

***EMDR and Sex Offenders: Using an Evidence Based
Trauma Treatment Approach to Unlock Treatment Successes***

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Often when working with sex offenders, we hit snags: what was once progressing toward successful treatment seems to grind to a halt as roadblocks are encountered. Often these roadblocks take the form of behavior relapse, re-offense or lack of treatment compliance. When these roadblocks occur, treatment providers, probation and families are left feeling frustrated and angry.

Brooks-Gordon, Bilby, and Wells (2006) systematically reviewed nine randomized control trials of CBT interventions for sexual offenders published between 1998 and 2003. They concluded that treatment reduced re-arrest rates at 1 year but increased re-arrest at 10 years. These disappointing outcomes have resulted in the call for more effective treatments for this difficult population. These results have led to a growing concern that our traditional cognitive-behavioral relapse prevention model does not produce the treatment results for which we are aiming.

Treatment providers and researchers have started looking more closely at other ways to treat sex offenders by reviewing paths of etiology for the sexual offending behavior. Some theorists propose that developmental difficulties can interrupt the offender's ability to join with the treatment process and, therefore, reap its benefits.

Furthermore, they posit that these developmental difficulties lead to elevated re-offense risk (Beech & Ward, 2006). Etiological theory and research suggests that one pathway toward sexual offending behavior in some offenders is that of disturbed sexual development (e.g., childhood sexual trauma; Ward & Siegert, 2002). Other researchers have theorized that sexual offending behavior can be linked to early distortions in the offender's "Lovemap," or love relationship assumptions (Miccio-Fonseca, 2007).

Researchers working on the effects of trauma also shed light into the etiology of sexual offending behavior. Research suggests that trauma effects may become the central core around which behaviors and even personality are organized. Trauma sequelae may include attachment/trust ruptures, unprocessed rage, retarded social/emotional development and abnormal sexuality and/or arousal. Furthermore, trauma might also reduce any sense of future thereby fostering a tendency toward the pursuit of instant gratification. These elements are common to many sexual offenders.

From this research emerged Ward and Seigert's (2002) pathways model which attributes clinical phenomenon evident in the treatment of sex offenders into four interactive psychological mechanisms: intimacy and social skills deficits, distorted sexual scripts, emotional dysregulation, and offense supporting beliefs. Ward and Seigert (2006) have gone on to develop the Integrated Theory of Sexual Offending, which broadens the perspective to include neurological as well as etiological factors. However, this theory further highlights the importance of early experiences on the sex offender.

While these theories of causation have emerged, little seems to have been done to incorporate this new model into sex offender treatment. In general, treatment for trauma is not a typical component of most sexual offender treatment, despite the emergence of these theories about etiology of the offending behavior. An effective application of the emerging etiology theories provides a means for interrupting these etiological paths toward sexual offending.

In particular, an effective use of the theories would impact the sexual offender along these etiological pathways and reduce their impact on day to day behavior. Eye movement desensitization and reprocessing (EMDR) is a treatment modality designed to help people end the effects of their previous traumatic experiences and the resulting distorted thinking processes (Shapiro, 2001).

What is EMDR?

EMDR is a well-established eight- phase treatment modality aimed at reducing the impact of traumatic or upsetting experiences. Treatment focuses on elements of the past, present and future effects of trauma, and traumatic sequelae, with an emphasis on healthy resolution (Shapiro, 2001; Shapiro, 1989). EMDR has been shown to be both efficacious and efficient in the treatment of trauma (e.g. Bradley, Green, Russ, Dutra & Westen, 2005; Hertlein & Ricci, 2004; Maxfield & Hyer, 2002) and has shown good results with other populations demonstrating problematic behaviors (Greenwald, 2002; Soberman, Greenwald, & Rule, 2002). Furthermore, Ricci (2006) illustrated that EMDR was a useful trauma treatment with a child molester as evidenced by increased motivation for treatment and empathic response.

Because of these measured effects and the emergence of new theories of offender behavior etiology, EMDR is seen as an effective adjunct to traditional cognitive-behavioral relapse prevention oriented sex offender treatment. In fact, Ricci, Clayton, and Shapiro (2006) found that adding EMDR to standard CBT-RP treatment resulted in statistically significant pre-post improvements on all six subscales of the Sex Offender Treatment Rating Scale, a scale

designed to measure progress on issues specific to CBT-RP treatment. Additionally, findings showed significant reduction in deviant sexual arousal as measured by the penile plethysmograph (PPG), which was not found in an ad hoc comparison group. These treatment effects remained at a 1-year follow-up re-evaluation.

How does EMDR work with sex offenders?

The use of EMDR with the sex offender population continues to be an experimental application of the EMDR treatment model. In the research noted above, treatment varied from the traditional EMDR treatment protocol (Shapiro, 2001) in a few key ways, which will be highlighted below. However, successful use of EMDR requires that the sex offender move through all eight phases of the EMDR treatment model (Shapiro, 2001; Ricci, Clayton & Shapiro, 2006).

This treatment unfolds with a process of history taking about the sex offender's sexual abuse history, a process of determining treatment targets (memories) that seem to be impeding their CBT-RP treatment, preparation for processing, memory processing and ongoing assessment of the treatment. Furthermore, focus upon anticipated

memory triggers is part of successful EMDR treatment, to help the offender successfully anticipate future triggers and develop an appropriate response when they experience the trigger. This process involves them visualizing successful navigation of a given trauma trigger and responding in an adaptive manner (Shapiro, 2001).

EMDR with sex offenders differs from the traditional EMDR treatment protocol in these ways. First, some offenders, who have few or no disturbing memories of their own victimization, negotiate a good target for treatment with the clinician (Ricci & Clayton, 2008). Often targeting memories that seem to be blocking traditional CBT-RP treatment is seen as effective. Also, unlike the traditional EMDR protocol (Shapiro, 2001), research has shown good outcomes when the sex offender continues to report some emotional disturbance regarding their memory of their own victimization. Leaving a level of disturbance for the sex offender is seen as a way to help the offender avoid relapse (Ricci & Clayton, 2008).

These research findings on these techniques, with the noted variations from the traditional EMDR protocol, suggest that EMDR is a valuable addition to standard CBT-RP sex offender treatment. By integrating this treatment modality into standard sex offender treatment, the roots and etiology of the sex offender's offense-supporting cognitive distortions are addressed and the blocks to relationships are addressed at their root (Ricci, Clayton, & Shapiro, 2006). This treatment modality offers a way to unlock further treatment successes by working through and overcoming the roadblocks to treatment success.

References

- Beech, A., & Ward, T. (2006). Risk assessment in the 21st century: Towards an integrative model of risk. *The Forum: The Association for the Treatment of Sexual Abusers*, 18(3), 1–13.
- Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry*, 162, 214–227.
- Brooks-Gordon, B., Bilby, C., & Wells, H. (2006). A systematic review of psychological interventions for sexual offenders I: Randomised control trials. *Journal of Forensic Psychiatry and Psychology*, 17, 442–466.
- Greenwald, R. (2002). Motivation—Adaptive Skills—Trauma Resolution (MASTR) therapy for adolescents with conduct problems: An open trial. *Journal of Aggression, Maltreatment, and Trauma*, 6, 237–261.
- Hertlein, K. M., & Ricci, R. J. (2004). A systematic research synthesis of EMDR studies: Implementation of the platinum standard. *Trauma, Violence and Abuse: A Review Journal*, 5, 285–300.
- Maxfield, L., & Hyer, L. (2002). The relationship between efficacy and methodology in studies investigating EMDR treatment of PTSD. *Journal of Clinical Psychology*, 58, 23–41.
- Miccio-Fonseca, L. C. (2007). Challenging the myths about sexual disorders: Understanding the role of bio-physio process, family lovemaps, and paraphilic fugue states. In D. S. Prescott (Ed.), *Knowledge and practice: Challenges in the treatment and supervision of sexual abusers*. Oklahoma City, OK: Wood ‘N’ Barnes.
- Ricci, R. J. (2006). Trauma resolution using eye movement desensitization and reprocessing with an incestuous sex offender: An instrumental case study. *Clinical Case Studies*, 5, 248–265.
- Ricci, R. J., Clayton, C. A., & Shapiro, F. (2006). Some effects of EMDR on previously abused child molesters: Theoretical reviews and preliminary findings. *Journal of Forensic Psychiatry and Psychology*, 17, 538–562.
- Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress Studies*, 2, 199–223.
- Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures* (2nd ed.). New York: Guilford Press.
- Soberman, G., Greenwald, R., & Rule, D. (2002). A controlled study of eye movement desensitization and reprocessing (EMDR) for boys with conduct problem. *Journal of Aggression, Maltreatment, and Trauma*, 6, 217–236.

Ward, T., & Siegert, R. J. (2002). Toward a comprehensive theory of child sexual abuse: A theory knitting perspective. *Psychology, Crime, and Law*, 8, 319–351.

Ward, T. & Beech, A. (2006). An integrated theory of sexual offending. *Aggression and Violent Behavior*, 11, 44–63.



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