Evaluating the Contribution of Relapse Prevention Theory to the Treatment of Sexual Offenders

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In the last 10 years, relapse prevention (RP) has been adopted as the most popular framework for the treatment of sexual offenders. Although RP is conceptually similar to other forms of cognitive/behavior therapy, it has made an important contribution by focusing therapists' attention on the problem of long-term recidivism. In RP, posttreatment behavioral deterioration is not considered evidence that sexual offenders are untreatable; instead, lapses are considered as expected and workable problems. There are certain difficulties, however, with the application of RP to the treatment of sexual offenders. In some cases, RP has been interpreted so generally that it has had little real influence on preexisting practices. As well, it is not clear how some of the most distinctive concepts of RP (e.g., lapse/relapse, abstinence violation effect) should be applied to sexual offenders. Special efforts may also be required to convince sexual offenders that they are at risk before they are able to benefit from RP interventions.

KEY WORDS: cognitive/behavioral therapy; relapse prevention; risk assessment; sexual offender recidivism.

Relapse prevention (RP) began as an approach to the treatment of alcohol abuse (Marlatt & Gordon, 1985) and was subsequently adapted to the treatment of sexual offenders (Laws, 1989). In 1985, when the State of California decided to evaluate a state-of-the-art treatment program, they selected a program based on RP theory (Marques, Day, Nelson, & Miner, 201)
Almost all current treatment programs for sexual offenders include some components of RP theory (Knopp, Freeman-Longo, & Stevenson, 1992; Wormith & Hanson, 1992). Laws (1995a) has argued that RP is a sufficiently distinct and comprehensive approach that it can stand alone as a general theory of therapy. This apparent revolution in the treatment of sexual offenders justifies a careful examination of the contribution of RP theory.

Choosing criteria for evaluating theories is in itself a difficult theoretical question (Meehl, 1978; Musgrave & Lakatos, 1970; Rorty, 1979). Without pretending to contribute to the broad epistemological debates, I would suggest that there are two broad criteria for evaluating theories of therapy. The first criterion is the extent to which the theory describes and organizes existing knowledge. A good theory should clearly describe what is believed to be true. No single piece of information can validate or invalidate a theory; instead, the empirical validity of theories can only be evaluated by an organized set of observations or findings (Lakatos, 1970). A second criterion for theories of therapy is that they should provide direction on how to intervene. It is not enough to describe or predict accurately a sexual offender's behavior; a good theory of therapy needs to provide suggestions on how sexual offenders can change. Theories need to be able to explain the strengths and weaknesses of existing practices, as well as to suggest new techniques that should work.

When evaluating the contribution of RP theory to the treatment of sexual offenders, one initial consideration is the extent to which RP is saying anything new. RP theory contains specialized language and many innovative treatment techniques, but the approach remains solidly rooted in traditional social learning–cognitive/behavioral theory (e.g., Beck, Rush, Shaw, & Emery, 1979; Meichenbaum, 1977). The basic concepts of dysfunctional behavior as learned habits, situational influences, unrecognized consequences of decisions, and behavioral chains are all standard features of cognitive/behavioral therapies (Rimm & Masters, 1979; Thoresen & Mahoney, 1974; Wilson & O'Leary, 1980). RP cannot be considered as a substantially new approach to treatment (as Jung was to Freud); instead, RP can make the more modest claim to be an innovative application of cognitive/behavioral theory to impulse control disorders (Marlatt, 1985).

The rapid adoption of RP to the treatment of sexual offenders can be partly attributed to its promise to address the problem of sexual offender recidivism. By the 1980s, there were a number of studies showing that the recidivism rate of "successful" graduates of treatment programs was unacceptably high (see review by Furby, Weinrott, & Blackshaw, 1989). Clinicians were becoming increasingly skeptical that any single treatment could "cure" sexual offenders. To quote from Laws' summary comments at the