

Sex Offender Treatment

**A Case Study Approach to
Issues and Interventions**

Edited by

Daniel T Wilcox, Tanya Garrett and Leigh Harkins

WILEY Blackwell

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Editorial Offices

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9600 Garsington Road, Oxford, OX4 2DQ, UK

The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

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About the Editors

Daniel T. Wilcox is Managing Director of Wilcox Psychological Associates, a private clinical and forensic psychology practice. He is a registered clinical and forensic psychologist, an honorary associate professor at the University of Nottingham, School of Medicine (Division of Psychiatry), and an honorary research fellow at the University of Birmingham, Centre for Forensic and Criminological Psychology. He is widely published, on the editorial boards of several journals in the field, and Editor of *The Use of the Polygraph in Assessing, Treating and Supervising Sexual Offenders* (Wiley, 2009).

Tanya Garrett is a registered clinical and forensic psychologist in private practice and an honorary senior lecturer at the University of Birmingham Centre for Forensic and Criminological Psychology. Tanya's published research relates to sexual violations in therapy and clinical psychology training, ethical issues in therapy, and sexual offender treatment and evaluation.

Leigh Harkins is an assistant professor in the Faculty of Social Science and Humanities, University of Ontario Institute of Technology, Canada. She has experience working in treatment groups for sexual offenders, completing psychological assessments in prisons and community criminal justice settings in Canada and the UK. Leigh's published research focuses on sexual aggression, offender rehabilitation, and multiple-perpetrator offending.

About the Contributors

Gene Abel is a board-certified psychiatrist and the inventor of Abel Assessment for Sexual Interest™. Dr. Abel has directed six National Institute of Mental Health research projects on the evaluation of sexual problems and has published over 130 scientific articles. Currently, he is the medical director of Behavioral Medicine Institute of Atlanta and is a clinical professor of psychiatry at Morehouse School of Medicine and Emory University School of Medicine.

Geraldine Akerman is a therapy manager at HMP Grendon, and C. Psychol, C.Sci, AFBPsS, and PhD candidate at the University of Birmingham. She has publications in the areas of sexual offending, developing empathy with service-users with learning difficulties, therapeutic communities, and offence paralleling behavior. Her PhD thesis involves the development and validation of a psychometric measure of current sexual interest.

Anthony R. Beech, D.Phil, C.Sci, FBPsS, C.Psychol, has authored over 160 articles, 42 book chapters, and six books in the area of forensic science. Professor Beech was the 2009 recipient of the Senior Award from the Division of Forensic Psychology, British Psychological Society for a significant lifetime contribution to Forensic Psychology.

Adam Carter is a chartered and registered forensic psychologist with over 20 years experience working in National Offender Management Services (NOMS) and Her Majesty's Prison Service, predominantly in the assessment and treatment of sexual offenders. He received his PhD from Leicester University in 2009 and is currently Head of Offence Specialism for Sexual Offending Treatment Programmes in Interventions Services, NOMS.

Franca Cortoni received her PhD in clinical and forensic psychology from Queen's University at Kingston, Ontario. Since 1989, she has worked with and conducted research on male and female sexual offenders. Dr. Cortoni is Associate Professor at the School of Criminology of the Université de Montréal and Research Fellow at the International Centre of Comparative Criminology. Dr. Cortoni has edited a book on female sexual offenders and a book on criminal violence (in French), and has published extensively and made numerous presentations at national and international conferences on sexual offender issues. She is a member of the Editorial Board of *Sexual Abuse: A Journal of Research and Treatment* and of the International Advisory Board of the *Journal of Sexual Aggression*.

Leam A. Craig, BA (Hons), MSc, PhD, MAE, CSci, CPsychol, FBPoS, and EuroPsy, is a consultant forensic clinical psychologist and partner at FPP Ltd. He is Professor (Hon) of Forensic Psychology, University of Birmingham. He is a fellow of the British Psychological Society, a chartered scientist, holds the European Certificate in Psychology, and has dual registrations in forensic and clinical psychology. He was awarded the 2013 Senior Academic Award by the Division of Forensic Psychology. He has over 70 publications including six books.

Marguerite L. Donathy has a Certificate of Higher Education in Psychological Studies from the University of Birmingham, a BSc (Hons) in Psychology from the Open University and an MSc in Criminological Psychology from the University of Birmingham. She currently works in private practice as a trainee forensic psychologist and is completing a doctorate in Forensic Psychology Practice with the University of Birmingham. Ms. Donathy is Branch Secretary and Treasurer for the Midlands branch of the National Organisation for the Treatment of Abusers (NOTA).

Helen Jane Elliott is a research assistant working for SOCAMRU, having completed her MSc in forensic psychology in 2012, Ms. Elliott now works for Nottingham Trent University and a large part of her research focuses on understanding sexual offending through research at HMP Whatton. Ms. Elliott is also involved in research with offenders who have mental-health difficulties and prison-based Circles of Support and Accountability (CoSA).

Caroline M. Foss has an MSc in Forensic Psychology from the University of Birmingham, England, and MA in Professional Counseling from Lindenwood University, Missouri, USA. She currently works in private practice as a licensed professional counselor. Ms. Foss is a board member of the Missouri Association of Treatment for Sexual Abusers and a member of the Association for the Treatment of Sexual Abusers (ATSA).

Theresa A. Gannon is a professor of forensic psychology in the School of Psychology at the University of Kent. She obtained a First Class Honours Degree in Psychology from the University of Birmingham in 1998, a doctorate in psychology from the University of Sussex in 2003, and forensic psychologist practitioner status in 2007. Dr. Gannon has written over 100 peer reviewed journal articles and book chapters in the areas of sexual, violent offending, and firesetting. She has also edited numerous books in forensic psychology and assesses and treats offenders who have sexually offended or set fires on a weekly basis. Dr. Gannon is Editor of the *Journal Psychology Crime and Law*, and Associate Editor of the *Journal of Sexual Aggression*. She now leads the University of Kent's Centre of Research and Education in Forensic Psychology (CORE-FP) in the School of Psychology.

Rosie Gray, Registered Forensic Psychologist, works at Wilcox Psychological Associates Limited, where she undertakes risk assessments, offense-focused treatment, and safeguarding sessions. Dr. Gray is also a qualified probation officer and has worked with individuals who have committed offences in a range of settings, including the National Health Service and HM Prison Service. Her doctoral thesis explored diversity in sexual offender assessment and treatment and she is on the executive committee for the Midlands branch of the National Organisation for the Treatment of Abusers (NOTA).

Elizabeth Hayes is an expert advisor in criminal justice corrections, in the UK and internationally, with a particular emphasis on the assessment, treatment, and management of sexual offenders. She has a professional background in probation and criminal justice social work with established clinical experience followed by regarded expertise in practice, policy, and strategy development. Most recently Ms. Hayes was national Head of Probation Sex Offender Treatment in the Ministry of Justice for England and Wales; her advancements of practice whilst in post included the design and national implementation of the I-SOTP; an accredited treatment program exclusively for online sexual offenders. Ms. Hayes is now CEO of an NGO she has established, providing criminal justice services in the UK and abroad. In Europe, she is currently employed on a number of European Union-led projects, directed at advancing provisions for the effective management of sexual offenders across multiple jurisdictions. In the UK, Ms. Hayes is currently expert advisor to the Scottish Government Justice Department, where she has completed the design of a new national sex offender treatment program, providing for an integrated approach to the treatment of online sexual offenders and a unified provision for delivery across prisons and community correctional settings. Ms. Hayes is on

international forums and registers of experts, present at professional conferences and symposia in the UK and abroad, and is published in her field.

Julie Hird is a consultant clinical psychologist in Greater Manchester Mental Health Trust and has worked in forensic NHS settings for 24 years. She has a special interest in sex offending and co-ordinates the Sex Offender Treatment Programme at the Edenfield Centre in Manchester.

Clive Hollin is Professor of Criminological Psychology in the School of Psychology at The University of Leicester, UK. He wrote the best-selling textbook *Psychology and Crime: An Introduction to Criminological Psychology* (2nd ed., 2013, Routledge). In all, he has published 22 books alongside over 300 other academic publications. As well as his various university appointments, he has worked as a psychologist in prisons, the Youth Treatment Service, special hospitals, and regional secure units.

Adarsh Kaul worked as a consultant forensic psychiatrist from 1994 onwards at secure psychiatric hospitals and in community forensic service managing medium and high risk mentally disordered offenders in the community. Having worked in prisons since 1988, Dr. Kaul moved fully into prison psychiatry with the formation of the Offender Health Directorate in Nottinghamshire Healthcare NHS Trust. He is Clinical Director of Offender Health, which provides healthcare to 11 prisons in the South Yorkshire and East Midlands regions of UK. He is a Fellow of the Royal College of Psychiatrists and has an MA in criminology. He was one of the founder members of Leicestershire Multiagency Public Protection Arrangements and worked for 7 years for the National Parole Board in England and Wales. He is currently a medical member of the Her Majesty's Courts & Tribunals Service and is also a member of the National Health and Justice Clinical Reference Group. Since 2010 he has worked at HMP Whatton, a prison exclusively for sex offenders in Nottinghamshire, where he has also started a prison based program of treatment with anti-libidinal drugs for high and very high risk sex offenders who have not adequately responded to psychological treatments.

Rebecca Lievesley is a research fellow for the Sexual Offences, Crime and Misconduct Research Unit (SOCAMRU) at Nottingham Trent University and a forensic psychologist in training. All of her research is focused on offenders, particularly sexual offenders, across a number of prison and forensic establishments and organizations. Ms. Lievesley is also undertaking a PhD on desistance and re-offending in short sentenced offenders.

William R. Lindsay, PhD, FBPS, FFIASSID, AcSS, is a consultant clinical and forensic psychologist and Clinical Director in Scotland for Danshell Healthcare. He is Professor of Learning Disabilities at the University of

Abertay, Dundee and Honorary Professor at Deakin University, Melbourne. He has published over 300 research articles and book chapters, published five books, held around £2 million in research grants and given many presentations and workshops on cognitive therapy and the assessment and treatment of offenders with intellectual disability. His current research and clinical interests are in dynamic risk assessment, sex offenders, personality disorder, alcohol related violence, and CBT, all in relation to intellectual disability.

Caroline Logan is Lead Consultant Forensic Clinical Psychologist in Greater Manchester West Mental Health NHS Foundation Trust as well as an honorary research fellow in the Institute of Brain Behaviour and Mental Health at the University of Manchester. She has worked in forensic settings for almost 20 years, working directly with clients who are at risk to themselves and others and, in a consultancy role, with the multidisciplinary teams and local and national organizations that look after and manage them. She is a former Board Member of the Scottish Risk Management Authority, the DSPD Programme Expert Advisory Group, and the Project Board of Resettle, the Merseyside clinical risk and case management service for high-risk offenders. She is currently a member of the Advisory Panel for the Close Supervision Centres and Managing Challenging Behaviour Strategy in the HMPS Directorate of High Security. She is a coauthor of the *Risk for Sexual Violence Protocol*, a structured professional judgment approach to sexual violence risk assessment and management, and a coauthor of the 2007/9 Department of Health guidelines *Best Practice in Managing Risk in Mental Health Services*. Dr. Logan has research interests in the areas of personality disorder, psychopathy, and risk, and a special interest in gender issues in offending, on which she has published two books and many articles.

William L. Marshall is Director of Rockwood Psychological Services, a service that provides treatment for sexual offenders. He has over 400 publications including 20 books and has served on the editorial boards of 17 international journals. He is a fellow of the Royal Society of Canada and in 2006 he was appointed an Officer of the Order of Canada.

Amanda Michie, MA, PhD, CPsychol, AFBPsS, is a consultant clinical psychologist and lead psychologist for learning disability services in Edinburgh City and West Lothian. She has specialist expertise in the field of forensic ID and provides a clinical service to community and IP forensic settings across Lothian. She works closely with criminal justice staff; providing training, consultancy, and clinical input. She is also an established researcher, publishing regularly, particularly in the area of assessment and treatment of offenders with ID.

Christine Norman is a senior lecturer in psychology at Nottingham Trent University and a member of the Sexual Offences, Crime and Misconduct Research Unit (SOCAMRU). Dr. Norman's research and teaching interests are in the area of biological and cognitive psychology with application to psychiatric disorders, forensic psychology, and behavioral addictions. Her particular research interests are in the role of associative learning and reward sensitivity theory in obesity and eating disorders; the origins and development of sexual deviance and sexual preoccupation; the use of anti-libidinal medication in sexually preoccupied sex offenders; the role of traumatic brain injury in offending behavior; and associative learning in gambling behaviors.

Dawn Pflugradt received her doctoral degree in clinical psychology from the Wisconsin Professional School of Psychology. She is a licensed psychologist and works for the Wisconsin Department of Corrections – Division of Community Corrections as a chief psychologist/sex offender risk assessment specialist. Dr. Pflugradt is primarily a clinician providing assessment and treatment services directly to offenders. In addition to her clinical duties, Dr. Pflugradt conducts research on female sexual offenders and issues related to female offenders in general. She has coauthored multiple peer-reviewed articles and has provided workshops on female sexual offenders at national and international conferences.

David S. Prescott is Director of Professional Development and Quality Improvement for the Becket Family of Services in Northern New England. He has published 13 books and numerous articles and chapters on topics related to sexual violence and trauma. Mr. Prescott is on the International Advisory Board for the *Journal of Sexual Aggression* and a Section Editor for the formative journal *Motivational Interviewing: Training, Research, Implementation, Practice*. He currently writes articles for the NEARI Press Newsletter, which has a monthly circulation of over 4,000. He is a past president of the Association for the Treatment of Sexual Abusers (ATSA) and edited that organization's newsletter, *The Forum*, from 2002 to 2007. He is currently *The Forum's* Review Editor. Mr. Prescott is also a member of the Motivational Interviewing Network of Trainers (MINT), an international organization devoted to a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence. Most recently, he has become a certified trainer with the International Center for Clinical Excellence, a worldwide community of practitioners, healthcare managers, educators, and researchers dedicated to promoting excellence in behavioral healthcare services.

Ethel Quayle is a senior lecturer in clinical psychology in the School of Health in Social Science at the University of Edinburgh and Director

of COPINE research, which until September 2008 was based at University College Cork, Ireland. She is a clinical psychologist and as a practitioner worked with both sex offenders and their victims. For the last 14 years she has been conducting research in the area of technology-mediated crimes, collaborating internationally with government and nongovernment agencies in the context of research, policy, and practice. Her most recent book, with Kurt Ribsl from the University of North Carolina, was published in 2012 and is called *Internet Child Pornography: Understanding and Preventing On-line Child Abuse* and is published by Routledge Taylor-Francis. In addition to academic research activities she plays an active role in a number of government and nongovernment organizations.

Funmilayo Rachal is a forensic psychiatrist who currently works at the Behavioral Medicine Institute of Atlanta and is an adjunct assistant professor of psychiatry at Emory University School of Medicine. Dr. Rachal is a coauthor of the book *Professionalism in Psychiatry* and also coteaches the PBI Professional Boundary courses in Atlanta.

Phil Rich is a consultant and trainer specializing in work with sexually abusive youth. He holds a doctorate in applied behavioral and organizational studies and a master's degree in social work. He was the clinical director of a large treatment program for sexually abusive and sexually troubled children, adolescents, and young adults, and is the author of several books, as well as chapters and articles, which address work with sexually abusive youth.

Karen Thorne is a chartered and registered forensic psychologist. She specializes in the assessment and treatment of violent and sexual offender, with a special interest in noncontact sexual offenders. She has worked for HM Prison Service since 1995 and is currently a psychology service manager for East Midlands Forensic Psychology Service, Public Sector Prisons.

Tony Ward, PhD DipClinPsyc, is a professor of clinical psychology at Victoria University of Wellington, New Zealand. Professor Ward is the creator of the good lives model and has published a number of books, book chapters, and journal articles on this approach. His research interests include offender rehabilitation, forensic and correctional ethics, theoretical psychopathology, and cognition in offenders.

Jayson Ware is the Executive Director of Offender Services and Programs, Corrective Services New South Wales, Australia. He has worked with sexual offenders for the past 15 years and has authored over 20 journal articles or book chapters relating to the treatment of sexual offenders. He has a particular research interest in sex offender denial and

is currently completing a PhD examining the effectiveness of treatment for sexual offenders who categorically deny committing a sexual offence.

Belinda Winder (PhD, Reader in Forensic Psychology, Nottingham Trent University) is Head of the Sexual Offences Crime and Misconduct unit (SOCAMRU). Dr. Winder works closely with HMP Whatton to facilitate an applied mixed-method program of research that makes a significant and practical contribution to our understanding of sexual offenders and sexual crime. Dr. Winder is leading the research team evaluating the use of anti-libidinal medication with sexually preoccupied sex offenders – work that has been ongoing since 2011. Dr. Winder is also involved with a number of other research studies, including denial, understandings of risk in Internet sex offenders, prison-based circles of support and accountability (CoSA), and religiosity in sex offenders. She is a trustee of the Safer Living Foundation – a charity set up in collaboration with HMP Whatton, Nottingham Police, and Probation Trust to offer prison-based CoSA for elderly and intellectually disabled high-risk sex offenders.

Foreword

The treatment of sexual offenders continues to be an important and challenging topic, particularly since the actual effectiveness of treatment continues to be debated in published works by “academic experts” more often than being improved upon by actual practitioners (some of whom may also be academics). This book is more about the latter than the former, and may result in practice improvements that may in turn improve outcomes in sexual offender treatment.

A perusal of the chapter titles from this book will impress upon its readers that the treatment of sexual offenders is very complex and that treatment approaches are as varied as the types of sexual offenders themselves. While many books have been written about the treatment of sexual offenders from an academic stance, this book is perhaps more “therapist-friendly” than most due to the use of the central organizing principle of case studies in all of the treatment chapters.

The book is very well laid-out with a convincing rationale for the utility of interventions designed for delivery at the individual client level rather than the usual group level intervention. This is a very useful and unusual approach, but much needed optic for addressing the needs of challenging clients. There are very few chapters that are not about treatment per se (e.g., the “Context Issues” section), but the majority of these also have provided case studies for examples. This approach will facilitate learning by practitioners and easy application for practice and supervision. I also can see that this book would be of great benefit to students who are interested in learning about sex offender treatment, as well for supervisory discussion, seminar material, and forensic coursework application.

For me as a practitioner, the “Offender Issues” and “Specialized Intervention” sections are of absolutely stellar value. Written by expert practitioners in their respective fields, these sections provide insights into how each of these authors thinks through and plans their intervention strategies. For all practitioners who wonder how to approach a difficult case, this approach is of incredible value as it will save time and energy for both the offender and therapist. I note that another Wiley book, written by William R. Lindsay, “The Treatment of Sex Offenders with Developmental Disabilities”, was explicitly “A Practice Workbook”, whereas the present book is perhaps more implicitly a compilation of best practice by client type. While the breadth of the scope of the book, in terms of types of offenders (“Offender Issues”; 12 chapters) and “Specialized Interventions” (3 chapters), could not allow comprehensive elucidation of all components of treatment, each of these intervention chapters in general provided a background rationale regarding the client type or intervention type, assessment issues, case description, case conceptualization, treatment plan, assessment of progress in treatment, and discussion of the treatment effectiveness plus recommendations regarding best practice.

The final chapter reiterates the rationale for the book’s case study approach. In my opinion, the outstanding preceding 19 chapters should make most of this chapter, theoretically at least, redundant. There should be no doubt in any reader’s mind that the case study approach used in the book is both useful and valuable by the time they read the last chapter! That said, I also have no doubt that the academics who are not clinicians, and who doubt the utility of sexual offender treatment, will see this book as a “How To” book in an area that is of speculative utility. However, this book is not about assessing effectiveness or utility, but about promoting and enhancing best practice with an incredible range of different types of sexual offenders utilizing case studies. The authors say it best: “although case studies cannot provide conclusive evidence for the overall effectiveness of a treatment approach, they can tell us what did or did not work when these approaches were implemented in real life practice with individuals who have multiple needs and this information can be used as a guide to inform future individualized work” (page 373).

In closing, I would like to congratulate the authors for putting a new twist on the important topic of sexual offender treatment and doing it so well. I also want to enthusiastically recommend this book to practitioners working with sexual offenders, whether on a group or individual basis. The book is a summary of current thinking about a wide range of subtypes of sexual offenders, best practice with such offenders, and a novel use of the case study approach that will allow practitioners to develop expertise

with individual clients with complex needs. In my opinion, any practitioner in the field of sexual offender treatment would be very much remiss if this book was not on their real or virtual bookshelf.

Douglas P. Boer, PhD
Professor of Clinical Psychology
Centre for Applied Psychology
Faculty of Health, University of Canberra, Australia
President, International Association for the Treatment of Sexual
Offenders

Preface

A great many books have been written about sexual offenders. We hope that this book will not be viewed as just another run-of-the-mill volume to add to the list, to be purchased, put on the shelf, and forgotten. What we have tried to achieve here is something quite different. By bringing together top-notch international experts in the field, we hope to showcase the current state of play in sex offender treatment worldwide, with a focus on individual approaches. The treatment of sexual offenders is so often formulaic; yet, this client group is diverse and has varied needs. This is perhaps quite difficult to appreciate when so much of what is written is to do with risk assessment and group-based treatment. In this volume, we have sought to illustrate sexual offenders' diverse issues and treatment needs by emphasizing the need for individual formulation. We hope that this approach really brings alive this fascinating area of work.

We have been privileged to work with some inspiring clinicians and researchers in this field, whose influence and support we would like to acknowledge. These include Brian Thomas-Peter, David Middleton, Clark Baim, and many others who have been supportive, close, local colleagues. Birmingham, England, and the surrounding Midlands area has definitely had a history of punching above its weight, with the West Midlands Probation Service Sex Offender Unit developing the first Home Office-accredited group sex offender treatment program in the UK, and conducting the first polygraph trials with sex offenders that ultimately led to acceptance of the polygraph for use in the assessment and treatment of convicted sex offenders in the UK. The University of Birmingham, School of Forensic and Criminological Psychology was instrumental in the development of dynamic risk-assessment tools in Britain, and took the

lead nationally in terms of both shaping and evaluating sex offender treatment programs in the UK. Many of the chapter authors emanate from this area and have authored or contributed to an extensive and impressive range of books on sex offender assessment, treatment, and community management. Working with our university, prison service, local authority, probation, and mental health services colleagues has always been a pleasure. Long may it continue.

This preface would not be complete without mention of the clients with sexual offending histories and those who have been sexually abused, with whom we have worked over the years. These clients, whether coming to us for assessment, treatment, or research purposes, have helped us to develop our understanding of this field in a way that we could not have done through academic pursuits alone. Often, they have shared their experiences bravely and openly. They have co-operated with us and have given us feedback about our work, and we have learned a great deal from them. We hope that, for our part, we have been able to be of some help to them.

This book has been a long time in the making. It was conceived of several years ago at the suggestion of Dan Wilcox, the first editor. He and I grappled with the idea on our own, but it never progressed to implementation stage because we always had other important “fish to fry.” It was Dan’s genius idea that brought our colleague Leigh Harkins on board as third editor, and Leigh has been a real catalyst in making the book happen, even though she has moved from the UK to Canada during the process, taking on various new responsibilities along the way. We seem to have become a great team and we miss her presence up the road from us at the University of Birmingham. However, Skype has proven to be a real boon, and we have met regularly in this way since Leigh’s departure from the UK, to get the book finished. It has been a pleasure and a privilege for me to work with Dan and Leigh on this book. I shall miss our collaboration and meetings.

We have needed to be hard taskmasters with our contributors at times (ourselves as well), but we are grateful to all of the book authors who have stepped up to the mark, and do not seem to have minded the (sometimes quite considerable) demands we have placed on them. In fact, the chapter authors have exceeded all our expectations, and have gone above and beyond the call of duty to produce chapters which really do reflect the “state of the art” of sex offender treatment. We are grateful to them for the vast knowledge they have brought to this book, as well as their willingness, hard work, and co-operation.

A great many people contributed to the completion of this book; in particular, we would wish to express our thanks to Roz Wilcox, for her

typing, amending, and editing assistance throughout. Thanks also to other WPA Ltd. staff who have all played some role in the completion of this book. The encouragement of Darren Read, early on, and Karen Shield, along with her assistant editor, Olivia Wells, at Wiley-Blackwell kept us on track and supported us throughout. Many thanks also go to Aileen Castell, Hairiani Rashid and Alec McAulay for their assistance in the final stages of completing this book. We are most grateful for their direction and guidance. Almost inevitably, there will be some errors and inaccuracies in a book of this length and we, the editors, take full responsibility for any such unfortunate occurrences. Lastly, we extend unreserved thanks and appreciation to our families and those closest to us who have borne the burden of our periodic preoccupation or unavailability over the last 2 years, and still managed to be both supportive and encouraging.

I'm sure I speak for the editors and all of the contributors when I say that we felt a great sense of achievement in taking this work through to completion. Lastly, in consideration of the vast experience of the chapter authors, it is our sincere hope that our readers will value this book as much as we enjoyed bringing it together.

Tanya Garrett
D. T. Wilcox
L. Harkins

Part I

Overview

The Continuing Need for Individualized Interventions with Sex Offenders

Daniel T. Wilcox, Tanya Garrett, and Leigh Harkins

Introduction

Among sex offenders, some do not deal well with the group process, while others can be disruptive in these settings. Still other offenders have complex treatment needs that cannot be fully met within a group treatment program. For this reason, although the authors are altogether supportive of group-based sex offender treatment programs (SOTPs), we consider that there are circumstances where either individualized interventions are required or a combination of group and one-to-one work is needed. For example, individuals with extremely high levels of assessed deviance or risk can, at times, have a marked adverse impact on standard SOTP groups.

Notably, individuals with significant psychopathic, paranoid or borderline personality features can also struggle in group treatment, demonstrating particular difficulties with group engagement concerning offense-related issues. They may also introduce an unhelpful dynamic in terms of inhibiting or otherwise interfering with the participation of other group members. Such offenders may, in the experience of the authors, benefit more from one-to-one sessions to explore their sexual interests and the pro-offending cognitive distortions that supported their offending behavior, or indeed as adjunctive treatment for any identified mental health related issues. However, the same individuals may progress better in a group setting in respect of developing better socio-affective skills and making necessary

self-management gains. In our experience, some offenders are also referred for individualized work because they lack the necessary coping abilities to contend with an SOTP. They may require individual clinical interventions to address inadequate emotional resilience and stress management abilities to be able to engage in an SOTP.

Perhaps unsurprisingly, in view of the unusual referral pathway that such individuals travel along, they almost invariably present as offenders with more complex needs than those taken through standard SOTP groups. In our experience, offenders referred for individualized treatment have more unusual and potentially challenging clinical or forensic histories and personality profiles. As such, even seasoned practitioners may at times be confronted with cases so unique that they would value the knowledge and experience of other professionals who have passed down similar roads before them.

Group Treatment

As a frame of reference, in Part II, Gray and Wilcox provide a summary of the assessment, treatment, and monitoring processes that are typically employed within accredited cognitive-behavioral-therapy-based SOTPs in North America, Europe, Australia/New Zealand and other parts of the world that are influenced by the Association for the Treatment of Abusers (ATSA), the National Organisation for the Treatment of Abusers (NOTA), the Australia and New Zealand Association for the Treatment of Sexual Abuse (ANZATSA), and the International Association for the Treatment of Sexual Offenders (IATSO). Research on treatment outcomes for these group-based SOTPs has consistently shown a significant positive effect, though in general not of a magnitude that would cause most professionals in this field to choose to rest on their laurels yet (Hanson, Bourgon, Helmus, & Hodgson, 2009; Hanson, et al., 2002; Hanson & Morton-Bourgon, 2005).

Over the last quarter of a century, assessment and treatment developments have been introduced and evaluated, giving much-needed structure to our work in this field (Beech, Craig, & Browne, 2009; Hanson & Busière, 1998; Hanson & Morton-Bourgon, 2004; Hanson & Thornton, 2000; Laws, Hudson, & Ward, 2000; Maletzky, 1991; Marshall, Anderson, & Fernandez, 1999; Marshall, Laws, & Barbaree, 1990). However, professionals working with sex offenders in the past have seemingly been as vulnerable to manipulation and grooming as anyone else. Salter (1988, 2004) has tracked and chronicled this phenomenon, noting that even qualified professionals in the field have, at times, characterized sexual

offenders as “harmless, unfairly judged or misguided” while directing a substantial weight of responsibility onto victims, impugning their characters, actions, and reputations. Further, Wilcox (2013) has noted that, even today, some professionals in practice continue to provide such explanations for the behaviors of abusers and victims. Nevertheless, while practitioners working with sex offenders on an individual case basis may be viewed as more vulnerable to manipulation and grooming than within the context of the structured group process (Wilcox, 2013), inevitably, this approach will be necessary in some circumstances to address identified needs and to reduce future risk of offending.

Fortunately, professionals in practice today have more tools available to assist them in maintaining an objective and informed perspective when applying structured professional judgment (Hart, 2013; Hart & Logan, 2011; Wilcox, 2013). From this starting point, sex offender workers may feel more equipped to develop treatment plans for offenders who do not fit into standard group-based intervention programs.

Case Formulation

The following chapters in this book describe the individualized interventions and the case formulations of acknowledged experts within which their assessment processes, intervention, and supervision plans are developed in relation to specific treatment issues or offender types. The book’s central focus on case studies and case formulation draws from a rich theoretical and clinical/forensic-practice base, identifying the continuing need for individually-tailored interventions and recognizing the interrelationship between case conceptualization, applied behavioral analysis, and risk assessment. This is a rapidly developing field, with important contributions from, for example, Sturmey and McMurrin (2011); Butler (1998); Eells (2007); Nezu, Nezu, Friedman, and Haynes (1997); and Tarrier (2005), which offer practitioners valuable guidance about case formulation in forensic settings.

We believe that case formulation is an essential tool in understanding offenders’ behavior, the underpinning thoughts and feelings that influenced their actions, and those factors which have contributed to their risk of reoffending. This approach provides a structure for organizing and integrating information gained about the individual and about their presenting difficulties, such that causes and precipitating factors may be given full consideration along with the person-specific features that serve to maintain any propensity for offending. Comprehensive case formulation will also reveal protective features, as well as the various resilience potentials

identified in the offender. These factors can be taken into account to provide the most robust assessment of risk possible, as well as an evaluation of desistance capacity (Harrison, 2010). Such a thorough review enables the treatment worker to develop a more comprehensive intervention and monitoring plan based on hypotheses drawn and tested from the case formulation. Eells (2007) has noted that effective case formulation does not concentrate on simply describing the offending behavior, but takes a further step to explain how the offending activity developed and progressed. Furthermore, Rich (2013) asserted that case formulation not only explains what happened, but more importantly offers a theory as to why the individual engaged in the sexually abusive behavior. Rich emphasized that a formulation-based approach to treatment cannot rely on a strict, inflexible, and predetermined strategy for intervention, or a manualized style of working. In a similar vein, Drake and Ward (2003) conclude that effective formulation is idiosyncratic and requires a comprehensive understanding of the underlying psychological characteristics of each individual being treated.

The Structure of This Book

Following this overview chapter, Part II describes the context within which sex offender work is undertaken. Prescott considers what impact working with sexual offenders has on professionals in the field, and focuses on therapist self-care. Ward explores the ethical framework for working with sex offenders, describing tensions between human rights and criminal justice perspectives with regard to treatment provision, and offers suggestions as to how they may be reconciled by professionals. Gray and Wilcox describe the typical journey of a convicted sexual offender by detailing accepted approaches to supervision, assessment, and treatment.

Part III focuses on offender issues, exploring treatment approaches applied with 12 different types of sexual offenders. These chapters variously take account of offender gender, age, deviant sexual preferences, mental state, and cognitive ability. It is hoped that the specificity of these offender-related chapters will assist workers in formulating their treatment approach with new and challenging cases. These chapters direct attention to treating those who sexually abuse children, men who sexually abuse adults, sexually abusive adolescents, intellectually disabled offenders, non-contact sexual offenders, and Internet offenders. A case study of a female sex offender is included, as well as a study of a sex offender with bipolar disorder. Professional sexual misconduct is addressed, as well as interventions with psychopathic sexual offenders, high deviance (zoophilic) offenders, and sexual killers.

Part IV describes specialist interventions employed with sexual offenders, with Ware and Harkins addressing denial issues and Marshall detailing techniques for changing deviant sexual interests. The final chapter in this part, by Winder and colleagues, explores the assistive role of anti-libidinal medication.

Part V of this book addresses future practice from the perspectives of the editors. It considers the training needs of practitioners and the skill base they require, as well as established and emerging assessment and treatment strategies that they may choose to employ. The authors are committed to the continuing development of responsive and focal treatment for sexual offenders and hope that the following chapters will offer novices and seasoned practitioners alike, helpful and relevant guidance tools that they can apply in their work with sexual offenders.

The continuing need for skilled individualized interventions is the central theme of this book and, relatedly, we recall the thoughts of Professor Simon Hackett when addressing the NOTA Annual General Meeting at the Edinburgh Conference in 2007. As the then outgoing editor of the *Journal of Sexual Aggression*, Simon advised, “The case study approach offers professionals in this field unique opportunities to link theory, research and practice”. In support of this guidance it has been our intention, through producing this book, to play a part in forging these links.

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Part II

Context Issues

2

Motivation, Compassion, and Self-care in the Treatment of Sexual Offenders

David S. Prescott

Introduction

Professionals working with people who have sexually abused face challenges that are uncommon in other treatment settings. Many enter the field to help build safer communities and healthier lives, only to discover aspects of human experience well beyond anything they learned in their formal education. Some professionals find the experience deeply disturbing, and they begin questioning human nature and sexuality. Others find the work meaningful and rewarding despite the necessity of working with a population that is often unhappy about having to be in treatment. Some professionals begin to question elements of their own sexuality while others experience sexualized countertransference. Amid challenging perspectives on sexuality, they are often confronted with shifting expectations in their work, as well. For example, many professionals have found that the confrontational approaches advocated in the past (e.g., Salter, 1988) are less conducive to job satisfaction than other, more positive approaches (Harkins, Flak, Beech, & Woodhams, 2012).

This chapter explores compassionate, motivational treatment and the importance for professionals working with sexual offenders of taking excellent care of his or her self, physically and psychologically. It describes a therapist, Julie Hart, and a client, Marcus Paul. These characters are fabrications based on many people the author has encountered in nearly

30 years of practice. The institution in which this case study is based is also fictitious, but is representative of the strengths and challenges of numerous facilities like it.

Background Information: Theoretical and Research Basis

Julie had earned the appropriate credentials to accept a therapist position at the Calisota Civil Commitment Center (CCCC) only a few years before her arrival. The CCCC treats sexual offenders deemed by courts to be at high risk to reoffend after the expiration of their prison sentences and is one of approximately 20 such programs in the USA. The civil commitment of sexual offenders can be highly controversial (e.g., Schlank, 2005). Even the word “civil” can be ironic, given the highly adversarial processes involved. For example, legal defense professionals in these cases very frequently – and understandably – seek to minimize the harm done by their clients (“what we really have in these cases, your honor, is a case of some very intoxicated people”). It is even more common for legal defense professionals to seek to discredit both the assessment processes preceding treatment and the treatment program itself. Even setting aside the fact that civil commitment involves indefinite detention from which an individual might never be discharged, it is no surprise that many people enter these programs bitter, resentful, and in despair.

The interview process left Julie with a clear impression that the organizational structure of prisons and sexual offender civil commitment programs can appear paramilitary in comparison to traditional mental health treatment programs. Vernon Quinsey and his colleagues once quipped that, “The universe is homogeneous with respect to forensic institutions” (Quinsey, Harris, Rice, & Cormier, 2006, p. 12). The staffing numbers would bear much of this out; there were many more security staff than therapists, a fact that contributed strongly to the culture of the center. Typically there is intense financial pressure to have new staff members work directly with clients after the bare minimum amount of training considered necessary to ensure their safety. The bulk of introductory training for staff in civil commitment programs focuses on quelling disturbances, handling evidence, maintaining routines, and the like. Although they typically receive training in communication skills, conflict resolution, and what happens within sexual offender treatment, there are good reasons for the emphasis on safety and security. Prisons and civil commitment centers can be toxic environments at many levels. Even in

programs where violence is rare, its potential is understood and felt at all times.

What receives far less attention in prisons and civil commitment programs is the importance of each staff member taking excellent care of him- or herself. There can be many reasons for this. Tight budgets and scant resources often make it necessary to teach only the basics of safety, supervision, and rehabilitation. Even the United States military has only recently developed positive psychology-based methods in the hope of reducing posttraumatic stress disorder (PTSD; Seligman, 2009). Prior to this, much of the military's efforts were about raising awareness that PTSD exists. The infrequency of organized attention to professional self-care can stem from many causes, but in the end there is one simple fact: long-term professional survival can depend on focusing efforts on managing short-term daily pressures.

When Julie reported for work on her first day, she filled out all of the usual paperwork and presented all the requisite documentation. A security captain gave her an identification badge containing a magnetic strip that would open locked doors in assigned areas to which she had access. Her badge would be stored in a locked cabinet requiring that she punch in a code. When she appeared slightly confused the security captain assured her that within two weeks, all of these procedures would fade into the background of her daily experience. She would come to realize that this was not only accurate, but a matter of some concern. Although not the subject of extensive research, it is nonetheless a common experience for staff not to notice how different the environment of a high-security setting is from the rest of the world. Likewise, when each workday flows smoothly into the next, it can be easy to minimize the level of depression and anxiety that many – perhaps most – clients experience. Likewise, it can be easy to underestimate the immense power that each staff member has in the life of the client.

This last point is worth a closer look. Authors on psychotherapy such as Michael Yapko (2005) have long noted a very simple element of human existence: whatever we focus on we amplify in our minds. In the mind of a professional working with sexual offenders, fulfilling documentation requirements can take center stage throughout much of a week. For Julie, this meant having case notes written in a timely fashion and focusing her efforts in a direction that would prevent upper management displeasure. To accomplish this, she might write more or less on a given day. She might select certain words for their expediency and in a way that would foster easy communication between clinicians in her immediate purview. Her clients, however, were clear in their own minds

that Julie's observations could easily fall into the hands of a prosecutor who might use them to bring new charges. In Julie's mind, case notes became another obligation, while the clients viewed them as potential barriers to their freedom. Under these circumstances, Julie quickly became puzzled by the reluctance of those on her caseload to speak openly with her, just as the clients were quick to perceive her as not understanding or respecting their concerns.

Similar problems would emerge when Julie was assessing treatment progress. In her view, she might try to provide feedback about what work the client had yet to accomplish. Her clients came to view feedback as a litany of problems and unfulfilled tasks rather than processes to experience. Under these circumstances it was no wonder that when Julie walked into a treatment group without adequate rest or with something on her mind, her clients would recognize it immediately.

Case Introduction and History

Marcus was 42 years old when he arrived at the CCCC. The security staff inventoried his belongings and confiscated a number of items, including newspaper clippings about his crimes and legal documents related to his convictions. The assistant attorney general had personally contacted the program expressing concern that although Marcus was entitled by the laws of his state to have these documents while in prison, they were likely a source of pornographic fantasy to Marcus. In fact, they contained victim-impact statements; the assistant attorney general was concerned that Marcus would use these descriptions to invoke a euphoric recall of his past conquests.

Marcus had reached the end of his prison sentence and was aware that in accordance with the laws of 20 states and the federal government of the United States, there was a very good chance he would enter a facility where he would be detained indefinitely or until he could demonstrate that he had sufficiently reduced his risk by completing a treatment program. Marcus' age placed him at the exact median for residents in this kind of program; a few years older than the average in many prison populations (e.g., Wilson, Looman, Abracen, & Pake, 2012), this may have reflected the severity of his earlier prison sentence.

Marcus' most recent crime had involved kidnapping a woman, whom he had never met, in a parking lot and forcing her to drive to an area adjacent to a cemetery, where he sexually assaulted her. A factor that had made this crime particularly frightening was that Marcus wore a black

hood and clothes typical of a member of an outlaw motorcycle gang (e.g., boots and a leather jacket with a club emblem sewn on the back). Following his arrest, police found handwritten narratives and maps describing his plan for this assault.

Following his admission, the staff escorted Marcus to a unit designated for those who had not yet consented to treatment. Upon finding out that he would share a room with another person, Marcus loudly threatened to assault the unit director, whereupon the security staff placed him immediately in a separation unit, reserved for those who posed an imminent risk to themselves and others. He would remain there for many months.

First Encounter: Presenting Complaints

As a therapist who was new to the institution and still inexperienced, Julie was assigned to the portion of the program that treats “conventional” clients, those with IQs in the average to above-average range, and who did not have high levels of psychopathic traits. Her work would involve the very first stages of treatment, which would seek to build amenability to treatment, improve decision making, provide education around thought patterns related to illegal behavior (called “thinking errors”), and help clients develop improved self-regulation. More than half of the clients in this treatment track had received diagnoses of Antisocial Personality Disorder and/or Pedophilia. Many carried more ambiguous diagnoses, such as Paraphilia, Not Otherwise Specified. In reviewing the diagnoses, Julie was fascinated by how few clients had received diagnoses in areas other than those related to sexual abuse. Her clients routinely expressed and displayed symptoms of anxiety, depression, Posttraumatic Stress Disorder, and Attention Deficit Hyperactivity Disorder that was either previously undiagnosed or untreated.

Part of Julie’s responsibilities included making periodic attempts to engage the clients who refused treatment and those on the separation unit (SU). She was already aware of Marcus’ presence, as his arrival had generated much discussion amongst the staff. Per institution policy, the treatment team held a meeting to review Marcus’ placement 72 hours after his placement. These meetings often put therapists into a difficult role. By design, there were more security (a psychiatric security worker and a unit manager) than clinical staff (Julie) present. Although the rules for decision-making in SU placement matters were clear and explicit, a number of challenges still entered the background of the discussion. Some members

of the security team, despite their training, were skeptical of their clientele's capacity to change and would prefer to err on the side of safety. Julie's supervisor had been clear with her that extended stays in the SU could quickly become the source of legal action, and urged Julie to do what she could to secure Marcus' commitment to treatment and placement on a unit for treatment participants. This put Julie into a bind; she could advocate for Marcus and risk creating an undesirable reputation with the security staff, or she could acquiesce to their wishes, creating doubts in her supervisor's mind. Although she told herself she would advocate according to her own assessment of the facts and Marcus' needs and rights, she was aware that she was also in a political bind and would likely be most successful in any situation where – as a local saying would explain – she could “go along to get along” with others. In this political calculus, Marcus' best interests could easily take second place to the institution's.

Fortunately, Marcus' situation was straightforward. His behavior had been stable for the full 72 hours, meaning that there was no reason to keep him on the SU. Julie then went to meet with Marcus. Her task was to explore Marcus' willingness to participate in treatment. The outcome of this discussion would determine whether he would move to a living unit for treatment participants or another unit for “refusers.”

JULIE:

Good morning, Mr. Paul. My name is Julie Hart. I'm a social worker and therapist here at the CCCC. I wonder if we could speak for a few moments?

MARCUS (making direct, expressionless eye contact, dispassionately assessing her):

A few moments. I'm here for the rest of my life, and you want a few moments of it.

JULIE (aware of sensations in her abdomen and forehead, and unaware that her posture had begun to orient slightly back toward the door to the unit):

Yes, I was hoping to talk with you about the treatment program. I'll understand if it seems hopeless or if it's not the right time.

MARCUS:

I'm not interested.

JULIE (slight slouch, but prepared for this response):

Okay, thank you. I'll be on my way then, and hope to check up on you in the next week to see if you've had any additional thoughts. In the meantime, the staff can help you contact me if you like (gets up to leave and starts to walk away).

Assessment

In this instance, Julia had been prepared for a client's request not to meet. There is a central axiom in motivational interviewing (MI) that MI is something done for and with a client, not to and on them (Miller & Rollnick, 2013, p. 24). Under these conditions, the only acceptable answer to a client who does not want to talk is to thank them and leave; offering to be available to the client if they change their mind is also acceptable. Having this response at the ready is not only respectful toward the client, it is a building block of professional self-care. Professionals who attempt to force their interventions on unwilling clients are prone to greater levels of subjective distress and are less effective (Parhar, Wormith, Derkzen, & Beauregard, 2008). A helpful approach to any form of intervention in criminal justice is to remind one's self that the client's decisions, for better or worse, are between them and their future. Even as every professional wants the best outcomes for their clients and the community, an emotional investment in the outcome, which can easily become expressed in attempts to persuade or cajole, will bring disappointment and risk for burnout.

Another advantage to honoring the client's decision not to speak is that it is respectful of his or her autonomy. Within Julie's first hours at the CCCC, it became very clear that her clients had very few opportunities to make any decisions for themselves, much less function as autonomous beings. Julie made an explicit decision that she would work differently from how many people seemed to behave. Whereas prison and civil commitment environments can seem to encourage staff members tacitly to serve as reminders of their clients' restricted liberties, Julie was determined to be a person who found ways to offer appropriate choices when virtually all other choices had been taken away. For example, where other therapists might say, "Today we are going to review your treatment plan," she could say "What part of your treatment plan would you be willing to talk with me about today?" To this end, Julie was determined to approach interactions like the famous dancer Ginger Rogers. Rather than going to each interaction prepared to issue directions and provide feedback, Julie determined to engage in a kind of choreography with each client in much the way that Rogers did with her partner, Fred Astaire: by dancing backward and in heels. In real life, Ginger Rogers brought out the best in Fred Astaire. So it can be that in adopting a "choreography" mindset the professional can seek out evidence of strengths, autonomy, and positive attributes in each client and openly demonstrate understanding and respect for him or her.