d catch myself doing, the day of, just feeling awful because of what it was opening up and things that like I didn’t remember of course would just burn into my brain. Just a lump would come up in my throat and just wanting to cry. But I kept talking to [girlfriend] like we said. I just kept telling her what was going on. That really got me through it.”

Another client with a history of psychotic features required hospitalization at one point during the EMDR treatment due to a suicide attempt. At the onset of treatment, a safety plan including crisis access, ongoing coordination with his primary case manager, and a written safety contract was put into place. These precautionary measures were valuable in helping this client access support during his crisis.

Reconciliation of Treatment Philosophies:

Another primary theme that emerged was the importance of reconciling the divergent philosophical points between the EMDR and CBT-RP treatment models. A component of CBT-RP treatment is to recognize, address, and alter distorted beliefs. A component of EMDR is to allow a free-flow of ideas, which may or may not be distorted, so that the brain might untangle the irrational beliefs that accumulated as a result of a trauma. This necessitates open communication between the EMDR treating clinician, the primary clinician, and the client. It also requires the support of the primary CBT-RP treatment team.

Clinical Cooperation and Support

“I was scared to say that I had these thoughts of hurting [my perpetrator]. I didn’t want to get locked up because I was threatening...saying I [felt like I] wanted to kill [him]. But I had [my counselors] here and it made me confident enough to know that if I couldn’t deal with it I can pick up the phone and call.”

Cognitive Distortions

Recall in Samuel’s treatment the cognitive hurdle he was unable to overcome regarding his “cognitive distortions” until his primary clinician gave him the freedom to explore those through EMDR:

“My group says I can’t be having these thoughts. That it’s [messed up] to think that what

he done to me has something to do with what I done. I can't be thinking that."

Fantasies

Sex offender clients in CBT-RP treatment are admonished about entertaining "fantasies."

Oftentimes participants needed the permission from their primary clinicians that, for the purposes of this adjunct treatment, it was appropriate to allow fantasies temporarily:

"When I hear the word fantasy, I, it makes me nervous. I don't want to...I can't go there. I can't."

"I guess too if I were to spend a lot of time thinking about [being sexually abused] I don't know where if I would try to turn it into a fantasy or, and I don't know which way I'd really go with it."

Secrets

Finally, a theme related to communication between the two systems is that of secrets. Clients in this CBT-RP program culture are aware that maintaining confidential information is not allowed. The belief is that sexual offending survives and thrives in an atmosphere of secrecy, and openness is a means of altering that environment. However clients often felt shame initially as they began to discuss their personal histories of sexual victimization. There was evidence of concern about proceeding with the individually focused EMDR work for fear that their disclosures would be shared:

"...this is getting easier to talk about, but I just don't want my Dad to know [the details of my sexual abuse]. He hates queers. If he has to know, I don't want to do this anymore."

"I am thinking stuff, but...are you going to tell the group about this stuff? Because I don't want to say it then. It's too shameful, embarrassing. I'd better not tell you."

Themes and Sub-themes That Relate to the Research Questions

In this following section I report themes and supporting data addressing the original research questions. The questions that are addressed include:

1. How might trauma-focused EMDR treatment augment CBT-RP group treatment for sexual offenders?
2. How do sexual offenders experience trauma-focused EMDR treatment?
3. What implications might this enhanced treatment model have for clients and their families?

Question 1. How might trauma-focused treatment augment standard treatment for sexual offenders?

Figure 24 represents mean scores from the SOTRS for all participants. Recall that the participant's primary clinician who has the opportunity to observe him weekly in his group treatment completed these instruments. Overall treatment gains were made in every category, with the largest gains made on measures of participation, victim empathy, and offense disclosure.

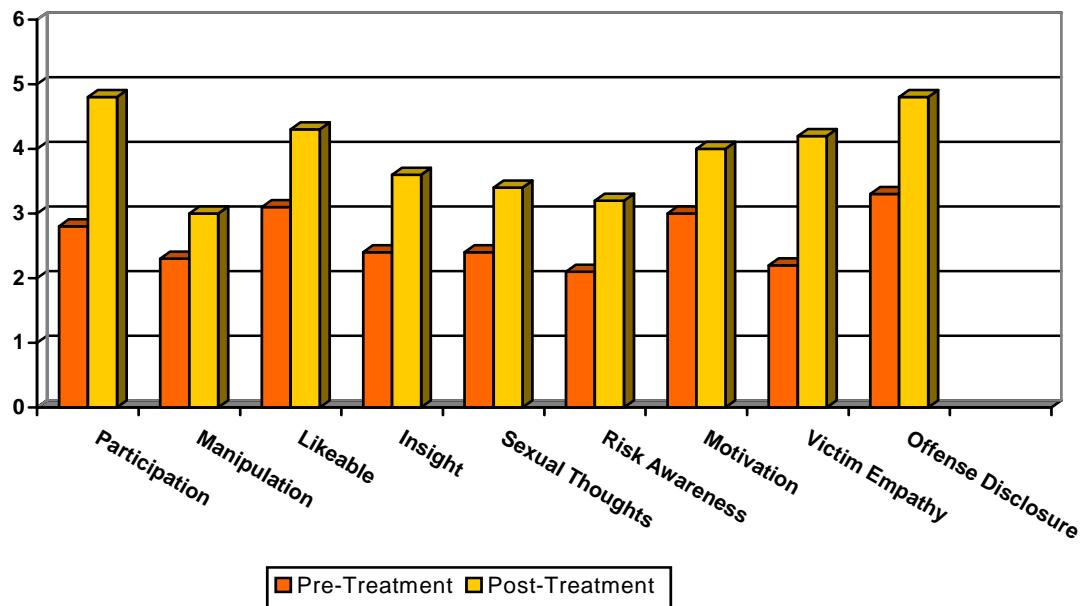


Figure 25. Mean scores for all participants on Sex Offender Treatment Rating Scale (Anderson, Gibeau, & D'Amora, 1995)

The following themes and representative quotations address this same research question.

Recognition of Contributors to Distorted Beliefs

A theme related to this question is the clients' ability to begin to recognize the development or origin of cognitive distortions related to their offending pattern. Some examples of clients' discoveries of their distorted thinking that they related to their own victimization are as follows:

Cognitive Distortions

"I think what he done to me made me think it's okay to have sex with younger people as long as you don't force them. As long as they say 'okay'."

"I remember that's when I started up to thinking that it's okay to use people, as long as it feels good to you."

“It didn’t hurt. He didn’t hurt me. Sometimes it even felt good. I thought about it a lot afterwards. I’d masturbate and think about it. I can’t explain why. I told myself that [my victim] was feeling like that. That he was liking it, like I did.”

“Knowing that I myself was a victim in the past, it’s helped me. I look at them now, and I go to myself ‘hey, that’s just a kid’.”

“I see now to where [my victims] didn’t really want me. You know, sexually or nothing like that. It was just to where they were wanting some attention, like I did with [perpetrator].”

“Where before I had myself kind of convinced that my victims really wanted what I was doing. And, uh, I think that it really helped me to just see the damage that I done.”

“I see now where she was just a kid. A baby really. And I was just a little kid too.”

Accountability

Also evident was the related theme of distorted thinking about their accountability for their offending:

“... I was blaming him for what I done. For what I molested my victims. I was blaming my Granddaddy. But then after the third (EMDR) session I knew it wasn’t his fault. No more than it was my victim’s fault.”

“I wanted to...take me being abused and blame what I had done, my [offending], on all that.”

Increased Participation in Group Therapy

Participants also described reasons they believed they were willing to be more active in their CBT-RP group sessions:

“I ain’t afraid to ask questions [in group] no more.”

“..it changed how I feel about myself and kind of raising my head up and that I am a good person and do have good things to offer in group, and to other people too.”

A related theme is that of an increased feeling of staying focused on CBT-RP group tasks:

“I think I got more in touch, here where I’m working on my (offense) pattern. I got more in touch with what was really going on with my victims, and how I did go about grooming them and everything...getting to see where I was a victim...helped me to look at both sides of it. I had a hard time explaining my (offense) pattern before.”

“Two weeks ago I did my (victim impact) presentation, and uh, I was, it helped me. I could talk about it, and it was okay.”

Increased Empathy

Another important goal of CBT-RP treatment is development of empathy. This theme of increased empathy was also prevalent in the data:

“ It helped me, uh, understand more about myself and other people.”

“As far as making love with [girlfriend], I’ve never been like rough you know, but it seems like now I have more of an understanding about her...”

“So like I say, if you don’t understand yourself, you’re not going to understand others.”

“...it’s kind of opened my views up on how they must really feel, and the heartache and pain I put on them.”

“I can, I can feel the hurt of my own victimization, as well as my victim.”

Clarification of Thoughts

The following metaphor represents another emergent theme was that the treatment helped clarify general thinking.

"It used to be like, like my mind was like a plate of spaghetti. I'd look at it, and it was all mixed up, twisted. Now my mind, it's like there's meat here, and potatoes, and a vegetable over here. It's like that now."

Raised Consciousness as a Self-Management Tool

Participants also described a decrease in, or better management of, deviant thoughts. The data suggests that participants cite a raised consciousness as a means to better manage their deviant thoughts.

"Yeah, I would see something that would [arouse] me...but once I been made aware of my own childhood, I can try to keep an eye on it. And if I get to that spot, like I say, I can stop myself now. I say 'you don't need to go there'."

"I noticed before [some things] would kind of arouse me a little bit. Uh, watching a movie like Jodie Foster (*The Accused*) when she fell victim to, uh, the gang rape. I [was] where I'd have deviant thoughts of her to the crime. And I didn't have that with this one. And a few other movies that have come on TV since doing [EMDR]."

Self-Esteem

"[The treatment was] well worth the time. I don't know where I would have been about as far as actually being able to feel good about myself. It made me feel good inside. About myself."

"...it made me understand more about how it was I can't help how I am (homosexual), you know. I can't do nothing about that."

Emotion Recognition and Management

"...and I was suppressed a lot of things which in the end result (laughs) helped me get where I am, which is the worst of who I am. I just couldn't cry, I just shoved it away like shoved

it down, if I thought about it I just blocked it, blocked it, just stomped on it for all those years until now.”

‘I had a disaster in my brain. I think it helped me. I think I can use it for just to take time to sit and think at lunch or whatever, just sit and close my eyes and focus on what’s really bothering me and process it out.

Question 2. How do sexual offenders experience trauma-focused EMDR treatment?

Themes on this item revealed mixed reactions to the treatment process. Clients acknowledged the bilateral process as being helpful to being able to focus on the difficult material of their past, however registered some skepticism about the process in general.

Stay Focused on Difficult Material

“...it was like a rhythm that I got into and it really helped me to look at my past, in my own mind.”

“I thought at first, well, you know, this was just a clap clap clap thing right there. But then as I got into it, it actually put my mind at ease as far as what I needed to draw out...”

Skepticism

“I felt a little uncomfortable at first, but then as he progressed into it a little bit more I felt a little better about doing it.”

“I guess I was a little skeptic, ah, and the word hypnosis kind of got..I thought maybe I’d come to and not have a clue of what I said.”

Question 3. What implications might this enhanced treatment model have for clients and their families?

Increased and Improved Communication with Family and Friends

The theme of increased communication was evident in regards to network and family relationships. Clients described increased family communication related to sub-themes of:

Forgiveness

[My mom and I are] getting along great now. And, uh, I don't think about that, what happened, that she didn't believe me and all."

Decreased feelings of shame:

"...now I know that people (in my family) ain't going to think less of me, because I wasn't to blame (for what happened to me).

and Increased awareness of a need for relationships:

"I need people to need me and to want me, and I never knew that. I only have a select few people I associate with and they've seen a difference in me on how I do..."

Resolution

Another theme that emerged which, though not specifically tied to the research questions, was prevalent in the data. This theme, resolution of traumatic memories, is at the core of the theory behind this treatment model. I present several representative quotations under sub-categories that support this theme:

Acceptance:

"Uh, you know. It was terrible. But I can go on with life and live. Since it's been brought out I can accept it. And before, I couldn't accept it."

"I think I'm aware of that it happened to me and I think I've come to terms with that."

Decreased sense of self-blame

"Before, I felt like it might have been my fault, what happened. But now, I, you know, I don't. Because now I feel like it was his fault. I really believe that now."

"It used to be, you know, just feeling bad. Just feeling no good, thinking about what happened to me sometimes [that would make me cut myself]."

"Now when I talk about it, I don't get the embarrassment feeling. Stuff like that."

"[Being offended is] not my fault and it wasn't right. That feels good to say that now, and it didn't before. [That] wasn't believable a few months ago."

Desensitization

"It's like pulling a thorn out of your foot that's been there for a long time. And I can go on a whole lot better without that sharp pain that's always been there."

"When I think what happened to me as a kid, and, I can look back at him and just say, it can just go out of my mind. Doesn't bother me."

Reprocessing

"I can see now where there was some love (from other family members), too. You can't always feel love. Sometimes you just have to know it's there. And now I know it was there. Now I can feel it."

"I don't feel sorry for myself. I knew it happened. There's nothing I can do to change that. The only thing I can do is to try to understand every little chunk of it that I can."

While most of the responses to trauma resolution treatment were positive, participants raised some negative points. Although these themes were not evident across data, they bear mentioning.

Loss of Sexual Desire

“...with my girlfriend, I didn’t want her. I didn’t want to have sex. I really felt we really don’t need this in our lives”

Ineffective in Reducing Deviant Arousal

“I’m not saying that I still don’t have some sexual arousal to teenagers. Uh, I think that a lot of that will have to do with, uh, you know, how much time I would spend, you know, dwelling on teenagers.”

Summary

Themes and sub-themes emerging from study data lend support to the idea that CBT-RP sex offender treatment may be enhanced by the addition of a trauma resolution component for those clients who recall childhood sexual abuse. The data indicate that the benefits result whether or not the client perceives his sexual abuse as traumatic. The data suggests an increased willingness and/or ability for participants to engage in CBT-RP treatment. Other themes relate to the difficult but important CBT-RP treatment goals of victim and general empathy (Murphy, Abel, & Becker, 1980), awareness of harm done, and cognitive restructuring (Abel & Blanchard 1974; Cautela, 1967, 1970, 1971; Neisser, 1976). Recall also the addition of social skills deficit training (Becker, Abel, Blanchard, Murphy, & Coleman, 1978) that became an important consideration in the CBT-RP model’s treatment goals. The data also suggests improved feelings about self. This concept relates to the early stages of the CBT-RP sexual offense pattern where negative emotional feelings can set off the offense cycle (Becker & Murphy, 1998). Finally, the data suggests that trauma resolution promoted interaction with family and others by reducing the communication barriers of shame and anger, and by raising awareness of the need for interpersonal connection. Salter (1988) emphasizes the importance of open communication and

the development of support networks in building working relapse prevention (RP) plans.

CHAPTER VI: DISCUSSION, FUTURE RESEARCH

In this section I first apply findings from this study as they inform the development of treatment protocol. I next consider the findings presented in chapter V as well as extant research as they relate to the original research questions. I then discuss theory that emerged from the study. Finally, I discuss some ideas for exploring this theory via future research.

Discussion of Treatment Protocol

I begin with points that were evident in the session transcripts, progress notes, and the research journal that I maintained throughout the project. Session transcripts and progress notes served to guide and inform the treatment process on individual cases. The journal served to highlight hurdles, raise questions, and track changes that developed overall as the study progressed.

I was generally able to adhere to the standard protocol for EMDR (Shapiro, 1995). However, the data revealed several points specific to work with an outpatient sex offender population:

- a) Clinicians should familiarize themselves with sex offender specific treatment before undertaking this treatment process. There are many facets of working with sex offenders that may be counter-intuitive for clinicians working in more traditional mental health fields.
- b) Clients should be screened carefully before engaging them in this treatment intervention. My clinical experience has shown me that sex offenders with a history of psychosis are not appropriate for this treatment in an outpatient setting. Furthermore, strong safety plans and outside network support should be developed before beginning this work with clients having histories of high-risk behaviors such as substance addiction or suicidal

ideation or attempts. Recall that Mikulincer, Florian, and Weller (1993) supported their hypothesis that those with avoidant attachment styles may not be able to recognize themselves as depressed or anxious, and their maladjustment to trauma may be manifested maladaptive coping responses.

- c) A working therapeutic relationship emerged as a key element of participants' willingness to engage in EMDR treatment. Attention to the joining and preparation processes seems particularly important with this population.
- d) Clinicians providing trauma resolution treatment to sex offenders should arrange to have close collateral contact with the primary treatment provider conducting sex-offender-specific treatment. Philosophical differences between the two treatment models must be recognized, acknowledged, and addressed as treatment progresses.
- e) Clinicians need to remain acutely aware of the legal and ethical considerations of working with this population. Clinicians and sex offender clients must be reminded that any admission of offenses not previously disclosed must be reported to the proper authorities. Furthermore, clinicians should make the sex offender client aware of the free and ongoing communication that will occur between the treatment and supervisory teams.
- f) My clinical experience indicates that sex offenders often present themselves in a favorable light. Feedback from sex offender clients, including feedback about treatment results, should be received with caution. Objective and physiological measures (e.g., polygraph, penile plethysmograph) are an important indicator of treatment progress and community safety.
- g) Any recommendations made to probation and parole and / or the legal system should be made by a qualified and / or certified sex offender treatment provider.

Figure 25 illustrates the treatment protocol resulting from my systematic treatment development. It is grounded in Shapiro's (1995) eight phases of EMDR treatment protocol. This expanded protocol accounts for the emergent themes of the importance of establishing working relationships with the primary treatment team, with the legal team, and with the client. It considers the necessity to establish alternative treatment goals when clients perceive their sexual abuse history to be non-problematic. It also emphasizes the importance of developing outside support networks where there exist high risk factors such as suicidal attempts or substance abuse histories. In the event these networks are unable to be adequately established, the recommended protocol is to stop application of this treatment. Finally, in cases where therapeutic movement is not evident, it suggests shifting the treatment focus to targeting emotional triggers such as impaired self-esteem, or distorted beliefs such as sex equals love. Desensitizing internal cueing to these triggers helps to strengthen the offender's ability to intervene early in his sexual offense pattern.

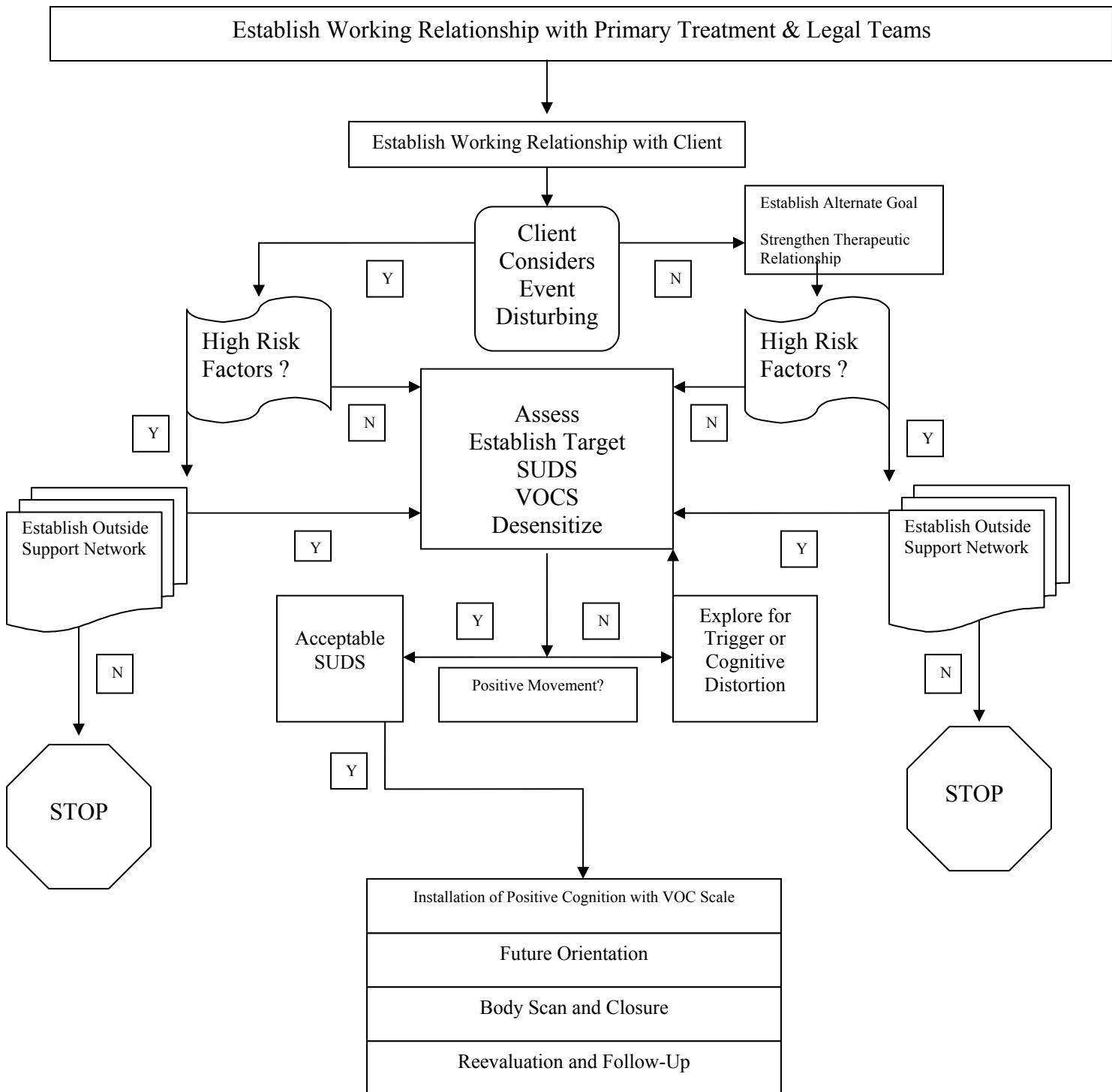


Figure 26. Flow chart depicting treatment protocol for using EMDR with sexual offenders .

Discussion Related to Research Questions

The primary research question explores the impact of adding trauma resolution treatment to standard CBT-RP treatment. The participants' improvement in treatment was evidenced both by self-report as well as the individual and collective scores from the SOTRS as shown in Figure 24. In the following section I discuss the emergent themes that apply to the primary research question.

Data revealed that participants both recognized and clarified distorted beliefs about their sexual offending. The measure of sexual thoughts showed improvement on the combined, post-treatment SOTRS. A fundamental principle of the CBT-RP treatment approach is that attitudes and beliefs play a major role in precipitating and maintaining sexually offensive behavior (Bickley & Beech, 2003). Addressing cognitive distortions is an integral part of CBT-RP treatment (Geer, Estupinan, & Manguno-Mire, 1999; Marshall & Eccles, 1991). Feminist theories (Brownmiller, 1975; Herman, 1990), social learning theories (Finkelhor & Lewis, 1988; Freeman-Longo, 1986; Howells, 1981), systems theories (Bentovim, 1996), and cultural theories (Grubin, 1990; Sanday, 1981) about sexual offending all incorporate the concept that cognitions can engender and support actions of sexual deviance. The clarification and restructuring of cognitions to align with the values upheld by our society, and those promoted by CBT-RP treatment, serves as an inhibitor to re-offending. The data suggests that participants progressed in that area following trauma resolution treatment.

The data revealed that after the treatment clients reported and demonstrated more engagement in their CBT-RP group treatment. This included both group discussions and verbal presentations. Changes in measures of participation and motivation on the SOTRS indicate that participants' primary clinicians concurred. Client involvement is essential to most theories of

change. Client participation and motivation are primary components of Prochaska's, Norcross', and DiClemente's (1994) transtheoretical model of change. Readiness for and engagement in the therapy process are fundamental in initial phase procedures of therapy (Brock & Barnard, 1988). Whitaker considers the first two essential phases of therapy to be engagement and involvement. Solution focused therapists rely on client involvement to negotiate a workable problem. Goals for behavior therapy are defined by the client. CBT-RP treatment requires clients to learn concepts, to complete homework assignments, and to present their work. These models posit that clients who are more engaged in the process of their therapy are more likely to derive some benefit. Looking specifically at treatment for sex offenders and sexual compulsives, Warren and Green (1995) integrate techniques to develop motivation into their Southwest Sexual Compulsivity Program. They hold that the offender will lack motivation for change unless he perceives some benefit equal to the challenge of developing and maintaining a new lifestyle.

Empathic ability showed increases over multi-data points. The measure of victim empathy on the SOTRS most closely represents this quality, and it was among the measures showing the largest improvement. Qualitative data also revealed themes of increased understanding and awareness of victim impact. Murphy, Abel, and Becker (1980) emphasized the importance of empathic skill enhancement as an integral part of CBT for sexual offenders. Schwartz (1994) supports the addition of empathy training to standard treatment for sex offenders. Empathy skill training is a priority objective for 94% of treatment programs (Knopp, Freeman-Longo, & Stevenson, 1992). This treatment objective is driven by the idea that increased offender empathy strengthens internal inhibitors against re-offending (Hilderbran & Pithers, 1989).

The factor of thought clarification may be best represented by the measure of insight on the SOTRS. Participants' reports of improved insight are supported by the increase shown on the collective SOTRS. Cognitive Therapy is based on the theory that affect and behavior are determined by the way one structures the world (Beck, 1976). Increased insight into one's sexual offending behaviors is essential for documenting an accurate and realistic personal sexual offense pattern. Clarity of thought is important to being able to recognize patterned behavior, and to invoke and apply interventions developed in the RP plan. These ideas also support the emergent theme of raised consciousness, which participants cite as an important self-management tool. Recall Lane's (1997) position that understanding for the offender of his own thinking, affective, and behavioral reactions is intended to allow the offender to cope more adaptively.

Finally, there was evidence of increased self-esteem and improved emotion recognition and management. A key component of CBT-RP treatment is to identify and manage triggers or risk factors (Becker & Murphy, 1998; Pithers, 1990; Salter, 1988) that can set off the offense cycle. Triggers are those internal and external items to which the offender is vulnerable, and which can result in negative thoughts and feelings. Negative self-esteem is one example of such an emotional trigger. Offenders oftentimes name an impaired sense of self as a trigger that can be activated by both major and minor life stressors. Recall Anechiarico's (1998) idea that "Sex offending...is an extortion of intimacy in an attempt to restore damaged self esteem" (p.18). The data suggests that this area feels less problematic to those participants completing EMDR treatment, thereby making them less vulnerable to the effects. Equally important is that in order for the offender to invoke his pre-determined intervention in the RP plan, he has first to be able to recognize the existence of a trigger, and next to be able to effectively manage it. The theme

that emerged from the data indicates these to be important factors that could assist offenders in successfully navigating triggers and the early stages of their offense cycle.

The third research question explored the impact trauma resolution treatment may have on family and social networks. The major theme of improved relationships was evident. Participants felt more engaged socially both with family and friends for a variety of reasons (i.e., forgiveness, decreased shame, desire for relationships). As participants and their families become less avoidant in their discussions of these difficult topics, the potential exists for the family to move towards becoming a more open system. Child molestation typically exists in environments of reticence and secrecy (Salter, 1988). Also, isolation is often cited as a risk factor of recidivism for sex offenders. Recall that Bentovim (1996) concludes that a characteristic of trauma-organized systems is that there is no confiding person to counter stressful effects. Recall also McFall's (1990) position that child molesters are more likely to have fearful or preoccupied attachment styles. This is consistent with research showing evidence of social anxiety, poor social skills, and intimacy deficits in this population (Marshall, 1989, 1993; Seidman, Marshall, Hudson, & Robertson, 1994). Marshall, Seran, and Cortoni (2000) have increased their focus on these deficits and sexual offending. Geer, Estupinan, and Manguno-Mire (1999) consider social skills to be among the most important areas of focus in sex offender treatment. Finally, recall Anechiarico's (1998) position that sex offending "is not only a behavior disorder but also a relational disorder." (p.18). The idea that participants report increased interaction with support networks, therefore, seems hopeful.

This theme in particular has important implications for marriage and family therapists. EMDR trauma resolution treatment is largely an intrapsychic process. However, the data reveals that it can serve as a perturbation to all levels of the human system – intrapsychic, familial,

community, and societal. Recall the case summaries of both Mark and Jake. After resolution treatment, these men initiated discussions with their families about the details of their abuse and their offending. In both cases this occurred after many years of silence. Watzlawick, Weakland, and Fisch (1974) label this second order change. In effect, the client's perceptual shift represents a reframe, and the family rules of silence and avoidance are changed.

Perhaps the relevance of the emergent themes discussed in this section is best summarized with a review of the generally accepted phases of CBT-RP treatment (Becker & Murphy, 1998; Pithers, 1990; Salter, 1988). These phases are reducing denial, correcting cognitive distortions or minimalizations, identifying internal and external risk factors, identifying and revising of arousal patterns, social competence training, assertiveness training, problem solving, and victim empathy.

Limitations

It is important to note the limitations of this project. First is the limitation of the fact that I was the sole EMDR therapist. This not only blurs attribution for change, but also brings into question the issue of transportability. Second, there is the possibility of system-wide influence and/or reactive assessment phenomenon given the confines from which participants were selected and in which they were treated. Participants were drawn from several sites of a single community-based treatment program, and all staff were aware of the project. Third and somewhat related is the fact that participants were selected from one region, were all Caucasian, and were similar in socio-economic status. Finally, as with all qualitative studies, my role as the researcher was not without bias. I bring to the project my own set of assumptions, values, and beliefs that form the lens through which I interpreted the qualitative data. Though I make no

apology for my bias, I concur with Kirk and Miller (1986) that objectivity is essential to all good research, including qualitative research.

I attempted to account for these limitations in several ways. First, by remaining vigilant for competing explanations for apparent client change (Elliot, 2002) when analyzing qualitative data. Second, I followed guidelines outlined by Bischoff et al. (1996) described as a “rigorous method of model and technique development” (p. 430). I also adhered to grounded theory methodology (Glaser & Strauss, 1967) in an effort to ensure the systematic collection and analysis of data. Third, I used multiple data sources including self-report, other-report, observation, interviews, research journals, session transcripts, and physiological measures. By using multi-modal data points I hoped to mitigate possible effects of researcher, assessor, and participant biases. Finally, I employed independent interviewers to gather qualitative data in an effort to minimize bias and relational artifacts. The interviewers were not EMDR practitioners and reported limited knowledge of, and no bias towards sex offender treatment or EMDR.

Future Research

Trauma resolution was a prevalent theme across the data. This was evident both in participants who considered their own sexual abuse traumatic as well as those participants who originally did not. Reductions on TSI measures support participants’ reports, as did observational reports of participants’ affect by their primary clinicians.

At face value, the theme of trauma resolution does not factor into the purpose of this study – to explore if addressing childhood trauma might enhance CBT-RP treatment. However trauma resolution served as the theoretical framework upon which this study was developed. A preliminary axial coding of this theme with other findings points in the direction of support for Groth’s and Burgess’ (1977) Abused-Abuser Hypothesis, Finkelhor’s (1986) Traumagenic

Dynamics of Sexual Abuse Model, Rasumussen's, Burton's, and Christopherson's (1992)

Trauma Outcome Process Model, and Schwartz's and Masters' (1993) theory of sexual compulsion (see Chapter II for a review).

It is beyond the scope of this body of work to attempt level II theory development (Ward & Hudson, 1998a), which concentrates on distal or predisposing factors of sexual offending (Lanyon, 1991; Marshall 1996). Theories on the development of abusive behavior remain non-definitive. The findings herein, however, support a call for future research that delves more deeply into this area of inquiry. An empirical study designed to control for multivariate determinism could illuminate factors that drive sexual deviance and abuse. These findings would then inform a protocol such as the one used in this present study, and perhaps increase its efficiency and/or effectiveness.

Objective measures reviewed during the study included polygraph examinations and penile plethysmograph assessments. Clients in the program from which participants were selected undergo maintenance polygraph examinations every six months. Therefore, all participants involved in this study had at least one polygraph examination during the course of this project. Maintenance polygraph examinations function to detect recidivism. None of the participants' polygraph results indicated deception in that regard. Penile plethysmograph data was reviewed where available. Though trends were positive, no consistent pattern emerged in this data. Several participants demonstrated clinically significant decreases in deviant arousal following EMDR treatment (i.e., Samuel, Alex, Richard, Kyle, Derek). One participant (Randy) demonstrated significant increases in deviant arousal immediately following treatment.

Although deviant arousal has been shown by research to be one of the strongest indicators of a risk to re-offend (Hanson & Bussiere, 1998), recidivism undoubtedly remains as

the definitive outcome measure. A controlled, long-range study using polygraph examinations as at least one outcome measure would be a clearer indicator of the efficacy of incorporating trauma resolution into standard treatment for sexual offenders.

This dissertation represents a first step toward exploring the benefits of including trauma resolution to treating the problem of sexual offending. Evident themes and patterns emerged which lend preliminary support to the idea. Perhaps the best evidence of the benefits is demonstrated by the programmatic changes adopted by the directors of the treatment program from which participants for this study were drawn. Clients are now screened at intake using the TSI or TSCC to assess for evidence of trauma symptomatology. Treatment plans for those clients who meet criteria now include intensive trauma resolution therapy using EMDR. This speaks to the favorable changes clinicians and clinical directors have seen in those who participated in this study. Perhaps future research will provide new tools to better address this difficult and serious problem.

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APPENDIX A

BASA = Behavioral Assessment of Speech Anxiety

BDI = Beck Depression Inventory

BRS = Behavior Rewards Scale

CAPS = Clinician Administered PTSD
Scale

CEQ = Credibility/Expectancy
Questionnaire

CMS = Civilian Mississippi Scale for PTSD

COT = Credibility of Therapy Questionnaire

CROPS = Child Report of Post-Traumatic Symptoms

DAST = Drug Abuse Screening Test

DES = Dissociative Experience Scale

DEVS-T = Distress Evaluation Scale for
Treatment

GAF = Global Assessment Functioning

GSI = Global Severity Index

HADS = Hospital Anxiety and Depression Scale

IES = Impact Event Scale

MACR-1 = McAndrew Alcoholism Revised

MCMI-II = Million Clinical Multiaxial Inventory

MMPI = Minnesota Multiphasic Personality Inventory

MMPI-K = Keane's PTSD Scale from the Minnesota Multiphasic Personality
Inventory

MPTSD = Modified PTSD Scale

MSI = Multiphasic Sex Inventory

PPD = Personal Problem Definition
Questionnaire

PROPS = Parent Report of Post-Traumatic Symptoms

PSD = Positive Symptom Distress Scale

PSS-SR = PTSD Symptom Scale Self-Report

PSWQ = Penn State Worry Questionnaire

SI-PTSD = Structured Interview for PTSD

SCL-90(R) = Symptom Checklist (Revised)

STAI-T/S = State-Trait Anxiety Inventory

SUD = Subjective Units of Disturbance

TSI = Trauma Symptom Inventory

VOC = Validity of Cognition

APPENDIX B CODING SCHEME

Themes and Sub-themes That Inform Treatment Protocol

- 1) Client's perception of trauma
 - a) Disturbed by the memory
 - b) Unaffected by the memory
- 2) Client's caution and fear about engaging in treatment
 - a) Therapeutic relationship
 - b) Perceived benefit to self
- 3) Leading and pacing
- 4) Safety plan
 - a) High risk factors
- 5) Reconciliation of treatment philosophies
 - a) Clinical cooperation and support
 - b) Cognitive distortions
 - c) Fantasies
 - d) Secrets
- 6) Therapist training
 - a) Counter-intuitive methods
 - b) Legal and ethical considerations
 - c) Client presentation – genuineness of feedback

Themes and Sub-themes That Address Research Question 1

- 1) Recognition of contributors to distorted beliefs
 - a) Cognitive distortions
 - b) Accountability
- 2) Increased participation in group therapy treatment
- 3) Increased empathy
- 4) Clarification of thoughts
- 5) Raised consciousness as a self-management tool
- 6) Self esteem
- 7) Recognition and management of emotions

Themes That Address Research Question 2

- 1) Stay focused on difficult material
- 2) Skepticism

Themes and Sub-themes That Address Research Question 3

- 1) Increased and/or improved communication with family and friends
 - a) Forgiveness
 - b) Decreased feelings of shame
 - c) Increased awareness of need for relationships

Themes and Sub-themes That Emerged From the Data

- 1) Resolution
 - a) Acceptance
 - b) Decreased sense of self-blame
 - c) Desensitization

d) Reprocessing

APPENDIX C

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY Informed Consent for Participants in Research Projects Involving Human Subjects

Title: Using EMDR with Offender Population

Investigator: Ronald J. Ricci; Dr. Scott Johnson, Major Professor

Purpose of this project: This project intends to look at the use of EMDR in processing traumatic memories with a population who identify as sexual offenders.

Procedures: Subjects will be selected from those undergoing group relapse prevention treatment, and who have been assessed as appropriate by his/her primary clinician. Clinicians from this project will explain the EMDR procedure to participants before treatment begins. EMDR is an individual treatment method which uses eye movement or bilateral tapping procedures to facilitate desensitizing and reprocessing of disturbing memories. Each session lasts between 60 and 90 minutes. Participants will undergo treatment until such time as treating clinician feels that processing is satisfactorily completed, or until such time as participant chooses to withdraw which he/she is free to do at any time during the study. Individual case records, including initial assessment, case notes, polygraph results, and phallometric testing results where available, will become part of the data available to the researcher. Participant will agree to be interviewed by treating clinician and/or research team at points during or following treatment. Participant may be asked to complete an assessment instrument, e.g. Trauma Symptom Inventory, both before treatment begins, and after treatment is completed.

Risks: Trauma work has the potential risk of bringing unpleasant memories or thoughts to the forefront, and may cause discomfort or emotional “flooding” for some clients. While EMDR is designed to minimize the duration of this discomfort, this potential risk does exist. In this event, participant will be offered supportive counseling. In addition, research clinician will coordinate treatment with participant’s primary clinician who will be available to participant for follow-up treatment.

Benefits: EMDR has reported been efficient and effective for some clients in being able to process and assimilate traumatic memories. Insofar as these psychological traumas may be part of the offender’s relapse cycle, processing of these traumatic memories may facilitate increased self management and self soothing skills.

Confidentiality/Anonymity: Any publication resulting from this research will not contain participant's real name. Participants' clinical records will be maintained by researchers within the standards of confidentiality outlined by the American Association of Marriage and Family Therapists Code of Ethics. Treating clinician will not give information about my therapy to others except when specifically required to by law, or with my specific consent. I realize that there are times when clinician may be legally or ethically required to divulge information against my wishes. I understand that my treating clinician is required by professional ethics and law to report evidence or suspicion of child or adult abuse or neglect, with or without client consent, including evidence or suspicions formed in the course of treatment. I further understand that my clinician are required by professional ethics and law to report threats to physically harm others or ourselves that I, my companions, or members of my family may make, regardless of my or our wishes. Finally, I recognize that my treating clinician is legally obligated to break confidentiality when ordered to testify by a court of law.

Freedom to Withdraw:

I understand I am free to withdraw from this project at any time without penalty. I also understand my treating clinician may determine that I should not continue as a part of this project.

Approval of Research:

This research project has been approved, as required by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University, by the Department of Human Development and the Marriage and Family Therapy Program.

IRB Approval Date: _____

Approval Expiration Date: _____

I understand if I have questions or concerns about this project I may contact:

Ronald J. Ricci, M.S., M.A.
540-231-7261 ext 6

Dr. Scott Johnson, LMFT
540-231-7201

David M. Moore, Chair IRB

Office of Research Compliance
Research & Graduate Studies
540-231-4991
Subjects Responsibilities:

I voluntarily agree to participate in this study with the responsibilities outlined above. I have read and understand the Informed Consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent.

Signature _____ Date _____

Investigator _____ Date _____

Faculty Advisor _____ Date _____

Departmental Reviewer/Department Head _____ Date _____

APPENDIX D

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Informed Assent for Participants
in Research Projects Involving Human Subjects

Title: Using EMDR with Offender Population

Investigators: Ronald J. Ricci; Dr. Scott Johnson, Major Professor

Purpose of this project: This project intends to look at the use of EMDR in processing traumatic memories with a population who identify as sexual offenders.

Procedures: If selected to participate in this project, I will be given a full explanation of what EMDR is, and how it will be used on me in treatment. EMDR is an individual treatment method which uses eye movement or bilateral tapping procedures to facilitate desensitizing and reprocessing of disturbing memories. Each session lasts between 60 and 90 minutes. I agree to undergo treatment until such time as treating clinician feels that processing is satisfactorily completed, or until such time as I choose to withdraw which I am free to do at any time during the study. I understand my individual case records, including initial assessment, case notes, polygraph results, and phallometric testing results where available, will become part of the data available to the researcher. I will agree to undergo a series of treatments using this process after all of my questions have been satisfactorily answered. I will agree to complete questionnaires both before and after treatment. I will agree to be interviewed about the treatment and my experiences with the treatment by the treating therapist and the EMDR researcher. I understand I have the right to stop the process at any time I choose.

Risks: I understand there is some risk with trauma treatment that I might experience unpleasant memories and feelings. In the event I experience these, I understand I have the right to request supportive counseling by the treating therapist and will also have continued access to my primary therapist for supportive counseling. I understand that the treating therapist will share information about my case with my primary therapist and his/her supervisor for the purpose of advancing and/or benefitting my treatment.

Benefits: I understand that while no benefit is guaranteed from this treatment, research has shown EMDR to be effective in helping clients process traumatic and unpleasant memories. I understand that insofar as traumatic memories may be a part of my offender cycle, the reprocessing of these memories may advance my progress in offender treatment.

Confidentiality/Anonymity: I understand that any publication which results from this project will not contain my real name. I understand that my records will be

treated within the guidelines of confidentiality as outlined by the American Association of Marriage and Family Therapists. I understand that information about my case will not be shared with other without my consent and my parent/guardian's consent, except where specifically required by law. I understand that my primary therapist and my treating therapist may be legally or ethically required to divulge information against my wishes. I understand that clinicians are legally or ethically required to report evidence or suspicion of child or adult abuse or neglect without my consent. I understand clinicians are required to report any threat of physical harm made by me, my companions or my family, and must do so without my consent. I understand my clinician may be obligated to break confidentiality when ordered to testify by a court of law.

Freedom to Withdraw:

I understand I am free to withdraw from this project at any time without penalty. I also understand my treating clinician may determine that I should not continue as a part of this project.

Approval of Research:

This research project has been approved, as required by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University, by the Department of Human Development and the Marriage and Family Therapy Program.

IRB Approval Date: _____

Approval Expiration Date: _____

Subjects Responsibilities:

I voluntarily agree to participate in this study with the responsibilities outlined above. I agree to undergo Eye Movement Desensitization and Reprocessing. I agree to be interviewed by an independent researcher at points during and following completion of this treatment. I agree to complete questionnaires before and after treatment. I agree to allow my clinical records to be shared with the researcher for the purposes of this project. I have read and understand the Informed Consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent.

I understand if I have questions or concerns about this project I may contact:

Ronald J. Ricci, M.S., M.A.

540-231-7261 ext 6

Dr. Scott Johnson, LMFT
540-231-7201

David M. Moore, Chair IRB
Office of Research Compliance
Research & Graduate Studies
540-231-4991

I have read and understand the informed assent and conditions of this project. I have had all my questions answered in a way that I can fully understand. I understand the limits of confidentiality as outlined in this assent. I understand the potential risks of this treatment. I hereby acknowledge all the above and give my voluntary assent to participate in this project.

Signature of Participant _____ Date _____

Signature _____ Date _____

Parent/Guardian _____ Date _____

Investigator _____ Date _____

Faculty Advisor _____ Date _____

Departmental Reviewer/Department Head _____ Date _____

APPENDIX E

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Informed Consent for Parents/Guardians of Minors
In Research Involving Human Subjects

Title: Using EMDR with Offender Population

Investigators: Ronald J. Ricci; Dr. Scott Johnson, Major Professor

Purpose: this project will look at use of Eye Movement Desensitization and Reprocessing (EMDR) in processing traumatic memories with a population identified as sexual offenders.

Procedures: If selected to participate in this project, you and your minor child will be given a full explanation of what EMDR is, and how it will be used in treatment. EMDR is an individual treatment method which uses eye movement or bilateral tapping procedures to facilitate desensitizing and reprocessing of disturbing memories. Each session lasts between 60 and 90 minutes.

Participants will undergo treatment until such time as treating clinician feels that processing is satisfactorily completed, or until such time as participant chooses to withdraw which he/she is free to do at any time during the study. Individual case records, including initial assessment, case notes, polygraph results, and phallometric testing results where available, will become part of the data available to the researcher. You will consent to have the minor participate in a series of treatments using this process after all of your questions have been satisfactorily answered. You will agree to allow the minor to complete questionnaires both before and after treatment. You will allow the sharing of any clinical records, including any phallometric or polygraph testing, to be shared with the primary researcher. You will agree to allow the minor to be interviewed about the treatment and his/her experiences with the treatment by the treating therapist and/or an independent researcher. You will have the right to stop the process at any time.

Risks: I understand that there is some risk with trauma treatment in that the participant may experience unpleasant memories and feelings. In this event, you and/or the minor will have the right to request supportive counseling either from the treating therapist, or the minor's primary therapist. I understand the treating therapist will share information about the case with the primary therapist and his/her supervisor for the purpose of advancing the benefits of treatment.

Benefits: I understand that while no benefit is guaranteed from this treatment, research has shown EMDR to be effective in helping clients process traumatic memories. I understand that insofar as traumatic memories may be a part of the minor's offender cycle, the reprocessing of these memories may advance treatment progress.

Confidentiality: I understand that any publication which results from this project will not contain real names. I understand that records will be treated within the guidelines of confidentiality as outlined by the American Association of Marriage and Family Therapists. I understand that information about the case will not be shared with others without the consent of the minor participant and the undersigned, except where specifically required by law. I understand the primary therapist and the treating therapist are required legally and ethically to report evidence or suspicion of child or adult abuse or neglect without consent. I understand clinicians are required to report any threat of physical harm made by me, my companions, my family, or the minor participant, and must do so with or without consent. I understand the clinicians may be obligated to break confidentiality when ordered to testify by a court of law.

Freedom to Withdraw: I understand this research project has been approved, as required by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University, by the Department of Human Development and the Marriage and Family Therapy Program.

IRB Approval Date: _____
IRB Approval Expiration Date: _____

Responsibilities: I voluntarily agree to allow my minor child to participate in this study which intends to look at the effects of trauma treatment, as adjunct to ongoing treatment for sexual offenders. I agree to allow minor to undergo Eye Movement Desensitization and Reprocessing. I agree to allow completion of questionnaires before and after treatment. I agree to allow clinical records of minor to be available to the researcher which may include information about his/her family. I agree to be available to treatment providers for interviews regarding my family and this case. I understand if I have questions about this project I may contact:

Ronald J. Ricci MS MA
540-231-7216 vm 6

Dr. Scott Johnson, LMFT
540-231-7201

David M. Moore, Chair IRB
Office of Research Compliance
Research & Graduate Studies
540-231-4991

I have read and understand the Informed Consent and conditions of this project. I have had all my questions answered in a way that I can understand. I understand the limits of confidentiality as outlined in this consent form. I understand the

potential risks of treatment. I hereby acknowledge all the above and give my voluntary consent for participation in this project.

Signature of Parent or Legal Guardian

Date

RONALD J. RICCI
222 Woods Edge Court
Blacksburg, VA 24060-4001
rricci@vt.edu

- CREDENTIALS:** Virginia Licensed Marriage and Family Therapist
Vermont Licensed Clinical Mental Health Counselor (inactive)
Level II Certified EMDR Practitioner
Certified Sex Offender Treatment Provider
- PROFESSIONAL:** AAMFT Approved Supervisor
AAMFT Clinical Member
EMDRIA Member
- EDUCATION:** PhD Marriage and Family Therapy
Virginia Polytechnic Institute and State University
Blacksburg, VA
- MA Marriage and Family Therapy
Antioch New England Graduate School
Keene, NH
- MS Organizational Behavior/Administration
Saint Michael's College
Colchester, VT
- BS Business Management
Green Mountain College
Poultney, VT
- GRANTS/AWARDS:** \$40K Hamilton Foundation Grant
For research and treatment of sexually reactive
children and adolescents
- 2002 Family Studies/Therapy Award
For work with marginalized population
- EMPLOYMENT:** 2003 – present
Counseling & Consultation Services, Inc.
Tazewell, VA/Piney Flats, TN
Outpatient Sex Offender Treatment Clinician
Clinical Supervisor
- 2001 - 2003
Family Therapy Center of Virginia Tech
Blacksburg, VA
Outpatient Clinician
Clinical Case Consultant

- 1997 - 2001
Evergreen Center
Rutland, VT
Child and Family Outpatient Clinician
STEP Clinician
Mental Health Consultant for Head Start
Clinical Supervisor
- 1995 - 1997
Associates in Child and Family Services
Rutland, VT
Short-term Home Based Clinician (crisis intervention)
School Based Clinician
Intensive Family Based Clinical Intern
- 1993 - 1995
Community College of Vermont
Rutland, VT
Adjunct Faculty
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- Ricci, R.J. (in press). Trauma resolution using eye movement desensitization and reprocessing with an incestuous sex offender: An instrumental case study. *Clinical Case Studies*.
- Hertlein, K.M., & Ricci, R.J. (in press). A systematic research synthesis of EMDR empirical studies. *Journal of Trauma, Violence & Abuse*, 5(3).
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