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CORRESPONDENCE: Response to "Opinion – The Sex Offender Freeze Frame Treatment Technique: A Comment on Larin (2013)"

I would like to thank the writers of the commentary on SOFFTT for their contributions to this discussion. Their passion for assessing and treating sexual offenders is evident. My response to their commentary deals mainly with two important issues that stem from discussion in their text:

1. The extent to which theory and evidence-based practices relevant to the treatment of sex offenders in the general population may or may not be applicable to the treatment of sex offenders with intellectual disability (ID); and

2. The extent to which the theory and evidence-based practices have or have not been incorporated into SOFFTT, and how SOFFTT is a technique intended to be a component of an overall treatment plan.

Our points of departure rest in the manner in which treatment relates to those with ID as opposed to the general population. Whereas one might assume that the findings based upon persons in the general population of offenders could readily be applied to those with ID, research and clinical experience would lead us to understand the challenges very differently. This is not to say that many of the patterns and factors operant in the general population are not also operant within the population of offenders with ID. It is, however, worth noting that there is a significant body of factors to be considered when assessing and treating offenders with ID. These factors are so prevalent that they require additional measures to help the therapist to identify them and target treatment accordingly. The SOFFTT was designed as such a measure with these factors in mind.

As noted in my original article, SOFFTT was designed to be a component part of an overall treatment plan and, as such, would incorporate additional treatment approaches and principles. The reader will note, by the end of this response article, that the SOFFTT's role also adds an essential element to working with people with ID in that it provides a structured way to tease out many of the array of additional considerations that are not common to offenders in the general population.

The Nethercott and Yates commentary relies heavily upon the work of Yates and her significant contributions to the field; as well, this has a particular focus upon the emerging practice of the SRM (Self-Regulation Model). The commentary advocates strongly that SRM be incorporated into the treatment plan. In practice with the general community, the SRM is well founded and is research-based. Though well intended, their assessment does not take into consideration the limitations of this approach when applied to peo-

ple with ID. Yates, herself, has acknowledged these and spoke to the limitations at the most recent ATSA (Association for the Treatment of Sexual Abusers) conference in the fall of 2013. Her presentation was based upon two abstracts published on the ATSA website (Hoath, Miller, Lynn, & Ioannou, 2013a; Hoath, Outhwaite-Salmon, Yates, & Billings, 2013b).

The first abstract (Hoath et al., 2013a) reads:

> While there is research supporting the validity and application of the self-regulation model with sexual offenders in general (Kingston, Yates, & Olver, 2013; Stotler-Turner, Guyton, Gotch, & Carter, 2008; Simons, Yates, Kingston, & Tyler, 2008; Ward, Hudson, & Keenan, 1998; Yates & Kingston, 2006), research is generally lacking with respect to individuals with intellectual disabilities (ID).

The second abstract (Hoath et al., 2013b) goes on to reflect that:

> However, given the limited amount of research and methodological concerns with these studies, the validity and applicability of these pathways with this group are inconclusive. Additionally, research indicates that individuals with intellectual disabilities have limited sexual knowledge and normative sexual experiences (McCabe 1999), suggesting that at least some ID offenders following approach pathways may not demonstrate the explicit anti-sociality associated with these pathways, thus resulting in an artificial over-representation of this group among the approach pathways.

Other findings indicate that participants with ID who have been included in research studies may not have constituted a "representative" sample. For example, Langevin and Curnoe (p. 401, Ethical Dilemmas, 2002) note a number of researchers who have pointed out that people with IQ scores below 80 on the Weschler Adult Intelligence Scale (WAIS) are frequently omitted from many research studies. Given such factors, we would be prudent to factor these elements into assumptions that are made in analyses and meta-analyses.

Another controversial facet is that Lindsay, Sturmey and Taylor (p. 6, Offenders with Developmental Disabilities, 2004) note that, "While the relationship between IQ and delinquency seems firmly established, there is some evidence that this relationship may not hold when considering individuals 1.5 or more standard deviations below the mean."

As far back as 1992, Hingsberger, Griffiths and Quinsey, and Luiselli (p. 338, Goldman & Morrison, Ethical Dilemmas) coined the concept of "Counterfeit Deviance" and this set the stage for considering some sexually deviant behaviours in a different light. Counterfeit Deviance

> …refers to behaviour which is undoubtedly deviant but may be precipitated by factors such as lack of sexual knowledge, poor social and hetero-social skills, and limited opportunities to establish sexual relationships and sexual naivety rather than sexual deviance. (p. 164, Lindsay, Offenders with Developmental Disabilities)

This is very important to note, given that if we are unaware of such dynamics, our treatment may not be addressing the salient issues for the presenting client.

The issue of moral judgement/development is another facet that is very important to consider when treating offenders with ID. The importance of this factor is so significant that a landmark decision was reached in the USA in abolishing the death penalty for people with ID.

> In rendering their decision in death penalty cases involving convicted defendants with ID (Penry v. Lynaugh, 1989; Atkins v. Virginia 2002), the Supreme Court of the US has justified its view of diminished responsibility on the grounds of a lesser awareness of consequences, a heightened impulsiveness and a decreased moral understanding. (p. 38, Baroff, Gunn, & Hayes, Offenders with Developmental Disabilities)

There are also several mitigating factors that can be considered in US courts such as "impaired capacity – as this may affect reasoning and moral judgment – also highly relevant to the offender with ID." (p. 45, Baroff, Gunn, & Hayes, Offenders with Developmental Disabilities)

Also:

> …Simply by virtue of the legal action against him, a defendant will understand that something he has done is 'wrong'. But to understand why it is wrong requires some moral appreciation and that appreciation is related to intellectual development." (p. 46, Lindsay, Offenders with Developmental Disabilities)

> A fundamental research question in this area concerns the hypothesis that offenders with developmental disabilities have not progressed beyond the basic stages of social or moral reasoning" (p. 332, Sturmey, Taylor, & Lindsay, Offenders with Developmental Disabilities).

To assume an act as being of driven by criminal intent before the matter has been vetted by the client as to being moral/not is to be premature at best. At worst, it may be to disregard salient facets of their disability which would misdirect treatment and/or punishment. These points highlight the degree to which the legal system has recognized the compromised presentation that some of our clients offer and this has to be taken into account when treating them as well.

Clark, Rider, Caparulo and Steege opine that:

> …Some offenders have poor knowledge of sexual matters or standards of behaviour in public versus private settings. Some adults with developmental disabilities have sometimes been allowed behaviours in their home with, if practised outside the home, would result in problems with the law." (p. 187, Offenders with Developmental Disabilities)

They go on to speak of gauging the treatment in accordance with the presenting profile of the individual, which would emerge through the increasing appreciation of the client's needs. They note that:

> With the uninformed offender, sometimes all that is needed is effective sex education. Treatment for the curious offender must involve good and complete sex education. Treatment for the offender seeking intimacy must involve social skills training as well as the necessary steps towards developing friends. Treatment for the replicating offenders must involve more empathy training even though they may not understand the concept. They can still be taught what it feels like to be hurt and can be helped to understand the emotional effects of abuse. (p. 188, Offenders with Developmental Disabilities)

These treatment goals are different from those typically targeted in work with sex offenders in the general population and do account for the risk, need and responsivity principles and affirm victim empathy as a credible target goal. (Work with people with ID is replete with modifications to approaches in order to address their learning styles and cognitive abilities and this remains true when using the SOFFTT as well.)

Further, for a portion of the people whom we serve, we treat those whose sexual norms have been developed within institutions. It is not uncommon for such clients to have to undergo a process in which they modify their understanding of the differences involved in community-based sexual relationships versus those within the institutions. The cognitive schema that provides the seedbed for cognitive distortions may well have its roots in the world-view that was fostered while being raised in such facilities/circumstances. In such cases, we are engaged in the multifaceted challenge of helping individuals to acculturate into the general community. Such work is not uncommon in our field of work but would not be as prevalent in working with offenders that have not experienced institutionalization.

Lindsay notes, in referring to sex offenders with ID, that they may have deficits in "social skills and sexual knowledge, dysfunctional attitudes towards sexuality, cognitions consistent with sex offences and deviant sexual preferences. Assessment is directed toward evaluation of ability, knowledge, thoughts, behaviour and psychological response in these areas [similar to the SOFFTT goals]" (p. 168, Offenders with Developmental Disabilities).

The application of SOFFTT should guide assessors in assessing the client's intention, understanding, and appreciation of the acts in light of normal sexual urges that might be expressed in an odd or deviant manner given either the client's availability of alternative/normal expression or due to a different (mis) understanding of the social/sexual dynamics involved. Langevin and Curnoe note that, "It is certainly important to distinguish inappropriate behaviour driven by ignorance of appropriate behaviour versus that which has a long history and is driven by APSD [Antisocial Personality Disorder]" (p. 387, Ethical Dilemmas). The SOFFTT approach is well geared to unearthing such matters.

It is not uncommon for people with ID to receive inadequate basic sexual education. It is also not uncommon for them to require dedicated teaching to many skills that the general population adopts by osmosis within the community. It follows, therefore, that some may also be lacking in direct teaching on mat-

ters concerning their own sexual functioning, arousal, and arousal regulations. These factors are mitigated by deficits in social skills and relationship building. Treatment frequently involves basic teaching of such areas, through the predominant learning styles of the individual, and much rehearsal/review is warranted to ensure comprehension and generalization. These factors justify the use of a psychodynamic intervention as a component of the treatment process for sex offenders with ID.

Nethercott and Yates spoke at length about RP (Relapse Prevention) in their comment. SOFFTT, as evident from my article, offers more than just an RP model which would (in the original sense) offer only methods of avoiding difficult situations. Whereas it does include this facet, it also offers a realm of additional treatment benefits built into the design. Some of these additional gains offered by using the SOFFTT are as follows:

- SOFFTT offers a route to help client move beyond the denial and/or overt lying stage. It offers the prospect of an honest reporting mechanism for assessing ongoing risk levels, allowing for therapist and c• lient to have a relationship that is based on honesty. This may well have an impact on the client's willingness to continue to stay in treatment given that the client may value the benefit more highly. (If they are not admitting to the initial problem, then the prospect of honest reporting in treatment, as they face new challenges in their day, may also be compromised. This would render the prospect of false impressions of growth for the therapist and could compromise public safety if errors in judgement are made accordingly.) The "inner peace" goal of the Good Lives Model (GLM) would be best served by the client integrating an honest and complete understanding of himself and finding a present peace about same, as he moves toward "excellence in agency" – which is one of the goals of GLM involving autonomy, power and self-directedness.

- Cognitive distortions, which are often indicators of larger-based cognitive schema that are facilitative in promoting sexual offending, are able to be unearthed with the client through the use of the SOFFTT. This self-discovery facet paves the way to target these areas in treatment and also improves the client's self-awareness/change. A preliminary step in altering a behaviour within oneself is to "notice" that it is occurring. This allows for the client, who may not have had the cognitive ability to discern their own patterns, to begin to "notice" when these patterns begin to be operant. Again, this is another feature that speaks to the learning needs of our clients and it does so in a manner that is initially both aural and visual.

- The built-in facet of illuminating patterns operant in multiple offences is another facet to help the client become self-aware. An analysis of multiple offences may yield more insight than examining them singularly. Such observations/analyses may have eluded the client due to their intellectual limitations.

- These patterns are made visual using the SOFFTT and may be more readily able to be understood by the client than if reviewed strictly aurally. The approach also addresses and helps to counter deficits in working memory, which often preclude such work. This leads into the seemingly benign behaviours that often lead to offending. Again, by bringing the client's ability to "notice" these behaviours, we begin to equip them in their skill development should they move become motivated to halt their offending behaviour.

- Whereas the areas of consent are fairly well understood by the general population, it is not uncommon to find offenders authentically deficient in their understanding of such matters. Teaching on consent and capacity is incorporated into the SOFFTT, as are awareness of arousal and arousal regulation skills.

- Handling treatment regression, if planned for and adeptly addressed using the SOFFTT, is built into the model.

- Skills-building is the logical next-step when areas of deficiency are evidenced while working through the SOFFTT with the client as they can become readily apparent through use of the SOFFTT.

- The Blue Cards can teach both escapements from difficult situations (RP) as well as tolerance/skill development/arousal regulation. The area of sexual education for people with intellectual delays continues to be identified as an area in need of teaching.

- The ability to read/interpret/respect verbal and non-verbal messages is assessed/enhanced/taught through the SOFFTT.

- The SOFFTT promotes an increasingly honest account of actions and, with it, the integration of the responsibility for the offense(s) into the client's sense of self.

- Values clarification is built into the design as well. (According to Andrews and Bonta, treatment should be "delivered in a manner that is responsive to various characteristics of the individual" including such factors as language, learning style, cognitive ability in order to ensure maximal effectiveness" (p. 90, Yates, 2013). SOFFTT was developed in order to address such elements, which are central to the client's ability to understand and benefit from therapy, as well as (according to p. 92, Yates) to enhance client-retention to allow for sufficient treatment to occur.

The development of SOFFTT is akin to development of the ERASOR (Estimate of Risk of Adolescent Sexual Recidivism, Worling & Curwen, 2001) in so far as this work attempted to better tailor the prevailing assessment tools to a specific sub-group of offenders – adolescents in that case. Worling and Curwen had recognized that the measures that were in use were created for adults and that there were differences between adult and juvenile sex offenders that were not adequately accounted for in the existing measures. Following the co-pioneering of ERASOR, others were invited to expand and build upon the gains that were made.

The SOFFTT, in a similar vein, is an innovation that attempts to capture some of the elements of sexual offending that would account for the prevailing disposition of people with ID. Without accounting for these facets, an accurate assessment cannot be made and the subsequent interventions would also be remiss.

The SOFFTT deliberately addresses this realm in order to assess the client's presenting understanding of the thoughts, feeling, motivations, and other elements of the events. This allows for the therapist to establish whether/what areas might firstly be misunderstanding/misinterpretations/lack of understanding/lack of appreciation/etc. This is critical because if the offense is genuinely based on such factors, then the interventions would be geared more accurately/appropriately. It also allows for the therapist to gain an understanding of the degree of proficiency to which the person is able to accurately interpret such matters as non-verbal communication. This is an important factor should the client present with either inadequate cognitive abilities to appreciate the dynamics or to present with elements of a nonverbal learning disability, which would begin to show itself through the SOFFTT. Specific work would then be done in this area to assess the degree of impairment, if present, and to direct session work and skill-building accordingly.

It should be noted again that the field of sexual offending is understudied. Compounding this is the fact that the subjects who are often studied are those who have been identified by the court system. This element of the population of sex offenders is only representative of the "tip of the iceberg," with most offenses going undisclosed; many of those that have been disclosed to someone go unreported to authorities; many of those that are reported do not make it to court; those that make it to court may find the offense(s) pled down; and then we are left with the question of what percentage of those will actually be found guilty. This leaves assessors with a very narrow view of the field.

> Studies may take place in police stations, courts, with remand and convicted prisoners, in secure hospital units and probation services. These studies may find different prevalence rates due to sampling bias and 'filtering' effects (Holland, Calre & Mukhopadhyay, 2002; Mason & Murphy, 2001). (p. 328, Offenders with Developmental Disabilities)

Many of the sex offender clients have been diverted from the typical court proceedings or have been pled down so that the offender would receive appropriate treatment to deal with range of issues that may not be common to the general sex offender population. It is also not uncommon to treat individuals for whom no legal proceedings have occurred or are planned; leaving this segment of the population largely outside those being studied as well.

Given this, some humility must be kept as to how much we claim to know about the perpetrators. This is not to say that studies and meta-analyses are not accurate in and of themselves, though they might be only as applicable to the population of people with ID included in the original studies.

In addition to the range of factors noted above, Nethercott and Yates fail to appreciate some of the new ground that the SOFFTT covers as noted above. They imply that there are elements of RP (Relapse Prevention) within the structure of SOFFTT. They attempt to subsequently coin the entire SOFFTT approach as "RP" and to then challenge that it is obsolete (i.e., one that they incorrectly report had been abandoned ten years ago) approach. (See above section noting the additional areas of benefit built into the SOFFTT.) The writers fail to appreciate that a component to treatment that they espouse, that of the Self-Regulation Model (Ward & Hudson 1998; Ward et al. 1995) (p. 91, Yates) has also been assessed as containing elements of RP within treatment of three of the four categories of offender types (Looman, 2004).

Yates (p. 91, 2013) also identifies that there continues to remain a difference between the research findings and the practice in the field in that:

> The Relapse Prevention (RP) approach has long been the predominant approach to sexual offender treatment (e.g., Laws, 1989, 2003; Pithers, 1990; Pithers, Kashima, Cumming & Beal, 1988; Pithers, Marques, Gibat, & Marlatt, 1983) and this continues to be the case (Mc Grath et al., 2010) in spite of a lack of evidence supporting its effectiveness with sexual offenders.

Given these elements, the views stated by Nethercott and Yates appear to be somewhat overstated and the subsequent conclusions that would stem from same would follow suit. They are correct in that in sex offender treatment, there is a trend toward other modalities, such as the GLM, RNR (Risk-Need-Responsivity) and SRM; however, facets of RP persist in various forms.

Yates' statements (p. 90, 2013) affirm many of the elements incorporated into SOFFTT:

> Common components of cognitive-behavioural intervention include general and sexual self-regulations, addressing relationship and intimacy deficits, developing empathy for victims of offending, challenging cognitive distortions, delineating the offense process and circumstances that trigger offending, inculcating responsibility for behaviour in the offender and developing relapse prevention plans.

The SOFFTT also builds upon a strength-based foundation (i.e., identifying instances when the client faced arousal and "did not" offend). This allows the client to view themselves as potentially being capable of what would likely be many more instances of effective self-regulation than the number of times in which they have failed to do so. This notion facilitates the atmosphere of successes and would be congruent with other elements that facilitate more authentic and longer client-engagement in session work.

Although the Good Lives Model was referred to several times within their article, Nethercott and Yates correctly identified a line in my original article that seemed to refer to it as merely to help with "coping" (Larin, p. 51). This was not my intention, and I thank the writers for pointing it out. The reader would do well to note that the GLM is a complementary approach to the treatment plan which is a positive-psychology, strength-based approach that helps the client to work on valued life goals and to achieve psychological well-being. It greatly enhances motivation, positive outcomes and improves treatment engagement and duration. The gains made in other life-domains often lend their momentum to the changes made in the client's resolve to alter offending patterns.

Nethercott and Yates noted times when the SOFFTT might be contraindicated such as when dealing with a client that might find the recollection of the offense to be arousing. They are correct in this caution. As with many techniques, the use of sound clinical judgment must always be present as the therapist selects the most suitable interventions for the client. I was, perhaps, incorrect in assuming that all readers might already use such clinical prudence, and I thank the writers for assisting accordingly. An inherent challenge in working with sexual offenders has always been the balance in doing such work while not sexualizing the session. This is something that all therapists working in this area should be mindful of.

Nethercott and Yates opined that the writing of a letter to the victim, absolving the victim of all responsibility and accepting same by the offender, is "unnecessary and ineffective." I argue that it can serve as one of the milestones in the offender's journey, which can function as a solidification of the truths involved in the matter, as opposed to previously resurfacing denial, and can be a marker-in-time for the

offender. While also working with victims of abuse, some of whom have access to such a letter, I cannot speak highly enough of its worth to some of the victims. The distortions and blockages of memory that may occur in the ensuing years for the victim, along with unwarranted self-blame emerging, can be contested through use of such a document; without such provisions to counter these elements (which is often the case in historic abuse cases), additional pain and suffering could (and does) take hold.

The SOFFTT, not unlike the GLM, is intended to be one component of the overall treatment plan and does not preclude incorporating the relevant facets that Nethercott and Yates have noted. It strives to address help the therapist to identify the nature of the deficiencies that may have contributed to the offense(s) by a person with ID.

It is clear that the best use of a clinician's time would be a blend of that which has been learned about offenders in the general population, melded with the unique features of those with ID as noted above. The SOFFTT aims to provide therapists with a tool to help reach that optimal balance.

I thank the writers for taking the time and raising the dialogue about gains made in emerging treatment approaches with sex offenders. The manner in which we must consider, apply, modify and create approaches to address the needs of offenders with ID are the challenges that we face in this field. The SOFFTT was created to address such needs and I invite the writers and others to build upon the approach further. Modifications of the SOFFTT also have been suggested to accommodate for the learning style and capacity of the presenting individual.

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