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EMDR With Sex Offenders: Using Offense Drivers to Guide Conceptualization and Treatment

Ronald J. Ricci
Specialized Treatment Services of Virgina, Charlottesville, Virginia
Philadelphia, Pennsylvania

Cheryl A. Clayton
Specialized Treatment Services of Virginia, Abingdon, Virginia

Evidence shows that sexual offenders have higher levels of adverse childhood experiences (ACE) than either the general population or other criminal populations. Historically, it was considered standard practice for sex offender therapists to dissuade their clients from addressing childhood trauma or adversity for fear of excuse making for his offending. The pathways model, which highlights etiology, made room for trauma treatment for offender's ACE as a legitimate treatment intervention. The adaptive information processing model inherent in eye movement desensitization and reprocessing (EMDR) trauma therapy is theorized to reorganize the maladaptively stored clustering of cognitions and emotions related to overwhelming or traumatic experiences such as childhood sexual abuse. We suggest EMDR therapy as a means of restructuring distorted implicit cognitions and personal vulnerability factors which are theorized to drive offending behavior. Through a comprehensive literature review, the authors considered 5 extant models in the sex offender literature and developed the *offense drivers* model. This model is designed to guide and inform EMDR therapy with sex offenders. A case example illustrates the implementation of this treatment process. A checklist of *offense drivers* is provided to assist in case conceptualization and treatment.

Keywords: eye movement desensitization and reprocessing (EMDR); sex offender treatment; offense drivers; adverse childhood experiences (ACE); trauma

Sex offending is a complicated, multidetermined disorder, and treatment models have evolved to respond to research over the past 30 years in an effort to effectively address it. A 2015 meta-analysis comparing 4,939 treated with 5,448 untreated sex offenders yielded recidivism rates of 10.1% versus 13.7%, respectively, leading the authors to conclude that the evidence basis for sex offender treatment remains unsatisfactory (Schmucker & Lösel, 2015). Following their meta-analysis, the authors concluded,

> . . . The only RCT [random controlled trial] on CBT [cognitive behavioral therapy] that reports sexual recidivism outcomes (Marques, 2005; described in more detail) did not show a positive treatment effect. Although CBT approaches have been advocated over the last decades, the effects are not as clear cut as one might wish for "best practice" approaches. (pp. 24–25)

The call for more effective and efficient means of treating the complex disorder continues.

Recent attention has been given to the practice of trauma-informed care with the idea that the offender client's own history of childhood adversity and/or trauma may be one of the factors interfering with more positive treatment outcomes (Levenson, Willis, & Prescott, 2014). This approach does not propose to directly target and resolve the trauma, perhaps because of the long-standing belief that doing so may foster excuse making, but rather proposes that given the evidence for trauma in high numbers of sex offenders that the sequelae be considered when designing and providing intervention. Etiological models of sexual offending such as the pathways model (Ward & Siegert, 2002) consider some of the sequelae associated with these adverse experiences or traumas and proposes them as contributory to the offense pathway. This allows for the idea that addressing

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these adverse childhood experiences (ACE) may in fact be acceptable, relevant treatment targets. There is a small body of literature describing the application of EMDR therapy with sexual offenders for issues of treatment motivation, empathy enhancement, and cognitive restructuring; however, a theory that guides a comprehensive approach to applying EMDR therapy with this population does not exist in the literature. This article is our first effort to describe a systematic way to conceptualize EMDR therapy for application with sex offenders that specifically targets factors described in the sex offender literature which are theorized to contribute to sexual perpetration risk. This article does not propose EMDR therapy be used as a substitute for standard best practice sex offender therapy but rather as an enhancing adjunct. Sex offender treatment and management is a specialty field with some concepts and practices which may initially seem counterintuitive to the unspecialized mental health provider. The EMDR practitioner applying the concepts presented herein is cautioned to do so only after undergoing specialized training in the treatment and management of sex offenders to gain the necessary knowledge to effectively collaborate with the credentialed, treating sex offender therapist and the larger supervision team.

Sex Offender Treatment

Relapse Prevention Treatment

For more than 20 years, the treatment of sex offenders was foundationally based on the work of William Pithers and his colleagues who are credited for adapting the relapse prevention (RP) model from the substance abuse field (Pithers, Marques, Gibat, & Marlatt, 1983). Risk reduction was believed to be best achieved by applying strategies for avoiding lapse and relapse in the addiction field, and similar strategies were predicted to be useful for sex offenders. The era of behaviorism ushered in widespread use of cognitive behavioral therapy (CBT), and a hybrid CBT-RP became recognized as best practice for treating sex offenders. Studies of treatment effectiveness showed mixed results. A meta-analysis encompassing more than 9,000 subjects reported lower rates for treated offenders of 12.3% recidivism compared to 16.8% for the comparison groups who received either no treatment or a form of treatment judged to be inadequate or inappropriate (Hanson et al., 2002). However, others (e.g., Rice & Harris, 2003) continued to question that the effectiveness of sex offense specific treatment had been demonstrated. The Schmucker and Lösel (2015) meta-analysis mentioned earlier compared 4,939 treated sex offenders with 5,448 untreated sex offenders. The results yielded recidivism rates of 10.1% versus 13.7%, respectively. Those researchers and others specializing in the sex offender field acknowledge serious gaps in the knowledge base and there continues a call for further study about what, when, and how treatment of sexual offenders works.

California Sex Offender Treatment Evaluation Project

In the early 1980s, the California Department of Mental Health called for a longitudinal study of innovative approaches to treating sex offenders. This fostered the Sex Offender Treatment Evaluation Project (SOTEP) which was a three-group, randomized controlled trial study that collected data from 1985 to 2001 (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005). The study evaluated the effectiveness of an intensive, inpatient, RP-based treatment program developed by Marques et al. (2005). The program addressed core issues related to the problem of sexual offending to include increased personal responsibility and decreased justification for sexually offending, decreased deviant sexual interest, understanding and application of RP techniques, and improved ability to identify high-risk situations. The sex offender field eagerly awaited results from the well-designed study. Despite some within group differences which met clinical significance, the final determination was that the researchers did not find an overall treatment effect for the program. These findings applied to both rapists and child molesters and to low- as well as high-risk offenders. The SOTEP researchers further analyzed the data beyond main effects to try to determine what worked, when, and with whom. One of the findings was that those participants without histories of childhood physical abuse responded better to treatment (Marques, Day, Nelson, & West, 1994). This finding supports our notion that addressing and resolving the lasting effects of childhood adversity may be an effective means to enhance treatment engagement. During this same period, Laws, Hudson, and Ward (2000) edited a book entitled *Remaking Relapse Prevention with Sex Offenders: A Sourcebook* that included the recently introduced Self-Regulation Model (Ward, Hudson, & Keenan, 1998) as an alternative to the traditional RP model for the treatment of sexual abusers described in the following text. Ward criticized the RP model as having several conceptual weaknesses and thus serving as an incomplete model of the relapse process (Ward & Hudson, 1996).

Self-Regulation Model

The Self-Regulation Model (SRM) (Ward et al., 1998) is a model to explain idiosyncratic motivation and dynamics of the offense process to individualize treatment planning. This model proposed to address the weakness in the RP model wherein RP did not allow for the idea of multiple pathways to offending and assumed all sexual offenders had a desire to refrain from offending behavior. The SRM outlines four offense pathways based on two criteria. The first criterion defines the offender's self-regulation style as (a) underregulation, (b) misregulation, or (c) intact regulation. Underregulation is defined as the failure to control behavior caused by a lack of adaptive skills; misregulation involves attempts to regulate behaviors with misguided or counterproductive strategies, whereas intact regulation involves application of effective strategies to control behavior toward a desired goal. The second criterion examines and defines the offense-related goal of the offender. Offenders may have an avoidant goal toward offending, indicating a desire to refrain from sexual offending. In contrast, approach-oriented offenders have a specific goal of offending and, once determined, move toward that goal without internal resistance. As mentioned, the RP model relied on a desire to refrain from offending and therefore did not apply to the approach group.

Permuting these two criteria in various combinations creates the four self-regulation styles outlined by Ward et al. (1998) which they labeled Avoidant-Passive, Avoidant-Active, Approach-Automatic, and Approach-Explicit. The Avoidant-Passive offender attempts to avoid sex offending, but they lack the skills to achieve their goal. The Avoidant-Active offender also attempts to avoid offending, but their coping responses are misregulated and are thereby ineffective or perhaps ironic. Approach-Automatic offenders have offense-related goals, while at the same time, they are underregulated, meaning they lack the specific skills to effectively plan their strategy and tend to rely on opportunities to offend. Finally, Approach-Explicit offenders have offense-related goals and have intact regulation, meaning they possess the desire to offend and the skills to fulfill that desire or goal. Proper identification of the offender's self-regulation style guides the clinical development of an individualized treatment plan. For example, an offender exhibiting underregulated strategies will benefit from learning prosocial, adaptive strategy development, whereas an offender exhibiting misregulated strategies will benefit from remediation, discovering the ironic nature of their former strategies and recognizing when those strategies became ineffective or abandoned in favor of moving forward with the offense. The SRM describes the offense process although does not discuss the etiology of the offending problem. To more fully explain the development of the offending problem and thus allow for the consideration of etiology in treatment, Ward and Siegert developed the pathways model of sexual offending (Ward & Siegert, 2002).

The Pathways Model

Ward and Siegert (2002) considered three of the most influential theories about underlying causes for sex offending in the extant literature (precondition model of sexual abuse, Finkelhor, 1984; quadripartite model, Hall & Hirschman, 1992; integrated theory, Marshall & Barbaree, 1990) and combined them with psychological concepts to develop the pathways model. They believed that clarification of the possible underlying causes to the offending was necessary to assist therapists in developing treatment interventions to address these issues and thus reduce the likelihood of sexual reoffense. The pathways model is a comprehensive etiological theory that attempts to explain child sexual abuse by considering dysfunctional mechanisms in four cluster areas: (a) intimacy deficits, (b) emotional dysregulation, (c) distorted sexual scripts, (d) antisocial or criminal attitudes and behaviors, and (e) multiple mechanisms. The dysfunctional mechanisms are theorized to be forged, at least in part, by idiosyncratic developmental influences which create predisposition and vulnerability factors to sexual offending which, when conjoined with situational triggers, result in sexual aggression. For example, an offender encountering a vulnerable other (e.g., woman, child) and who holds antisocial views regarding the rights and boundaries of others may sexually abuse the vulnerable other out of an implicitly held sense of entitlement. An offender who has distorted implicit views about children's sexuality and children's rights in relation to adults may satisfy his own disrupted affective state, for example, when rejected by an adult partner, by using a child to do so.

The developmental considerations inherent in the pathways model coincides with a growing body of research indicating a strong positive relationship between childhood adversity and later antisocial behavior (Duke, Pettingell, McMorris, & Borowsky, 2010; Greenwald, 2002; Reavis, Looman, Franco, & Rojas, 2013). Perhaps in response to this awareness of the prevalence of ACE in offenders, many in the sex offender treatment field have shifted away from

a confrontational, accountability approach toward a collaborative, trauma-informed approach to care (Levenson et al., 2014). This trauma-informed approach gives consideration to the effects of trauma when developing and implementing treatment interventions; however, it does not propose to treat and resolve the trauma. We suggest, as do Greenwald (2002, 2009), D'Orazio (2013), and Carich, Colwick, Cathell, and Moore (2015) that although this is a good effort toward improving treatment engagement, it fails to adequately address etiological factors believed to be contributors to offending. As mentioned historically, sex offender clients were dissuaded from discussing any ACE because it was perceived as excuse making. However, these new views on developmental adversity and trauma so prevalent in this population provide an opportunity to reverse this practice and address and resolve those contributory and vulnerability factors which we label as the *offense drivers* described in more detail in the following text.

Relationship Between Adverse Childhood Experiences and Offending

Evidence shows that those with criminal careers tend to have higher levels of ACE than do the general population (Duke et al., 2010; Greenwald, 2002; Reavis et al., 2013), with sex offenders having even higher levels of developmental adversity than other criminal populations (Levenson et al., 2014). Common knowledge in the trauma field is that trauma sequelae may include disengagement, dissociation, isolation, criminal involvement, mistrust, depression, dependency, impaired social skills, decreased self-esteem, decreased sense of control, and identification with the aggressor among other dynamics. Sexual trauma often leads to confusion about sexual norms, confusion of sex with love and caregiving, sexual preoccupation, fetishism of sexual parts, bonding of sexual activity with negative emotions and memories, and sexual dysfunction (Finkelhor, 1986). These also tend to be common features in the sex offender population, and we theorize that they originate, at least at times, in ACE such those measured on the Adverse Childhood Experiences Scale (Felitti et al., 1998).

Offense Drivers

Criminogenic needs are characteristics, traits, problems, or issues of an individual that directly relate to the individual's likelihood to reoffend and commit another crime (Andrews & Bonta, 2010). These criminogenic needs are identified as the relevant targets of sex offender treatment as proposed by the well-regarded risk-needs-responsivity model (Andrews, Bonta, & Hoge, 1990). We propose that these criminogenic factors are often symptoms which originated in early trauma or ACE. For example, a child who is molested by a trusting caregiver may develop a mistrust in others which then creates intimacy deficits, which is one of the pathways to sexual offending identified by Ward and Siegert (2002). These intimacy deficits then can result in an inability to forge and maintain healthy relationships which is a stable dynamic risk factor (Hanson & Morton-Bourgon, 2005) or criminogenic need associated with sexual reoffense risk. We developed the concept of *offense drivers* to help guide the clinical conceptualization and intervention to ensure that the relevant items believed to create vulnerability and drive the offense process are identified and addressed by treatment. We define *offense drivers* as those elements, features, dynamics, and cognitions that, when exposed to environmental or situational cues, are conceptualized as having *driven* the individual to cross the line between prosocial and antisocial or legal and illegal sexual behaviors. The *offense drivers* are a compilation of elements taken from extant theories in the sex offender field. For example, the idea of implicitly held offense supportive beliefs described in the following text is based on the work of Ward and Keenan (1999) and Polaschek and Gannon (2004). Vulnerability factors described later are described by Marshall and Barbaree (1990), and etiological pathways and self-regulation styles were ideas developed by Ward and his colleagues (1998, 2002) as described earlier. These factors are typically examined to assess clients and to guide treatment of sex offenders. The *offense drivers* checklist provided herewith can serve as an assessment rubric to conceptualize a case and guide individualized trauma treatment to complement standard sex offender treatment in targeting criminogenic needs and dynamic risk factors associated with recidivism.

Implicit Core Belief(s) as Offense Drivers

There have long been psychological theories which propose that early life experiences create beliefs, perceptions, and implicit theories that guide expectations and future behaviors (Dweck, Chiu, & Hong, 1995; Mihailides, Devilly, & Ward, 2004). Early childhood experiences have been shown to shape personality, affect brain development, and affect the way that genes are expressed. Although good early experiences help the brain to develop in a healthy way, adverse experiences can contribute to lifelong problems with learning, behavior, and health (National Scientific Council

on the Developing Child, 2010). It is theorized that implicit beliefs develop over the course of time in response to life experience. When these experiences are adverse or traumatic, they can develop into dysfunctional or problematic views including beliefs about the world in general as well as views of self and others. These developed beliefs, perceptions, and implicit theories contribute to criminogenic factors in sexual offenders (Keenan & Ward, 2000). An example would be the self-preserving belief of an incest survivor wherein it is too threatening to think that the trusted parent is flawed or bad, so the child/survivor adopts the belief he is the cause of his own abuse. This theory was supported by a study of 218 victims of sexual abuse aged 4–17 years involved in criminal cases (Quas, Goodman, & Jones, 2003).

Ward and Keenan (1999) identified five implicit theories which they found to account for most cognitive distortions articulated by males who are also child molesters. Briefly, these distorted beliefs are that (a) *children are sexual beings* who desire sex and have the knowledge and the capacity to initiate sexual activity in pursuit of pleasure; (b) the *offender is entitled* to seek what he wants at the expense of others because men are of greater importance than children; (c) the *world is a dangerous place* where it is necessary to fight to achieve dominance and control and adults are not as trustworthy as children; (d) the *world is uncontrollable* where emotions, sexual feelings, and events happen to people, none of whom have the ability to exert major personal influence on the world; and (e) *nature of harm*, meaning given that sex is desired by children, it is an inherently beneficial experience, or at least a benign one, in the absence of violence or threat. It is easy to imagine how experiencing an adverse, hostile, sexualized, abusive, or neglectful environment during one's developmental years might forge these perspectives for the abused individual.

Polaschek and Gannon (2004) outlined implicit theories commonly held by rapists. They are (a) *women are unknowable*, meaning that the rapist believes women are so inherently different from men that men cannot easily understand them; (b) *women are sex objects*, meaning that the rapist views their own sexual needs as primary over other domains and view women as constantly sexually receptive; (c) *male sex drive is uncontrollable*, meaning the rapist believes men's sexual energy can be difficult to control and can build to dangerous levels; (d) *entitlement*, meaning that the rapist believes one's needs should be met on demand; and (e) *dangerous world*, meaning the rapist sees the world as hostile and threatening where actors must be constantly on guard against exploitation by others.

We consider these implicit beliefs to be *offense drivers* and propose the selection of the trauma treatment targets be guided by early events or developmental antecedents to forging these belief systems. For example, a child who was sexually engaged with physical gentleness and words of affirmation by his older sister but who was also forcibly raped and physically abused by his older brother may develop the *nature of harm* belief structure described earlier. Assuming his later sexual perpetration mimicked that of his sister's, those incidents of sexual abuse perpetrated by her against him would be the relevant treatment target for trauma therapy to resolve the relevant *offense driver* (Table 1).

Vulnerability Factors as Offense Drivers

Marshall and Barbaree (1990) define vulnerability factors as deficits in the skills, attitudes, preferences, values, and beliefs which, when appropriately functioning, inhibit the temptation or opportunity toward sexual aggression. These authors were perhaps the first to discuss the idea that these deficits are formed via critical adverse developmental antecedents to sexually offensive behaviors. These deficits, thereby, are thought to leave the individual vulnerable to maladaptively attempting to get his basic human needs and wants met, for example, by using another sexually. As an example, a son raised by a father who continually demeans and objectifies females, and who shames and ridicules his son for showing respect to females, may treat women disrespectfully or abusively whenever he perceives his masculinity is threatened. This idiosyncratic vulnerability factor (*offense driver*), when triggered by the situational cue results in offensive behavior (see Table 1). Trauma treatment designed to achieve risk reduction, then, would best target memories of when he felt his masculinity was endangered or diminished and restored only when he adopted his father's hostile attitudes and demeaning behaviors toward women.

Etiological Pathways as Offense Drivers

Ward and Siegert's (2002) pathways model described in detail earlier identifies the etiological pathways to sexual offending as (a) *intimacy deficits*, (b) *emotional dysregulation*, (c) *distorted sexual scripts*, and (d) *antisocial or criminal attitudes and behavior*. There is a fifth pathway Ward and Siegert call *multiple mechanisms* (see Table 1). This pathway is composed of all four of the former in addition to deviant sexual interest which can be forged by early childhood sexual abuse. We also consider these pathways as *offense drivers* when

TABLE 1. Offense Drivers

Offense Driver	Description	Present
Implicit belief(s)	Children as sexual beings	
	Nature of harm	
	Entitlement	
	Dangerous world: revenge	
	Dangerous world: children safer	
	Dangerous world: predator or prey	
	Women are unknowable	
	Women are sex objects	
	Uncontrollability	
Vulnerability factor(s)	Skill deficits	
	Values deficits	
	Preferences deficits	
	Attitudes or beliefs deficits	
Etiological pathway(s)	Antisocial attitudes	
	Distorted/deviant sexual scripts	
	Intimacy deficits	
	Emotional dysregulation	
Self-regulation style	Underregulated strategies	
	Misregulated strategies	
	Regulated strategies	

Note. Implicit belief(s) from Ward and Keenan (1999) and Polaschek and Gannon (2004), vulnerability factor(s) from Marshall and Barbaree (1990), etiological pathway(s) from Ward and Siegart (2002), self-regulation style from Ward et al. (1998).

determining the developmental determinants to be addressed and resolved with trauma therapy. For example, a child abandoned and left alone by his mother nightly may develop the self-soothing habit of masturbating while fantasizing about her return. This habit can later generalize into the use of fantasy and sex as a means to regulate or moderate his emotions such as described in Ward and Siegert's emotional dysregulation pathway. Assuming the child later acts out sexually in a period of extreme emotional distress, perhaps caused by fear of abandonment, his early memories of loss and abandonment become the primary target of resolution which is believed to be the *offense driver*. Another example may be a male child who is sexually engaged by his mother each time his father is away on business and who is told (expressly or tacitly) that this is an appropriate expression of love between a mother and her son. This instilled belief then becomes the target of resolution in trauma treatment for this client who went on to sexually engage his own daughter when his wife became preoccupied with work.

Self-Regulation Style as Offense Drivers

The SRM described earlier gives attention to the offense-related goal of the offender and the regulation style he uses to avoid or achieve it. This information is considered in conceptualizing the case for trauma therapy because it helps to identify and highlight the motivating and strategic factors present in the sex offender's offense chain. For example, a client raised in an environment wherein sexual talk and activity is prevalent and pervasive, while at the same time the topic is denied and ignored, may develop underregulated strategies in terms of how to deal with sexual urges when they arise. A different child raised in a similar environment may develop regulated strategies to pursue any or all sexual opportunities while being driven by a perception that doing so is normal and acceptable behavior. The former might represent the Avoidant-Passive offender, whereas the latter example represents an Approach-Automatic offender. These *offense drivers* are then considered when

identifying the dynamics that developed from these early experiences which must be restructured and resolved through trauma treatment.

Table 1 is a checklist of the proposed *offense drivers* which can help the therapist to ensure he or she has considered all possible factors which may have contributed to the offense. The therapist is encouraged to look for any evidence of the *offense drivers* listed on the table and then explore with the client the etiological contributors to the *offense driver*, which then becomes the proposed trauma therapy target. For example, a client exhibiting intimacy deficits would be encouraged to look for evidence of betrayal of trust or abandonment. Clients may have one, two, several, or (rarely) all of these *offense drivers*, and the trauma therapy would need to address each factor in turn. The authors find this table a useful checklist to ensure all relevant *offense drivers* are considered during case conceptualization.

EMDR Therapy as an Adjunct to Sex Offender Treatment

EMDR

We have found that when applied in working with sex offenders, eye movement desensitization and reprocessing (EMDR) therapy is an efficient and effective means of addressing those adverse developmental experiences contributing to the offense pathways. EMDR therapy is an eight-phase treatment initially developed to treat emotional trauma (Shapiro, 1989, 1995, 2002). Processing the emotionally traumatic targets for comprehensive treatment includes addressing the memories that set the foundation for current dysfunction, the triggers of current disturbances, and templates for appropriate future functioning. EMDR's eight-phase treatment protocol (Shapiro, 1995, 2001, 2002) accesses and processes this traumatic material, and various theorists have suggested that EMDR therapy may facilitate appropriate memory storage within integrative memory networks (e.g., Siegel, 2002; Stickgold, 2002; van der Kolk, 2002) leading to trauma resolution.

The Eight Phases of Treatment

Phase 1 of treatment involves thorough discussion of the problem that brought the client into therapy, the behaviors stemming from that problem, and the symptoms of the problem. Phase 2 involves explaining the theory and process of EMDR and what the person can expect during and after treatment. To prepare for disturbance which may arise during processing, clients learn relaxation techniques for calming with the goal of self-induced state change. Phase 3 involves selecting an image that best represents the target memory, identifying the negative self-belief associated with the memory, picking a positive self-statement that they would rather believe, and identifying the negative emotions and physical sensations associated with the target. Phase 4 involves employing some form of bilateral stimulation (BLS) to desensitize and reprocess the traumatic memories. A set of standardized procedures guide the focus of attention as the client is instructed to attend to the different aspects of the memory network identified in Phase 3. Initially, the client concentrates on the disturbing memory, including the accompanying cognitions and emotions. The therapist provides BLS in the form of visual tracking, auditory stimulus, or tactile stimulation. Treatment progress is assessed using the Subjective Units of Distress Scale (SUDS; Wolpe, 1982). Phase 5 involves strengthening and installing the client's positive cognition which is measured using the Validity of Cognition (VOC) Scale (Shapiro, 1989). Phase 6 involves evaluating any residual tension the client feels in the body and targeting remaining physical sensations for reprocessing. Phase 7 is a closure phase at the end of each session which ensures that the person leaves the session feeling better than at the beginning. If the processing of the traumatic target event is not complete in a single session, the therapist assists the client in using various self-calming techniques to regain a sense of equilibrium. Phase 8 occurs at the beginning of subsequent sessions. The therapist checks to make sure that the positive results (low SUDs, high VOC, no body tension) have been maintained, identifies any new treatment targets, and reprocesses them.

Sexual Offending, Offense Drivers, and EMDR

We propose that EMDR therapy has use with sex offenders in reducing recidivism risk by addressing the contributing and vulnerability factors to the offense described earlier as *offense drivers*. We hold that sexual offenses are propelled by *offense drivers* which may be implicitly held beliefs, vulnerability factors, maladaptive coping strategies, or any combination thereof that contribute to crossing the line between legal and illegal sexual behavior.

The adaptive information processing (AIP) model (Shapiro, 1995, 2001) inherent in EMDR therapy provides a framework for understanding the rapid

change process seen in EMDR therapy. AIP suggests that the intense affect associated with the initial experience interferes with the brain's ability to process the information to an adaptive resolution. Consequently, perceptual information associated with the traumatic or overwhelming event, including affect, cognitions, images, and bodily sensations, becomes dysfunctionally stored and essentially isolated within the memory network. Similar events encountered subsequently serve to trigger this material, thus causing the individual's view of the present to be influenced by affective and cognitive distortions forged in the past. When applied to sex offenders, AIP (Shapiro, 1995, 2001) offers an explanation for the negative effects of unresolved experiences including those involving dysfunctional and deviant behavior. In sex offenders, various kinds of ACE (e.g., related to the desire for love or attention or sexual arousal) leave offenders with distorted memories of their victimization which may contribute to the development of the *offense drivers*.

Use of EMDR Therapy With Forensic Populations

There is small but growing body of literature regarding the use of EMDR therapy with forensic populations; however, a theory that guides a comprehensive approach to applying EMDR therapy with this population does not exist in the literature. The first known application of EMDR with the forensic population can be found in the work of Datta and Wallace (1994, 1996). The 1996 study found an increase in perpetrator empathy subsequent to EMDR treatment. In that study, Datta and Wallace investigated their hypothesis that addressing childhood trauma in the treatment of sex offenders would reduce anxiety and increase victim empathy, thus facilitating a break in the offense cycle. Ten incarcerated adolescents with histories of sexual abuse were given three sessions of EMDR. Pre- and postmeasures revealed a statistically significant reduction in anxiety and an increase in victim empathy as measured by a scale designed for the study. The authors acknowledged a weak design; however, their significant results warrants further investigation of this theory. Finlay (2002) investigated the addition of EMDR therapy to a cognitive behavioral therapy program with standard RP treatment for 27 adult male sex offenders. A substantial and statistically significant reduction in justifications for offender behavior was found after EMDR therapy directed at the offenders own prior victimization. This suggests that addressing the offender's own trauma, through EMDR therapy, may reduce their justification for victimizing others.

Ricci (2006) illustrated EMDR as a useful trauma treatment with a child molester, as evidenced by a measured increase in motivation for treatment, an important element in terms of treatment benefit. The SOTEP study discussed earlier found that participants who showed low motivation for treatment did not gain benefit from treatment involvement and that not attending to issues of motivation for change was a factor with reoffenders, or treatment failures, who did not accept or apply the basic goals of relapse avoidance (Marques, Nelson, Alarcon, & Day, 2000). It was also a differentiating factor for high-risk offenders who absorbed the material as measured by a "Got It scale" (Marques et al., 2005, p. 102) designed for the study. Those who showed understanding reoffended at rates of 10%, whereas those who did not reoffended at a rate of 50% (Marques et al., 2005). Ricci's (2006) case study also found increased empathic response in an incest offender post-EMDR according to the Sex Offender Treatment Rate Scale (Anderson, Gibeau, & D'Amora, 1995).

EMDR was again employed with 10 sex offenders and showed significant changes in insight (understanding of offense), deviant thoughts (offense-related impulses), awareness of situational risks (challenges the capacity for self-control), motivation (as for personal change through treatment), victim empathy (emotional impact of sexual offenses), and offense disclosure (Ricci & Clayton, 2008) as well as sustained reductions in deviant sexual arousal as measured by penile plethysmography in 9 of 10 subjects (Ricci, Clayton, & Shapiro, 2006). The findings of decreases in sexual arousal are particularly important given Hanson and Bussièrre's (1998) report that deviant sexual interest in children as measured by phallometry is the single strongest predictor of sexual recidivism as well as Hanson and Morton-Bourgon's (2005) observation that sexual recidivism is associated with deviant sexual interests. Ten Hoor (2013) again applied EMDR with a sex offender and published a 2013 single case study which describes the usefulness of EMDR therapy in restructuring cognitive distortions and in enhancing sex offender treatment engagement in an adult male sex offender. The small but promising body of research on the use of EMDR with sex offenders supports a call for further research. Projects are presently underway at Wisconsin's Sand Ridge Treatment Center and Virginia Center for Behavioral Rehabilitation.

Applying the Offense Driver Model to EMDR Therapy

Our approach to sex offender therapy is to explore for, examine, and *resolve* those early life adverse

experiences that helped forge the *offense drivers* believed to have propelled the sex offending behavior. Under this therapeutic framework, the therapist listens for the seminal dysfunctionally stored events and experiences which are believed to have forged the *offense drivers*. Given the new sex offender treatment environment which supports a trauma-informed approach to care, we feel an opportunity exists for therapists who are willing to receive specialized training in both EMDR therapy and sex offender treatment to bring an important adjunctive piece of therapy in resolving and moderating these *offense drivers*. As a cautionary note, we are not suggesting this EMDR protocol be considered general instruction for EMDR therapists. Nor are we suggesting this EMDR protocol as a replacement for, but rather an adjunct to, standard sex offender treatment. Therapists choosing to undertake this work must receive specialized training in sex offender treatment and partner with the client's primary sex offender treatment provider.

An Example of EMDR Therapy Using the Offense Drivers Model

The details in the following case have been altered to protect the identity of the client. Jared presented for weekly outpatient sex offender treatment. Jared was then a 28-year-old male who appeared slightly younger than his chronological age. He was described in records as socially isolated, and his interpersonal skills were noted to be markedly impaired. Jared was convicted of child molestation after he performed cunnilingus and digitally penetrated the vagina of his 7-year-old niece several times over the course of 1 year.

Relevant History

During Phase 1 (history taking) of Jared's EMDR therapy, he revealed his early sexual history is marked by previously unreported sexual abuse beginning at age 4 years by a 20-year-old male cousin. Jared recalls playing in a swimming pool with his older cousin who asked Jared if he wanted to try something fun. Jared was dunked under water where his cousin forced his penis into Jared's mouth. This was repeated several times until Jared's cousin ejaculated. Jared recalls feelings of panic and fear. Thereafter, his cousin gave Jared much time and attention, spending a lot of time with him which Jared naturally enjoyed. Jared continued to willingly perform fellatio on his cousin whenever they were together, ending when he was 7 years old and his cousin left for military service. Jared now describes the sexual incident as frightening and unwanted, but his description made it apparent that he had come to believe he had behaved in such a way as to invite the sexual abuse by seeking his older cousin's attention.

In historical records, Jared was labeled as a strange child with few friends and strained parental relationships. From an early age, he stayed to himself in his room, showed an explosive temper, and when confronted, adopted a tiger-like pose and growl which served to make others fear and/or laugh at him but keep their distance nonetheless. He was seen by several mental health professionals during childhood and was prescribed medication which included Ritalin related to a diagnosis of attention deficit hyperactivity disorder (ADHD), Zoloft related to a diagnosis of depression, Lithium related to a diagnosis of childhood bipolar disorder, and Zyprexa related to a diagnosis of preschizophrenia, none of which proved effective. His adolescent mental health record also contained a rule-out diagnosis of schizoid personality. Throughout high school, Jared was friendless and never dated. He developed a habit of compulsive pornography viewing and masturbation as often as five times daily. His sexual fantasies were of little girls he saw on television shows such as *Full House* or of the sexual interactions with his older male cousin. He spent most of his time alone in his room although he would allow his niece to come in and play with his video games whenever she visited. It was in that context that the sexual molestation occurred.

Adjunctive EMDR Therapy

Jared only superficially engaged in his sex offender treatment group and was noted by his sex offender treatment provider to be guarded and defensive. Polygraph examinations revealed that his compulsive masturbation and use of pornography continued. Given his poor treatment engagement and progress, EMDR therapy was recommended. Jared was referred to an EMDR therapist who was also trained and credentialed in sex offender treatment. The therapists collaborated and conceptualized Jared's case with the *offense drivers* as follows:

- Implicit beliefs: (a) The world is a dangerous place (related to initial oral rape); (b) children are curious, sexual beings (related to his "consensual" sexual involvement with his older male cousin); (c) nature of harm (related to his belief that while he did not enjoy the initial oral rape which was scary, by comparison, there was no harm caused by the subsequent "consensual" sexual activity with his older cousin).
- Sexual offense pathways: (a) distorted/deviant sexual scripts, (b) intimacy deficits, (c) emotional dysregulation

- Vulnerability factor: (a) emotional dysregulation (related to use of sexual thinking and behavior to cope with emotional distress), (b) distorted sexual scripts (related to belief "I get attention and connection through sex"), (c) intimacy deficits (related to belief "I am unimportant"), (d) intimacy deficits (related to belief "I cannot trust others").
- Self-regulation style: Avoidant-Active (misregulated)

In Phase 3 of his EMDR therapy during target identification, the EMDR therapist guided Jared to work on the target of the oral rape that occurred in the pool when he was 4 years old. Jared identified the negative cognition (NC) as "I am unimportant, of no value" and given this aligned with the sex offender therapist's conceptualization, the EMDR therapist proceeded with that cognition. Jared was readily able to process and complete all eight phases of EMDR over the course of four sessions, reducing the SUDS from an initial 9 rating to a subsequent rating of 1.

Over the next several weeks, Jared's probation officer, family members, sex offender therapist, and Jared all commented on his changed presentation described as increased sociability, improved overall mood, and decreased irritability and reactivity. Jared was pleased with his progress and noted his frequency of masturbation had decreased to levels he considered appropriate. He reported he no longer felt urges to fantasize about his childhood sexual abuse, his victim, or to view pornography at all. His EMDR therapy was considered completed and Jared returned to his sex offender treatment group where he was reported by his sex offender treatment provider to be more engaged.

Approximately 8 weeks later, Jared sought an EMDR therapy appointment after he told his group that he had lapsed by viewing pornography again which led to unhealthy and deviant fantasy. It was theorized that the EMDR had not adequately addressed the *offense driver* implicit belief that children are sexual beings, sexually curious, and that the absence of force in sexual interactions with adults results in harmlessness.

Jared reengaged in EMDR treatment and this time, during Phase 3 of the EMDR therapy (target selection), he was guided to target a memory of later childhood sexual abuse by his cousin wherein no force was used. Jared again elected the NC "I am worthless" but was encouraged to explore the memory more thoroughly until he eventually identified the NC "I am not really likeable." The EMDR therapist was guided to help him find this NC by her knowledge of his offense driver of implicitly held beliefs forged by his misdirected attribution of responsibility to self. The therapist was aware that Jared had previously described his victim's behaviors by saying, "She used to flirt around with me, wriggle in my lap, you know the stuff kids do when they want attention." This statement illustrated Jared's implicit belief *children are sexual beings* who desire sex and have the knowledge and the capacity to initiate sexual activity in pursuit of pleasure. Left unprocessed, this provided no barrier to ongoing sexual ideation about children including self and victim. Over the course of the next three sessions of EMDR, Jared came to recognize that despite the fact that his cousin did not use physical force in later offenses, his cousin was taking advantage of Jared's want for attention by using him sexually. This spontaneously travelled to thoughts of Jared's sexual perpetration of his niece wherein he recognized, "She just wanted me to care about her and pay attention to her. She did not want the sexual contact. And I didn't either when I was her age." During Phase 5 (installing and reinforcing the positive cognition), the newly identified positive cognition that "I can trust some people will like the real me" was installed and reinforced.

Jared's EMDR therapy was again considered complete and he returned to group treatment where he successfully met all treatment milestones and expectations within the year. He reported no lapses in sexual behaviors or problematic sexual ideation in the final year of his treatment or in the two aftercare sessions which occur annually as part of his treatment and probation phase out plan.

Considerations for Employing Resource Development and Installation

Korn and Leeds (2002) developed the practice of Resource Development and Installation (RDI) which has since been incorporated into the EMDR International Association (EMDRIA) approved training courses. RDI is designed to provide the EMDR client with feelings or images of strength to facilitate their ability to process difficult material. Although we respect this as a useful intervention, we suggest that it be employed carefully with individuals who have seriously hurt others. When applying the *offense drivers'* conceptualization in cases of childhood sexual abuse with individuals who have sexually offended others, for example, EMDR therapists must remain aware that the client is likely processing his own childhood sexual abuse while simultaneously and covertly processing his perpetration of others. When the case conceptualization is correct, it is common for the client's cognitions during the reprocessing phase (Phase 4) to travel from the target adverse childhood

experience to his sexual offense in the midst of his processing (e.g., "That time I thought of my offense, and I realize I used those same ways to offend that my abuser used."). For this reason, we suggest that RDI be employed carefully. For example, a client who was nearing the end of his sex offender treatment program was continuing to exhibit durable risk dynamics which were of concern to his sex offender treatment provider. He was referred to EMDR therapy and was at the early stages of processing (Phase 4) but continued to be blocked, stating he was hesitant to process the material and justified his hesitancy by stating he did not wish to minimize the abuse that happened to him by reducing his distress about it. His EMDR therapist postulated that the genuine source of his fear was experiencing the intense emotions and sensations he anticipated would occur through EMDR processing. Given that his EMDR therapist was also a knowledgeable sex offender treatment provider, she recognized that the client was talking about not wanting to return to minimizing his offending but was representing it to the therapist as pertaining to his own childhood sexual abuse in parallel form. The therapist recognized that by employing a strength enhancing RDI, she ran the risk of supporting the cognitive distortion that if he is strong enough and capable enough to think about his sexual abuse, that his victim is also strong enough to cope with his abuse of her, thus supporting the comforting belief that he caused minimal harm by sexually aggressing. Note that this is not a conscious process that the client is able to verbalize, and for this reason, the EMDR therapist must remain acutely aware of the potential for underlying cognitive and emotional dynamics to avoid that which is contraindicated in doing therapy with sex offenders.

Informing Cognitive Interweaves

Shapiro (2001) describes the technique of using cognitive interweaves designed to help clients overcome processing blocks occurring during the reprocessing phase (Phase 4). A training example used when teaching the use of cognitive interweaves is as follows:

> A man was sexually abused at age 14 by a family friend. His negative cognition is "I'm damaged." His positive cognition is "I'm OK as I am." In the course of BLS processing, he becomes stuck on the thought "I deserved it."

A typical and perfectly appropriate cognitive interweave would be something that would allow the client to understand that he is not worthless and not deserving of abuse. However, in this case, let us suppose that the man is in treatment for sexually offending an adolescent and he has himself convinced that she was sexually interested in him, flirting with him, and that she wanted to experiment with and learn about sex from him (implicit belief that *children are sexual beings*). Because the case conceptualization is that this implicit belief was an *offense driver*, the EMDR therapist needs to consider this when devising the cognitive interweave intervention. For example, when the client was looping with the belief "I deserve what I got," the EMDR therapist can recognize that the client likely feels he did something to invite his own sexual abuse at age 14 years, and this helped forge the implicit belief he carried into his offending that his young victim also invited her sexual abuse from him. Given this is the client's maladaptively stored information, the therapist wishes to target to restructure the implicit belief (*offense driver*); a more appropriate cognitive interweave would be "as you revisit the target memory (childhood sexual abuse), try to observe and learn what it is you might be wanting or needing by being there with him (your offender)?" As the client resumes processing, he comes to recognize that he was merely interested in attention, recognition, or friendship from the older male and that he did nothing to "invite" the sexual behaviors which were perpetrated against him. This intervention then integrates adaptive cognitions which counter the implicit offense supportive beliefs (*offense driver*).

Discussion

The sex offender treatment field, and the field of forensic psychology in general, have come to recognize the prevalence and relevance of childhood adversity and trauma in the criminal population. In response, treatment programs are recognizing trauma sequelae as barriers to client responsivity and motivation for treatment and adjusting treatment delivery accordingly. The field of sex offender treatment has shifted to the consideration of etiology and approach goals as opposed to solely focusing on the relapse-prevention avoidant goals as in the past. These changes provide opportunity for trauma therapists to augment sex offender treatment with trauma resolution interventions, which is believed to increase treatment readiness and motivation and to resolve some of the factors which are believed to have driven the criminal behavior initially and may again.

This article was our first attempt to describe a process to identify and resolve those factors which we call *offense drivers*, which are believed to have contributed to and motivated sexual offenses and thereby may

remain pertinent to reoffense risk. The currently accepted view in the sex offender literature is that sexual offending is driven by affective, cognitive, and behavioral variables. Ward and Siegert (2002) considered extant theories to develop the pathways model which encompasses all three of these areas. Inherent in the pathways model is the idea of etiology which is to say that there are multiple pathways leading to sexual abuse, each involving developmental influences. In the pathways model, situational triggers interact with the potential offender's idiosyncratic predispositions to sexually violate others and his particular vulnerability factors and thus results in sexual aggression. We propose that systematically identifying, targeting, and resolving the *offense drivers* moderates or eliminates the idiosyncratic predisposition/vulnerability factor and thereby removes one of the elements in the risk factor versus situational trigger formula for reoffense. As stated, we are not suggesting this as a replacement for best practice sex offender treatment models which have consistently shown statistically significant levels of effectiveness. We are instead suggesting that this can be a valuable adjunct to enhance the primary treatment goal of risk reduction. We reviewed some small studies in which EMDR therapy was applied with forensic populations with favorable results suggesting the need for further study. The model proposed in this article draws from several extant theories in the sex offender literature, some of which have not yet been adequately tested by research. These models and concepts include the SRM, the pathways model, the implicit beliefs of child molesters, the implicit beliefs of rapists, the risk-needs-responsivity model, stable dynamic risk factors, and criminogenic needs. All of the concepts incorporated into our framework are well-respected ideas incorporated into present day "best practice" for the treatment of sexual offenders and have gained popularity with North American treatment providers (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2009).

Sex offender therapy is a specialty field that typically requires special licensing or certification overseen by government agencies such as Boards of Psychology. EMDR therapy is also a specialty with requisite qualifications and evidence of competencies to achieve certification by EMDRIA. We believe that there is opportunity for a synergistic effort between these fields to address the problem of forensic psychological treatment to include both general criminals and sex offenders. We suggest this collaboration requires the specialist from each field to rely on the expertise of the other to help guide treatment interventions toward maximum benefit. The ideas we present here require a collaboration between two specialized disciplines within the mental health field: sex offender treatment and trauma treatment. We believe that in order for implementation of the model to achieve maximum benefit, each of these specialized fields must be understood and accepted by the practitioners who must form a close, collaborative working relationship.

We focus attention in this section on the features that a nonsex offender-specific therapist should be aware of when working with this population. There are undoubtedly things that a sex offender treatment specialist should also expect and respect when working with an EMDR therapist which warrants attention, but which go beyond the scope of this article. The case examples provided herein are meant to be illustrative and cannot replace the rigorous training required in each of the specialty fields. We offer these theories and these illustrative case examples in hopes of opening conversation and collaboration to maximize treatment efforts toward socially pernicious problems.

Sex offender treatment is in some ways considerably different from standard mental health therapy, and the EMDR therapist applying these concepts should be trained in sex offender treatment and well versed in those differences. In addition to formal training in the treatment and management of sex offenders which cannot be substituted, we highlight some key points that EMDR therapists should be aware of when entering into work with this population:

- The EMDR therapists must keep in mind that the client has used sex to hurt others. This is important because unlike other clients with trauma, should they become overwhelmed and act out, for example, by using substances or self-injury, clients who have hurt others may do so again and this warrants special attention through community safety efforts.
- The EMDR therapists must recognize that he or she is part of a larger team with whom information must be shared to help insure community safety. Members of this team typically include the courts and by extension a probation, parole and surveillance officer, the sex offender treatment specialists, the polygraph examiner, and a community support and accountability team assuming the client is living in the community.
- Forensically involved clients such as sex offenders are typically mandated to treatment by the courts and are sometimes resistant and difficult to engage. Special motivational interviewing skills are helpful in establishing a working therapeutic relationship.
- The sex offender client may provide graphic sexual details about his perpetration. Although EMDR

therapists may be accustomed to hearing details of abuse from the victim's perspective, it may feel unsettling to hear details from the perpetrator's perspective. The EMDR therapist should be prepared to use supervision and self-care techniques to avoid secondary trauma.

- There is a high level of denial prevalent with sex offenders which must be navigated. By denial, we do not necessarily mean outright denial of wrongdoing but rather layers of denial the offender may rely on to protect self from recognizing harm done, for example. Because of this, treatment with sex offenders tends to be more structured and therapist-led, and the EMDR therapy process often requires similar structure as illustrated by the prior case example. For example, it is recommended that the EMDR therapist help guide the selection of the target memory based on the sex offender treatment provider's conceptualization of the *offense drivers*. Similarly, the case conceptualization should inform the development and implementation of negative and positive cognitions and cognitive interweaves as described in this article. Another aspect of denial may be the offender's distorted perception of his own childhood sexual abuse against which he may be defended. This helps to forge distorted beliefs regarding, say, adult–child sex which the offender carries, typically implicitly, into his offense chain wherein it becomes an *offense driver*. Some common examples are "I did things to cause the sexual stuff that happened to me when I was a kid, and I saw my victim doing the same things" and "I liked the sexual contact with my offender. It made me feel cared about so I know my offending made my victim feel closer to me."
- RDI should be applied thoughtfully so as not to reinforce offense supportive beliefs. As illustrated by the prior case example, the sex offender client's cognitions typically travel to his perpetration when processing his childhood sexual abuse. However, in cases where this does not occur naturally, it is recommended that the EMDR therapist use the offender's perpetration as a target before EMDR therapy is ended to ensure that all relevant dynamics and dysfunctionally stored memories theorized to drive the offense process have surfaced and resolved. Also as illustrated, the EMDR therapist must use caution to not intervene with things that might enhance or solidify the offender's denial, minimization, or cognitive distortions regarding his offense. This is often counterintuitive and is best addressed via close collaboration with the sex offender treatment provider. Similarly, ancillary treatment targets such as feelings of shame regarding wrongdoing should be processed with caution and only subsequent to resolution of all *offense drivers*.

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Correspondence regarding this article should be directed to Ronald J. Ricci, Specialized Treatment Services of Virgina, Charlottesville, Virginia, 2200 Arch Street, Unit 205, Philadelphia, PA 19103-1348. E-mail: atsacave@hotmail.com