3.4 Treatment Readiness: Preparing Sexual Abusers for the Process of Change

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Abstract

The Risk/Needs/Responsivity model has proliferated throughout correctional treatment and has also greatly influenced programmeming for persons who have sexually offended. The Responsivity Principle decrees that effective interventions will attend to client-based concerns and idiosyncrasies; particularly, regarding such variables as cognitive ability, maturity, motivation, and personal and interpersonal circumstances. Surprisingly, little research has attended to the issue of client motivation to change in persons who have sexually offended, despite the high degree of face validity this concept holds. Prior research has suggested that motivation to change may be as difficult to operationalize as it is to maintain in clients in treatment. Persons who have sexually offended face many challenges (e.g., disenfranchisement, social ostracism, hopelessness) that serve to preclude problem identification and motivation to change. However, as a field, our current understanding is that successful interventions with this population will require long-term focus on changing values and attitudes on the road to lasting behavioral change. Maintaining motivation for success requires that treatment participants persistently focus on establishment and continuation of a balanced, self-determined lifestyle that is ultimately consistent with the sort of community existence described in the Good Lives model. In doing so, treatment readiness group participants need to address such important topics as:

- Why am I here?
- Getting ready for change
- Conflicting thoughts and deciding to change
- Overcoming the push and pull of ambivalence
- Identifying and tackling barriers to change and treatment interfering factors
- Overcoming hopelessness
- Development of a plan for lifestyle balance and self-determination

In this chapter, we will discuss the concept of motivation to change as it applies to treatment responsivity in transforming persons who have sexually offended. In particular, we will focus on precontemplation and flipping the decisional balance in favor of sustaining increased lifestyle balance and prosocial self-determination.

Résumé

Le modèle Risque/Besoins/Réponse Adaptée a proliféré dans le monde du traitement pénal et a également fortement influé sur la détermination des programmemes applicables aux personnes qui ont commis des infractions à caractère sexuel. Le principe de "Réponse adaptée" énonce que toute intervention efficace implique une approche fondée sur les problématiques et les particularismes de la personne, et tout spécialement sur des variables comme les compétences cognitives, la maturité, la motivation, ainsi que les circonstances personnelles et interpersonnelles. De manière étonnante, peu de recherches se sont penchées sur la question de la motivation de l'intéressé à changer, s'agissant de ceux qui ont commis des infractions sexuelles, malgré l'importance cardinale d'un tel élément. Des recherches antérieures avaient suggéré que la motivation à changer était sans doute aussi difficile à obtenir dans le cadre institutionnel que le fait de fidéliser de telles personnes dans un traitement donné. Les personnes qui ont commis des infractions à caractère sexuel ont à faire face à de nombreux défis (par ex. l'incapacité électorale, l'ostracisme social, et le sentiment d'impuissance) qui ont pour conséquence d'exclure toute identification du problème et la motivation à changer. Cependant, il y a là une discipline, qui permet de comprendre aujourd'hui qu'une intervention efficace avec ce type de population et requiert de s'attacher à changer sur le long terme les valeurs et attitudes dans le but d'obtenir des changements comportementaux durables. Pour maintenir la motivation dans le temps, il faut que les patients se focalisent de manière constante sur l'établissement et la poursuite d'un mode de vie équilibré mais autodéterminé qui doit être au bout du compte conforme au type de vie en communauté tel que décrit dans le Modèle « Good Lives ». A cette fin, les participants aux groupes « prêt pour le traitement » doivent affronter des sujets importants comme :

- Pourquoi suis-je là ? ;
- Comment se préparer à changer ? ;
- Idées contradictoires et décisions de changer ;
- Surmonter les ambivalences qui poussent ou au contraire freinent ;
- Identifier et affronter les obstacles au changement et les facteurs pouvant interférer avec le traitement ;
- Dépassement du sentiment d'impuissance ;
- Développement d'un plan permettant de mener une vie équilibrée et d'être apte à se prendre en main.

Dans ce chapitre, nous discuterons du concept de motivation à changer en tant qu'il interagit avec celui de réponse au traitement, en transformant les personnes qui ont commis des infractions à caractère sexuel. Nous nous attacherons en particulier à la pré-contemplation et hésitations à faire pencher la balance dans le sens du choix de conserver dans la durée un mode de vie de plus en plus équilibré et une autodétermination toujours plus pro-sociale.

1. Introduction

Community mental health services remain a predominantly optional service in the United States. For the most part, only the chronically mentally ill and mandated (e.g., court order, probation conditions) clients attend psychotherapeutic services when they may not have a personal desire to do so. It is in the latter realm — substance abuse, domestic violence, impulse control, and related antisocial behaviours — that we find the literature related to client readiness for treatment. However, the existing literature has not yet adequately defined the concept of "treatment readiness". In this chapter, we discuss aspects of treatment readiness as they relate specifically to sexual abusers, a socially contentious and clinically challenging clientele. We begin with a brief historical overview of the treatment strategies that have been employed with sexual abusers. Next, we will present how the field has evolved from interventions based on adaptations of substance abuse programmeming to the more recent amalgamations of risk-needs-responsivity (see Andrews et al., 2007) and self-regulation (e.g., good lives — Ward et al., 2003) models. Then, we discuss pre-treatment strategies and targeted goals of pre-treatment for resistant or 'denying' clients. Finally, we conclude the chapter with speculation regarding future directions and the need for further study to enhance our understanding of effective pre-treatment interventions.

The vast majority of persons convicted of sexual offenses receive determinate sentences, meaning that they will be released to the community at some point. However, sexual abusers are more likely than other offender groups to be detained until the ends of their sentences (i.e., 'max-ing out'), despite any involvement in institutionally-based treatment (see Wilson, 1996). As such, there is often little motivation for sexual abusers to engage in treatment, if they believe that doing so will have no measurable effect on their status regarding early release. Further, given the almost universal hatred most sexual abusers engender from members of the community — including other types of offenders — many such offenders choose to keep quiet about their offense histories and wait for the end of their sentences. The risks to their wellbeing — physical and psychological — are just too much to bear.

Put in those terms, it is easier to understand why many sexual abusers sentenced to finite terms of incarceration have a vested interest in denying their offense (Schwaebe, 2005). Our submission is that this is actually an adaptive strategy intended to increase chances of physical and emotional survival. That is, rather than adapting and reinforcing a change in self-identity free of sexual offending, the individual adopts an identity of 'I am not a sexual offender.' It should surprise nobody then that when sexual abusers are ordered to engage in treatment, either during or post-incarceration, that these clients frequently disavow their offenses and the attendant identity. It is also important to remember that treatment for sexual abusers is typically mandated by the legal system and a common response for clients in such circumstances is to do whatever it takes to 'get through' mandated treatment and get on with their lives. Upon release, most offenders would prefer to

simply dissolve into the community and put their experiences behind them. However, without true participation in efficacious treatment (including community-based aftercare and maintenance), these offenders are likely at higher risk to possibly repeat the socially and sexually deviant behaviours that initially brought them to the attention of the community in the first place. How, then, do we encourage the sort of internal motivation necessary for sexual abusers to revisit such difficult and often painful experiences?

As is often the case with any person presenting with psychological and behavioural difficulties, sexual abusers typically demonstrate a constellation of problematic functioning (see Hanson et al., 2007). Anxiety, depression, and obsessive-compulsive disorders are common presentations, co-morbid with paraphilias and personality disorders (Marshall, 2006; Raymond et al., 1999). However, sexual abusers are somewhat unique among clinical populations, in that they often express these other diagnoses through dysfunctional sexualized behaviours. As such, we need to devise comprehensive intervention schemes that are mindful of these 'other' problem areas, but that are specifically oriented towards clients who sexually abuse.

2. Treatment of Sexual Abusers

Laws and Marshall (2003; Marshall et al., 2003) present an excellent history of the interventions used for those who sexually abuse. In general, it is interesting to note that developments in the treatment of offenders have mirrored treatment interventions with non-offenders. For instance, when psychotherapy for non-offending clients was predominantly psychodynamic in nature, so was treatment for offenders. The same is true of behavioural and cognitive-behavioural approaches. Laws and Marshall suggest that interventions began to show incrementally better results with the advent of behavioural and cognitive-behavioural approaches, the latter being the current theoretical framework of choice (Andrews et al., 2007).

However, it was not until the early 1970s that the field began to include elements of cognitive theory in its approaches to psychotherapeutic interventions (Gurman et al. 2003). These concepts have ultimately made significant changes to the way most treatment providers approach this clientele. For instance, the important inclusion of cognitive restructuring provided a framework to address problems inherent with a strictly behavioural approach to sexual abuser treatment. However, such early interventions remained skills-building and psycho-educationally based — the concept of treatment readiness had not yet arrived. Individual interventions remained external in their conceptualization — that is, 'We will treat you' and not, 'What can we do to help you not offend?' This distinction is in the co-opting of the client in changing undesirable behaviours. Further, the problem with cognitive-behavioural approaches to modifying human behaviour remains the individual's ability to choose their behaviour despite possessing knowledge of certain negative consequences.

In the mid 1980s, a more scientific understanding of sexual abuse began to come into its own as an organized field of psychological inquiry. In answer to the 'nothing works' condemnations of the 1970s (see Martinson, 1974), concerted effort by social learning theorists established what we now know as the 'principles of effective correctional interventions', likely best set out by Andrews, Bonta, Gendreau, and colleagues (see Andrews et al., 2007; Gendreau et al., 1996). The resultant risk-needs-responsivity model (hereafter, RNR) decrees that successful interventions will match treatment intensity to assessed level of risk, while precisely targeting individualized criminogenic needs in a manner that accounts for motivation and client idiosyncrasies (e.g., cognitive abilities, learning styles, scheduling, etc.). In many ways, the Andrews and Bonta text 'The Psychology of Criminal Conduct' (2006) has become the classic text of the 'what works?' movement of the past 20 or so years. However, even classics are not without their critics. Recently, Ward (2006) suggested that the general idea behind RNR is supportable, but that practical applications often fail to pay real attention to the responsivity principle. Wilson and Yates (2009) suggested a means by which to incorporate RNR concepts into a self-regulation formulation, particularly as embodied in Ward's Good Lives Model (hereafter, GLM — see Ward, 2002). Ultimately, the RNR's focus on ensuring adequate intensity and focus in treatment meshes nicely with the GLM's focus on human goods and ensuring sufficient motivation to change. But, we get ahead of ourselves.

Perhaps, the most significant innovation in the treatment of sexual abusers was the adaptation of the relapse prevention (hereafter, RP) model from the addictions field (Pithers et al., 1982). The RP model was the first codified structure developed to provide a cohesive treatment approach for persons demonstrating sexually abusive behaviour. In addition to providing a much needed theoretical framework, the adaptation of this model permitted exploratory analysis and a broadening of understanding and targeted interventions for sexual abusers. The basic premise was that sexual abusers engage in such behaviour as a result of a cycle of maladaptive regulation of emotion leading to dysfunctional (and abusive) sexual behaviour. At the time, it seemed as if there were many correlations between deviant sexuality and addictive behaviour; however, what appeared at first to be a workable adaptation eventually started to demonstrate theoretical shortcomings and problems in practical implementation (see Yates, 2007). RP was fundamentally an addictions model upon which treatment of sexual abusers was overlaid. Of particular difficulty was programme drift — the idea that different providers would each call their interventions 'relapse prevention' even though there were striking differences on key programmematic elements.

Notwithstanding our later acknowledgment that relapse prevention was not what we hoped it would be, we learned many important lessons as a field from its adoption. Today, the proliferation of research in the field has resulted in scientifically-supported structures for risk analysis, psychological assessment, taxonomies of offender types, and an expansion of understanding regarding offending by children, juveniles, and women — not to mention

special needs groups and culturally-sensitive approaches supporting the movement away from the RP model. In the new millennium, we are seeing the transition in focus from relying on adaptations of addictions-based models to placing treatment of sexual abusers in the greater correctional literature, with its focus on risk-needs-responsivity and self-regulation models. To use a developmental analogy, this represents something akin to a transition from childhood to juvenile stages of development in the field of treatment of sexual abuse. Whereas we were previously concerned with finding a model (at all), we are now more concerned with refinement of interventions.

3. Treatment Responsivity and the Migration from Relapse Prevention to RNR/GLM

Although the RP model served usefully as an early framework for the treatment of sexual abusers, by the late 1990s understanding of this client group forced us to recognize that sexual abusers have a much more complicated aetiological process than earlier thought. Whereas RP espoused a single pathway to offending (negative emotions leading to bad problem-solving leading to bad behaviour), new research (see Yates, 2007) supported the notion that persons who sexually abuse likely follow multiple pathways to developing sexually abusive behaviours. The RP model was demonstrating deficiencies in meeting emergent research regarding attendance to dynamic risk factors (Hanson et al., 2000), and interventions needed to adapt to the current understandings of how best to intervene for individual offenders.

Simultaneous to the movement away from the RP model was the rise in popularity of the risk-needs-responsivity model (Andrews et al., 2006). The RNR began to present itself in the sexual offender literature in the mid 1990's. It was the beginning of the movement from an addictions model of sexual abuse treatments to one where multiple needs presented by the individual offender could be empirically identified and targeted interventions developed. Further, Ward (2000 – also see Ward and Willis, Volume 3, *Theoretical approach of social work : Risk Assessment versus Good Life Model and Making Good*) contemporaneously introduced the Good Lives Model (GLM) as a conceptual framework for managing sexual abusers. The GLM derives much from self-regulation theory which, in turn, finds its origins in elements of Self Psychology (Kohut, 1971), in which clients are encouraged to develop a conscious, reflective personality. Having a better sense of themselves as people serves to assist offenders in developing a more realistic moral structure and increased interpersonal capacity, ultimately leading to reductions in risk for dysfunctional personal and interpersonal behaviour.

The migration from the single-pathway of RP to the multiple pathways of an RNR/GLM amalgam provides individual offenders with better options. This theoretical formulation provides for a better understanding of the complexities and idiosyncratic aspects of individual offender cognition and behaviour. Further, it reinforces the positive aspects of making the changes required to live a balanced, self-determined lifestyle free of offending. The GLM also

addresses individual needs in a way that serves to better engage clients in developing an intrinsic desire to change. However, no matter how engaging we make treatment, we cannot succeed if we cannot get clients-in-need in the room. There remain many barriers to providing effective treatment to sexual abusers, such as poor motivation, poor treatment engagement, treatment resistance, denial (categorical and otherwise), and minimization. To date, little has been written as to how to effectively address these areas.

4. History of Treatment Strategies for Resistant or Denying Clients

In psychology, the construct of resistance is the conscious or unconscious opposition to change and or the recollection of egodystonic events and or memories. Resistance is a form of clinging to dysfunction for the purpose of secondary gain. In cognitive-behavioural therapy, client resistance is framed in terms of a failure to establish a therapeutic alliance (Raue et al., 1994), resulting in treatment non-responsiveness. Resistance is conceptualized as something to be managed and overcome. While primarily focused on the therapeutic alliance, various strategies have been developed to overcome treatment resistance or non-responsiveness. One such measure, negative reinforcement, was an early form of intervention with this population. The goal was to decrease offending behaviour by increasing aversive stimuli (e.g., jail), such that avoidance or escape strategies would develop wherein the offender recognized his triggers and was somehow motivated to extricate himself from dangerous situations. In 1975, Sadoff described aversive conditioning, covert sensitization, and shame aversion therapy as therapeutic techniques commonly employed with this population, stating:

> *"In summary, psychotherapy has not been significantly successful with the violent sex offender. Other forms of management such as containment, confinement, physiological methods of treatment, as well as some behavioristic approaches have been found to be more successful in reducing recidivism."*

However, in the years since Sadoff made these statements, we have learned much about the treatment and behaviour management of offenders and, specifically, treatment of sexual abusers. Overall, it would appear that the apparent failure of historical attempts at psychotherapy with offenders may have had more to do with the type of psychotherapy being offered or, more precisely, in the manner in which that psychotherapy was offered. Our relative successes or failures regarding getting sexual abusers into treatment and having them approach a more functional lifestyle have been influenced by the bigger picture, including measures implemented in non-therapeutic domains. Whereas historical attempts at offender treatment have emphasized confrontation and insistence on (often painful) full self-disclosure by offenders, recent therapeutic approaches have highlighted the need to 'buy' offenders in

to the treatment process and to work collaboratively towards the common good — balanced, self-determinism and reduced probability of offending.

Tangney (e.g., Tangney et al., 1992) has done much to clarify the respective contributions — or lack thereof — to desistance available from shame versus guilt. Interventions that have, as an added bonus, an enhanced punitive element are popular with politicians and citizens alike. However, Tangney's work has shown that shame often leads to anger, resentment, and externalization of blame, among other negative outcomes. In contrast, shame-free guilt appears to be inversely related to these outcomes, most interestingly, this includes externalization of blame. In many theoretical frameworks, accepting responsibility for past bad behaviour and making sincere pledges to engage in future prosocial behaviour would be seen as indicative of treatment success. Despite research (see Levenson et al., 2007) decrying them as ill-considered or unlikely to enhance public safety, many legislative attempts at behavioural control promote 'naming and shaming' approaches (e.g., coloured license plates, publicly-accessible sex offender registries, certain aspects of public notification).

The construct of therapeutic alliance raised earlier in this chapter is fundamental to facilitating a client's movement to change. Successful development of this collaborative endeavour requires the therapist to join with the client and empathize with him/her as therapy progresses. However, this is complicated when working with sexual abusers. It has often been said that, as sexual abuse therapists, we need to 'hate the offense, not the offender'. So, in order to be successful, therapists must learn to address clients as human beings with distinct needs, and recognize that this is equally as important as focusing on the distasteful manifestations clients demonstrate in meeting those needs in maladaptive ways. Coercive methods must give way to more person-centred interventions, with the recent literature on motivational interviewing being particularly helpful in this regard (see Miller et al., 1991). In this vein, contemporary discussions of sexual abuser treatment have begun to include more focus on goal congruence and management of the individual offender in the big picture, not only relating to sexual deviance and sexually abusive behaviour (see Ward 2002; Ward et al., 2003).

In recent years, treatment processes and best practice models for interventions with sexual abusers have demonstrated measurable decreases in the frequency of recidivism among those considered to have successfully completed a treatment programme. The Association for the Treatment of Sexual Abusers (ATSA) Collaborative Data Project (CODC, 2007) has demonstrated a significant treatment effect, in which the treated group reoffended almost 60 percent less than the untreated comparison group (10 percent vs. 17 percent, respectively). Similar meta-analyses of treatment outcome by Lösel and Schmucker (2005), Hall (1995), and Hanson, Bourgon, Helmus, and Hodgson (2009) also support the contention that successful completion of evidence-based treatment programmeming adhering to RNR principles can reduce risk for re-offense. However, in fairness, others have conducted scientifically-rigorous research showing no such effect (e.g.,

Marques et al., 2005); although, one might argue that Marques et al. showed that relapse prevention, specifically, did not work.

Overall, we believe that the field is now at a point where it acceptable to suggest that the consistency of the outcome studies points to a need to move beyond 'does treatment work?' and to reframe the discussion as one of 'what works best?' (e.g., Abracen et al., 2005). In particular, the Hanson et al. (2009) meta-analysis indicates that those programmemes that adhere to the principles of effective corrections (i.e., RNR) were the most effective, producing recidivism rates less than half those of comparison groups, whereas those that adhered to none of the principles of RNR had no effect on recidivism.

5. Motivation to Change: Practical Implications

Probably one of the most crucial responsivity issues surrounds instilling and maintaining motivation to change in offenders (Stirpe et al., 2001; Barrett et al., 2003). Clearly, those offenders who are unmotivated will not benefit from programmeming — we will essentially be wasting both their time and money and ours. Worse still, we will be doing nothing to increase public safety. From the research on motivation (see Barrett et al., 2003), we know that it cannot be adequately measured by self-report. Additionally, how people behave is a better source of information (i.e., actions speak louder than words). Further, motivation can be observed and quantified from the individual's degree of engagement. Regarding the latter point, there are key issues to consider when assessing a client's investment in the process of change. First and foremost, does he/she state an inclination to change? That may seem overly simple, but it is surprising how often we forget to ask clients this important question before we put them into treatment. Client input and user satisfaction are key components of treatment readiness, which we will discuss in a moment. Other indicators of motivation and engagement are attendance and active participation (e.g., listening, contributions to discussions, and giving and receiving feedback). These are all indicators of quality involvement in the change process. Additionally, people who are working on their problems have goals — goals about which they are able to describe some purpose and plan for attainment.

However, what do you do with the clients who are so entrenched and 'anti' everything? These are the clients who make our lives difficult, and who often cause us the greatest concern. Why are they so problematic? Part of the answer to this lies in what is known as the 'demand situation' of the client, which we alluded to above. Demand situation is a psychological concept related to how someone perceives the situation they are in (Orne, 1962). We make subtle or greater changes to our behaviour, or our appearances depending on what we perceive to be the relative benefit or outcome. Think of it this way: Do you wear jeans and a T-shirt to a job interview? Do you wear a tuxedo to the pub on a Friday evening? Similarly, we behave in different ways depending on what outcome (or persona) we wish to promote. People who

have engaged in bad behaviour know that behaviour was bad and they are likely ashamed of it (at least on some level). What is the first thing a parent hears in response to the question, 'Who left the milk out?' ... 'Not me.' Right?

In Western cultures, most people who break rules or engage in illegal behaviour were raised with the same basic Judeo-Christian values as the rest of us — they know right from wrong. But, somehow, they are able to suspend those morals or values long enough to engage in nefarious activities. Sometimes they use cognitive distortions — tricks our minds play on us to try to convince us that what we are doing is okay. For example: 'If she didn't want sex, why would she dress so provocatively?' or 'I only did it a little bit.' Deep down, we all want others to think that we are nice people. We certainly do not want to be thought of as being monsters. That is the demand situation concept at work. Yet, the public's perspective when it comes to those who sexually assault women, children, and other vulnerable people is that only monsters do such things. Let us not mince words — sexual offenders are hated, and our clients know it. This is why it is so difficult for them to come clean and start to be honest about their thoughts, feelings, attitudes, and behaviour.

6. Treatment Readiness

The literature on effective interventions (remember RNR) stresses that all successful treatment endeavours must attend to issues of client responsivity. That is, all programmeme components must take into account the personal attributes and skills levels of participants in order to ensure maximal treatment efficacy. Programmemes also need to ensure that participants understand why they are there and why they must engage — all the while ensuring that they appreciate that such engagement will assist them in making the changes necessary to achieve the sort of balanced, self-determined lifestyle that we promise them will lead to better lives. Accomplishing all of that is a tall order. Lasting change requires personal investment and we need to help our clients understand that the process will take time and effort.

So, the first part of treatment is the process of getting ready for treatment. In treating persons who sexually abuse, this may arguably be the most important thing a therapist will accomplish. Therapists also need to be mindful of the fact that some offenders will never get to a place where they can admit all aspects of what they did wrong. This is a reality of sexual offender treatment. The authors' personal experiences over more than two decades of offering treatment to sexual abusers has demonstrated quite clearly that offenders in categorical denial are usually more motivated to maintain that denial than we are to break it down. There is a point at which we just give up. But, it does not need to be that way.

Making lasting changes in one's personal life requires a workable problem-solving model. Most schemes include a rough approximation of the following steps:

1. problem identification (e.g., acknowledgment that a problem actually exists);
2. outline boundaries of the problem;
3. develop and implement alternatives;
4. evaluate the outcomes;
5. make changes/revisions as indicated.

While this seems pretty straightforward, at least on paper, we know that some processes of the human psyche — ego defence mechanisms, like denial and minimization — often serve to disrupt this process. Indeed, even the seemingly simple task of acknowledging that we must change some part of ourselves or our behaviour can prove daunting.

The Transtheoretical Stages of Change model (see DiClemente et al., 1998) was devised to inform interventions for clients with alcohol and substance abuse issues. As we have noted elsewhere in this chapter, there are similarities and crossovers in the way we treat various impulse control problems (e.g., alcohol/substance abuse, gambling, overeating, sexual offending). The stages of change model has been particularly helpful in that it helps us to 'map out' where a client is in terms of his movement in treatment. Each stage of change brings with it certain challenges as we try to move clients ahead in the treatment process. The following table shows the clinical presentations and degree of motivation inherent in clients at each stage of change, as well as suggestions for intervention at each of the stages:

Phase	Presentation	Motivation	Tips for Clinicians
Pre-contemplation	No acknowledgement of problem's existence	Defensive/unmotivated	Create dissonance; raise doubts
Contemplation	Acknowledgement that problem 'might' exist	Vacillation between minimization and acknowledgement of the problem	Tip the decisional balance; evoke reasons for change (pros/cons); support change
Preparation	Recognition of the problem	Appearance of motivation	Explore best course of action
Action	Active engagement with process of change	Good motivation	Take steps toward change
Maintenance	Maintenance of change through application of effective coping strategies	Good motivation	Identify and use adaptive coping strategies

In discussing motivation for change, DiClemente (1999) posits several dichotomies related to change. He describes these as intrinsic and extrinsic motivators related to imposed versus intentional change and how they relate to readiness for change, or readiness for treatment. On the one hand is the internally-motivated client who perceives a need to make life changes and is committed to that pursuit. On the other hand is the client under some form of duress who perceives change as a means of relieving their stressor and who is willing to do whatever is necessary to make that happen. For clients of the second variety, treatment is perceived as that route available to relieve the perceived stressor. This is where sexual abusers are frequently found; under duress and seeking relief. However, sometimes treatment may be perceived as a capitulation and threat to self-identity and therefore not a desirable

alternative. As such, efforts to move clients through the stages take, perhaps, more hard work than what one might expect.

The stages of change model has received some recent criticism regarding goodness-of-fit in the literature related to the process of change and sexual abusers (Casey et al., 2005; Burrows et al., 2009). However, it has also found support, (Olver et al., 2007; Eckhardt et al., 2008). Ultimately, to return to the concept of therapeutic alliance, it is often how the client is approached and the quality of the interaction between the therapist and client that predicts treatment readiness and ultimate success.

7. Targeted Goals of Pre-treatment

Treatment readiness is all about moving clients from pre-contemplation to contemplation and preparation. This is the process of bringing clients to a point at which they acknowledge a need to change their personal identity, perspective and, ultimately, their behaviour in such a manner as to bring their lifestyle into harmony with the needs of the community and social interest. A more modern approach to Adler's early work describing social interest as a psychological construct (Adler, 1956) is Ward's good lives model (Ward, 2000; Ward et al,, 2003). In Ward's conceptualization, treatment related to the risk, needs, and responsivity of the individual is embedded in a framework that regards individuals as active, goal-seeking beings who seek to acquire fundamental primary human goods — actions, experiences, and activities that are intrinsically beneficial to their individual well-being and that are sought for their own sake. Examples of primary human goods include relatedness/intimacy, agency/autonomy, and emotional equilibrium. All humans seek to attain these. Our submission is that making lasting changes to how someone attains these primary human goods requires preparation.

It has long been known the therapeutic relationship is the primary factor in any successful therapeutic intervention (Marshall et al., 2002). If the client has the respect and genuine concern of the therapist, he/she will be more willing to tolerate the psychological discomfort of a truly therapeutic intervention. Polascheck and Ross (2010) demonstrated that with high-risk offenders, such as those with psychopathic traits, the stronger the therapeutic alliance the more likely the patient will be successful in treatment. Specifically, they found that a strong therapeutic alliance prior to the intervention predicted patient success in the programme. This supports the idea that early therapeutic contact with difficult treatment populations will directly benefit later participation in more intensive treatment. This suggests that a successful programme begins well before the patient begins the treatment process and, as such, we might be wise to see the process of motivating treatment readiness as beginning before the patient is even approached for treatment. Or, that treatment in fact begins with the first contact with the client, before any discussion of treatment has even begun.

8. Development of Pre-treatment Strategies and Programmes

Addressing the needs of clients who have a hard time coming to terms with acknowledging their problems often requires an indirect approach. Essentially, if admitting to sexually abusive conduct is too personally threatening, then we might be better advised to tackle other problem areas first. Many offenders have difficulties in basic and enhanced problem-solving skills in a variety of domains. As such, we suggest that treatment readiness programme providers consider 'easing' sexual abuser clients into the process of problem acknowledgment and change.

Moral Reconation Therapy (MRT — see Little et al., 1988; Little et al., 1999) is an evidence-based approach to increasing problem-solving skills and moral decision-making. In using a variety of exercises and tasks, MRT is a 'cognitive skills development' psycho-educational programmeming. Programme evaluation research (Little et al., 1999) has shown MRT to be effective in lowering recidivism rates in those who successfully complete the programme. MRT has seven parts:

1. *Confrontation and Assessment of Self*: Assesses residents' beliefs, attitudes, behaviours and defence mechanisms.
2. *Assessment of Current Relationships:* Includes planning to heal damaged relationships.
3. *Reinforcement of Positive Behaviours and Habits:* Residents help others to raise their own awareness of moral responsibility to the community.
4. *Positive Identity Formation:* Explores the inner-self and setting goals.
5. *Enhancement of Self-Concept*: Building self-esteem and positive habits.
6. *Increased Impulse Control*: Residents develop skills to delay gratification and manage their pleasure-seeking behaviour.
7. *Developing Higher Stages of Moral Reasoning*: Residents demonstrate greater concern for others and social systems.

The Thinking for Change (T4C) programme developed by Glick, Bush, and Taymans for the National Institute of Corrections debuted in 1997. This programme represents one of the earlier attempts in developing treatment readiness and is one of the more widely applied interventions in the US corrections environment. T4C challenges the cognitive behaviours of individuals, using exercises related to cognitive restructuring, social skills development, and the development of more effective problem solving skills. Although T4C was designed with the general offender in mind, it has been found to be a useful therapeutic adjunct for various programmes that require persons to consider making changes in their life as an option to continuing with known dysfunctional behaviours. This includes comprehensive programmeming for persons who sexually abuse (see Wilson, 2009).

Marshall, Marshall, Fernandez, Malcolm, and Moulden (2008) describe a prison-based programme in Canada designed to prepare sexual abusers coming into the system for the programmeming they will be offered throughout their incarceration. In their perspective, treatment readiness is achieved upon successful completion of a pre-treatment programme in which

the client is brought to the point of acknowledging a need to change in order to be more competent in society. Although the genesis of their programme was related to dealing with deniers, they ultimately found that motivation was the more worthy treatment target, as shown in other research (Barrett et al., 2003; Stirpe et al., 2001). However, of most interest, Marshall et al. (2008) showed that offenders who failed to complete their preparatory programme ultimately had greater difficulty engaging in treatment. Further, the offenders were retained in prison longer than their peers who completed the preparatory programme. Essentially, it appeared that offenders who completed treatment readiness programmeming were better prepared for the process of change, more readily incorporated those changes in their daily lives, and were more likely be released in a timely fashion as a consequence of these gains.

Treatment Readiness for You (TRY — see Cullen et al., 2003) was designed to specifically address the need for treatment readiness programmeming targeting sexual abusers. TRY is a workbook-based programme that presents exercises that can be completed either individually or in a group setting. TRY offers a straightforward approach to confronting persons with sexually abusive histories. TRY encourages clients to address their own offending behaviours through structured exercises and, in the group setting, giving and receiving feedback from peers and group facilitators. TRY offers different, graphic, and realistic scenarios in each chapter, the purpose being that clients will begin thinking about their actions and behaviours. Each offender is then expected to reflect on the exercises and how aspects of the vignettes and the experiences of their compatriots compare to their own sexually abusive behaviours; thus encouraging him/her to begin the therapeutic process.

9. Future Directions: A Need for Further Study to Enhance Pre-treatment Efficacy

Recently, there has been a developing interest in the perspective of the individual offender as to what makes a treatment programme effective (Levenson et al., 2009; Levenson et al., 2009). Programme evaluators have begun asking for feedback from sexual abusers — individuals and groups — regarding what they feel is most important in a treatment programme. While this information is gathered to ensure relevancy of treatment, it also has the potential to play a critically important role in pre-treatment programme development. In reviewing this literature, it appears as if the goals of sexual abusers as a group are not so far removed from those of the community that initially mandated their treatment. Significantly, Levenson and Prescott (2009) found that two of the most important treatment goals in their sample were directly related to those espoused in the good lives model; that of meeting needs in healthy ways and creating a more satisfying life. While only preliminary, Levenson and Prescott's work appears to indicate that the continued efforts at moving from the relapse prevention model to the good lives model is the future of treatment for sexual offenders.

In closing, we wish to leave readers with what we believe are important considerations. Those who offer treatment to sexual abusers are

fundamentally involved in the business of public safety. Anyone who seeks to reduce sexual violence is by definition a victims advocate. Often, the public's opinion of sexual abusers is that they should be locked away forever, with no possibility or hope of release. The truth is that most cases of sexual abuse never make the newspapers or six o'clock news. Only those offenders who most offend the public's sensibilities receive this level of attention. As such, the community has a somewhat jaded view of the prospects for sexual abuser rehabilitation. The simple truth is that most sexual abusers are at relatively low risk to engage in such behaviour in the future, provided that they receive appropriate handling. In our opinion, appropriate handling consists of a period of social sanction (e.g., incarceration, community supervision, or other means of social monitoring) and engagement in evidence-based treatment. This perspective is well-supported by emerging meta-analytic research, such as that referred to above. The research clearly shows that many sexual abusers can be safely returned to the community to live healthy, goal-directed lifestyles free of offending behaviours. Perhaps the next great challenge will be to develop readiness within the community regarding humane methods to support and encourage safe and dignified reintegration of offenders following sanction and treatment.

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