Development and Structure of a Two-Part Treatment Program for Sexual Offenders[1]

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Abstract

The current paper briefly describes the development, theoretical background, and structure of a German treatment program for sexual offenders, the Behandlungsprogramm für Sexualstraftäter *(BPS [Treatment Program for Sexual Offenders]). Since the publication of the corresponding manual in 2000 the BPS has become the most widely used treatment program in Germany. While the first part of the BPS focuses on educational aspects (such as learning to talk about sex and sexual assault in an acceptable manner), the second part emphasizes cognitive-behavioral interventions and follows the relapse prevention model. Within part 1, motivational aspects as well as general beliefs and attitudes condoning sexual offending are decisive. In part 2, the sexual offending history of the participants is in the main focus of attention. The results of a survey show that the BPS is judged positively by the treatment providers. Furthermore, positive treatment effects have been reported.*

Keywords: Sexual offender, treatment program, preparatory group, Germany, relapse prevention, cognitive behavioral approach

In the aftermath of some serious sexual offences occurring in Germany in the 1990s, the Ministry of Justice of the federal state of Lower Saxony set up an interdisciplinary working group in 1997. The task of the working group was to develop a treatment program for sexual offenders. End of the 1990s, the *Behandlungsprogramm für Sexualstraftäter* (BPS; in English: Treatment Program for Sexual Offenders) was first being applied in the correctional system of Lower Saxony. In 2000, a manual for the BPS was published (Wischka, Foppe, Griepenburg, Nuhn-Naber, & Rehder, 2000).

DEVELOPMENT OF THE BPS

In developing the program, the authors began with a simple theoretical model demonstrating basic relations between social and psychological factors, on the one hand, and sexual assault, on the other hand (please see Figure 1). Origins of the considerations were surveys of Pithers, Kashima, Cumming, Beal, and Buell (1988), Hartmann (1989), Ertel (1990), and Proulx, McKibben, and Lusignan (1996). These authors found (1) that sex offenders reported strong emotional status prior to relapse (Pithers et al., 1988), (2) that the frequency of sexual fantasies in normal males is a function of boredom, loneliness, tension and sexual dissatisfaction (Hartmann, 1989), (3) that in a representative sample of German males 28% had rape fantasies with a grateful victim, but usually these fantasies are under control (Ertel, 1990) and (4) that there is a significant relationship between affective components and deviant sexual fantasies (Proulx et al., 1996).

The model illustrates the critical antecedents to subsequent sexual offending that treatment with the BPS should focus on: Experiencing distress and holding attitudes or beliefs supportive of sexual aggression (see Malamuth's confluence model [1996] and his hierarchical-mediational confluence

model [2003]).

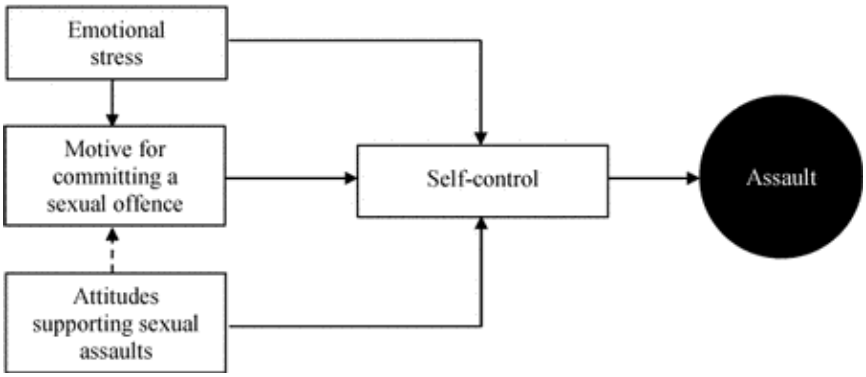

Figure 1: Factors related to sexual assaults

Analogous to Finkelhor's first precondition model (1984), the starting point of the assault is the motive for committing a sexual offence which is usually caused by sexual fantasies or may simply be opportunistic (Malamuth, 1996; Knight & Prentky, 1990). Implementation of this motive is usually prevented by self-control, which may negatively be effected by (1) emotional stress as well as (2) attitudes and behavioral patterns which support the assault (for instance, lack of ability to establish sexual contact, inappropriate attitudes toward women or consumption of disinhibiting substances). Emotional stress additionally leads to an increase of (deviant) sexual fantasies (Hartmann, 1989; Proulx et al., 1996), thus enlarges the probability of an assault.

Corresponding to the above-mentioned model, the BPS should focus on (a) strengthening social skills (to reduce emotional stress induced by interpersonal conflict); (b) improving self-control; and (c) reducing the influence of attitudes, traits, and beliefs supportive of sexual aggression. In contrast, elucidating the developmental or biographic origins of the underlying motive for committing a sexual offence should play a minor role.

Based on own research and on prior experience in the assessment and treatment of sexual offenders in custody (Rehder 1990, 1996a, 1996b) the authors of the BPS also took into account:

- the oftentimes limited ability of sexual offenders to take part in treatment
- the notion that their willingness to take part in treatment may rather be triggered by external incentives (such as earning good reports or qualifying for parole)
- their often limited abilities at establishing a therapeutic relationship and
- their fears associated with the prospect of disclosing their own sexual fantasies and details of their offenses.

For these reasons it has been proven useful (and often necessary) to implement a "preparatory group" before beginning with the actual treatment program (Rehder, 1990). In view of these experiences, the BPS was divided into two parts, namely in (1) a general (non-offence) part and (2) an offense-specific part. This differentiation of the program offers several advantages: First, the group members can become familiar with group therapy, knowing that they are not expected to disclose sexual fantasies or details of their sexual crimes. Only upon completion of Part 1 they have to decide whether they want to continue with the treatment. Second, the participants are engaged in

group work and may experience its benefits. Third, they can learn how to act and discuss in a therapeutic group, possibly beginning to reflect upon their own motives for sexual offending. Fourth, the participants get accustomed to the group situation and come to trust each other. Fifth, the group members develop social skills that often are fundamental to later training of social competence. More specifically, these social skills are needed for the behavioral aspects of relapse prevention as taught and practiced in Part 2. In addition, a therapeutic rapport can be established between group members and group leaders[2]. Last but not least, even those participants can benefit from treatment who are not willing to talk about their offenses.

GENERAL (NON-OFFENSE) PART OF THE BPS

During the 33 sessions[3] of Part 1 of the BPS the sexual assault is not part of the treatment. Instead, the first part focuses on three points:

Enabling the participants to take part in group therapy

In the *Introductory Session*, the participants learn about the organizational arrangements, get to know each other and discuss and accept group rules, which are (1) obligation to maintain secrecy, (2) let others finish, (3) openness, (4) mutual understanding, (5) criticize others in a positive way and (6) avoidance of the German term "man", a word which has no correct equivalent in English (sometimes translated as one, they, you or we) and is often used to generalize and thereby hide one's own opinions and feelings.

The following three sessions focus on different aspects of *Communication*. Methods: role-playing; transfer of knowledge; analysis of videotaped role-plays from the group.

The next three sessions center on *Perception of One's Self and Others*. Methods: group discussion using attitude/question cards; transfer of knowledge; nonverbal exercise (each participant gives the other group members feedback by delivering them letters with notecards of different colors; each color represents a specific behavior; before opening the envelopes, each member hast to estimate, how many cards of each color he will get; the difference between received cards and estimation represents the difference of perception of one's self and others).

The following two sessions will concentrate on *Giving and Receiving Feedback*. Methods: transfer of learning; discussion; exercise: giving one positive and one negative feedback, where the latter should be expressed in form of a wish.

The last two sessions of this section address the *Perception of Feelings*. Methods: listing of emotions and grouping them into two categories; transfer of knowledge (influence of emotions on behavior with examples from films, TV, and examples from day-to-day life of the group members); discussion about the occurrence of emotions and their possible impact on behavior; exercise: assessing the emotional states of other group members.

Treatment of critical behaviors and beliefs that may be conductive to sexual offenses

The methods of the two sessions of *Contact Training* are transfer of knowledge and role-playing (McGurk & Newell, 1987).

The seven sessions of *Moral Action and Empathy* form the basis for victim empathy in Part 2.

Methods: transfer of knowledge and exercises (Lind, 1998).

The next three sessions deal with *Gender Roles* and their negative influence on a positive partnership. Methods: discussion of the social expectations concerning the roles of men and women; reporting personal experiences; planning of an equal partnership for mutual benefit.

The analysis and *Management of Stress* (Kanfer & Phillips, 1975) takes four sessions. The Section ends with three sessions about *Control of Addictive Substances*. Methods: group discussion using attitude/question cards; transfer of learning; role playing: say "no" to an invitation to drink alcohol.

Learning to talk about sexuality in an acceptable way

In the next two sessions titled *Human Sexual Behavior*, sexual education is used to establish a vocabulary that the group members are expected to use when they talk about sexuality and sexual assault. The vocabulary should neither be too medical-academic nor too close to street slang. The group members also learn about the negative impact of sexual assaults on victims.

Part 1 ends with the *Final Session* in which the participants give feedback about the sessions so far and receive information about Part 2 of the program.

Participation in the general part of the BPS that is not offense-specific does not necessarily entail participation in Part 2. Consent of group members as well as approval on behalf of the group leaders is required.

PART TWO OF THE BPS: OFFENCE-SPECIFIC

In accordance with the research and with experiences on extant programs available at the time of the development of the BPS (e.g., Greer & Stuart, 1983; Laws, 1989; Marshall, Laws, & Barbaree, 1990; Marshall, Fernandez, Hudson, & Ward, 1998; Marshall, Anderson, & Fernandez, 1999), the methods of choice for Part 2 of the BPS were (1) the cognitive-behavioral approach and (2) relapse prevention.

The **cognitive-behavioral approach** assumes that thought and evaluation patterns influence perception and can ultimately lead to misperceptions of a situation and - as a consequence - to adverse emotional reactions. It is therefore more important from a cognitive-behavioral point of view to deal with the subjective evaluation that is triggered by a situation than with the feelings which seem to be directly caused by a situation.

Relapse prevention (RP) was originally developed to treat addictive behavior such as alcohol abuse (Marlatt & Gordon, 1980). This approach was modified for the treatment of sexual offenders (Pithers, Marques, Gibat, & Marlatt, 1983). RP puts its emphasis on self-control and has three main aspects: (1) volitional aspects, i.e., the perpetrator must intend not to commit another sexual offense; (2) cognitive aspects, i.e., in order to avoid a relapse, the perpetrator must be aware of behavior patterns which may lead to a new assault; (3) behavioral aspects, i.e., the offender must develop behavioral techniques so that he is able to cope with high-risk situations.

For training purposes, Pithers' (1983; as cited in Marshall, Anderson, & Fernandez, 1999) model of the offense chain was adapted and an almost true episode from the author's life was used, to illustrate how the relapse process works in real life (Rehder, 2003). Figure 2 illustrates the model.

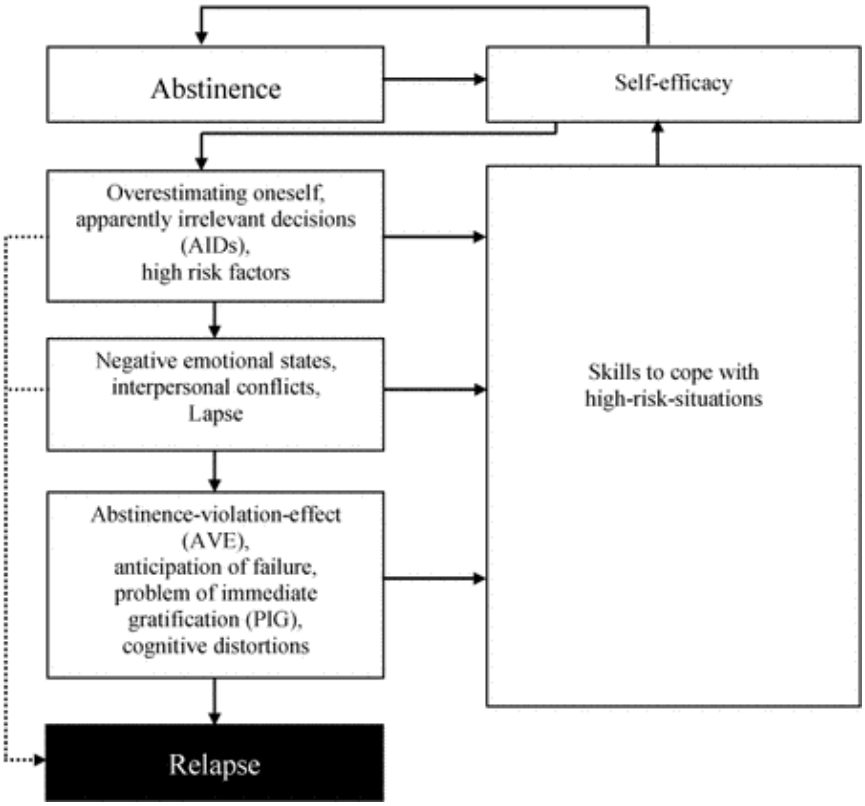

Figure 2: Model of the offence chain

Volitional aspect of the relapse chain: Mr. R. receives a phone call from his friend, who raves about his new computer und its numerous opportunities. Mr. R. - whose computer is rather old - develops the desire to buy a new one. He discusses his wish with his wife, but she has a totally different position. As a result the decision has been made. Her arguments are reasonable: Mr. R.'s main tasks work with his old computer. Photo editing is not necessary, because he has no digital camera. He realizes that there is no rational reason to buy a new computer and accepts this goal. His abstinence from buying a new computer reinforces his strong belief that buying a new computer would be an irrational decision.

Cognitive aspects of the relapse chain: Some days later Mr. R. sees an advertisement of a popular electronic shop in the newspaper offering cheap high-performance computers. As he passes the shop on his regular way to work, he decides to enter and take a look at the computers on offer. Overrating his own willpower in connection with the apparently irrelevant decision of entering the shop leads to a high-risk situation. Contrary to his expectation a clerk appears immediately and provides detailed information on the technical specifications of the new computers. He adds: "We have stored a cheaper and even more powerful model. However, there is only one left, so you have to decide straight away." In this situation Mr. R. may (a) have a relapse (buy a computer), (b) communicate clearly that he only wanted to get some information or (c) go home with negative feelings.

His wife has no doubts about his emotional state and asks: "What's wrong?" His harsh reply causes a marital conflict. Mr. R. feels misunderstood and reckons that his needs should be cared for more strongly. In his angry mood he may (a) decide to buy a computer the next day, (b) try to explain the

reasons of his dissatisfaction or (c) satisfy his addiction to new technique by buying a new graphics card and install it after his wife has gone to bed.

After installing the new graphics card he realizes the violation of his own, self-defined goals. Moreover, the graphics card does not improve the performance of the computer in the way he expected it to. Mr. R is still dissatisfied. His need for a new computer is growing. Two days later he sees another advertisement in the newspaper and comes to believe: "With a new computer I will be highly satisfied. My wife wants to have a satisfied husband. So it makes sense to buy a new computer." In this situation there are two possibilities: He may (a) convince himself that it is necessary to buy a new computer or (b) realize his erroneous chain of reasoning and abstain from buying a new computer.

Behavioral aspects of the of the relapse chain: In the above sequence of events, option (b) always necessitates social competency and social skills in order to enable a person to re-adjust to the cycle of abstinence and self-efficacy. Core aspects of these skills are trained in Part 1 of the BPS. It should be noted that there are more sophisticated models, such as, for instance, the model of self-regulation developed by Ward and Hudson (2000).

Sessions in Part 2: Calculated on the basis of eight participants, Part 2 has on average 53 sessions. The outline of this offense-specific part of the BPS shows that its underlying concept is in accordance with other programs dating back to the 1990s: The *Introductory Session* - in which the group members give comprehensive information about their assaults - is followed by eight sessions of the *Personal History* of the participants. The group members tell each other about their family history, their educational and employment background, their social relationships, their sexual development, and their marital relationships. Furthermore, participants address the question how their life history affected their sexual offenses. The other topics in Part 2 are: *Cognitive Distortions* (two sessions), *Preconditions for Committing a Sexual Crime* (three sessions), *Apparently Irrelevant Decisions* (one session), *Risk Situations* (four sessions), *Problem of Immediate Gratification* (one session), *Control of Sexual Fantasies* (two sessions), *Process of the Assault/Offense Scenario* (eighteen sessions), *Victim Empathy* (eleven sessions), *Relapse Prevention Plan* (eight sessions) and a *Final Session*. As can be seen, the offense scenario, the development of victim empathy and working out an individual plan for relapse prevention are the main aspects of Part 2.

DISSEMINATION, ACCEPTANCE, AND EVALUATION OF THE BPS

Since 2000 the BPS has become the most widely used treatment program for sexual offenders in Germany - at least in socio-therapeutic institutions (Spöhr, 2009). Socio-therapeutic institutions are correctional facilities for violent and sexual offenders by providing treatment in a secure setting. Every offender who is (a) sentenced to a prison term of more than two years for a sexual offense and (b) is in need of treatment has to be transferred to a socio-therapeutic ward or institution. As a result of this regulation, more than 50% of the inmates in socio-therapeutic institutions are sexual offenders (Niemz, 2013a). Currently, the BPS is being used in more than 50 different institutions in Germany, mostly within the correctional system but also in forensic psychiatry and in the probation service.

A survey of 75 treatment providers in 22 different institutions carried out in 2008 shows that the BPS is met with acceptance by participants and group leaders alike and that its efficacy is judged favorably (Rehder, Wischka, & Foppe, 2012). The same authors found that the BPS also represents the most important component of therapy in many treatment centers.

Evaluation of treatment programs for sexual offenders in Germany is difficult because (a) legal requirements do not allow sexual offenders in need of treatment to be left untreated (which means that it is not possible to design a study with an untreated control group) and (b) the outcome of treatment evaluation is complex because the BPS is usually performed together with other treatment methods. Despite these difficulties, an evaluation project of socio-therapeutic institutions is under development by the *Criminological Service of Lower Saxony* (Niemz, 2013b). In this federal state of Germany the BPS is the core treatment.

In a first evaluation approach Wischka (2013) found some changes in attitudes and self-assessment before and after application of the BPS, changes which are necessary albeit not sufficient conditions to prove the effectiveness of a treatment program:

- A comparison of the results of psychological tests between the beginning of the custodial sentences and before the application of the BPS, on the one hand, and between the start of the BPS and the end of the general part of this program, on the other hand, showed only few (and partly negative) changes in the first period but remarkable positive changes in the second period ($N = 54$).
- A pre-post comparison with psychological tests between the start of the BPS and the end of the general part of the program (N between 132 and 140) showed positive changes.
- Assessment of an opinions questionnaire (N between 138 and 145) and victim letters ($N = 32$) showed a change in offense-related attitudes, on the one hand, and a significantly more self-critical attitude to their own sexual offence, more responsibility, more insight into the progression of the offence and into the victim's perspective, on the other side.

REVISED VERSION OF THE BPS: BPS-R

A revised version of the BPS, the BPS-R, was developed in 2012 (Wischka, Rehder, & Foppe, 2012). Its general structure remained unchanged; however, the new manual takes into account experiences acquired by long-term providers of the BPS. Furthermore, a review of more up-to-date literature as well as additional information on implementing each session was added. Another important addition to the new version of the BPS is a collection of 15 research reports written by the authors of the BPS-R offering basic knowledge for group leaders. Among other things these articles address: (1) deviant sexual behavior - disease, sin or offense? (2) sexual fantasies, (3) sexual offenses - prevalence, recidivism and public opinion, (4) classification of sexual offenders, (5) impact of sexual offenses on victims, (6) basic conditions for the treatment of sexual offenders, (7) results of treatment research, (8) theoretical background of the BPS, (9) structure and contents of the BPS, (10) empathy, (11) perpetrators as victims, and (12) difficulties and fears in dealing with sex offenders.

On the basis of therapeutic experiences in forensic-psychiatric hospitals and in socio-therapeutic facilities a manual for sexual offenders with learning disabilities has been published (Löhr & Wenzlaw, 2013). A manual for violent (non-sexual) offenders is currently being developed.

DISCUSSION

The BPS is the most used treatment program for sexual offenders in Germany. As is apparent from the training of group leaders most of them are psychologists, social workers, prison officers or qualified nurses and some of them are teachers, psychiatrists, or other physicians. For the application of the program the authors recommend two group leaders; one of them should be

female, to bring a certain degree of normality to the sessions; the male partner can provide support if he notices inappropriate behavior by some group members. Based on feedback and on experience this combination is used wherever this is possible and it seems to be the most promising approach.

The main difference between the BPS and other treatment programs for sexual offenders - according to Spöhr (2009) in Germany mainly the *Sex Offender Treatment Programme* used in England and Wales (the SOTP Core Program; SOTP Team, 2000) and *Maintaining Change* (MC; Eldridge, 1997; German edition by Bullens) - is the two-part structure of the BPS. The advantages of this partition are (1) that group members have a relatively long phase for "warming up" in which they are enabled to take part in group therapy; (2) that even those offenders can take part in treatment who are not willing to talk about their sexual assault(s); and (3) that the participants learn to talk about sexuality in an acceptable way. The high levels of acceptance reported for the BPS seem to indicate that its two-part structure is considered useful and tailored to the needs and expectations of participants and group leaders[4]. Furthermore, other preparation programs are described by Brown (2005), Marshall and Moulden (2006), Nagtegaal and Mulder (2010), and Sheehan and Ware (2012). Ware (2011) suggests that preparatory programs for sexual offenders enhance treatment effectiveness. A disadvantage of the structure of the BPS is, of course, the relatively long duration of treatment: A full course of the BPS treatment takes approximately 90 sessions which means that applying the BPS would take one and a half year (two sessions a week).

Another obvious difference between the three mentioned programs is the size of the manual of the BPS (more than 600 pages without research reports). The reasons for this are (a) a higher degree of structure of the BPS sessions than that found in the other both programs, (b) the numerous handouts for the participants (each of them has an own folder for their information materials) and (c) several written instructions for the group members, how to do their homework (such as how to prepare themselves for the description of their biography during the group sessions). The strong structuring of the BPS sessions is most often welcome by inexperienced group leaders; however, psychotherapists and also sophisticated social workers and psychologists sometime feel limited by the necessary time management.

The points addressed in Part 2 of the BPS and in the two other programs mentioned above are very similar which is not surprising considering the common theoretical background. However many points addressed in the core program of the SOTP and Eldridge's MC are not part of the BPS: Preparation for release and transferring responsibility to the probation services are principle tasks of the correctional system in Germany and, more particularly, main tasks of socio-therapeutic institutions. It should be noted that socio-therapeutic institutions have the option to stepwise release their inmates (special leave for a time of six months).

The MC differs from SOTP and BPS insofar as the former is an open ended program, making it possible, to start treatment at once. This may be advantageous, if (a) the sentence to serve is too short to wait until a treatment program can be applied or (b) the number of sex offenders in an institution is so low that it is not possible to form a closed group with a sufficient number of group members over a longer period. However, the closed groups of SOTP and BPS provide an uninterrupted process of integration within the group over the complete period of treatment. To minimize waiting time in some socio-therapeutic institutions there are parallel BPS-groups using a different start date.

The question must be asked as to whether the BPS meets the criteria of Andrews and Bonta (2007). Their RNR principles are considered as most important for the treatment of (sexual) offenders (Hanson, Bourgon, Helmus, & Hodgson, 2009). To answer this question it is not only

necessary to have a look at the BPS but also to take account of the German correctional system.

- "Risk-principle: Match the level of service to the offender's risk to re-offend" (Bonta & Andrews, 2007, p. 1). According to the German *Strafvollzugsgesetz* (law on the penitentiary system), all sexual offenders serving a sentence of more than two years are assessed thoroughly at the beginning of their penal incarceration. After this risk assessment it is decided, whether an offender is to be transferred to a socio-therapeutic institution (which is part of the correctional system) or if the therapeutic interventions of the normal penitentiary system are sufficient to reduce the risk of reoffending. Assessment is repeated several times, both in socio-therapeutic institutions and in the normal penal system. In this context the BPS is used as diagnostic instrument to find out which other treatment methods are necessary to prevent future relapses.
- "Need principle: Assess criminogenic needs and target them in treatment" (Bonta & Andrews, 2007, p. 1). The cognitive-behavioral BPS was originally developed to provide the prison staff with a systematic, science-based treatment approach for incarcerated sexual offenders. Recidivism studies (Schmucker, 2004; Schmucker & Lösel, 2009) show that the cognitive-behavioral approach is the most appropriate one for sexual offenders. Furthermore, the two part structure of the BPS ensures that not only offense-related issues are addressed but also objectives which are not directly related with sexual assaults. In addition, other treatment approaches - such as individual therapy - can be applied if necessary.
- "Responsivity principle: Maximize the offender's ability to learn from a rehabilitative intervention by providing cognitive behavioural treatment and tailoring the intervention to the learning style, motivation, abilities and strengths of the offender" (Bonta & Andrews, 2007, p. 1). As shown above, the BPS is well accepted by the participants. Experience shows that this program meets the offenders at their level. Only in rare cases the BPS is intellectually too demanding. Because of this an additional program for intellectually disabled offenders was developed.

In summary it can be said that the BPS in the German penal system meets the RNR-principles of Andrews and Bonta.

After more than 10 years of practice combined with continuous feedback from numerous users, the BPS was revised to enhance its applicability and to take new research findings into account (Laws, Hudson, &Ward, 2000; Laws, & O'Donohue, 2008; Beech, Craig, & Browne, 2009). In this regard it is important not to lose sight of some main principles of social therapy: The guidelines of the "good lives model" (Ward, Collie, & Bourke 2009) were - and hopefully will always be - part of treatment in these facilities.

It should be mentioned that the manual of the BPS-R is not sold separately. It can be purchased together with a special training only by treatment providers. This ensures that group leaders have the theoretical knowledge and the practical skills at their disposal in order to apply the treatment accordingly.

Conflict of interest: The author wishes to be known that he is earning money by selling the BPS and by training treatment providers.

Notes

[1] Presented at the 12th International Conference of the International Association for the Treatment of Sexual Offenders (IATSO), September 6, 2012, Berlin, Germany

[2] The term group leader [German: Gruppenleiter] was chosen to indicate that the providers of the BPS have attended appropriate training but are not necessarily psychotherapist within the meaning of the German law.
[3] The number of sessions was calculated on the basis of eight participants.
[4] In the federal state of Mecklenburg-Vorpommern Part 1 of the BPS is used in combination with the SOTP (Niemz, 2013b).

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