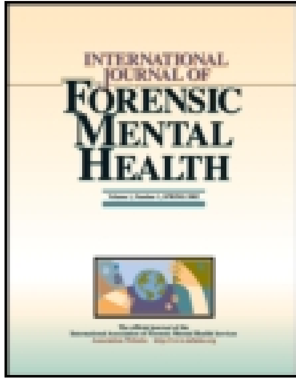
This article was downloaded by: [Nina ten Hoor]
On: 31 May 2013, At: 02:52
Publisher: Routledge
Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



International Journal of Forensic Mental Health
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/ufmh20

Treating Cognitive Distortions with EMDR: A Case Study of a Sex Offender

Nina M. ten Hoor [a]

[a] De Waag , Outpatient Centre for Forensic Psychiatry , Leiden , the Netherlands

Published online: 23 May 2013.

To cite this article: Nina M. ten Hoor (2013): Treating Cognitive Distortions with EMDR: A Case Study of a Sex Offender, International Journal of Forensic Mental Health, 12:2, 139-148

To link to this article: http://dx.doi.org/10.1080/14999013.2013.791350

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: http://www.tandfonline.com/page/terms-and-conditions

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae, and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand, or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

INTERNATIONAL JOURNAL OF FORENSIC MENTAL HEALTH, 12: 139–148, 2013
Copyright © International Association of Forensic Mental Health Services
ISSN: 1499-9013 print / 1932-9903 online
DOI: 10.1080/14999013.2013.791350

Routledge
Taylor & Francis Group

Treating Cognitive Distortions with EMDR: A Case Study of a Sex Offender

Nina M. ten Hoor
De Waag, Outpatient Centre for Forensic Psychiatry, Leiden, the Netherlands

This single-case study illustrates how eye movement desensitization and reprocessing (EMDR) can be of use in the treatment of cognitive distortions in sex offenders who themselves have been victimized in their childhood. A 56-year-old man did not perceive his childhood sexual experiences as negative. As a consequence, he could not see any harm in his own offending in later life. He spent one year in cognitive-behavioral group therapy barely making any progress. After nine EMDR sessions, most cognitive distortions appeared to be resolved. He was able to attend his group sessions in a more open and involved manner.

Keywords: Child sexual abuse, childhood victimization, cognitive distortions, sex offender, EMDR, single-case study

Downloaded by [Nina ten Hoor] at 02:52 31 May 2013

INTRODUCTION

Cognitive Distortions

Blaming the victim, justifying offending, or excusing sexually abusive behavior are all examples of cognitive distortions found in sexual offenders (Ward, 2000). For example, children may be perceived as wanting sex, as not being harmed by sexual contact with an adult, and offenders may see themselves as not really being responsible (Hanson, Gizzarelli, & Scott, 1994; Hayashino, Wurtele, & Klebe, 1995; Stermac & Segal, 1989). Marshall, Marshall, and Kingston (2011) defined the term *cognitive distortions* as encompassing various thoughts, perceptions, beliefs, and ideas that are understood to present obstacles to the offender taking responsibility for his crimes. In the debate led by these authors regarding the need to address cognitive distortions in sexual offender treatment, Ó Ciardha and Gannon (2011) pointed out that there are some inherent differences in how the term cognitive distortion is defined in the field of sexual offending. Marshall and his colleagues focus their arguments regarding cognitive distortions more explicitly upon excuses, denial and minimizations, whereas Ó Ciardha and Gannon tend to focus upon deeper cognitive processes and structures such as schemas and higher-order beliefs.

Another issue in the debate is whether cognitive distortions should be considered as post-hoc rationalizations that serve to diminish responsibility and protect the offender's sense of self-worth (Anderson & Dodgson, 2002; Marshall et al., 2011) or as 'etiological cognitions' or schemas, causally linked to the offending (Abel, Becker, & Cunningham-Rathner, 1984; Ó Ciardha & Gannon, 2011; Ward, 2000). If cognitive distortions are to be viewed as a by-product of offending, there may not be a need to challenge them. On the one side of the debate, it has been argued that confrontation of cognitive distortions can even have a negative effect in terms of blocking treatment progress and benefits (Marshall et al., 2003). On the other side of the debate, Ó Ciardha and Gannon too have their doubts about the interview being an effective tool for discovering etiological cognitions. In accordance with Marshall and colleagues (2006), they argue that schemas are activated when the individual faces challenges or is emotionally aroused and that this kind of activation may not occur when questioning an offender in a clinical setting. According to Ward (2000), the more extensive an individual's sex offense history is,

The author would like to thank Ron Ricci and Moniek Verster-Bosman for their inspiring guidance throughout the treatment of the participant and the writing process of the study. Deep gratitude is also expressed to Ron van Outsem and Ad de Jongh for their valuable comments and contributions to the manuscript. Finally, a special thanks is owed to the participant for his willingness to try EMDR, his courage to go through with it, and his contribution to the article.

Address correspondence to Nina M. ten Hoor, De Waag, Haagweg 5, 2311 AA Leiden, the Netherlands. E-mail: ntenhoor@dewaagnederland.nl, n.hoor@upcmail.nl

the more elaborate his implicit beliefs will be and the less alternative concepts an offender has to evaluate his own actions and victims' responses. Fundamentally changing these deep beliefs will be a time-consuming and painstaking process, hence accounting for the treatment resistance so often seen in offenders.

Despite all these difficulties, the reduction of cognitive distortions remains an important objective in most treatment models and programs for sex offenders (e.g., Becker & Murphy, 1998; Bumby, 1996; Burn & Brown, 2006; Graig, Browne, & Stringer, 2003; Ward & Siegert, 2002). It is likely that failure to develop more adaptive ways of conceptualizing their own offense pattern will render sex offenders vulnerable to relapse. Hudson and colleagues (2002) assessed pro-offending attitudes prior to and following treatment and found that a reduction of cognitive distortions is indeed associated with reductions in re-offending.

Downloaded by [Nina ten Hoor] at 02:52 31 May 2013

Childhood Victimization

In sex offender theory and research, the term *cognitive distortion* is often linked to the concepts 'attachment' and 'schema.' Both terms refer to early cognitive processes in the development of a person and are presumed to form the starting point from which cognitive distortions can develop. This connection seems most clear in perpetrators of child sexual abuse who suffered from victimization in their own childhood. Much has been written about the neglect, violence, and disruption, found in the early development of many sex offenders (e.g., Craissati, McClurg, & Browne, 2002; James, 1989; Ward, 2000). Affectionless parenting seems to result in impaired attachment abilities within the child. Such an attachment style often leads to poor peer and later adult relationships, impaired emotional and behavioral regulation, and distorted beliefs concerning other people, themselves, relationships, and sex (Ward & Moreton, 2008). Lisak (1994) in his study with male survivors commented that this produces a profound and often lifelong isolation and separation from others. Child sex offenders may view the world as threatening and believe themselves incapable of self-defense or retaliation over other adults. Instead, they may believe that their intimacy needs can be best met by children. Children provide a safe alternative as they are presumed not to hurt or reject the adult (Freeman-Longo, 1986; Ward, 2000).

Early abuse may also create distortions in developing sexual scripts. Sexually abused children are exposed to sexual experiences before they are cognitively and emotionally ready to process them. These distortions could account for aberrations, such as age discrepancy or impersonal sex (Ward & Siegert, 2002). As adults, they may seek reassurances through sex and equate sex with intimacy. A notable finding is that if victims are properly informed by family or others that the abuse is not their fault, and the perpetrator is clearly labeled as responsible, they are less likely to incorporate the abuse into a sexual script and become perpetrators themselves (Davis & Petretic-Jackson, 2000, Ward & Siegert, 2002). Hence, close family bonding can be seen as a protective factor against developing perpetrator traits. Childhood sexual abuse and insufficient attachment bonds with direct caregivers seem to work together in increasing the risk for an individual to become a sex offender through the development of distorted schemas, distorted sexual scripts, and a dysfunctional (e.g., avoidant, anxious, dismissive) attachment style.

Overall, research has indicated that child molesters report relatively high incidences of childhood sexual and physical abuse (e.g., Craissati et al., 2002; Marshall et al., 2006). Studies have indicated that 15% to 70% of adult sex offenders report histories of past sexual abuse (Ward & Moreton, 2008). Many of these victims learn to use abusive behavior as a coping mechanism (Graham, 1996). Groth (1979) suggested that the offender's pattern of victimization often is a repetition of his own childhood abuse. Research with pedophiles has supported this theory (Freud & Kuban, 1994). It even seems that the closer the relationship a victim has with an abuser, the more chance he or she has of sexually offending when older (Garland & Dougher, 1990). Ricci, Clayton, and Shapiro (2006) describe how many offenders have memories that distort the facts of their own victimization, causing them to deny to themselves and others that any harm was done, or to believe that they as children were responsible for the abuse. The offender can project this on future victims and find justification for his behavior. Often, these offenders do not perceive themselves as victims. They may not report any symptoms of traumatization. Their distorted views appear to detach them from early experiences of abuse.

Ward and Moreton (2008) suggest that an early goal of therapy should be to help offenders reach an understanding of how childhood experiences have affected their emotional and psychological development and to explore how these experiences influence their current behavior and functioning. However, Ricci and colleagues (2006) point out that some offenders have effectively numbed their feelings associated with traumatic memories. This can make accessing material difficult, if not impossible. They found eye movement desensitization and reprocessing (EMDR) trauma treatment to be an effective intervention for this purpose. As a result of EMDR, the increased clarity with which the offender perceives his victimization allows him the opportunity to challenge the cognitive distortions he previously held. After EMDR treatment, participants are reported to take on appropriate levels of responsibility for events that have occurred. There is preliminary, though growing evidence from three small-scale quantitative studies (Datta & Wallace, 1994; Finley, 2002; Ricci et al., 2006), a qualitative analysis (Ricci & Clayton, 2008), and a case study (Ricci, 2006), that combining EMDR with standard cognitive-behavioral therapy-relapse prevention (CBT-RP) group treatment, increases the offender's treatment motivation, enhances his empathic

capacity, increases his internal locus of control, and increases his tolerance for emotions that could trigger the sexual offending cycle.

EMDR

EMDR is known as an evidence-based and first-line treatment for traumatic memories (Bisson et al., 2007; National Collaborating Centre for Mental Health, 2005). The procedure induces a physiological condition in which unprocessed memories of traumatic events become linked up with networks that already include adaptive information and skills in order to reduce posttraumatic stress disorder (PTSD) symptomatology (Shapiro, 2001). The method involves having the participant concentrate intensely on the most upsetting part of a traumatic memory while simultaneously moving the eyes from one side to the other, usually by following two fingers of the therapist. Alternative forms of bilateral stimulation can be provided by auditory or tactile stimulation. After one set of bilateral stimulation (duration about 30 to 60 seconds), the participant is asked what came up to his or her awareness. This can be images, thoughts, feelings, sensations, or other experiences. Whatever the participant reports becomes the focus of the next set of bilateral stimulation. This procedure continues until the traumatic memory has ceased to bring emotional stress and there has formed a more positive and adaptive perspective regarding the memory. The Subjective Units of Disturbance Scale (SUDS; Wolpe, 1982) and the Validity of Cognition Scale (VOCS; Shapiro, 1989) are ratings reported by the participant during the process. These ratings are used to measure treatment progress.

One of the basic premises of EMDR is that most psychopathologies are rooted in past trauma. The goal of EMDR then, is to transform the dysfunctional material or residue from the past into something that is functional and useful (Shapiro, 2001). The underlying theoretical model developed by Shapiro is Adaptive Information Processing (AIP). This model states that adaptive resolution of experiences involves integrating and using an individual's experience in a constructive manner, as part of a positive emotional and cognitive schema. When something traumatic happens, this process is disrupted and the memory is stored in such a manner that the necessary processing is unable to take place. The information remains available in a dysfunctional state, causing additional stress to the system when triggered.

Researchers have argued whether the active ingredient in EMDR differs from exposure (e.g., Boudewyns & Hyer, 1996; Schubert & Lee, 2009). Furthermore, it has been questioned whether the eye movements involved in EMDR add anything to its effects (e.g., MacCulloch, 2006). An early review (Cahill, Carrigan, & Frueh, 1999) and meta-analysis (Davidson & Parker, 2001) concluded that the eye movements did not contribute to EMDR effects. Recently, the study by Davidson and Parker has been criticized on methodological grounds (Lee & Cuijpers, 2013). In their encompassing meta-analysis, Lee and Cuijpers found significant additive effects for eye movements in clinical trials. Jeffries and Davis (2012) in their review also found evidence that the processes involved in EMDR are different from other exposure-based therapies, acknowledging that the eye movements are essential to this therapy. Major differences include the degree of emphasis placed on reliving versus distancing in re-experiencing the trauma, and the degree to which participants are encouraged to focus on direct trauma experiences versus experiences associated with the trauma (Lee, 2008). In traditional exposure therapy, participants are encouraged to verbalize the traumatic material until there no longer is any associated stress. In contrast, EMDR encourages free association and distancing (Shapiro, 2001).

EMDR has gained widespread acceptance in treating rape and molestation survivors and individuals dealing with grief, alcoholism, panic attacks and specific phobias (Shapiro & Forrest, 1997). Several meta-analyses have concluded that EMDR is comparable to other efficacious treatments, including exposure therapy, in reducing PTSD symptomatology (Bisson et al., 2007; Bradley et al., 2005; Seidler & Wagner, 2006). It is increasingly applied in other conditions and symptoms than PTSD, which developed following an adverse event.

Considering the difficulties discussed earlier in treating cognitive distortions in sex offenders, including EMDR sessions may be of benefit. Ricci (2006) indicates that the method does not require a significant amount of verbal processing on the part of the participant, making it an appropriate choice for individuals reticent to discuss their own histories. As a consequence, the possibility of therapists blocking the process by becoming too confrontational is restricted. In cases where individuals are blocked due to internal emotional numbing, EMDR can be used to help them overcome this state. An inherent feature of EMDR is that during the process, unconsciously stored dysfunctional material usually will present itself. Dysfunctional schemas can become activated when the problematic emotional states are evoked. This can be particularly useful to offenders who experience barriers in reflecting on their offensive behavior. Furthermore, the dysfunctional material can then immediately be reprocessed into a more adaptive and functional form. Ward and Siegert (2002) described how distorted sexual scripts develop due to the fact that victims of sexual abuse, as children, lack the necessary cognitive and emotional capacities to adequately comprehend the abusive context of the event. EMDR allows the participant to make use of his own adult perspective while reprocessing the dysfunctional memories. This can be an effective mechanism in overcoming the distortions. The following case study is meant to give an illustration of how EMDR can be applied in the treatment of cognitive distortions in sex offenders who have been sexually victimized in their childhood. It is stressed that EMDR is intended as a supplement to the standard care given, not as a replacement.

Downloaded by [Nina ten Hoor] at 02:52 31 May 2013

CASE VIGNETTE

Participant

The author invited the participant, given here the fictitious name of Peter, to write his own contribution to this article. He introduces himself as follows:

> At the age of 54, I committed a crime. I left a note for my newspaper delivery boy inviting him to have sex with me. I knew that the boy was only 14 years old. I ended up in group therapy with seven other sex offenders. In the course of these sessions it became apparent that I myself had experienced a similar event at the age of 14. A man, about 50 years old, invited me into his home and this became my first sexual experience that I could remember. My group members and the group therapists proposed to explore these experiences in a one-to-one contact with a psychologist. They considered me to be both a perpetrator and a victim, which I couldn't see myself. I was skeptical about it. I assumed that my whole childhood was going to be dragged up and I had told about this many times. I didn't see any point in it.[1]

Downloaded by [Nina ten Hoor] at 02:52 31 May 2013

When Peter spoke about his first sexual experiences in therapy, he emphasized that he had experienced them as beneficial to him. During one year he had oral sex on 10 to 15 occasions. After this, the man introduced him to other men and Peter engaged in a wide range of sexual activities with many different men. He called himself a 'butterfly,' always on the move and open to adventure. He never had any doubts about his homosexuality. Three times he had a close relationship lasting up to one year. In these relationships, he felt anxious and highly uncomfortable with intimacy. For this reason, he felt compelled to end these relationships. At the beginning of his treatment, Peter simultaneously had about five longer lasting sexual relationships with married men whom he saw occasionally. He had initiated these men in homosexual lovemaking. He liked the idea of having been their first homosexual partner. Peter found it hard to make social contact with others. He spent most of his free time on his own. Growing older and losing his sex appeal was difficult for him to accept. In everyday life, he worked in a greengrocery. Though people seemed to like him there, he preferred to eat his lunch alone.

Peter was the seventh child in a family of eight children. His parents ran a bakery and the children were expected to assist in the business, which was considered the main priority in the family. At home there was frequent domestic violence. His father was aggressive towards his mother and the children. Peter attended vocational education but started working before graduation. At age 41, he visited a psychiatrist twice because of persistent grief after the death of his mother. For years, his general practitioner subscribed sedatives (Diazepam). Since his arrest, the general practitioner added an antidepressant (Venlafaxine) because of depressive moods and excessive tension. Peter's consumption of alcohol was moderate, averaging one bottle of wine per week.

Peter had no criminal history prior to his conviction for his current offense. The following DSM-IV (APA, 2000) diagnoses were given by his clinician at the beginning of his treatment: On Axis I: paraphilia NOS (not otherwise specified) and adult antisocial behavior. On Axis II, no personality disorder was identified. Based upon his personal history and his behavior in treatment, an avoidant attachment style was assumed to be present.

The CBT-RP group Peter joined incorporated elements of the Risk Need Responsivity Model (Andrews & Bonta, 2007) and the Good Lives Model (Ward & Maruna, 2007; Willis & Ward, 2011). The average time of participation in the group was two years. Personal treatment goals were based upon individually structured risk assessment. Central themes in the group therapy were: the impact of family background and life events, intimacy and sexual development, sexual preferences and deviancy, gaining insight in the perpetrator's grooming process, cognitive distortions, victim empathy, enhancement of emotion regulation and self-control, coping and communication skills, extending social networks, involving the social network in the treatment process, and relapse prevention. During treatment, a number of family sessions took place with Peter and his sisters.

The group therapy was a heavy burden for Peter. He complained a lot about his sentence and kept repeating that he had not done anything wrong. He found it hard to listen to the stories of other group members. He appeared to try to repress all memories related to the offense. Over the course of his first year in the group, treatment involvement was low and barely any progress was perceived by his therapists.

Assessment

The SUDS (Subjective Unit of Disturbance Scale) is a process measure used in EMDR in which the participant is asked to recall the trauma relevant memory and to rate the accompanying anxiety level using an 11-point scale, in which 0 represents neutral intensity and 10 equals the highest possible disturbance (Shapiro, 1989; Wolpe, 1982). It is a widely used measure that has been shown to correlate with several physiological measures of stress (Thyer et al., 1984; Wilson et al., 1996). Kaplan, Smith, and Coons (1995) confirmed the concurrent validity of the SUDS with self-reported anxiety. Kim, Bae, and Park (2008) found that the SUDS scores obtained in EMDR sessions have good psychometric properties, with evidence of convergent and discriminant validity, concurrent validity, and predictive validity. It is unknown whether the same psychometric properties are applicable to offending populations in general or sex offenders in particular.

Once the memory has been desensitized, as indicated by satisfactory SUDS, the participant is guided in replacing negative cognitions with participant-generated positive

cognitions. The VOCS (Validity of Cognition Scale) is a process measure developed by Shapiro (1989). The participant is asked to rate the degree in which the cognition intuitively feels to be true. The 7-point scale runs from 1 to 7 with 1 representing 'feels completely false' and 7 equaling 'feels completely true.'

Intervention

Prior to the EMDR, four individual sessions were spent on preparing Peter for the trauma therapy. In these sessions psycho-education was given about trauma and EMDR. Peter's coping skills were reinforced so that he could use them more effectively during the EMDR process. An inventory of his early sexual experiences took place in order to design a plan concerning the experiences the EMDR treatment should be focused on. During these sessions, Peter continued to question the need for trauma therapy. The rationale given was that Peter's own perception of his offense was opposite to generally accepted views concerning sexual relationships between adults and minors. These beliefs appeared to interfere with his therapy, as he remained convinced that there was nothing wrong with his offending. It was proposed that EMDR could be of help in acquiring insight into this discrepancy. Furthermore, it was suggested that EMDR could be a tool in overcoming his feelings of loneliness and social isolation. As Peter admitted to suffer from this, he was finally prepared to give EMDR a try. In total, nine EMDR sessions of 90 minutes were implemented by the author, an experienced psychologist with complete ("advanced" or "level II") training in EMDR. The duration of the EMDR treatment was 11 months. The introductory phase lasted three months, and started at the time Peter had spent ten months in group therapy. The actual EMDR sessions took the eight following months to complete. The frequency of appointments was once every two weeks but Peter regularly cancelled sessions. A couple of times he reported ill. When the EMDR sessions were getting more demanding, he skipped a couple of sessions in a row. A holiday break of the therapist delayed the treatment further.

Sessions 1–3: 'I Asked for it Myself'

The initial target was an experience where Peter was 14 years old, and was forced for the first time to orally stimulate a man aged over 50. According to the EMDR protocol, a negative cognition (NC) needs to be selected expressing a dysfunctional self-appraisal and a positive cognition (PC) is formulated to be used as a replacement. Establishing a NC that meets the criterion was difficult, as Peter could not come up with any other belief than 'I am a curious person.' Finally, it was decided to go along with this NC and the desensitization process and not to formulate a PC, as this would not make sense. It was expected that the EMDR process itself would develop in a constructive manner. At the start of the desensitization, Peter rated the SUDS at 7. The course of SUDS ratings of each EMDR session is given in Figure 1. Over the first three EMDR sessions, Peter's SUDS dropped from 7 to 0. During the desensitization process, Peter remembered an astounding quantity of sexual experiences with grown-up men during his adolescent years. Some of these men took erotic pictures of him and published them in magazines. They also proposed to him to work for them as a male prostitute. In the beginning, Peter continued to believe that he had consented to all of these activities out of his own sexual curiosity. However, the EMDR process did bring up vivid feelings in him of being shocked and forced into his first sexual encounter. He realized that at that time, he was looking for a caring father figure, rather than for a sex partner. Peter stated that this man taught him that sex between people with a large age difference is acceptable. He believed that he would not have accepted this notion if the man had been convicted for what he had done to him. As the desensitization process continued, Peter started talking about a much earlier incident of sexual abuse when he was 7 years old. This, he was quite clear about, happened against his will.

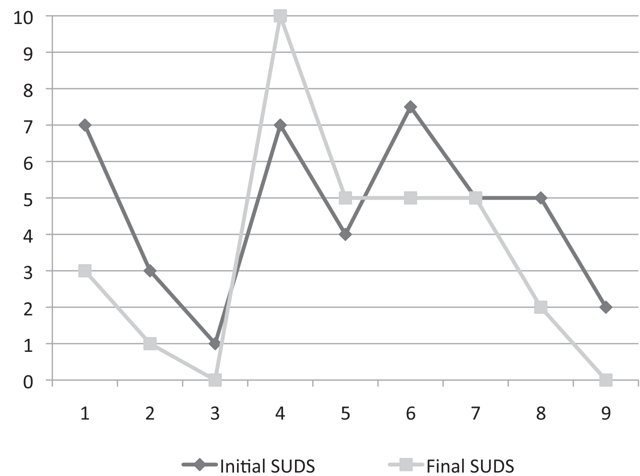


FIGURE 1 Course of SUDS ratings EMDR sessions 1 to 9.

Sessions 4–6: 'Adults can't be Trusted'

After the first memory lost all emotional stress, the focus was transferred to Peter's earlier memories. The target memory was an event in which Peter was forced to manually stimulate an aged adult man who lived in his neighborhood. This time, it was possible to identify a suitable NC and PC as the protocol prescribes. The NC was 'I am weak.' The PC was 'I am able to defend myself.' The desensitization process during these sessions developed in an unusual and opposite manner. The SUDS started at 7 but raised during the desensitization to end at maximum level (10). This means that at the end of the EMDR session, the memory caused Peter more distress than at the beginning of the session. Apparently, this memory was highly painful for Peter. The following session

Downloaded by [Nina ten Hoor] at 02:52 31 May 2013

Downloaded by [Nina ten Hoor] at 02:52 31 May 2013

the SUDS raised and dropped during the desensitization to end one point higher than the starting point. Between the sessions, the memory now caused Peter considerable distress. He repeatedly stated that he regretted ever having started the EMDR treatment. He talked about quitting EMDR treatment in his therapy group, but he was persuaded by his fellow group members to continue. The EMDR treatment seemed to make Peter more conscious of his victimization and his accompanying feelings, which he had earlier managed to detach himself from. Meanwhile, he appeared to gain a much clearer understanding of the psychological significance of sexual abuse. His comprehension of the differences in power between a child and an adult, and of the manipulation of the child that resulted from this, seemed to be in development. He talked a lot about his loneliness at that time, not having caring parents around with whom he could have shared his experience. He stated that he had assumed an adult lifestyle very early in life. Also, he stated that it was then that he had learned not to trust adults anymore, and to never let them near him in an emotional way. These feelings of emotional isolation seemed to be upsetting him the most. In session 6, a regular pattern developed again with end SUDS below starting SUDS. Around that time, the therapy group saw Peter become more open and involved with the therapy. He considered disclosing his sexual abuse history to his sisters. Peter had always kept his sexual history secret to his family.

Sessions 7–9: 'I am only Worthy of being Cared about for Sexual Purposes'

The desensitization process concerning the early abuse at age 7 continued. Peter remembered how repelling it was for him to have sex with someone who was that much older. He said that if he had remembered that while he was making contact with his own victim, he would not have proceeded with his offense. The SUDS started at 5 and ended at the same level. A central theme that arose during the session appeared to be that of guilt. Peter was convinced that his victimization was his own fault because in his view, he did not resist adequately. In the next session, the SUDS dropped from 5 to 2. The EMDR procedure helped Peter to process his feelings of guilt by adopting different perspectives, e.g., a more objective stance and the viewpoint of the adult person. This enabled him to overcome his feelings of inadequacy and guilt. Once these convictions ceased, Peter described a feeling as if 'everything fell into place.' He spontaneously related his experiences at age 7 to his later experiences at age 14. He perceived both situations clearly as forms of sexual abuse. Even though he still held pleasurable memories from his experiences at age 14, he could simultaneously acknowledge that his perpetrator used him as a sexual object. He understood how he grew into confusing sex with love. Also, new memories came up of adequate love and attraction he felt in his adolescent years towards persons of his own age. He talked about his new insight in the group and to his parole officer. He was able to give a clear and convincing account of harmful effects that both events had on him. He came to perceive his love life as an adult as poor and unfulfilling. He started to consider his adulthood as being a period in which a lot of time had been wasted on superficial sexual contacts. He wanted to change his ways and somehow, in the future he had left, make up for what he now knew he had missed. In the final session the SUDS dropped from 2 to 0. The following positive cognitions (PC) were installed: 'I am able to defend myself' and 'I am worthy of real love and care.' Peter rated the Validity of these Cognitions (VOC) at respectively 7 and 6 on a 1–7 scale with 1 representing 'feels completely false' and 7 equaling 'feels completely true.'

Participant Evaluation

After completing the EMDR sessions, Peter wrote the following evaluation:

> As a result of the two fingers that move back and forth in front of your eyes, one goes far back in time. I suddenly felt like a boy aged 7. Something that I hadn't given a moment's thought to for 49 years came up like living images on a television screen.
>
> EMDR was a revelation for me. From my childhood years on, I have been able to clarify matters. Some sessions were difficult, but at the end I felt that it had made me feel 'lighter.' A burden from my past was gone. I have always been a very reticent person. I am now more able to share my problems with others. I feel more free and comfortable around others.
>
> It is much easier for me now to put myself in the place of my victim. I know from my own experience that at age 14, one is not mature in a physical or mental way. I can fully declare that I myself was abused, both at age 7 and at age 14. Because of this, I also understand that I was wrong myself. I never want to have sex again with someone under 18 years old. I noticed that I look less at adolescents. I have distanced myself from it.
>
> In group therapy, it is harder to grasp these issues. EMDR deals with one's own experiences on a more profound and detailed level. It feels safer to do this on a one-to-on basis, instead of in a group setting. Personally, I feel that 70% of my progress can be accounted for by the EMDR treatment.[1]

Follow-up

Peter continued his group therapy for three more months after finishing the EMDR sessions. His group members and the group therapists experienced him as being more responsive. However, he decided to end treatment at the moment he completed two years in group therapy, the regular duration of attendance. To monitor the effects of his treatment, Peter was interviewed on two occasions: at six months follow-up and at twelve months follow-up after ending the EMDR treatment. During his EMDR sessions, Peter stopped all multiple

Downloaded by [Nina ten Hoor] at 02:52 31 May 2013

sexual contacts because it made him feel like a sexual object. At both follow-up moments, he was still refraining from engaging in impersonal sex. Peter expressed a need for a more emotionally intimate relationship at the end of his treatment. At six months follow-up, Peter had met a 42-year-old man with whom he was considering to start an intimate relationship. At 12 months follow-up, however, he had not seen this man in six months. Peter said that he had developed a skin eruption and felt unattractive and ashamed. He also claimed not to feel a sexual need so much any longer. He stated he was quite happy to stay single. As far as his closeness to family and friends goes, a similar pattern became apparent. At the end of treatment, Peter had become more open towards others and wanted to inform his family about his early abuse. He had already told a friend about it. At six months follow-up, he was arranging a family meeting to improve family bonds. He said that prior to treatment, this would have been something that would make him anxious, but now he was looking forward to it. At 12 months follow-up, it became clear that Peter had not succeeded in arranging the meeting. The bond he experienced with his family was not any different from the way it had been prior to treatment. After the EMDR treatment and at both follow-up occasions, Peter stated that he considered himself to be a victim of sexual abuse both at age 7 and 14. His opinion about his own victimization had not changed during the follow-up period.

DISCUSSION

Only three months after finishing the EMDR sessions, Peter decided to end his group therapy. In the author's opinion, this was far too early to be able to work on his newly formed goals to strengthen family bonds and to seek an intimate relationship. Three months later (at six months follow-up), he could still approve of these goals but at 12 months follow-up these needs appeared to have vanished. It also seemed that Peter had slipped back into behavior patterns he held prior to treatment. Hence, it seems important to start EMDR early in treatment so that enough time is available to fully benefit from the results in the further treatment process. The duration of mandatory forensic treatment is often restricted by the Court's verdict, at least it is in the Netherlands. After cognitive distortions have diminished, it is argued by the author that offenders need to anchor their progress in new behavioral skills in order to prevent them from falling back into their old behavioral repertoire.

Due to frequent cancellations, the EMDR sessions took a longer time to complete (nine sessions over a period of eight months). While this frequency is not optimal, studies have shown that the effects of single EMDR sessions generally last over time (e.g., Nijdam et al., 2012; Wilson, Becker, & Tinker, 1995). The course of SUDS ratings depicted in Figure 1 confirms this assumption. In the first and last sessions, the final SUDS scores of each session correspond with the initial SUDS scores of the next session. Only in the middle part of the treatment, when the earlier memories of abuse are processed, the SUDS scores deviate from this.

When we take a look at the EMDR process more closely, the first three EMDR sessions appear to have been less productive in treating cognitive distortions than the later ones, which concern the earlier abuse. An interesting coincidence might be that at the beginning of the EMDR process, establishing a suitable NC and PC failed. This may suggest that cognitive distortions need to be addressed in conjunction with the events that created them and lie at the base of their development. However, the first three sessions did function as a prerequisite for enabling this, as they seemed necessary to gain access to the earlier memories. One can raise questions about the truthfulness of these earlier memories of abuse, and the possibility of the memories being false. In EMDR, however, it is not uncommon for participants to gain access to specific memories from the past. Experimental memory studies have shown evidence that the eye movements in EMDR induce a neurobiological change in the interhemispheric interaction which enhances the retrieval of episodic memories (Christman et al., 2003; Christman, Propper, & Brown, 2006).

It is significant that the course of SUDS levels showed quite a distinctive pattern while processing the early memories of abuse with end SUDS scores raising above starting SUDS scores. This might be accounted for by the fact that the event, in the beginning, did not cause much distress to Peter. The EMDR process may have worked here as a tool for overcoming emotional numbness. As the level of his distress raised, there seemed to develop a therapeutic opening in which previously held cognitive assumptions could be challenged. Similar results were found in a case study of an incestuous sex offender (Ricci, 2006). Here the duration of EMDR treatment was also lengthy (12 sessions) and involved a process in which past traumatic memories became more accessible. In these cases, readiness for EMDR and managing distress coping during treatment are important factors to consider when adjuncting CBT-RP with EMDR.

In general, the results of this case study correspond with the findings of the quantitative study by Ricci and colleagues (2006) and the qualitative analysis by Ricci and Clayton (2008) which indicate that the EMDR process can lead to a recognition in the sex offender of the contributors to distorted beliefs, a higher level of accountability, an increase of the offender's participation in group therapy, increased empathy, and an increased clarity in the perception of the offender's own victimization. Other studies using EMDR as an additive to sex offender treatment (Datta & Wallace, 1994; Finley, 2002) also showed an enhancement of victim empathy and a reduction in justifications for offender behavior. The Finley study, however, failed to establish a change in cognitive distortions or immaturity and treatment attitudes. Because the study only involved three EMDR sessions, it may be hypothesized that this number of sessions may not

be sufficient to address the more deeply embedded emotional issues stemming from early childhood trauma (Finley, 2002).

Distorted beliefs and behaviors may not be deliberate or conscious, but rather the manifestation of the perspective inherent in the stored memories of the childhood abuse (Shapiro, 2001). These distorted cognitions can emerge during the course of the EMDR treatment (Ricci & Clayton, 2008) and may not be apparent at the start of treatment. Because of this, determining beforehand what type of cognitive distortions will be eligible for EMDR treatment can be difficult. At least a hypothesized etiologic connection between the childhood victimization of the offender, and his offense pattern later in life, seems important. The results of these studies suggest that the benefits of EMDR treatment are not dependent on whether or not the participant perceives his childhood sexual abuse as problematic. Another factor to consider in the treatment matching is the presence of early and deviant sexual experiences in childhood, which are difficult for the offender to discuss and which seem to interfere with the ability to reflect on the offense cycle.

In his own commentary, Peter pointed out that he greatly appreciated and benefited from the possibility to work on his trauma in an individual setting. Graham (1996) confirms this by stating that it is not easy for offenders to share their sexual victimization, especially in group sessions. Freeman-Longo (1986) mentioned: 'the offender is often more troubled by disclosing what has happened to him than to discuss what he had done sexually to others.'

A limitation of this case study is the lack of control for other variables such as time, the addition of individual sessions to group-based treatment, or the continuing group sessions themselves. Any improvement could be (in part) due to these factors. It is also not clear whether trauma treatment in general is responsible for the treatment effects, rather than some specific aspects of EMDR. Considering the modest treatment gains when external or objective outcomes are taken into account, there remains the possibility of a placebo effect. A further methodological weakness is the absence of questionnaires directly measuring cognitive distortions. However, the measurement of cognitive distortions still faces practical concerns like bias caused by socially desirable response tendencies (Kolton, Boer, & Boer, 2001; Langevin, 1991), or problems with measuring deep implicit beliefs and schemas, rather than shallow cognitive phenomena such as denial and excuse-making that may emerge post-offense (Ó Ciardha & Gannon, 2011). Deviant sexual arousal is another variable that has not been measured because in this case, the participant information did not give any indication that this factor constituted a specific risk factor. In future studies however, both factors should be included in the research design.

The application of EMDR in the treatment of sex offenders is only recently developing. With this single-case study a novel approach is presented for the treatment of cognitive distortions in offenders who have been victimized in their own childhood. In practice, cognitive distortions can be very difficult to work with, and they can form barriers preventing progress in treatment. Their presence is assumed to be an important risk factor for sexual reoffending. This study illustrates how EMDR can make a valuable contribution by resolving cognitive distortions and enhancing involvement in further treatment. In order to represent an advance in exploring the utility of these techniques, the pursuit of this kind of work with larger scale quantitative research is necessary.

NOTE

1. This commentary was originally written in Dutch by the participant, at the end of his group treatment, three months after his last EMDR session. Consent to publish in English translation was received.

Downloaded by [Nina ten Hoor] at 02:52 31 May 2013

REFERENCES

Abel, G. G., Becker, J. B., & Cunningham-Rathner, J. (1984). Complications, consent and cognitions in sex between children and adults. *International Journal of Law and Psychiatry*, *7*, 89–103. doi:10.1016/0160-2527(84)90008-6

American Psychiatric Association (APA) (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision). Washington, DC: APA.

Anderson, D., & Dodgson, P. G. (2002). Empathy deficits, self-esteem, and cognitive distortions in sexual offenders. In Y. M. Fernandez (Ed.), *In their shoes: Examining the issue of empathy and its place in the treatment of offenders* (pp. 73–90). Oklahoma City, OK: Wood "N" Barns Publishing.

Andrews, D. A., & Bonta, J. (2007). *The psychology of criminal conduct* (4th ed.). Cincinnati: Anderson.

Becker, J. V., & Murphy, W. D. (1998). What we know and do not know about assessing and treating sex offenders. *Psychology, Public Policy and Law*, *4*(1/2), 116–137. doi:10.1037/1076-8971.4.1-2.116

Bisson, J. I., Ehlers, A., Matthews, R., Pilling, S., Richards, D., & Turner, S. (2007). Psychological treatments for chronic post-traumatic stress disorder: Systematic review and meta-analysis. *British Journal of Psychiatry*, *190*, 97–104. doi:10.1192/bjp.bp.106.021402

Boudewyns, P. A., & Hyer, L. A. (1996). Eye movement desensitization and reprocessing (EMDR) as treatment for post-traumatic stress disorder (PTSD). *Clinical Psychology and Psychotherapy*, *3*, 185–195. doi:10.1002/(SICI)1099-0879(199609)3:3<185::AID-CPP101>3.0.CO;2-0

Bradley, R., Green, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry*, *162*(2), 214–227. doi:10.1176/appi.ajp.162.2.214

Bumby, K. (1996). Assessing the cognitive distortions of child molesters and rapists: Development and validation of the MOLEST and RAPE scales. *Sexual Abuse: A Journal of Research and Treatment*, *8*, 37–54. doi:10.1007/BF02258015

Burn, M. F., & Brown, S. J. (2006). A review of the cognitive distortions in child sex offenders: An examination of the motivations and mechanisms that underlie the justification for abuse. *Aggression & Violent Behavior*, *11*, 225–236. doi:10.1016/j.avb.2005.08.002

Cahill, S. P., Carrigan, M. H., & Frueh, B. C. (1999). Does EMDR work? And if so, why?: A critical review of controlled outcome and dismantling research. *Journal of Anxiety Disorders*, *13*, 5–33. doi:10.1016/S0887-6185(98)00039-5

Christman, S. D., Garvey, K. J., Propper, R. E., & Phaneuf, K. A. (2003). Bilateral eye movements enhance the retrieval of episodic memories. *Neuropsychology*, *17*, 221–229. doi:10.1037/0894-4105.17.2.221

Christman, S. D., Propper, R. E., & Brown, T. J. (2006). Increased interhemispheric interaction is associated with earlier offset of childhood amnesia. *Neuropsychology*, *20*, 336–345. doi:10.1037/0894-4105.20.3.336

Craissati, J., McClurg, G., & Browne, K. D. (2002). Characteristics of perpetrators of child sexual abuse who have been sexually victimized as children. *Sexual Abuse: A Journal of Research and Treatment*, *14*, 225–240. doi:10.1023/A:1015318408395

Datta, P. C., & Wallace, J. (1994). *Treatment of sexual traumas of sex offenders using eye movement desensitization and reprocessing*. Paper presented at the 11th Annual Symposium in Forensic Psychology, San Francisco.

Davidson, P. R., & Parker, K.C.H. (2001). Eye movement desensitization and reprocessing (EMDR): a meta-analysis. *Journal of Consulting and Clinical Psychology*, *69*, 305–316. doi:10.1037/0022-006X.69.2.305.

Davis, J. L., & Petretic-Jackson, P. A. (2000). The impact of child sexual abuse on adult interpersonal functioning: A review and synthesis of the empirical literature. *Aggression and Violent Behavior*, *5*, 291–328. doi:10.1016/S1359-1789(99)00010-5

Finley, P. (2002). Eye movement desensitization and reprocessing (EMDR) in the treatment of sex offenders. *Dissertation Abstracts International*, *63*(10), B. (UMI No. 3068413).

Freeman-Longo, R. (1986). The impact of sexual victimization on males. *Child Abuse and Neglect*, *10*(3), 411–414. doi:10.1016/0145-2134(86)90017-7

Freud, K., & Kuban, M. (1994). The basis of the abused abuser theory of pedophilia: A further elaboration of an earlier study. *Archives of Sexual Behavior*, *23*(5), 553–563. doi:10.1007/BF01541497

Garland, R., & Dougher, M. (1990). The abused/abuser hypothesis of child sexual abuse: A critical review of theory and research. In J. Fierman (Ed.), *Pedophilia: Biosocial dimensions* (pp. 488–509). New York: Springer Verlag.

Graham, K. R. (1996). The childhood victimization of sex offenders: An underestimated issue. *International Journal of Offender Therapy and Comparative Criminology*, *40*(3), 192–203. doi:10.1177/0306624×9604000303

Graig, L. A., Browne, K. D., & Stringer, I. (2003). Treatment and sexual offence recidivism. *Trauma, Violence, and Abuse*, *4*, 70–89. doi:10.1177/1524838002238946

Groth, N. (1979). Sexual trauma in the life histories of rapists and child molesters. *Victimology: An International Journal*, *4*(1), 10–16.

Hanson, R. K., Gizzarelli, R., & Scott, H. (1994). The attitudes of incest offenders: Sexual entitlement and acceptance of sex with children. *Criminal Justice and Behavior*, *21*, 187–202. doi:10.1177/0093854894021002001

Hayashino, D. S., Wurtele, S. K., & Klebe, K. J. (1995). Child molesters: An examination of cognitive factors. *Journal of Interpersonal Violence*, *10*, 106–116. doi:10.1177/088626095010001007

Hudson, S. M., Wales, D. S., Bakker, L., & Ward, T. (2002). Dynamic risk factors: The Kia Marama evaluation. *Sexual Abuse: A Journal of Research and Treatment*, *14*, 103–119. doi:10.1177/107906320201400203

James, B. (1989). *Treating traumatized children: New insights and creative interventions*. Lexington, MA: Lexington Books.

Jeffries, F. W., & Davis, P. (2012). What is the role of eye movements in eye movement desensitization and reprocessing (EMDR) for post-traumatic stress disorder (PTSD)? A review. *Behavioural and Cognitive Psychotherapy*, 1–11. doi:10.1017/S1352465812000793

Kaplan, D. M., Smith, T., & Coons, J. (1995). A validity study of the subjective unit of discomfort (SUD) score. *Measurement and Evaluation in Counseling and Development*, *27*, 195–199.

Kim, D., Bea, H. & Park, Y. C. (2008). Validity of the subjective units of disturbance scale in EMDR. *Journal of EMDR Practice and Research*, *2*, 57–62. doi:10.1891/1933-3196.2.1.57

Kolton, D. J. C., Boer, A., & Boer, D. P. (2001). A revision of the Abel and Becker Cognition Scale for intellectually disabled sexual offenders. *Sexual Abuse; A Journal of Research and Treatment*, *13*, 217–219. doi:10.1177/107906320101300306

Langevin, R. (1991). A note on the problem of response set in measuring cognitive distortions. *Annals of Sex Research*, *4*, 287–292. doi:10.1007/BF00850059

Lee, C.W. (2008). Crucial Processes in EMDR: More than imaginal exposure. *Journal of EMDR Practice and Research*, *2*(4), 262–268. doi:10.1891/1933-3196.2.4.262

Lee, C. W., & Cuijpers, P. (2013). A meta-analysis of the contribution of eye movements in processing emotional memories. *Journal of Behavior Therapy and Experimental Psychiatry*, *44*(2), 231–239. doi:10.1016/j.jbtep.2012.11.001

Lisak, D. (1994). The psychological impact of sexual abuse-Content analysis with male survivors. *Journal of Traumatic Stress*, *7*(4), 525–548. doi:10.1007/BF02103005

MacCulloch, M. (2006). Effects of EMDR on previously abused child molesters: Theoretical reviews and preliminary findings from Ricci, Clayton, and Shapiro. *Journal of Forensic Psychiatry & Psychology*, *17*, 531–537. doi:10.1080/14789940601075760

Marshall, W. L., Marshall, L. E., & Kingston, D. A. (2011). Are the cognitive distortions of child molesters in need of treatment? *Journal of Sexual Aggression*, *17*, 118–129. doi:10.1080/13552600.2011.580572

Marshall, W. L., Marshall, L. E., Serran, G. A., & Fernandez, Y. M. (2006). *Treating sexual offenders: An integrated approach*. London: Routledge.

Marshall, W. L., Serran, G. A., Fernandez, Y. M., Mulloy, R., Mann, R. E., & Thornton, D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behavior change. *Journal of Sexual Aggression*, *9*, 25–30. doi:10.1080/355260031000137940

National Collaborating Centre for Mental Health. (2005). *Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care*. London: National Institute for Clinical Excellence.

Nijdam, M. J., Gersons, B.P.R., Reitsma, J. B., De Jongh, A., & Olff, M. (2012). Brief eclectic psychotherapy v. eye movement desensitisation and reprocessing therapy for post-traumatic stress disorder: randomised controlled trial. *British Journal of Psychiatry*, *200*(3), 224–231. doi:10.1192/bjp.bp.111.099234

Ó Ciardha, C., & Gannon, T. A. (2011). The cognitive distortions of child molesters are in need of treatment. *Journal of Sexual Aggression*, *17*, 130–141. doi:10.1080/13552600.2011.580573

Ricci, R. J. (2006). Trauma resolution using eye movement desensitization and reprocessing with an incestuous sex offender: An instrumental case study. *Clinical Case Studies*, *5*(3), 248–265. doi:10.1177/1534650104265276

Ricci, R. J., & Clayton, C. A. (2008). Trauma resolution treatment as an adjunct to standard treatment for child molesters: A qualitative study. *Journal of EMDR Practice and Research*, *2*(1), 41–50. doi:10.1891/1933-3196.2.1.41

Ricci, R. J., Clayton, C. A., & Shapiro, F. (2006). Some effects of EMDR on previously abused child molesters: Theoretical reviews and preliminary findings. *The Journal of Forensic Psychiatry & Psychology*, *17*(4), 538–562. doi:10.1080/14789940601070431

Schubert, S., & Lee, C. W. (2009). Adult PTSD and its treatment with EMDR: a review of controversies, evidence, and theoretical knowledge. *Journal of EMDR Practice and Research*, *3*, 117–132. doi:10.1891/1933-3196.3.3.117

Seidler, G. H., & Wagner, F. E. (2006). Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD: A meta-analytic study. *Psychological Medicine*, *36*(11), 1515–1522. doi:10.1017/S0033291706007963

Downloaded by [Nina ten Hoor] at 02:52 31 May 2013

Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress*, *2*, 199–223. doi:10.1002/jts.2490020207

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York: Guilford Press.

Shapiro, F., & Forrest, M. S. (1997). *Eye movement desensitization and reprocessing (EMDR): The breakthrough eye movement therapy for overcoming anxiety, stress, and trauma*. New York: Basic.

Stermac, L. E., & Segal, Z. V. (1989). Adult sexual contact with children: An examination of the cognitive factors. *Behavior Therapy*, *20*, 573–584. doi:10.1016/S0005-7894(89)80135-2

Thyer, B. A., Papsdorf, J. D., Davis, R., & Vallecorsa, S. (1984). Autonomic correlates of the subjective anxiety scale. *Journal of Behavior Therapy and Experimental Psychiatry*, *15*, 3–7. doi:10.1016/0005-7916(84)90115-0

Ward, T. (2000). Sexual offenders' cognitive distortions as implicit theories. *Aggression and Violent Behavior*, *5*, 491–507. doi:10.1016/S1359-1789(98)00036-6

Ward, T., & Maruna, S. (2007). *Rehabilitation: Beyond the risk paradigm*. London: Routledge.

Ward, T., & Moreton, G. (2008). Moral repair with offenders. Ethical issues arising from victimization experiences. *Sexual Abuse: A Journal of Research and Treatment*, *20*(3), 305–322. doi:10.1177/1079063208322423

Ward, T., & Siegert, R. J. (2002). Toward a comprehensive theory of child sexual abuse: A theory knitting perspective. *Psychology, Crime, and Law*, *8*, 319–351. doi:10.1080/10683160208401823

Willis, G. M., & Ward, T. (2011). Striving for a good live: The good lives model applied to released child molesters. *Journal of Sexual Aggression*, *17*(3), 290–303. doi:10.1080/13552600.2010.505349

Wilson, D., Silver, S. M., Covi, W., & Foster, S. (1996). Eye movement desensitization and reprocessing: Effectiveness and autonomic correlates. *Journal of Behavior Therapy and Experimental Psychiatry*, *27*, 219–229. doi:10.1016/S0005-7916(96)00026-2

Wilson, S. A., Becker, L. A., & Tinker, R. H. (1995). Eye movement desensitization and reprocessing (EMDR) treatment for psychologically traumatized individuals. *Journal of Consulting and Clinical Psychology*, *63*(6), 928–937. doi:10.1037/0022-006X.63.6.928

Wolpe, J. (1982). *The practice of behavior therapy*. New York: Pergamon Press.

Downloaded by [Nina ten Hoor] at 02:52 31 May 2013