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Cognitive Behavioral Therapy Interventions With Sex Offenders

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The majority of convicted sex offenders are eventually released back into the community. Consequently, effective treatment interventions that can lower the recidivism rates of sexual offenders are needed. Cognitive behavioral interventions based on the principles of risk, needs, and responsivity are the most common form of treatment used with sex offenders. To date, there is preliminary evidence that suggests that treatment using cognitive behavioral techniques decreases subsequent sex offender recidivism. This article reviews the current research on cognitive behavioral techniques for the treatment of sex offenders and provides guidelines for treatment providers.

Keywords: sex offenders; cognitive behavioral therapy; correctional heath care; recidivism

Since the 1980s, the number of incarcerated sex offenders has been steadily increasing (Greenfield, 1997; Porporino & Motiuk, 1991). Most convicted sex offenders are eventually released back into community settings under parole supervision or probation (Center for Sex Offender Management, 2000). The average length of sentence imposed on sexual offenders in 1994 was 8 years, with only 3.5 of those years being served before their release from prison. It is estimated that about 60% of all the 265,000 sexual offenders managed by the U.S. correctional system are not in prison but instead under some form of conditional supervision in the community (Greenfield, 1997). Once released into the community, the average sexual recidivism rate for convicted sexual offenders is believed to be between 10% and 15% over 5 years, with the latest data observing a rate of 13.7% over 5 to 6 years (Hanson & Morton-Bourgon, 2005). Based on these findings, it can be concluded that most sex offenders will at some point be released back into the community, possibly before their sentences have been completed. As a result, there is a tremendous need for effective interventions that can lower the recidivism rates of sexual offenders in America.

History of Sex Offender Treatment Programs

The earliest sex offender treatments were behavioral in nature and focused on altering the deviant sexual arousal patterns of sex offenders (Kirsch & Becker, 2006). These early treatments

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were based on Pavlov's classical conditioning model and the theories of Watson and Skinner and used techniques such as aversion therapy to change deviant sexual arousal patterns (Kirsch & Becker, 2006). It was not until the 1970s and 1980s that the theories and treatment of sexual offenses began to incorporate the idea of cognitive processes as a significant element of offending behavior (Marshall & Laws, 2003). Following this shift in sexual offense theory, new treatment interventions were added to the previous behavioral model, including social skills training, assertiveness training, challenging distorted cognitions, and sexual interest reconditioning (Abel, Mittleman, & Becker, 1985; Marshall, 1971). During the 1980s, as sexual offender therapies were expanding and incorporating new components, the idea of relapse prevention (RP) became an important element in sex offender treatments (Kirsch & Becker, 2006). RP was a technique first used with people who completed substance abuse programs and was recognized as having significant potential when applied to sexual offenders (Marlatt & Gordon, 1985; Pithers, Marques, Gibat, & Marlatt, 1983).

Currently, the majority of sex offender treatment programs in the United States and Canada now use a combination of cognitive behavioral treatment (CBT) and RP (Center for Sex Offender Management, 2000). These treatment interventions generally involve group and individual therapy and focus on victim awareness and empathy training, cognitive restructuring, learning about the sexual abuse cycle, RP planning, anger management and assertiveness training, social and interpersonal skills development, and changing deviant sexual arousal patterns (Center for Sex Offender Management, 2000).

Efficacy of Sex Offender Treatment Programs

There has been a great debate in the literature about the efficacy of different forms of treatment interventions for sexual offenders and the ability of these treatments to lower sexual offense recidivism rates. When evaluating program effectiveness, the issues of risk, need, and offender responsivity must be taken into account (Andrews, Bonta, & Hoge, 1990). This risk-need model has been empirically supported as a means of effectively evaluating offender treatment programs (Andrews & Bonta, 1998). The basic principles of the risk-need model are that correctional interventions must be structured on these three core rehabilitation principles. The risk principle addresses the fact that offender treatments must change according to the offender's risk to the community so that offenders of greater risk must receive more intensive treatment interventions. According to the need principle, effective offender therapies must primarily address the offender's criminogenic needs and attempt to modify his or her dynamic risk factors. Lastly, the responsivity principle addresses the need for offender treatment therapies to match an offender's learning style, motivation level, and cultural background (Andrews & Bonta, 1998; Ward, Vess, & Collie, 2006).

Cognitive behavioral interventions are the most common form of treatment used for general offenders as well as sexual offenders (Andrews & Bonta, 1998; Becker & Murphy, 1998; Freeman-Longo & Knopp, 1992; Laws, 1989) and have been found to produce modest treatment effects (Kirsch & Becker, 2006). Hanson et al. (2002) conducted a meta-analysis of 43 sexual offender treatment outcome studies since 1980 and found that, on average, sex offenders who had completed treatment had a 12.3% sex offense recidivism rate compared with the 16.8% recidivism rate seen for offenders who did not complete treatment. When looking only at more recent CBT interventions, the authors uncovered a difference in sexual recidivism rates of 9.9% for offenders who completed treatment and 17.4% for offenders who did not receive treatment (Hanson et al., 2002). Similar sexual and nonsexual recidivism reduction rates based on CBT interventions have also been identified by other researchers (e.g., Barbaree & Seto, 1997; Gallagher, Wilson, Hirschfield, Coggeshall,

& MacKenzie, 1999; Hall, 1995; Hanson, 2000; Looman, Abracen, & Nicholaichuk, 2000; Marshall, Barbaree, & Eccles, 1991; McGrath, Cumming, Livingston, & Hoke, 2003; McGrath, Hoke, & Vojtisek, 1998; Nicholaichuk, Gordon, Deqiang, & Wong, 2000; Scalora & Garbin, 2003).

Basics of Cognitive Behavioral Therapy

Cognitive behavioral therapy is based on the cognitive model that posits that distorted and dysfunctional thinking is a common symptom of all psychological problems and illnesses and that these distorted thoughts influence a person's moods and behaviors (Beck, 1995). CBT is centered on the idea that in any given situation or interaction, a person's thoughts, attitudes, and beliefs determine his or her emotional experience and behavior. Therefore, if someone wants to change the way he or she behaves or experiences and expresses emotion, cognitive behavioral therapy dictates that the person must study and change his or her thoughts and beliefs. CBT uses many different processes to assist the subject in critically examining the relationship between thoughts and the subsequent emotions and behaviors. Some of the techniques used by cognitive behavioral therapists include restructuring of incorrect cognitions, behavioral rehearsal, and role-play (Beck, 1995). The CBT practitioner also teaches the client skills to augment his or her thoughts and behaviors, such as identifying and evaluating automatic thoughts, identifying emotions, problem solving, decision making, and activity monitoring and scheduling. Additionally, most cognitive behavioral therapies include homework for the client to complete between sessions (Beck, 1995).

The main goal of using cognitive behavioral therapy interventions with sexual offenders is to reduce sexual recidivism. Nevertheless, there are various other goals that cognitive behavioral therapists should keep in mind. One important objective should always be to help offenders regain a sense of self-worth so that their postincarceration lives can be both constructive and prosocial (Marshall, Anderson, & Fernandez, 1999). Therefore, when conducting CBT interventions with sexual offenders, it is necessary to practice a comprehensive therapy that both protects the community and nurtures the offender.

Certain components are included in almost all cognitive behavioral interventions for sex offenders. These include the treatment of cognitive distortions, the teaching of empathy and social skills, and the implementation of emotion management and RP. Additionally, some programs incorporate the elements of anger management and deviant sexual arousal.

Cognitive Distortions

One of the most important elements of CBT interventions for sexual offenders is the treatment of cognitive distortions. Cognitive distortions are incorrect attitudes and beliefs that support offending behavior (Marshall et al., 1999). For example, a pedophile may believe that by engaging in sexual contact with a child he is actually educating the child and acting in the child's best interest, or he may blame the victim and believe the child was seductive (Hall, 1996; Happel & Auffrey, 1995).

Blumenthal, Gudjonsson, and Burns (1999) found that sexual offenders hold attitudes and beliefs that minimize and justify their offending behavior. They found that sexual offenders of children supported their offending with more permanent cognitive distortions, such as the belief that the young victim wants and accepts a sexual relationship, whereas those who offend against adults more often use blame attributions associated with the particular offense.

Sex offenders also can misperceive their victim's actions, behaviors, or cues. Lipton, McDonel, and McFall (1987) conducted a study examining rapists' perceptions of behaviors in a dating situation. They found that the rapists accurately picked up on the men's cues in a nondate social outing; however, they mistook the women's negative and discouraging cues for positive and encouraging ones. Similarly, Beckett, Beech, Fisher, and Fordham (1994) found that sex offenders who molest children also misperceive cues. Their studies found that pedophiles hold distorted beliefs in which they believe that the children consented to the molestation and were not harmed by sexual interaction with adults (Beckett et al., 1994). Child molesters may perceive nonresponsiveness as an indication of enjoyment and compliance, whereas rapists often perceive distress as an evident expression of enjoyment (Hudson et al., 1993).

Another form of cognitive distortion is the denial and minimization of sexual offenses. Denial is the acceptance of explanations that reduce accountability and are reinforced by distorted beliefs and self-deceptive thinking processes (Schneider & Wright, 2004). At the beginning of treatment, it is common for sexual offenders to deny or minimize their offenses (Beckett et al., 1994). Barbaree (1991) found that 66% of child molesters and 54% of rapists deny their offenses, whereas Maletzky (1991) reported that 87% of the sex offenders in his study denied at least some part of the crime.

CBT Interventions for Cognitive Distortions

The reduction of cognitive distortions is a key element of an effective CBT intervention program because this decrease is needed to reduce recidivism rates (Hall, 1996; Marshall et al., 1999). Cognitive restructuring methods have been found to be effective in changing offenders' beliefs (Murphy, 1990). These methods include (a) explaining to the offenders the role of the deviant thoughts in their sexual offending behavior, (b) providing offenders with information on correcting these thoughts, (c) helping offenders recognize the appropriate thoughts from the inappropriate ones, and (d) helping offenders challenge the inappropriate thoughts.

The treatment process begins with the offender depicting the sexual offense in detail, including the thoughts/beliefs that preceded the behavior. The first goal of the personal description is to realize the offense chain. This aspect of treatment generally deals with numerous cognitive distortions held by the sex offender. The offender is asked to speak about his offense over the treatment period, which eventually leads to the final step of treatment, which is RP. Having the offender talk about his offense in a group setting allows for other members to think critically about their offenses as well as that of the fellow offender, in conjunction with identifying their cognitive distortions (Murphy, 1990). The offender's feedback on other offenses also allows the offender to reexamine his own offense. This give-and-take approach of group therapy offers a learning environment for the other group members.

Through the offender's discussions, the group is allowed to evaluate the offender's cognitive distortions with regard to the victim and the offenders' behavior. This process continues until the offenders' cognitive distortions diminish (Marshall et al., 1999). When offenders verbalize their distortions, they are challenged, their negative consequences are emphasized, and prosocial views are offered (Hall, 1996).

One large obstacle to treating cognitive distortions is the fact that many sexual offenders deny committing a crime. Schlank and Shaw (1996) developed a program for offenders who denied their crimes and were not changing their position in treatment. They presented the module as a pretreatment session, where offenders were continuously allowed to change their statements. Using this strategy, they were able to reduce the percentage of deniers by half.

In similar studies, Barbaree (1991) and Marshall (1994) used offenders who admitted their crime to challenge the deniers. Both Barbaree and Marshall's approaches generated positive results (Marshall et al., 1999). Many programs refuse to admit offenders who deny

their crimes. However, some treatment programs accept deniers and proceed to challenge the denial through phallometric measures (Barnard, Fuller, Robbins, & Shaw, 1989).

Emotion Management

The role of emotional states and their mismanagement as causes of sexual offending have become a relevant topic in both sex offender research and treatment interventions (Howells, Day, & Wright, 2004). Emotion management refers to the idea that a person's ability to cope with negative affect is directly related to his or her psychological well-being (Endler & Parker, 1990). Historically, most offender programs have addressed anger when targeting negative emotional states related to offending behavior. Although there is evidence that for some sex offenders anger many contribute to their offending behavior, there are often many other emotions in play. However, the experience and management of other emotions by sex offenders has been paid relatively little attention in research and practice compared with the study and treatment of anger (Yates, 2003).

To learn effective emotion management, an offender must learn how to identify his affective states and how he experiences and copes with his negative emotions. When learning to manage emotions, many aspects must be taken into account, and an offender should learn to recognize different aspects of emotion, such as intensity, expression, appropriateness, and cultural influences (e.g., Beck, 1995).

Although most of emotion management deals with the ability to recognize and cope with negative affect, it should be noted that these negative emotions are not the salient factors in all sex offender emotion management. For some offenders, the inability to manage the experience of positive emotions can lead to sexual offending behavior. Some examples of this are offending while in a state of elation, while experiencing a sense of entitlement, or while casting away inhibitions. Finally, there is one group of sex offenders who are not enabled by their positive or negative emotions, but instead by a complete lack of emotion (Howells et al., 2004).

Thus, it is clear that the teaching of emotion management is required to appropriately and comprehensively treat sexual offenders and curb recidivism. Offenders must be assessed for emotional control deficits and taught the skills necessary for managing their emotional states (Yates, 2003).

CBT Interventions for Emotion Management

Many researchers have identified a variety of emotional states that are associated with sexual offending behaviors, and these emotions can occur throughout any of the stages in the offense cycle (Hall & Hirschman, 1991; Johnston & Ward, 1996; Marshall, Hudson, Jones, & Fernandez, 1995; Ward, Louden, Hudson, & Marshall, 1995). The treatment for emotion management issues is based on the identification and subsequent management of emotions that contribute to the sexual offending behavior. Sexual offenders must develop an understanding of how their emotions and feelings influence their behavior patterns, both appropriate and inappropriate. Some key components of this therapy include the understanding of depression, anxiety, anger, loneliness, shame, and guilt. It should also be noted that for some offenders the emotions related to offending may be positive (Johnston & Ward, 1996).

In this treatment module, offenders are asked to identify the emotions that put them at risk for sexual offending behavior. This may vary from one offender to another. If this proves difficult for the offenders, an offense chain diagram may be drawn in which they sequentially delineate the thoughts, feelings, and emotions that preceded the sexual offending behavior. Once these emotions are identified, it is important to highlight to the offenders that these types of emotions (be it loneliness, depression, or anger) put them at risk for reoffending.

The next step is for the offenders to be aware of when they are experiencing those emotions. The therapist may facilitate an exercise in which the offenders can describe the first thing they notice when they feel angry or depressed, for example. An offender for whom anger is a trigger for sexual offending may notice that he starts sweating and his heart starts racing when he starts to feel angry, whereas an offender who gets depressed before offending may notice a decrease in his appetite and difficulty sleeping.

Many of the techniques in the emotion management module can be based on the dialectical behavior therapy model (see Linehan, 1993a, 1993b), in which offenders would learn mindfulness and behaviorally based skills to help them cope more effectively with their emotions.

Interpersonal Skills

Sexual offenders have historically been viewed as lacking in social skills, but the specific skill deficits were never defined. Traditionally, clinical interventions for these deficits focused on general skills such as assertiveness and communication (Hudson & Ward, 2000). More recent research has identified specific areas that need attention in sexual offenders, most importantly intimacy, attachment deficits, self-esteem, relationships, and loneliness (Keenan & Ward, 2000; Marshall, 1996; Marshall & Barbaree, 1990; Marshall, Bryce, Hudson, Ward, & Moth, 1996; Marshall, Serran, & Cortoni, 2000; Marshall et al., 1999; Smallbone & Dadds, 2000; Ward, Hudson, Marshall, & Siegert, 1995; Ward, Keenan, & Hudson, 1999). Marshall et al. (1999) hypothesized that childhood parental attachment patterns may be one cause of the feelings of loneliness and the lack of intimacy in some sexual offenders. Because of estrangement from their parents or abuse, many of these offenders form inadequate attachment styles that later lead to the inability to relate to or interact with others (Marshall et al., 1999). Marshall proposed a theory that as a result of these inadequate attachments sexual offenders are unable to find satisfaction in their intimate relationships with consenting adults and therefore look for sexual satisfaction with nonconsenting adults or children (Marshall, 1989). Another aspect of Marshall's theory on sexual offender social skills deficits is that these offenders often identify intimacy with sex, leading them to believe that any sexual behavior will meet their intimacy needs. When their sexual offenses do not meet the offenders' intimacy needs they often experience great loneliness (Marshall et al., 1999).

CBT Interventions to Enhance Interpersonal Skills

The goal of CBT interventions for social skills deficits is to improve the sexual offender's appropriate communication skills and to initiate and maintain consenting relationships with suitable partners (Correctional Service of Canada, 1995). The first topic that should be addressed is the definition of intimacy. It is important for the offenders to realize that for intimacy to exist in a romantic relationship the distribution of power and control must be equitable. Furthermore, the offenders must learn that their intimacy needs cannot be met by their sexual offenses. Marshall et al. (1999) recommend having offenders discuss within a group their parental and early romantic relationships. It should be pointed out that much of the distrust they have in relationships today results from these early attachments.

The second topic addressed in this CBT intervention is developing and maintaining relationships. Offenders should be made aware that the secrecy they employ because of their sexual offending plays a great part in distancing them from their adult partners. The benefits of having an open and equitable relationship should be discussed, and offenders should be taught that equitability cannot come from a sexually abusive relationship. They will then hopefully see that their full range of intimacy needs cannot be met by their sexual offending behaviors, but instead by consensual adult partners (Marshall et al., 1999).

Some offenders may have skills deficits that prevent them from having age-appropriate consensual relationships (both platonic and romantic). It is important for the treatment provider to identify these deficits as they may contribute to the maintenance of inappropriate sexual behavior and relationships. Deficits can be assessed through in-group role-plays. If an offender lacks social skills, then it is recommended that the treatment provider follow the skills training protocols set forth in cognitive behavioral interventions for social phobia, in which offenders learn basics of social interaction (see Heimberg, 2001; Van Dam-Baggen & Kraaimaat, 2000). These skills can be practiced and reinforced in group and assigned as homework assignments between sessions.

Empathy

Empathy can be defined as the ability to cognitively identify someone else's perspective, to recognize emotions within oneself, and to apply these emotions by behaving compassionately as a result of another's feelings (Pithers, 1994, 1999). There is a general belief that empathy helps regulate human behavior (Moore, 1990). However, to what extent one needs to be engaged in empathy and how human beings come to experience empathy is not yet thoroughly understood (Marshall et al., 1999).

Numerous theories have been postulated regarding the relationship between sex offending behavior and empathy deficits. Some research has shown that sex offenders are able to feel empathy toward others, much like the rest of the population. However, differences arise when this population is dealing with their victims. For example, rapists are not able to sense a woman's distress level during a simulated date scene (Lipton et al., 1987). Furthermore, child molesters, when compared with other sex offenders, have a deficit in ability to decipher a child's distress level (Stermac & Segal, 1989).

Ninety-four percent of sex offender treatment programs in North America contain empathy enhancement modules (Knopp, Freeman-Longo, & Stevenson, 1992). This empathy enhancement treatment stems from the belief that if the sex offender understands how the victim feels and is able to develop empathy for this victim, then future sexual deviancy may be prevented (Williams & Khanna, 1990).

CBT Interventions for Empathy Deficits

Numerous techniques can be employed to help sex offenders develop empathy for their victims. Marshall and Fernandez (2001) suggest using videos and victim impact statements. Videos (including documentaries, talk shows, and movie clips) can be used to show the offender the aftermath of a sexual assault (Carich, Metzger, Baig, & Harper, 2003). The treatment group can then discuss how the assault affected the victim. The therapist may use Socratic questioning and cognitive restructuring to encourage empathic responses (Carich et al., 2003).

Another technique that is frequently employed to increase victim empathy is letter writing. This includes both letters from the offender to the victim and letters from the victim to the offender. Offenders are asked to write a letter to their victim expressing remorse for what they have done and accepting full responsibility for their crime (these letters are not mailed) (Freeman-Longo & Pithers, 1992; Marshall et al., 1999). The offenders are asked to read their letters aloud to the group, and they are given feedback from the other members. An offender may have to rework his letter numerous times before the group agrees that the offender has demonstrated sufficient empathy for his victim.

Occasionally, a victim may write to an offender detailing the effects of the sexual assault. If this is the case, the offender is asked to read the letter to the group, and the group discusses

the emotions evoked in the letter. The offender is also asked to share his sentiments about how the letter affected him (Carich et al., 2003). If none of the offenders has received such a letter, the victim voice technique may be used. The offenders are asked to write a letter to themselves as if they were the victim. The therapist asks the offenders to put themselves in the victim's place and imagine some of the thoughts and emotions that the victim may be experiencing as a result of the sexual assault and write this on paper. As with the other techniques, the letters are then read aloud in group and discussed (Carich et al., 2003).

Deviant Sexual Behavior

Deviant sexuality can be defined as sexuality involving children and exploitive or violent sexual activities (Dougher, 1996). Deviant sexual preferences were believed to result from early conditional learning of inappropriate sexual stimuli and sexual arousal (McGuire, Carlisle, & Young, 1965). As a result, sexual abuse has been viewed as a way of appeasing the deviant sexual desire, regardless of the method or the victim (McGuire et al., 1965).

Sex offender treatment programs usually assess sexual attraction by attaching a device called a plethysmograph to the offender's penis. This device measures and records penile erection as the offender is exposed to various visual or auditory stimuli. The visual stimuli may be of naked children or adults, while auditory stimuli may be descriptions of sexual acts with adults or children (Hall, 1996). The plethysmograph is useful in identifying those offenders who are sexually attracted to minors. It also helps therapists determine whether treatment has aided in a reduction or elimination of deviant sexual attraction (Hall, 1996).

CBT Interventions for Deviant Sexual Arousal

Most sexual offenders who receive cognitive behavioral therapy do not need this intervention as part of their sexual offender treatment. When deemed necessary, there are five techniques that therapists use to reduce and eliminate deviant arousal. Each of these techniques has been proven to work with certain types of offenders, and in general, behavioral intervention techniques are most effective at reducing sexual recidivism (Dougher, 1996).

Covert sensitization is a form of aversive conditioning that attempts to eliminate an unwanted behavior. The offender is taught to imagine unpleasant and related aversive consequences while engaging in the unwanted habit. It is a procedure that relies on the offender to imagine a deviant sexual act. This is followed by the offender imagining a negative reaction, such as nausea or anxiety. The offender relieves the negative experience by removing himself from the deviant fantasy. The offender also is able to turn to avoidance scenes, in which the offender imagines he is turning away from the deviant stimulus (Dougher, 1996).

Masturbatory satiation and verbal satiation are two therapies used to reduce inappropriate sexual arousal in sexual offenders (Dougher, 1996). Masturbatory satiation involves the offender masturbating to a healthy fantasy, such as sexual intercourse with a consenting adult, until ejaculation, while being asked to verbalize the fantasy. After the offender reaches orgasm, he is asked to continue masturbating and is instructed to this time use an inappropriate fantasy, such as nonconsensual adult sex or sexual acts with children, for a period of 50 minutes to 2 hours, while once again being asked to verbalize the fantasy. If the deviant masturbation results in arousal, the offender is asked to switch to a healthy fantasy. According to Abel and Annon (1982), this technique can significantly reduce deviant arousal after 12 sessions.

Verbal satiation is similar to masturbatory satiation, except that after the initial ejaculation the offender has to verbalize deviant sexual fantasies for a set time period, until these fantasies become tedious. This verbalization has to continue for at least 30 minutes, at least

3 times per week. Reduction in deviant arousal is said to occur between 40 and 60 sessions (Laws & Osborn, 1982).

Barlow and Abel (1976) recommended that instead of reducing inappropriate arousal, treatment should begin by first increasing appropriate arousal. Davison (1968) and Marquis (1970) recommended that the offender begin masturbating to a deviant fantasy but switch to a healthy one at the point of orgasm. This alteration method is preferable over basic orgasmic reconditioning as it simultaneously increases appropriate arousal while decreasing deviant arousal (Dougher, 1996).

Relapse Prevention and Self-Management

Although most sex offenders are likely to say that they will never reoffend, they are not able to explain how they will be able to prevent similar occurrences from happening in the future (Marques & Nelson, 1992). The goal of RP, when applied to sexual offending, is to help sex offenders maintain behavioral changes by anticipating and coping with the problem of relapse (Center for Sex Offender Management, 2000). Although RP was not a treatment component based on any etiological theories of sexual offending, it has quickly become a key element in many sex offender treatment programs (Kirsch & Becker, 2006; Laws, Hudson, & Ward, 2000).

The RP model was originally developed to help alcoholics overcome their addiction to alcohol (Marlatt & Gordon, 1985). Although RP is commonly used with the sex offender population, it does not assume that sex offending is an addictive behavior. However, there are some similarities between alcoholics and sexual offenders, including denial of the severity of their offending cycle and problems maintaining abstinence (Marques & Nelson, 1992).

RP focuses on the cycle of offending and attempts to stop the behaviors from reoccurring. RP plans are developed to identify triggers and dangerous situations and to create strategies to avoid high-risk situations where lapses may occur. This is accomplished by teaching offenders how to recognize and avoid situations that may increase their temptation. This plan also includes teaching skills to cope with situational variables, because there is no way to determine that an offender will never place himself or be placed in a high-risk situation (Marshall et al., 1999).

Offenders are taught to be conscious of their thoughts and to recognize when they are at risk for reoffending. Sexual offenders are instructed to think of their sexual thoughts as deviant, but at the same time as controllable, and stoppable. Although the goal of RP is self-control, there is always the fear that an offender cannot manage his RP on his own. Therefore, an RP plan often includes the possibility of intervention by others, such as the family or probation department (Hall, 1996).

CBT Intervention for Relapse Prevention and Self-Management

According to the RP model, if an offender is to avoid having lapses and full relapses, he must devise a concrete intervention for the relapse process. This includes (a) identifying the triggers that lead to a relapse and (b) developing, planning, and practicing coping skills for the factors that place him at risk of reoffending (Marques & Nelson, 1992).

After he has committed to abstinence, the first step to stopping a reoffense is for the offender to realize his own relapse cycle. Once he has grasped this, the offender must break down this cycle into specific risks and devise effective coping skills for each trigger or factor. The definition of the risks and coping skills has to be individualized for each offender, as no two offenders have identical relapse patterns (Nelson & Jackson, 1989). The next step is for the offender to identify events that occurred before the offense, along with thoughts and feelings that accompanied these prior events. When done correctly, the process outlined above helps

create the offender's cognitive behavioral relapse chain, the last links of which are his high-risk behaviors that eventually lead to sexual assault or child molestation (Marques & Nelson, 1992).

The offender must also learn to identify a high-risk situation. He must be aware of any triggers that he encounters and must highlight them to ensure that he does not act on them (Marques & Nelson, 1992). This may be as simple as an offender refusing to babysit because he may find the child attractive.

As stated previously, most sexual offenders experience some form of cognitive distortion. Therefore, the next step in RP is to reevaluate the past offenses. Within this reevaluation, the offender must identify the justifications he used to allow himself access to the high-risk situation in the first place (Marques & Nelson, 1992).

A very important lesson contained in RP training is that of mitigating urges. Offenders must learn that succumbing to an urge is a decision that they have chosen for themselves and that the immediate gratification they receive from their actions is not worth the consequences such as feelings of guilt and shame or imprisonment (Blanchette, 1996).

The final step in the RP model is to follow through with appropriate behavioral responses. The offender should always have a support system in place so that when he feels tempted by a situation he will have someone to turn to for help and support (Marques & Nelson, 1992). If all of these steps are followed correctly, it is hoped that an offender's RP plan will keep him from reoffending.

Conclusion

The need for effective treatments for sexual offenders is a pressing issue in America. The sexual offender population is increasing and most of these offenders will eventually be released into the community without having received any treatment. Although sexual recidivism is a problem that can never be solved, there are very promising ways in which its impact on both the community and the offender can be reduced. By using cognitive behavioral therapy interventions for sexual offenders, some reduction in sexual recidivism can be assured. Cognitive behavioral therapy has consistently been empirically proven as an effective treatment for a myriad of mental illnesses and problems. CBT interventions are comprehensive and effectual treatments for this population and should be considered best practice for treatment with sexual offenders.

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