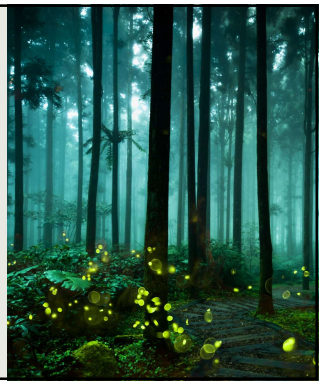
Sex Offense-Specific Treatment: Learning (And Re-Learning) the Basics

Bud Ballinger, Ph.D



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Evolution of Treatment

Everyone referred for/mandated for sex offense-specific treatment was treated with the same type of program (relapse prevention). They developed a cycle of abuse and a relapse prevention cycle that let them know all of the things that they were not supposed to do to avoid risk. Everyone learned about victim impact/empathy. Underlying assumption was that unhealthy sexual behavior was a repetitive pattern for all participants. This model was not effective.

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Relapse Prevention

Strategy intended to help an offender identify Internal/external factors associated re-offending

- Conceptualizes behavioral patterns as a "cycle"
- Goal = learn to identify the "cycle" and intervene

Originally designed for substance abusers in order to help them maintain treatment gains and avoid relapsing

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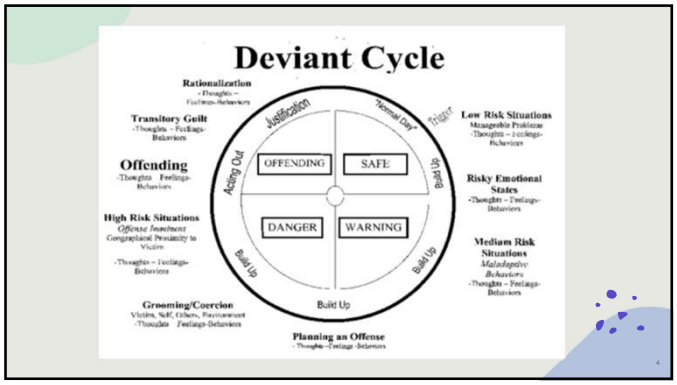

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Problems with Relapse Prevention

RP for sex offense programs used as a primary treatment modality, rather than an adjunct to successful treatment/change

Excessive focus on avoidance goals.

RP IS NOT A PRIMARY TREATMENT APPROACH

- Not designed to stop problem behavior
- Not designed to persuade individual that he should abstain from the problem behavior
- Not developed for individuals whose "commitment" to abstain is externally imposed
- Used as a "One Size Fits All" approach

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Old School Sex ~~Offender~~ Offense Specific Treatment

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Old School Sex Offender Treatment

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Old School

Relied heavily on Relapse Prevention and confrontation

Lack of confidence in participants' ability to regulate their behaviors

"Breaking through denial" essential to treatment.

Deniers discharged from treatment

Full and complete disclosure akin to the Holy Grail

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Evolution of Treatment

Cognitive-Behavioral techniques (mostly cognitive) were added to the relapse prevention model to address offense-supportive cognitions and beliefs. Distorted thoughts identified and replaced with more accurate/pro-social cognitions. Treatment demonstrated to reduce recidivism.

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Cognitive Behavioral

Goal is to identify and address maladaptive beliefs which underlie unhealthy and harmful patterns of thinking and behavior.

Heavy emphasis on cognitive distortions/criminogenic thinking

Advantage: Everyone who went to graduate school in a mental health discipline in the last 30 years already has CBT training

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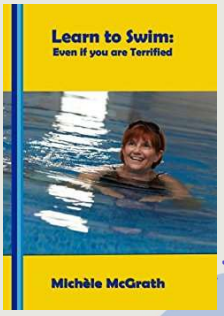
Is it
Cognitive Behavioral
Or
Cognitive Behavioral?

Providing opportunities for skills practice is essential.



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Thinking Distortions Assignment:

After carefully reading the Thinking Distortions:

1. Select the ten that you use the most frequently.
2. Rank them in order of the one you use the most, the second most, and so on.
3. For each of the ten, write out what you think they are in your own words.

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Thinking Distortions Assignment:

4. For each, write out three times you have used it:

   A. The first time you can remember having used it.

   B. How you used it in connection with your sexual offenses (the thinking distortions you use most are very likely to have been used in your offenses).

   C. The most recent time you used it.

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Thinking Distortions Assignment:

5. Explain the costs and benefits of using this thinking distortion.

6. Describe a strategy to reduce your use of that Thinking Distortion.

7. Once group members have presented this assignment, you will be expected to help point out to them when you see them using these Thinking Distortions. You will also be expected to be open to hearing feedback from your group members when you are using them.

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Evolution of Treatment

Risk-Needs-Responsivity integration. Improvements in risk assessment allowed for stratified treatment interventions/supervision based on level of risk. RNR adherent programs produced stronger results.

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RNR: Assessment Guides Treatment

Programs using the elements of the RNR framework are more effective than those who do not.

RNR highlights the need to individualize treatment to maximize the effectiveness of interventions.

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RNR: Assessment Guides Treatment

Risk: Assess static and dynamic risk using a validated instrument.

Needs: Determine treatment needs based on the risk assessment to develop an intervention plan targeting meaningful, risk-relevant factors.

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RNR: Assessment Guides Treatment

Responsivity: Assess individual characteristics that will need to be accounted for in your delivery of intervention and make adjustments that are responsive to those individual characteristics.

Treatment plan should flow directly from risk assessment and prioritize identified needs.

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Evolution of Treatment

Dynamic Risk Factors identified and added to risk assessment. DRF's considered during treatment, but treatment programs still largely using manualized approaches and one-size fits all (within risk groups). Outcome research indicates that reductions in DRF's during treatment improves outcomes.

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Evolution of Treatment

Integration of approach goals. Borrowing from positive psychology and general psychotherapy literature, Good Lives Model helps to shift focus from avoidance of negative behaviors to attainment of positive goals.

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Avoidance vs. Approach Goals

Avoidance Goals:

Focus is to **not achieve** or to avoid an undesired outcome - All the things you can't do

Individual is anxious or fearful about possibility of undesired outcome

Associated with negative emotional states

Psychological distress + increased mental effort/vigilance = impairment of ability to self-regulate in stressful situations

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Avoidance vs. Approach Goals

Approach Goals:

Focus is to **achieve** a desired outcome – What do I want? How do I get it?

Individual anticipates possibility of desired outcome

Associated with positive emotion states

Reduced mental effort + lower levels of psychological distress = less effect on self-regulation

Motivate individual to achieve desired outcomes

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Self-Regulation/ Good Lives Model

Assists offenders to:

- identify values and important goods (needs)
- understand the relationship between their unmet needs and sexual offending
- develop strategies to obtain these goods using healthy methods

Offenders will be less likely to re-offend if they learn more appropriate ways to meet their needs (e.g., leisure activities, social needs, sex, etc.)

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Evolution of Treatment

Highly individualized treatment tailored to each participant's overall level of risk and individual profile of dynamic risk. Treatment specifically targets those factors with interventions likely to produce results. If attending to dynamic risk factors within the framework of conventional treatment improves results, targeting them deliberately is likely to provide more benefit.

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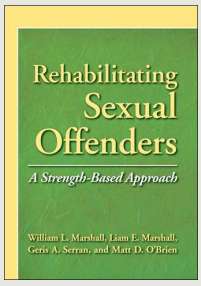
Required Reading



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Marshall, et al 2011

William Marshall and colleagues' approach:

- Motivational
- Strength-based
- Emphasizes warmth, empathy, and support for offenders
- Presents criminogenic factors to clients as targets for the development of strengths as opposed to simply deficits to be overcome.

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Starting Point

Your program:

Uses effective sex offense specific interventions (i.e. CBT)

Is RNR adherent

Develops effective working relationships

Wants to grow.

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Personal Ad?

Mature SOTP - strong CBT and RNR, enjoys Dynamic Risk Factor play, long talks in the group room, and strong working alliances. Seeking growth, improved outcomes, and possible long-term relationship with best practices. (No smokers, drug users, or RP programs please).

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Applying RNR: Risk

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Risk Assessment

Risk Assessment forms the basis for all that is to come in treatment and supervision

Better risk assessment leads to more successful treatment and supervision

Becoming appropriately **trained in the use of an established measure** and obtaining supervision/consultation to ensure consistent scoring is essential.

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Static Risk Assessment

Static variables are generally historical, unchangeable variables

Provides a baseline for risk for future arrest or conviction for new offenses

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Static Risk Assessment

Most commonly used instrument to assess Static Risk is Static-99/99R

Categorizes offenders' risk as

- Very low
- Below average
- Average
- Above average
- Well above average

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Static-99 risk factors

- **Age**
- **Ever Lived With A Lover For 2 Years**
- **Prior Non-sexual Violence**
- **Index Non-sexual Violence**
- **Prior Sex Offenses**
- **Four Or More Sentencing Dates**
- **Non-contact Sexual Conviction**
- **Stranger Victim**
- **Unrelated Victim**
- **Male Victim**

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VRS-SO

- Pre-treatment risk is assessed using 7 static & 17 dynamic variables

- The sum of the total static and pre-treatment dynamic variable scores is the pre-treatment level of risk.

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VRS-SO Static Factors

- Age at time of release
- Age at first sexual offense
- Sexual offense victim profile
- Prior sexual offenses
- Unrelated victims
- Number and gender of victims
- Prior sentencing dates

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Dynamic Risk Factors

(criminogenic needs, psychological risk factors)

Individual characteristics that:

- Influence the ways people interact their environment
- Are meaningfully related to sexual recidivism
- Are possible to change with effortful intervention

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Dynamic Risk Factors

SEXUAL SELF-REGULATION

- Sexual Preoccupation
- Deviant Sexual Interests
- Poor Coping/Using Sex to Cope (promising)

(Mann et al. 2010)

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Dynamic Risk Factors

- **Antisocial Orientation**
  - Grievance Thinking – Hostility
  - Offense Supportive Attitudes (Cognitive Distortions)
  - Resistance to Rules and Supervision
  - Machiavellianism
  - Negative Social Influences
  - Hostility toward Women
  - Lack of Concern for Others

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Dynamic Risk Factors

- **GENERAL SELF-REGULATION**
  - Impulsivity
  - Grievance Thinking
  - Poor Cognitive Problem Solving Skills
  - Emotion Management Deficits
  - Substance Use

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Dynamic Risk Factors

INTIMACY DEFICITS

- Hostility toward Women (promising)
- Lack of Adult Intimacy/Conflicts in Intimate Relationships
- Emotional Identification with Children

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Factors NOT related to risk reduction

Major mental illness
Low Self-Esteem
Depression
Poor social skills
Victim Empathy
Lack of motivation
Denial

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VRS-SO Dynamic Factors

Sexual Deviance:

- Sexually deviant lifestyle
- Sexual compulsivity
- Offense planning
- Sexual offending cycle
- Deviant sexual preference

Criminality

- Criminal personality
- Interpersonal aggression
- Substance Abuse
- Community support
- Impulsivity
- Compliance with community supervision

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VRS-SO Dynamic Factors

Treatment Responsivity

- Cognitive distortions
- Insight
- Released to high-risk situations
- Treatment compliance

Sad and lonely (but important) DNL's

- Emotional Control
- Intimacy Deficits

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Applying RNR: Needs

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Treatment Planning

- The overall risk level (VRS-SO Static + dynamic items) will determine treatment intensity.
- Use the results of the dynamic risk assessment to identify specific treatment targets. (e.g. score of 2 or 3 on VRS-SO).

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Treatment Planning

- Review risk factors identified as treatment needs.
- Formulate individualized treatment plan that incorporates those factors
- Discuss with client their personal goals and priorities
- Negotiate mutually agreeable, risk-relevant treatment targets/interventions
- Assess progress, seek feedback from client

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Treatment Planning

Treatment consists of two primary components:

Sex offense specific treatment

Skill building/risk-relevant interventions

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Treatment Planning

Method of implementation of the two components and ratio between the two depends on factors such as:

- Setting
- Heterogeneity of risk among the program participants
- Size of the program
- Intensity/duration of the program (e.g. time-limited or open ended?)

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Treatment Intensity

Outpatient - Very low risk

- Consider not intervening if possible.
- Brief psychoeducational intervention to provide basic knowledge regarding consent, coercion, manipulation, respect in relationships, etc. [NOTE: this psychoeducational group can be useful as an extended evaluation because sometimes risk factors may become evident over time]

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Treatment Intensity

Outpatient – below average static risk – some dynamic factors present

- Consider not providing sex-offense specific treatment.
- Consider brief psychoeducational intervention to provide basic knowledge regarding consent, coercion, manipulation, respect in relationships, etc.
- Recommend treatment for needs related to identified DRF's.

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Treatment Intensity

Outpatient/mixed risk/ average risk

- Sex-offense specific treatment including psychoeducational intervention plus cognitive treatment targeting distorted beliefs and thoughts underlying problematic sexual behaviors.
- Treatment for needs related to identified DRF's.

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Treatment Intensity

Outpatient/mixed risk/ average risk
Options for addressing DRF's

AD1

- Adjunctive groups within the SO program in addition to or alternating with SO-specific treatment.
- Requires that you have a sufficient number of individuals with similar risk factors and sufficient staff to provide alternative programming.

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Treatment Intensity

Outpatient/mixed risk/ average risk
Options for addressing DRF's

- Integrated into programming by alternating between skill-building interventions and SO-specific modules.
- Example: Alternate in 3 month cycles between SO specific treatment and skill based programming such as DBT.
- Example: Alternate weekly between skill-based programming such as DBT and SO specific content.

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Treatment Intensity

Outpatient/mixed risk/ average risk
Options for addressing DRF's

- Referrals to existing community mental health services if available (Relationship Skills, DBT, Anger Management, Partner Violence)
- Be aware of mixing offenders and potentially vulnerable individuals. Requires collaboration with providers.

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Slide 55

AD1 I'm not exactly understanding what this would look like but it could be just me...
Alayna Davison, 10/9/2020

Treatment Intensity

Outpatient - mixed risk/average risk
Addressing DRF's

- Individual therapy.
- Guided independent study using workbooks with check-ins either in group or individually.

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Treatment Intensity

Above-Average to Well Above Average risk

- Higher intensity sex-offense specific treatment including psychoeducational interventions, cognitive treatment targeting distorted beliefs and thoughts underlying problematic behaviors, and increased focus on offense-specific interventions.
- Treatment for needs related to identified DRF's.

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Treatment Intensity

High risk –Residential/Inpatient

- Offer a varied menu of empirically informed, risk-relevant skill building interventions on a rotating basis occurring alongside sex offense specific programming.

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Treatment Intensity

High risk –Residential/Inpatient

- Provide feedback to participant regarding identified needs and relative priority.
- Collaborate with participant to choose the needs/risk factors on which they are willing to work.

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Consideration of Deniers

ATSA Practice Guidelines (13.05 – 13.08) allow, but do not explicitly require treatment of deniers.

- 13.05 - denial and minimization… need not preclude access to treatment.
- 13.06 - the influence of denial and minimization on sexual recidivism risk has not yet been clearly established and may vary among client groups.

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Consideration of Deniers

- 13.07 …it is not the role of treatment providers to attempt to determine or verify a client's legal guilt or innocence, or to coerce confessions of unreported or undetected sexually abusive behaviors.
- 13.08 …attempting to provide treatment for problems that a client persistently denies having may result in limitations in making reliable clinical recommendations about the individual's treatment progress and reoffense risk, and that this has ethical implications.

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Treatment of Deniers

- Treating individuals who categorically deny offending can reduce risk. (Marshall, et al, 2001)
- Individuals who are unsuccessfully discharged from SO specific treatment (e.g. "I won't treat you for a problem you don't have") have higher rates of recidivism.

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Treatment of Deniers

- Offering opportunities to engage in **meaningful** treatment to address needs related to identified dynamic risk factors allows for risk-relevant work in the absence of offense-specific disclosure.

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Strategies for addressing dynamic risk

- Non-Specific Therapist Factors

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Good Sex Offense Specific Therapists

If you want to be a good sex offense specific therapist, a good starting point is being a good therapist.

SO treatment is a specialized application of therapeutic skill

The most powerful part of therapy is the therapeutic relationship

There is a bigger difference between the best and worst therapists *within* treatment models than there is between treatment models

It is possible to have a relationship AND maintain firm boundaries

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Turns out we're not that special

In recent years, greater acceptance of the idea that general psychotherapy research applies to sex offense specific treatment

• Working Alliance accounts for a large portion of variance in therapeutic outcomes

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Non-Specific Therapist Factors

- Therapeutic qualities such as warmth, empathy, using the relationship to reward prosocial behaviors, developing shared/collaborative goals, and being directive/encouraging contribute to positive therapeutic outcomes.

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Non-Specific Therapist Factors

- Process of building relationship with therapist provides opportunities for novel experience with healthy relationship and modeling of boundaries/appropriate use of power.
- Provide safety for exploration of alternative thoughts and behaviors.

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Non-Specific Therapist Factors

- Building a strong working alliance that provides opportunities for feedback regarding unhealthy behaviors and ability to reward appropriate behaviors.
- Bonding and development of a strong positive group culture provides prosocial social pressure to move toward goals in healthier way.
- Strong group culture/cohesion allows for social learning through observations of peers' success.

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Non-Specific Therapist Factors

Relevant dynamic risk factors:

- Compliance with Treatment
- Compliance with Community Supervision
- Intimacy Deficits
- Interpersonal Aggression
- Insight

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Group Therapy Skills

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What do we mean by confrontation?

<<insert Gordon Ramsey video>>

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What do we mean by confrontation?

Clients have experienced unhealthy confrontation/judgement throughout their lives

Validate experiences/feelings but encourage them to consider a different perspective

Goal is to get clients to be honest about their thought processes(what lead them to make the decisions or have the thoughts/feelings they have) while considering alternative point of view

Confrontation can an important therapeutic tool when done in a manner that is empathic yet direct AND when it is used in the context of a strong relationship.

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Confrontation VS Challenging

What do you think of when you hear the word confrontation?

What about challenging?

Confrontation Clients have experienced unhealthy confrontation/judgement throughout their lives

Just telling clients something they did was wrong is not helpful

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Challenging

This is still a collaborative process

- Goal is to teach clients what they can do instead and help them raise awareness of cues, so they know when to do something different

Validate experiences/feelings but encourage them to consider a different perspective

Goal is to get clients to be honest about their thought processes(what lead them to make the decisions or have the thoughts/feelings they have) while considering alternative point of view

Confrontation is an important therapeutic tool when done in a manner that is empathetic yet direct

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Validating Experiences VS Cosigning Distortions

- How do we validate client experiences without cosigning distortions?

- Why is this important?

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Strategies for addressing dynamic risk

- Non-Specific Therapist Factors
- Sex-Offense Specific Treatment
- Dialectical Behavior Therapy (DBT)
- Cognitive Processing Therapy (CPT)
- Systems Training for Emotional Predictability and Problem Solving (STEPPS)
- Acceptance and Commitment Therapy (ACT)

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Questions to Consider for Engaging

How comfortable is this person in talking with me?

How supportive and helpful am I being?

Do I understand this person's perspective and concerns?

How comfortable do I feel in this conversation?

Does this feel like a collaborative partnership?

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Group Process

What is process?

What is a process group?

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Group Process

Processing is focusing on the here and now experience

- Interactions in the room with facilitators and other group members

When groups function well it provides social support and pressure to change

- This is something that cannot be achieved in individual therapy
- Group needs to be a discussion between all participants and not individual therapy in a group setting

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Treatment is MORE than a workbook

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Tell me about your treatment program

I use _____ manual.

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Consider the plumber

What if plumbers viewed their jobs the way we sometimes view ours?

85

Consider

Tell me about your job?
-I have a cool van.

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Consider the plumber

I like my truck.
I've used it for years.
People say it has helpful stuff in it.

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Consider the plumber

My van has tons of tools in it. Someone who knows a lot about plumbing said that all of these wrenches, snakes, plungers, pipe cutters and other stuff were really useful. I drive it to my customers' houses and tell them how the tools work. Sometimes it helps…if they're motivated

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Effective Plumbers

- Accurately assess the problem.
- Understand the likely causes that contributed to the specific problem.
- Educate the consumer.
- Develop a plan to address the problem.
- Offer options to prevent future problems.

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Effective Treatment Providers

- Accurately assess the problem.
- Understand the likely causes that contributed to the specific problem.
- Educate the consumer.
- Develop a plan to address the problem.
- Offer options to prevent future problems.

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So we're like plumbers?

Manuals are merely a vehicle containing potentially useful tools. They are helpful, but only to facilitate the work you need to do.

The real work is in understanding the problem, knowing how to fix it, and how to prevent future problems.

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Sex Offense Specific Treatment

- Components of conventional SO-specific treatment appear directly relevant to some DRFs.
- Practice deliberately: The focus is NEVER to "get through" material.
- It is important when delivering treatment to keep in mind the rationale for the content included AND for group process.
- Think about the specific risk factors that your participants need to address, how your interventions/treatment materials match them, and opportunities to discuss them.

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Sex Offense Specific Treatment

- Example of SO Specific Programming
  (from NYS OMH-PBSOTP)
  - Treatment Readiness/Goal Setting (MI)
  - Cognitive Distortions/Interpersonal Tactics (CBT/IPT)
  - Autobiography (Insight/Core Values)
  - Offense Process (Lifestyle Risk/Cycles/Deviant Lifestyle)
  - Healthy Lifestyle Plan (Approach Goals/Community Support/Release to High-Risk Situations)

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Sex Offense Specific Treatment

- Treatment Readiness/Goal Setting (MI)
  - Building Rapport
  - Earning Trust
  - Teaching Group Skills
  - Personal investment/commitment to goals & values
- Relevant DRFs: Cognitive distortions, Insight, Treatment compliance

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Sex Offense Specific Treatment

- Cognitive Distortions/Interpersonal Tactics
  - Look at distortions BOTH as they relate to sexual offending AND more broadly criminal or unhealthy behavior.
  - Rates of general offending are higher than sexual re-offending.

Relevant DRF's: Criminal Personality, Cognitive Distortions, Insight, Interpersonal aggression, Treatment Compliance, Compliance with Community Supervision

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Sex Offense Specific Treatment

- Autobiography
  - Providing a context for offending behavior, identifying recurring patterns (individually and intergenerationally).
  - Identifying likely origins of core beliefs.
  - Understanding the cumulative effects of traumatic/adverse experiences.

Relevant DRF's: Insight, Criminal Personality, Cognitive Distortions, Intimacy Deficits, Substance Abuse, Sexually Deviant Lifestyle

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Sex offense-specific treatment

- Offense Process
  - Exploration of a wide variety of lifestyle risk factors that occurred in the time period before, during, and after each offense.
  - For participants who deny committing offenses: modify to examine the time surrounding the accusation/arrest for an alleged offense.
  - Relevant DRF's: Sexually Deviant Lifestyle, Offense Planning, Sexual Offending Cycle (For people who HAVE a Cycle), Deviant Sexual Preference, Sexual Compulsivity, Intimacy Deficits

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Sex offense-specific treatment

- Healthy Lifestyle Plan
  - Using the risk factors from the offense process as a roadmap to identify skills developed in treatment that will help participants manage their risk.
  - Relevant DRF's: Sexually Deviant Lifestyle, Offense Planning, Sexual Offending Cycle, Community Support, Impulsivity, Compliance with community supervision, Released to High Risk Situations

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Applying RNR: Needs

Case Examples

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Case Example 1

- Participant in outpatient treatment program. Average risk for recidivism.
- Difficulty with relationships with multiple staff
- Sometimes overcontrolled, sometimes dysregulated.
- Very self-critical, but externalized negative assessments of self onto program staff.

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Case Example 1

- Sometimes disruptive in groups, hyper-sensitive to feedback/criticism.
- Generated a cycle with other group members. Anticipated/feared rejection, but his behaviors elicited rejection from peers.

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Case Example 1

- Options?
  - Discharge from treatment due to disruptive behavior?
  - Remove from groups and provide treatment individually?
  - Report to probation that participant is not compliant with conditions? Possible Violation?

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Case Example 1

- Plan
  - Referred participant to DBT skills training groups in the same outpatient clinic.
  - Made arrangements with DBT clinicians for safety of their group participants.
  - Participant had regular individual meetings with primary therapist in SO program, but no SO specific treatment.

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Dialectical Behavior Therapy

- DBT (Linehan, 1993) was originally developed for treating parasuicidal behavior of individuals diagnosed with borderline personality disorder.
- DBT skills training designed to *reduce therapy interfering behaviors and provide clients with the skills needed to engage meaningfully in difficult therapeutic work.*
- Skills training is generic – it is *generalizable and can be individualized to specific needs.*

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DBT Skills: Mindfulness

- Attending nonjudgmentally to the present moment, living in the moment, fully experiencing one's emotions and senses, maintaining perspective.
- Radical Acceptance of emotions and situations

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DBT Skills: Emotion Regulation

- Understanding and naming emotions.
- Changing perception of unwanted emotions.
- Reducing vulnerability.
- Managing extreme conditions.

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DBT Skills: Distress Tolerance

- Accept oneself and the current situation in a non-evaluative and nonjudgmental fashion.
- Recognize negative situations and their impact, rather than becoming overwhelmed or hiding from them.
- Make wise decisions about whether and how to take action, rather than falling into the intense, desperate, and often destructive emotional reactions.

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DBT Skills: Interpersonal Effectiveness

Building and maintaining relationships by:

- Communicating one's needs.
- Giving of one's self appropriately.
- Maintaining respect for self and others.

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DBT Skills

Relevant dynamic risk factor changes:

- Impulsivity
- Insight
- Treatment Compliance
- Emotional Control
- Interpersonal Aggression

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Case Example 1

Outcome

- Participant completed DBT skills training modules
- Returned to SO specific programming
- Completed program and performed very well. Became a valued member of the group.
- Able to live a more stable life and maintain employment
- Got new clothes and looked spiffy.

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Case Example 1

Outcome

Was this treatment plan more risk relevant/risk reducing than "treatment as usual"?

What if the participant did not return to SO specific treatment? Would he (and the community) be better off?

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Case Example 2

- Exceptionally high risk for recidivism.
- Participant in institutional/residential program.
- Would either walk out of groups or sit in groups and refuse to participate.
- Was physically and sexually assaulted by his stepfather and other family members as a young child over the course of several years. PTSD symptoms including nightmares and frequent crying.

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Case Example 2

- Had difficulty tolerating group because he was triggered when other group members discussed abusive behaviors.
- Very rigid beliefs about his self-worth and being a failure. His stepfather had repeatedly call him worthless. Beliefs about self-worth were also tied to crying spells (said he was a crybaby).
- Difficulty regulating affect, especially if he tried to speak in group.
- Distortions about victim/perpetrator dichotomy.

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Case Example 2

- Options?
  - Remove from groups due to lack of participation?
  - Write negative evaluations regarding poor progress?
  - Add group for trauma symptoms?
  - Remove from groups and provide treatment individually?

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Case Example 2

- Plan
  - Removed participant from groups and referred to individual therapist using CPT protocol.
  - Weekly individual sessions, proceeding very slowly with protocol due to difficulty with discussing anything related to trauma.

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Cognitive Processing Therapy

CPT (Resick & Schnicke, 1992)

Short-term structured intervention for people suffering from post-traumatic symptoms.
Provides education about the connections between trauma-related thoughts, feelings, and behaviors.

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Cognitive Processing Therapy

Education about PTSD.

Participant asked to write an Impact Statement to begin to identify problem areas in thinking about the trauma (i.e., "stuck points").

Participant taught to identify and label thoughts and feelings and recognize the relationship between them.

Trauma account of the worst traumatic incident and reads in session.

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Cognitive Processing Therapy

Therapist uses Socratic questioning to begin to challenge distorted cognitions such as self-blame, hindsight bias, and other guilt cognitions.

Therapist teaches the participant cognitive therapy skills and focuses on specific topics that were disrupted by trauma, such as safety, trust, power/control, esteem, and intimacy.

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Cognitive Processing Therapy

Patterns of Problematic Thinking Worksheet

Listed below are several types of patterns of problematic thinking that people use in different life situations. These patterns often become automatic, habitual thoughts that cause us to engage in self-defeating behavior. Considering your own stuck points, find examples for each of these patterns. Write in the stuck point under the appropriate pattern and describe how it fits that pattern. Think about how that pattern affects you.

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Cognitive Processing Therapy

Patterns of Problematic Thinking Worksheet

Jumping to conclusions or predicting the future?

Exaggerating or minimizing a situation (blowing things way out of proportion or shrinking their importance inappropriately).

Over-generalizing from a single incident (a negative event is seen as a never-ending pattern).

Mind reading (you assume people are thinking negatively of you when there is no definite evidence for this).

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Cognitive Processing Therapy

Challenging Questions Worksheet

Below is a list of questions to be used in helping you challenge your maladaptive or problematic beliefs/stuck points. Not all questions will be appropriate for the belief/stuck point you choose to challenge. Answer as many questions as you can for the belief/stuck point you have chosen to challenge below.

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Cognitive Processing Therapy

Challenging Questions Worksheet

What is the evidence for and against this stuck point?

Is your stuck point a habit or based on facts?

In what ways is your stuck point not including all of the information?

Does your stuck point include all-or-none terms?

Does the stuck point include words or phrases that are extreme or exaggerated (i.e., always, forever, never, need, should, must, can't, and every time)?

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Cognitive Processing Therapy

Challenging Questions Worksheet

In what way is your stuck point focused on just one piece of the story?

Where did this stuck point come from? Is this a dependable source of information on this stuck point?

How is your stuck point confusing something that is possible with something that is likely?

In what ways is your stuck point based on feelings rather than facts?

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Cognitive Processing Therapy

Relevant Risk Factors:

- Insight
- Cognitive Distortions
- Emotional Control
- Treatment Compliance

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Case Example 2

Outcome

- Participant initially very rigid. Unwilling to discuss or consider alternatives to beliefs/distortions.
- Gradually willing to discuss stuck points and complete writing assignments about cognitions.
- Experienced decreased symptoms and increased emotion regulation.
- Requested return to SO specific programming group.

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Case Example 2

Outcomes

- As a person with an exceptionally high risk for sexual recidivism, what was the most important treatment need for the participant?
- Are there unintended effects of requiring detailed disclosures of offending behavior in groups?
- Is it likely that the treatment received reduced risk, even if the participant did not return to SO specific treatment?

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Responsivity Needs: Psychopathic Traits

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Treatment of People with High Psychopathy

- Historically this population has been inadequately treated and poorly understood.
- Evil is not a useful construct in psychotherapy. (M. Olver, 2013)
- Psychopathy is a heterogeneous construct, meaning that it doesn't always look the same. There are many ways one can get to a score of 30 on the PCL, and while 30 is the threshold used for a cutoff in various settings, important to remember dimensional nature of the construct.

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Treatment of People with High Psychopathy

While research shows psychopathy is a predictor of poorer treatment compliance and outcomes, but those that do engage show improvement in risk and recidivism rates. (Abracen, Looman, & Langton, 2008; Olver & Wong, 2011)

- How do we get individuals who may be higher in psychopathy to engage in treatment?

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Treatment of People with High Psychopathy

- Capitalize on their goal-oriented nature
- Bring attention to the present moment via mindfulness skills and processing
- Substance use / deviant sexual interest are important targets (research shows these two dynamic risk factors are particularly relevant to future risk in psychopathy)
- Can be likeable, important to consider the therapeutic relationship and countertransference

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Treatment of People with High Psychopathy

- Articulate goals clearly: What's in it for them?
- Think about motivation that does not rely on empathy
- Cost / benefit analysis is a useful tool to shift to a long-term strategy
- Remain objective and neutral, set and enforce healthy boundaries
- Don't turn the relationship into a chess match

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Wrapping it all up

- Adhere to RNR principles.
- Good Therapy is Good Therapy
- Sex Offense-Specific Treatment is a specialized application of psychotherapeutic skill.
- Practice intentionally. Understand WHY you are doing what you are doing and including specific content.
- Attend to process with specific goals in mind.
- Have fun and be kind.
- Be proud of yourself: you're making the world a better place!

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