Trauma Resolution Using Eye Movement Desensitization and Reprocessing With an Incestuous Sex Offender

An Instrumental Case Study

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Abstract: This case describes the use of eye movement desensitization and reprocessing (EMDR) to reduce reactivity to childhood trauma in an incestuous sex offender. It explores the relationship between desensitization and reprocessing of traumatic memory and how this may promote sex offender treatment progress as an enhancement of, not a replacement for, the cognitive-behavioral or relapse prevention treatment of sexual offenders. Pretreatment and posttreatment self-report and other-report instruments and semistructured interviews are employed to explore the results of this intervention. Implications and suggestions for this treatment protocol are suggested.

Keywords: childhood trauma; EMDR; sex offender; treatment

1 THEORETICAL AND RESEARCH BASIS

The number of sex offender treatment programs declined from 1994 to 2000 (Burton & Smith-Darden, 2000). With the decline in numbers of treatment programs comes the importance of developing efficient and effective models to address this significant problem in our society. Research on effectiveness focuses primarily on cognitive-behavioral therapy, relapse prevention (CBT-RP) models (Maletzky, 1993; Marques, 1999) and does suggest them to be effective in reducing recidivism (Aytes, Olsen, Zakrajsek, Murray, & Ironson, 2001; Maletzky & Steinhauser, 2002; McGrath, Hoke, & Vojtisek, 1998; McGuire, 2000; Miner & Dwyer, 1995), although some long-term studies continue to question such efficacy (Hanson, Steffy, & Gauthier, 1993; Marques, 1999).

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The idea behind the treatment model used in this case is that helping sexual offenders to resolve past trauma may facilitate their engagement and progress in CBT-RP treatment programs. Desensitizing and reprocessing internal conflicts may forward recalcitrant treatment goals such as motivation for treatment, reduction of denial, and development of victim empathy.

Finkelhor's (1986, 1988; Finkelhor & Browne, 1985) Traumagenic Dynamics of Sexual Abuse Model and Rasmussen, Burton, and Christopherson's (1992) Trauma Outcome Process Model describe trauma sequelae to 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). Many of these same characteristics are prevalent in profiles of sexual offenders.

Schwartz and Masters (1994) developed a theory of sexual compulsivity (including rape and child molestation) that combines psychodynamic, trauma-based theories with cognitive-behavioral and addiction models. The theory postulates that sexual compulsivity is rooted in early traumas maintained through cognitive distortions and behavioral reinforcements. Schwartz and Masters discussed the trauma resolution portion of their integrative treatment approach in the following:

> Trauma-based approaches to treatment, including abreaction, catharsis, and cognitive restructuring, are then useful in resolving the original issues for which the compulsivity symptoms had served as functional distorted survival strategies and anxiety, and keeping the individual from having overwhelming intrusion of memory and cognition. By blending therapeutic approaches, treatment efficacy improves dramatically. (pp. 73-74)

Perhaps support for this idea can be found in the preliminary results of the sex offender treatment evaluation program (Marques, 1999). Results show that sexual offenders who did not have a history of physical abuse in childhood responded better to CBT-RP treatment.

Further support for this idea can be found in an unpublished study conducted by Datta and Wallace (1996). They 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 eye movement desensitization and reprocessing (EMDR). Premeasures and postmeasures revealed a statistically significant reduction in anxiety and an increase in victim empathy as measured by a scale designed for the study. Their results tend to support further investigation of this theory.

James (1989) suggests that trauma ruptures emotional attachment, thereby violating basic trust and interfering with empathic abilities. Other literature highlights the

idea that trauma can result in a perpetual state of hypervigilance against threat, which impedes the development of social skills and may develop primitive defense mechanisms such as aggression (Chemtob, Roitblat, Hamada, Carlson, & Twentyman, 1988). Trauma also disintegrates any sense of future (Fletcher, 1996; Terr, 1991), which fosters a propensity for the pursuit of instant gratification. These characteristics are among those that are prevalent in profiles of sexual offenders, and these trauma effects may become the central core around which behaviors and even personality are organized (van der Kolk, 1996).

Finally, following the work of Clifton Wolf, McMulin (1994, 1998) proposes a blend of psychodynamic and relapse prevention techniques by incorporating trauma incident reduction (French, 1991) and EMDR into an RP program. McMulin holds that the internal cueing of unresolved childhood trauma could lead to maladaptive, compulsive, and addictive behaviors.

EMDR is a psychological treatment method developed by Francine Shapiro (1989a, 1989b, 1995). Its initial and primary use is treatment for individuals who have experienced emotional trauma. This eight-phase treatment protocol uses bilateral stimulation to allow clients to work through traumatic events with the goal of desensitizing and reprocessing memories to reduce posttraumatic stress disorder(PTSD) symptomatology (Shapiro, 1995, 2002). During desensitization and reprocessing phases of treatment, the therapist asks clients to focus on a traumatic or disturbing memory as well as the accompanying cognitions and emotions. The therapist provides bilateral stimulation in the form of visual tracking, auditory stimulus, or tactile stimulation. Subjective units of disturbance scales (SUDS) and validity of cognition scales (VOCS) reported by the client are the measures of treatment progress. Once the memory has been desensitized, as indicated by satisfactory SUDS, the therapist guides the client in reprocessing the accompanying negative cognitions and replacing them with client-generated positive cognitions. The process is considered complete when the client reports satisfactory VOCS.

EMDR has received much attention and mixed reaction by the scientific and professional communities. Initial results of EMDR effectiveness studies appeared promising, and EMDR was given a treatment rating of "effective" by the Treatment Guidelines Committee of the International Society of Traumatic Stress Studies (Chemtob, Tolin, van der Kolk, & Pitman, 2000).

Hertlein and Ricci (in press) conducted a review of the recent empirical literature published on EMDR. We looked at studies following DeBell and Jones's (1997) review through April 2003. Of the 15 empirical studies reviewed, 10 (Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998; Edmond, Rubin, & Wambach, 1999; Korn & Leeds, 2002; Lazrove, Triffleman, Kite, McGlashan, & Rounsaville, 1998; Lee, Gavriel, Drummond, Richards, & Greenwald, 2002; Marcus, Marquis, & Sakai, 1997; Rogers et al., 1999; Scheck, Scheffer, & Gillette, 1998; Soberman, Greenwald, & Rule, 2002; Taylor et al., 2003) indicated that EMDR showed positive treatment results, superior in

those cases where a comparative method was used. Four of the studies reviewed (Cusack, & Spates, 1999; Devilly, Spence, & Rapee, 1998; Lytle, Hazlett-Stevens, & Borkovec, 2002; Power et al., 2002) indicated results that were similar to the comparison treatment method, whereas only 1 study (Devilly & Spence, 1999) concluded that EMDR was inferior to the comparison. Given my positive clinical experience with EMDR as a means of desensitizing and reprocessing trauma, I felt it was a suitable method for the purpose of this study. Furthermore, my clinical experience with sex offenders shows that they are commonly emotionally restricted and often reticent to discuss their own histories. The methods employed in EMDR do not require a significant amount of verbal processing on the part of the client, thereby making it an appropriate choice for this case.

2 CASE PRESENTATION

Samuel is a middle-aged, White male who was incarcerated for 5 years for sexually abusing his 7-year-old daughter over a 2-year period. His sexual offenses of his daughter included genital groping, digital vaginal penetration, and forcing his daughter to masturbate him. He is currently on probation and adjudicated to outpatient sex offender treatment. He has not seen his ex-wife or daughter since his arrest. Samuel appears to be of average intelligence with speech and memory recall within normal limits. He is of average height and build, and his appearance is congruent with his stated age.

3 PRESENTING COMPLAINTS

Samuel has been involved in CBT-RP group sex offender treatment for approximately 7 years, beginning during his incarceration. He has been involved in his current outpatient group treatment for approximately 1.5 years. The primary clinician was concerned that Samuel was not progressing in his treatment, despite what appeared to be commitment to and motivation for the process. Despite repeated attempts, Samuel was unable to complete his victim impact statement, an important component of his treatment program. Samuel reported that each time he approached the material he was overcome with memories and flashbacks of his own childhood abuse and was unable to stay focused on his work.

4 HISTORY

Samuel is the youngest of eight children. He grew up on a Midwestern farm operated by his mother and father. Samuel's father died when he was 8 years old, leaving his

mother struggling to raise the eight children on a limited income. His oldest brother assumed the father's role in the family. It was this brother whom Samuel was closest to until the brother left for the armed services when Samuel was approximately 10 years old. His leaving was a significant loss for Samuel, as was the death of his father. At the first interview, Samuel reported that sexual molestation by his second oldest brother had begun shortly before his father's death, at approximately age 7. However, as treatment progressed, Samuel began recalling memories of earlier abuse. Samuel recalled that he and his three older brothers shared a bed and that he was often fondled and encouraged to fondle his older brother while two other brothers slept nearby. After the death of their father, the abuse became more overt, and the older brother would offer to watch Samuel during the day, promising him rides on farm equipment and other things that were appealing to him. Samuel recalls that abuse continued for several years with increasing frequency until he turned 13. At that time, his older brother brutally penetrated Samuel, causing tremendous physical pain and confusion. Samuel became angry and sullen and told his brother that was the last time he was willing to comply. After that, Samuel recalls that his perpetrating brother became angry and verbally abusive to him. Samuel remembers clearly that it was the day of the rape that he made up his mind to "become bigger than all of them so they can't hurt me anymore." Samuel began to binge eat until in his midteens when he reached a weight in excess of 350 lbs, with a waist size of 56 in. (1.42 m). It was also during this time that Samuel became involved in illegal drugs and recalls being "high" during most of his adolescent years. Shortly after high school, Samuel married his first girlfriend. He describes their relationship as "loveless and primarily sex based." Samuel became a frequent user of pornography and describes himself during this period as being "out of control" with sex and drugs. His behaviors stopped only when he was arrested for molesting his biological daughter and sent to prison for 5 years. The age of Samuel's daughter at the onset of sexual abuse was 7, the same age he initially recalled being first abused by his brother. Samuel describes a "grooming" process he used with his daughter similar to that used on him by his older brother. His offense bore markings of isomorphic reenactment, as described by Finkelhor (1985, 1986, 1988) and Haapasalo, Puupponen, and Crittenden (1999).

5 ASSESSMENT

In addition to a posttreatment interview by an independent researcher, measures of self-report and other-report were used in this case. Interview and self-report techniques provided a subjective view of Samuel's experience of treatment. An assessment scale completed by Samuel's primary clinician provided an objective measure CBT-RP treatment work progress.

Trauma Scale Inventory (TSI). John Briere (1995) developed the TSI for use in the "evaluation of acute and chronic traumatic symptomatology" (p. 1). It is designed at a fifth- to seventh-grade reading level. The TSI is a 100-item paper-and-pencil test describing trauma-related symptoms. Overall, the TSI assesses symptoms based on 10 clinical domains. The TSI also has three built-in validity scales to detect underendorsement or overendorsement and inconsistent responses. This assessment has shown high reliability ($M = .86$) and reasonable convergent, predictive, and incremental ($p < .012$ relative to Impact of Event Scale, Symptom Checklist, and Brief Symptom Inventory) validity. Construct validity measured in the normative sample was significantly associated with elevated TSI scores as follows: (a) adult interpersonal violence, $\chi^2(12) = 137.39$, $p < .001$; (b) childhood interpersonal violence, $\chi^2(12) = 135.90$, $p < .001$; (c) adult disaster, $\chi^2(12) = 46.35$, $p < .001$; and (d) childhood disaster, $\chi^2(12) = 25.33$, $p < .014$ (Briere, 1995). The TSI was normed on male and female adult populations.

Sex Offender Treatment Rating Scale (SOTRS). The SOTRS (Anderson, Gibeau, & D'Amora, 1995) is a "revised version of a rating scale constructed in 1989 for use with state-funded sexual offender treatment at the Center for the Treatment of Problem Sexual Behavior in Connecticut" (p. 223). Essentially, it is a "process and outcome measure for cognitive/behavioral sex offender treatment" (p. 221). The scale consists of six clinical rating dimensions, defined by behavior. These include "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" (pp. 223-224). These ratings are combined for one progress score. The scale also calls for clinicians to make an "undefined progress estimate" (p. 223).

Samuel's pretreatment results for the TSI (Briere, 1995) showed clinical elevations in the subscales of intrusive experience (IE) and defensive avoidant (DA). Elevated IE scores indicate intrusive posttraumatic reactions and symptoms including nightmares, flashbacks, unpleasant memories easily triggered by current events, and repetitive thoughts of unpleasant experiences. High IE scores typically reflect distress states. High IE scores are "often, if not implicitly, linked to a previous experience of psychological trauma" (p. 13). Elevated DA scale endorsers frequently attempt to eliminate painful thoughts or memories by stopping thoughts or pushing unpleasant thoughts out of the client's mind. They often attempt also to avoid events or stimuli that might trigger such thoughts. Respondents with this profile do not necessarily dissociate as much as make a conscious effort to control cognitive and behavioral responses as a means of managing posttraumatic stress. Clinical elevations on these subscales reflect a classic posttraumatic presentation, showing both the intrusive and avoidant components of PTSD. Samuel's TSI profile also showed midrange elevations on subscales of dissociation and impaired self-reference. Individuals showing these scores in the clinical range often have an uncertain sense of identity and may have a difficult time understanding or expressing

their feelings. This results in a limited ability to predict reactions to certain circumstances (e.g., stressful situations; p. 15).

6 CASE CONCEPTUALIZATION

Samuel is an incestuous sex offender who admits to his crime. He has passed a full disclosure polygraph, supporting his admission of one victim, his daughter. Samuel accepts and admits his ongoing risk to reoffend. He appears to be motivated to engage in his CBT-RP treatment program to learn new ways of thinking and behaving to minimize this risk. The primary therapist believes that Samuel is blocked in treatment as he becomes overwhelmed with emotion when he attempts to discuss the details and the impact of his offense. As a result, he loses clarity and becomes incoherent. Samuel agrees with this assessment, citing memories of his own childhood sexual abuse that overwhelm him and prevent him from doing the treatment work he wants to do. Samuel describes symptoms consistent with a diagnosis of PTSD, and this symptom picture is supported by the results of his TSI.

7 COURSE OF TREATMENT

SESSIONS 1, 2, AND 3

Tolerating emotions. I began treatment with a relaxation and resource installation designed to develop internalized resources the client can access in times of stress (Shapiro, 1995). We then targeted an abuse experience. We established the SUDS to be between 8 and 9 (on a 0-10 scale, with 0 = *no disturbance or neutral* and 10 = *the highest disturbance one can imagine*), the negative cognition to be focused around shame, and the positive cognition VOC scale to be between 1 and 2 (on a 1-7 scale with 1 = *feels completely false* and 7 = *feels completely true*). As we began the eye movements, Samuel identified a "sad" feeling but quickly "blocked it out." This happened repeatedly. Samuel described the feeling as being like a hand that started at his head and passed over his entire body washing away the feelings. The result was having "absolutely no feelings." Despite periodic episodes of tearfulness, Samuel was unable to maintain a feeling state for any length of time. Intermittently, however, he identified feelings of "sad," "mad," "disgusted," and "confused." He also "heard" the words "it isn't fair." Toward the end of the session (35th eye movement set), he stated, "My mind is just wanting to destroy [my brother]." I spent this session doing very little verbal processing with Samuel, relying instead on 42 eye movement sets averaging 40 to 50 passes each. (A pass is defined as one complete back-and-forth movement of the arm or fingers that the client follows with his or her eyes.) Revisiting the resource and restoring a sense of "OK" in Samuel ended the

session. He described the experience as "opening so many doors. I open one and there's a scene, then another, then another."

For Session 3, I switched to a bilateral hand-tapping technique as opposed to eye movements. My hope was that by allowing Samuel to close his eyes and by being able to perform extended sets (tapping is easier on the arms than finger movements) that he would be able to maintain a feeling state longer. He reported a week of dreams of doors opening, with scenes behind each door. He also recalled earlier abuse, beginning around age 5 or 6. The goals of Phase 1 of treatment had been achieved: Samuel had formed a working therapeutic relationship with me and was able to maintain feeling states for extended periods of time.

SESSIONS 4 AND 5

The "knot" between self and brother. Samuel acknowledged the "knot" in his thinking wherein he equated himself with his brother. This presented significant hurdles for Samuel in that he was unable to accept full responsibility (accountability) for his actions given his belief that he had been "imprinted" by his brother's sexual abuse. His own feelings about his abuse and thoughts about his brother were clouding his ability to clarify his thoughts and feelings about his offense as well as his victim's right to have her thoughts or feelings about him and what he had done to her. During the initial tapping set in Session 4, Samuel developed an image of himself as an adult standing next to his brother as an adult and facing his victim at age 7 while the image of his brother as an adult faced off with Samuel as a small child of age 7. This image seemed to represent the tangle of feelings and thoughts Samuel carried about his abuse and his offense. I encouraged him to allow the four people (two of which were himself) to have conversations with each other as we did tapping sets. Though he heard apologies "all around," he (as a child) was unwilling to believe that his brother's apology was sincere. This resulted in feelings of "fear" and "anger" and also revealed the first evidence that there were some parts of the relationship with his brother that he enjoyed. This admission was a source of shame and would become the focus of the next phase of treatment. Samuel's images then flashed to a series of times during which he was being repeatedly molested ("it became more severe and more often after my father passed") to a final image wherein Samuel was "doing the same thing to my daughter."

Samuel hit a blockade in treatment at this point. He took this idea of parallelism to his process group and perceived he was being criticized for having these "cognitive distortions." This was the first treatment hurdle created by the philosophical differences between EMDR and CBT-RP protocol. EMDR conceptualizes that cognitive balance will be restored naturally as the brain or mind processes its way through cognitive distortions and negative cognitions. Oftentimes, this processing takes a circuitous and arcane route as the mind unravels beliefs that have been accumulated without the benefit of the

so-called rational or left orbitofrontal hemisphere of the brain. However, Samuel perceived a proscription from his group to entertain these ideas long enough to allow processing to occur. Consequently, each time these beliefs would arise, he would actively attempt to suppress or alter them as he was taught in his CBT-RP work. I addressed this difficulty with his primary clinician explaining the conceptual model of cognitive reprocessing outlined by EMDR protocol. We agreed that with careful monitoring, we would give Samuel permission to entertain whatever thoughts and feelings arose.

Samuel's thinking seemed to flow more freely after our conversation. He explored the ideas of needing the attention from his brother and of the confusion about why no one noticed what was happening to him. ("People who care notice things about kids. My wife noticed stuff about my daughter. . . . If you're in touch with your kids . . .") He also recalled earlier incidents of abuse, possibly starting at age 3. He stated, "I feel like my mind has been opened up. My mind can sweep across it without skipping that part."

SESSIONS 6 AND 7

Isolation, neglect, loss. Treatment moved ahead rapidly at this point. For the first time, Samuel was able to visualize the memories from the perspective of himself as a child. In addition, he was able to tolerate the idea that there were parts of the relationship that he liked, and although at this point he felt a lot of "shame" and "disgust" about this, he was able to admit and explore it. He began to acknowledge the sexualization he felt at his experience. This freedom Samuel now felt to allow his thoughts to move without judgment allowed him to venture more deeply into his tangled feelings. He acknowledged some physical and emotional pleasure from the abuse ("he asks does it feel good. I said 'yes.' I told him I didn't want to do it anymore, but it does feel good.") He was able to stay in touch with the mixture of feelings he was experiencing ("confused, mad, and the hurt—the hurt is always there"). Samuel was able to tolerate revisiting the image of a painful rape he experienced from his brother. The episode of penetration was significant in that it marked the end of approximately 10 to 11 years of ongoing sexual abuse. During tapping sets, Samuel recalled through many of his senses the painful experience. ("I heard him say 'roll over.' I could hear the sheets rustle. I felt the pain—then coldness all over. The pain was unbelievable, and I can feel it right here, in this room, more than I want to feel it.") This episode was significant in two ways: (a) It was this day that Samuel stood up to his brother and told him he would never go with him again. Although he was able to garner some sense of power and control from this, he came to recognize that it established a deep sense of guilt and shame, believing that perhaps he had had the power to stop the abuse all along ("I'm bad. Why didn't I tell him no before I did?"); (b) by being able to tolerate the memory, he identified feelings of isolation ("I can't trust anyone. I don't have anyone who loves me.") and neglect ("There were so many warning signs. Nobody paid attention. I had bowel problems, blood. [The doctor] said I had hemorrhoids. My teacher said 'you're awfully young for that.' That was all like a running tape; I

just saw it all.") and loss ("I [felt that way] the day they told me my father died. Now I remember the first time [my brother] touched me"; "It seemed I lost everything the day of the rape"; "I have this feeling he's hurting me so he doesn't love me anymore.").

The permission Samuel felt to think freely and without judgment was crucial to allowing memories and feelings to flow freely. He was unraveling cognitive distortions and resulting negative cognitions he had carried for more than 35 years.

SESSIONS 8 AND 9

No one would have believed me. Samuel reported that during the week, he had many memories of his abuse: "It didn't really upset or aggravate me or make me mad. It was just a review." He described them "like frames, like a slideshow. And the memories were not all just of me being abused. There was also some good stuff. And usually, before, my memories would go right to the abuse."

Samuel described a recurring image where he saw himself as a very small child sitting on a tricycle in his boyhood farmyard. The image made him feel "aggravation." As we used EMDR to process this, he was overcome with a sense of loneliness. He recalled he was home from school with a severe headache from being punched by a schoolyard bully. He recalled that his mother did not believe that his head really hurt or that he had been hit. Despite the pain, he did not cry because "I was not much allowed to cry. My brothers would say 'boys don't cry. I'll give you something to cry on.' " He then saw the perpetrating brother "walking around the side of the house, grinning at me. I knew something sexual was gonna happen." Samuel did not believe the memory was accurate, yet the thoughts hung together in his mind. "Then right behind that, there's this fear, this dread. I am getting a picture of the day he raped me." As this session ended, Samuel came to the idea that "no one believed me." He was referring to the incident of the headache, but it was also the beginning of his being able to make sense of why he never told anyone about the sexual abuse.

Throughout this and the next session, Samuel began to understand his loneliness and need for the attention he received from the perpetrating brother. Between the sessions, he was overcome with strong senses of loneliness that "engulfed my whole being. I was starving for attention."

SESSIONS 10, 11, AND 12

I am not him. He is not me. Sex is not love. Samuel began to explore the anger he felt toward his brother. My sense was that this was possibly the last part of the glue that was holding the thinking knot together. His thoughts at this point remained tangled ("How can I hate him, be angry at him, when I'm no better"). His feelings of anger were consistently focused on the memory of being penetrated. Samuel was willing, and believed he was able, to target this memory again with the goal of getting in touch with the feelings of

anger he believed he had. He did express some reservation about this, however. "Yeah, if I be open and find my anger—I do want to, I have so much. But I know what my anger has done. Can do." He recalled an incident where he became angry and tore the door off of a pickup truck. "That scares me. To think about that. I've tried to do that since. It can't be done." Yet I felt that, despite his concerns, we would be able to manage whatever anger may surface during the tapping process. Samuel was able to revisit the rape scene. He approached feelings of anger, but the feelings quickly turned to extreme sadness. Furthermore, he was seeing himself as an adult instead of a child, which "makes me feel safer." His memory would not allow the rape to happen. "My mind just shrieks. It's unreal, right there I can just see everything like an explosion. It blows my fuses and everything disconnects right there. It just goes to black." This remained the outcome despite several attempts at processing the memory. A new thought began to surface, however, that "he is just using me for his pleasure. He doesn't care about me at all." Although this was important progress, it still felt as if the anger was being blocked. He explained to me that his anger scared him, that he was unable to access it. "That scares me. I've been in prison. I have to shove the hate down 'cause once I let it out . . ." Despite my assurance that thoughts are not actions, Samuel was clearly blocked from his anger.

Over the next week, I discussed this situation with Samuel's primary clinician. She joined us briefly in session and assured him that he could (and should) make use of the group for support when feelings such as this became too difficult for him to manage. Samuel's face relaxed, and he seemed to have a renewed sense of determination to proceed with our work.

Samuel was finally able to face his anger. We began to process the rape incident. He was able to experience fully the confusion, the pain, the hurt, and the anger. As is common with EMDR, Samuel continued to process during the 2 weeks between this and our next session. When he returned, he stated that he had been able to face the anger several times over the 2 weeks and that it had lost much of its power. He postulated that perhaps the real reason he had not wanted to face the anger was not so much fear of acting on it as it was the idea that he wanted to maintain it ("Maybe I didn't want to go there because I don't want [the anger] to go away. I don't want to forgive him."). Samuel seemed able to separate the anger he feels toward his brother from the anger he feels toward himself and the anger his victim must feel toward him. The knot was unraveling.

We spent the balance of the session processing these ideas using bilateral tapping. Samuel's mind flowed to ideas of being a survivor rather than a victim. He also came to recognize and feel the love he had from his mother and his oldest brother. He was able to distinguish that from the attention he received from his perpetrating brother ("It's a trick. He don't want me on the tractor, he just wants me for sexual reasons.") and to clarify love in his mind ("There were people who loved me. You can't feel or touch love. You just got to believe it."). These ideas were checked using the VOC scales, and Samuel stated he was able to believe these things fully, differently than he had before. "It feels different. I

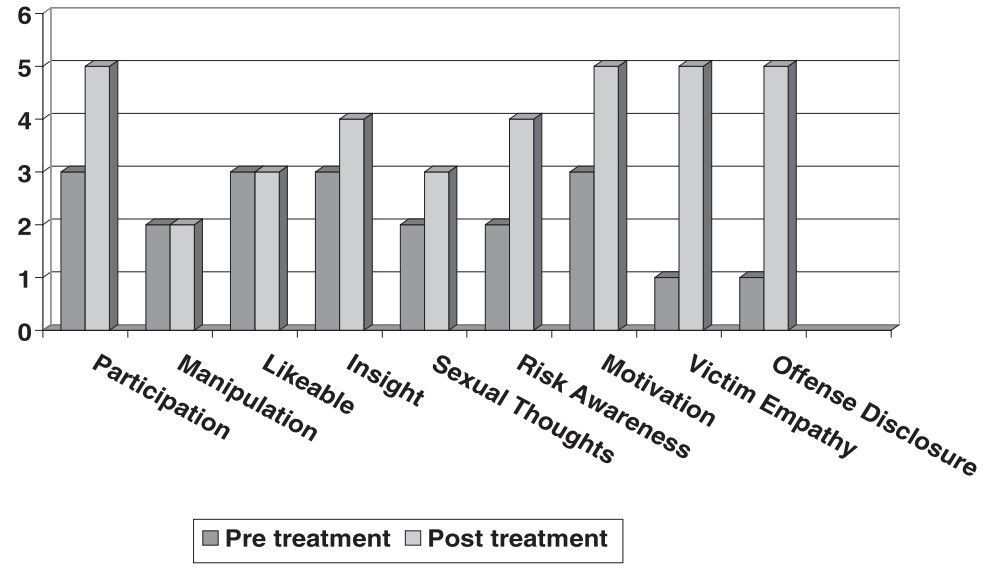

Figure 1. Sex Offender Treatment Rating Scale

know my thoughts are right. I felt the sadness come up in my throat, then it went right down. I wasn't shoving nothing away—it just went down on its own."

At the end of treatment, Samuel's scores on the TSI were all in the subclinical range and were maintained at the 3-month follow up (see Figure 2).

Samuel's primary clinician assessed improvement on five of the six ratings on the SOTRS (i.e., insight, sexual thoughts, risk awareness, victim empathy, and offense disclosure). The most significant changes were noted in the latter two (victim empathy and offense disclosure), but motivation was felt to be unchanged (see Figure 1).

The exit interview, conducted by an independent researcher, depicts a favorable response to EMDR trauma treatment. Samuel acknowledged his initial reservations, including periodic thoughts of abandoning the treatment.

> There was [a time] in there that I didn't want to show up 'cause I knew where I was going and what I had to do . . . until I started getting those good feelings. . . . After I struggled, then I knew that, hey, this is working.

However, he stated that the intensity of the treatment was cleansing.

> I can't remember which session it was, but it was several into it that I was in here almost an hour and a half and I think I did cry the whole [time]. I stayed focused, I never lost the images, the thoughts, the feelings, and all was just right there. And I know that next week I felt like I had been washed or something. I just felt better.

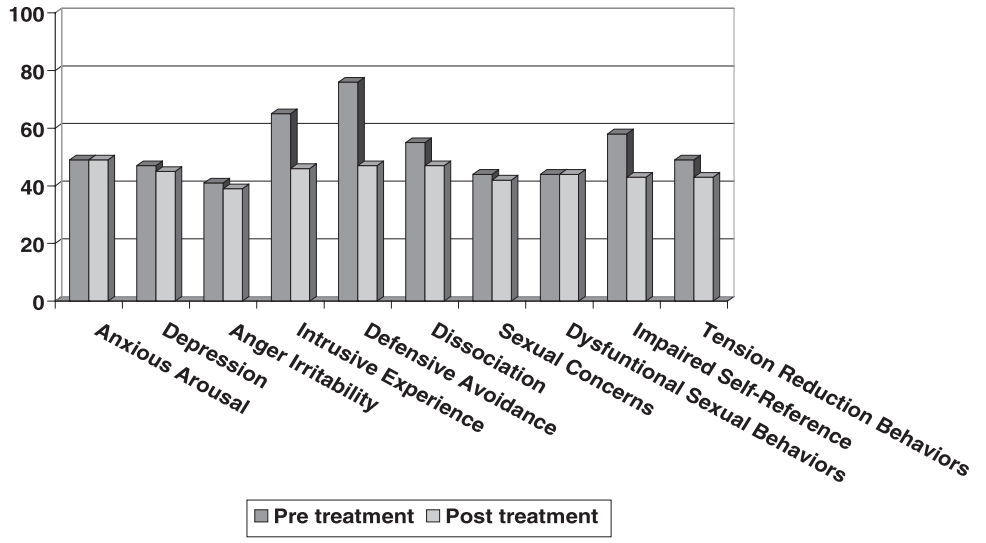

Figure 2. Trauma Scale Inventory

Samuel also acknowledged the change he experienced in terms of his previous defensive or avoidant stance: "I couldn't be talking to you right now. There's no way I could talk to you, just these few things I've said . . . now that I can talk about my thoughts. It's amazed me."

In talking specifically about the benefits Samuel said,

> There's so many things. Ah, just everyday life. . . . I get up and go to work and my past doesn't haunt me [like] before. . . . Now it's more like a passing thought. . . . It helped me with my thought process because now I've got it kind of put in its place and can get on with the rest of my life.

In talking specifically about his offending he states,

> I wanted to blame everybody about it and even take me being abused and blame what I had done, my mistakes, on all of that.

8 MANAGED CARE CONSIDERATIONS

Managed care and/or insurance reimbursement do not apply to the majority of sex offenders in this outpatient treatment program. Fees for service are covered individually by the client and may be subsidized by the department of corrections having jurisdiction of the client. Given that this client meets criteria for a diagnosis of PTSD, however, it is

likely that a managed care company would support treatment targeting trauma symptomatology.

9 FOLLOW-UP

I reviewed my findings with Samuel in two meetings: approximately 6 months after treatment ended and again at approximately 14 months when this manuscript was completed. My purpose was twofold. First, I wanted to confirm Samuel's comfort level with having his information published. I reviewed the limits of confidentiality with him and explained that although efforts were made to disguise his identity, there always remains the possibility of identification by some reader. Second, I wanted to verify the data and his experience of the treatment process. Samuel concurred with the findings as they are presented here. Perhaps most telling was his comment that he continues to feel focused and that he has been able to do the intense work he wants to do in his treatment program. He also stated that his girlfriend continues to notice a difference in his attitude, mood, and behaviors. He said,

> I used to hate group, hate coming to group. I used to hate having to think about my work. The work and the group discussions were always a reminder of my brother and what happened to me. It's not like that anymore. I still remember it, but it doesn't bother me like that anymore.

He was perhaps most pleased by the fact that shortly after treatment ended, he successfully completed his victim relationship statement and had it accepted by his group. Recall that this had been the task on which Samuel was stuck when he initially presented.

10 TREATMENT IMPLICATIONS OF THE CASE

In most ways, this case used EMDR much the same way it would be used with any childhood sexual trauma victim. However, there are at least two primary differences that demand close attention. First, the client has acted out sexually against someone else, and this must be considered at every step of treatment. Dissimilar to work with trauma victims who internalize their trauma (e.g., depression, anxiety, self-abuse) or externalize their trauma in other ways (e.g., violence, rage), the primary goal with a sexual offender needs to remain focused on community safety. This cannot be ignored.

Second, somewhat related perhaps, is the close coordination required with the primary clinician to help manage the philosophical differences between the two treatment modalities. In this case, the primary clinician was willing to allow some flexibility (temporarily at least) in allowing Samuel to entertain and process some of his cognitive distortions. Evident in the case is that without this cooperation (and permission to Samuel),

the thinking knots may not have unraveled, and Samuel may not have moved forward. This is no small hurdle to overcome. Undoubtedly, there are many CBT-RP treatment providers who would be unwilling to take this risk with their clients.

Another important feature in this case was that Samuel's offending behaviors were isomorphic to his own victimization. Samuel is an incestuous sexual offender and was offended incestuously. His victim was age 7, the same age he initially believed he was at the onset of his sexual abuse. He identified similar patterns of grooming and offending between those he used and those used on him. Although these patterns may have contributed heavily to the thinking knot Samuel was experiencing (e.g., "I can't hate him. I'm just like him."), it also may account for (some of) the dynamics that made this a successful intervention with Samuel.

There are many idiographic characteristics of this instrumental case study that must be considered when interpreting the findings. Samuel was a motivated client and had been in treatment for many years. It is possible that had this intervention been applied earlier in his treatment, he would not have responded as favorably. In addition, interview data revealed feelings of trust and connection to the treating EMDR clinician, thereby making outcome attribution difficult. The primary clinician who assessed progress on the SOTRS was not blind to treatment, and although the interviewer was independent, she too was aware of the purpose of the project. Finally, although this case illustrates use of EMDR to address the traumatic memories, it is possible that other therapeutic techniques would show similar results. However, the positive results from this case lend support to prior findings of Datta and Wallace (1996), whose research supports their hypothesis that addressing childhood trauma in adolescent sexual offenders may facilitate a break in the offense cycle. Soberman et al. (2002) had positive results using brief EMDR treatment to address childhood trauma in a sample of adolescents with conduct problems. Conduct problems may represent another externalized outcome of trauma.

11 RECOMMENDATIONS TO CLINICIANS AND STUDENTS

1. Clinicians should familiarize themselves with sex-offender-specific treatment before undertaking this treatment process. There are many facets of working with sex offenders that may be counterintuitive for clinicians working in more traditional mental health fields.

2. Clinicians providing trauma resolution treatment to sex offenders should arrange to have close collateral contact with the primary treatment provider conducting sex-offender-specific treatment. Philosophical differences between the two models must be recognized, acknowledged, and addressed as treatment progresses.

3. Clinicians need to remain acutely aware of the legal and ethical considerations of working with this population. Sex offender clients must be reminded that any admis-

sion of offenses not previously disclosed must be reported to the proper authorities. Furthermore, clinicians should make the sex offender client aware of the free and ongoing communication that will occur between the treatment and supervisory teams.

4.Clients should be screened carefully before engaging them in this treatment intervention. My clinical experience has shown me that sex offenders with a history of psychosis are not appropriate for this treatment in an outpatient setting. Furthermore, safety plans and outside network support should be arranged before beginning this work with clients who have histories of substance addiction or suicidal ideation or attempts.

5. Clinical experience indicates that sex offenders often present themselves in a favorable light. Feedback from sex offender clients, including feedback about treatment results, should be received with caution. Objective and physiological measures (e.g., polygraph, penile plethysmograph) are an important indicator of treatment progress and community safety.

6. Any recommendations made to probation and parole and/or the legal system should be made by a qualified and/or certified sex offender treatment provider.

7. Sex offenders represent a special class of research participants. Clinicians should obtain approval by an institutional review board overseeing research with humans. Furthermore, permission by probation, parole, or legal systems may be required before attempting any alternative treatment with this population.

8. Clinicians should engage in ongoing supervision with a qualified supervisor while providing this or any treatment.

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