

Exploring Responsivity: Trauma, Risk, Motivation, and the Working Alliance

David S. Prescott, LICSW
Nikole Nassen, PhD
Welcome!

1

Welcome!

We're glad you're here

We know you're busy



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2

Gratitude



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How It Works

- Please check your email for any handouts
- We take your certificate needs seriously!
- Please use the chat and Q&A features towards the bottom of your screen to ask questions
 - Please keep comments on-topic
- Feel free to share resources in the chat!

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How it Works

- The intended audience is professional
 - We assume everyone is aware of the harm of abuse and the need for those affected by it to receive excellent care.
 - Please understand the information, language, and commentary in the spirit in which it is intended.

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Join us after!

- A Zoom meeting link will go to your email during the training.
- Join us!
- Ask questions and deepen your learning
- Meet the presenter
- Meet each other!

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Gratitude

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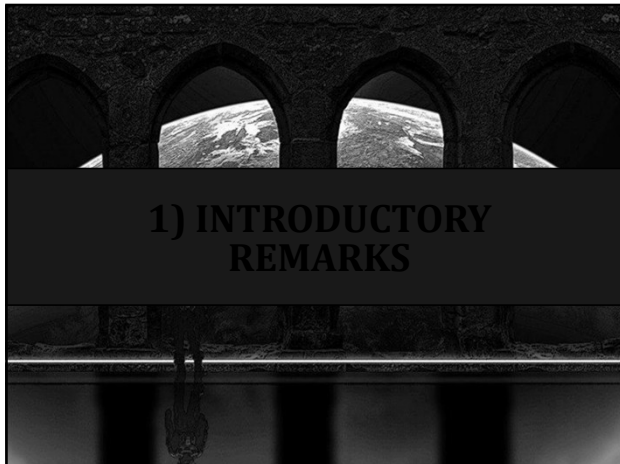
Hello! Hello! Welcome!

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Agenda

1. Introductory remarks
2. Principles of effective correctional rehabilitation
3. Responsivity defined
4. How do we lose responsivity?
5. How does change happen?
6. Institutional responsivity
7. Implications of trauma and adverse experiences
8. Motivational interviewing and related skills
9. Feedback-Informed Treatment

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Take Home Messages

1. What you do matters
2. What you do works
3. Follow the research
4. Beware of false advertising
5. Always keep the big picture in mind

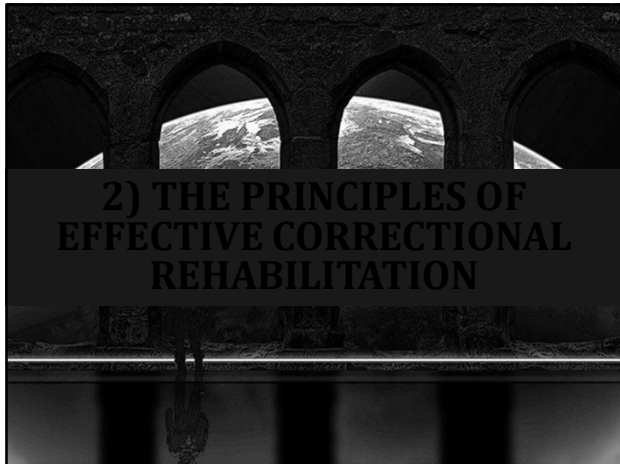


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Please be patient with me

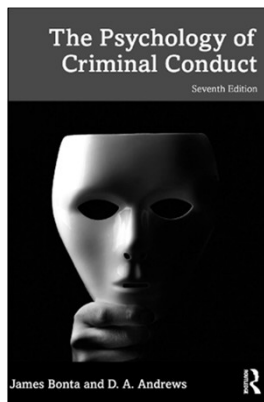
- We live in troubled times
- I may be provocative
- I may have a sense of humor
- This address is for professionals
- I come in peace and believe in human dignity
- I mean no harm
- Please take everything I say in the spirit in which it is intended

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**Treatment context:
What works?**



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RNR: Core Aims and Assumptions

- Primary aim of correctional intervention is to reduce harm inflicted on community
- Most important treatment targets are those empirically associated with reduced recidivism rates
- Clients should be treated humanely, with research and treatment delivered in an ethically responsible manner
- Client rights trumped only by community needs

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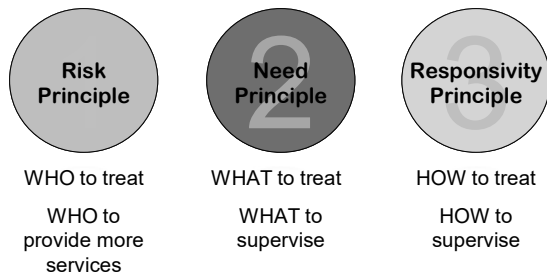
Treatment context: What works?

- **Risk:** Match level of services to level of risk
- **Need:** Target dynamic risk factors/criminogenic needs
- **Responsivity:** Use empirically supported approaches; also *specific* responsivity

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Effective Rehabilitation:

Core Principles (Jung, 2026)



Bonta & Andrews (2024)

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Antisocial personality pattern	Dynamic risk factors / Criminogenic needs (e.g., Bonta & Andrews, 2023; Hanson & Morton-Bourgon, 2005)
Antisocial cognitions	
Antisocial (and/or lack of prosocial) social influences	
General self-regulation difficulties	
Emotional identification with children	
Poor sexual self-regulation	
Offense related sexual attraction/preference	

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Treatment context: What works?

- **Risk:** Match level of services to level of risk
- **Need:** Target dynamic risk factors/criminogenic needs
- **Responsivity:** Use empirically supported approaches; also *specific* responsivity

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“We know a lot about risk;
we’re learning about need;
and we’re awful at
responsivity”

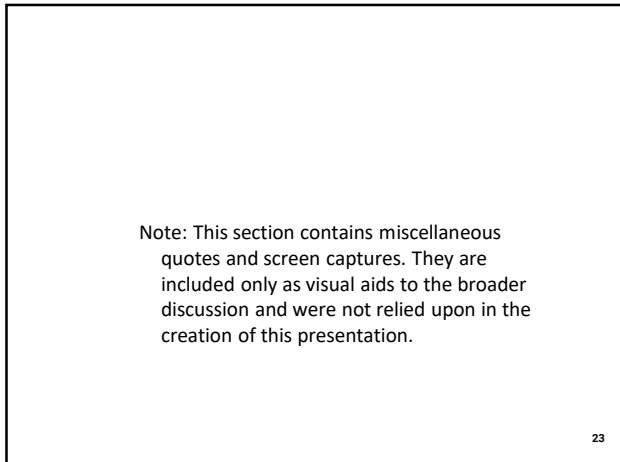
Katie Gotch, personal communication
July 2026

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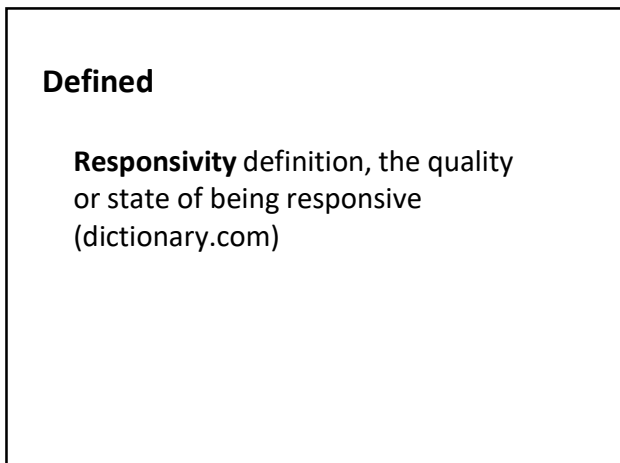
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Bonta (2007)

"3) the *responsivity principle* describes how the treatment should be provided. ...

"**Responsivity principle:** Maximize the offender's ability to learn from a rehabilitative intervention by providing cognitive behavioural treatment and tailoring the intervention to the learning style, motivation, abilities and strengths of the offender."

<https://www.publicsafety.gc.ca/cnt/rsrctns/pblctns/rsk-nd-rspnsvty/index-en.aspx>

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Bonta (2007)

"There are two parts to the responsivity principle: general and specific responsivity. General responsivity calls for the use of cognitive social learning methods to influence behaviour. Cognitive social learning strategies are the most effective regardless of the type of offender (i.e., female offender, Aboriginal offender, psychopath, sex offender). Core correctional practices such as prosocial modeling, the appropriate use of reinforcement and disapproval, and problem solving (Dowden & Andrews, 2004) spell out the specific skills represented in a cognitive social learning approach.

Specific responsivity is a "fine tuning" of the cognitive behavioural intervention. It takes into account strengths, learning style, personality, motivation, and bio-social (e.g., gender, race) characteristics of the individual.

<https://www.publicsafety.gc.ca/cnt/rsrctns/pblctns/rsk-nd-rspnsvty/index-en.aspx>

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Corrections Canada

Client Responsivity Factors	
General Population	Factors more common in offenders
Anxiety	Poor social skills
Self-esteem	Inadequate problem-solving skills
Depression	Concrete-oriented thinking
Mental illness	Poor verbal skills
Age	
Gender	
Race/ethnicity	

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Taylor (2014)

- ...the general responsivity principle, which states that programs should use theoretically relevant models for individual change, specifically cognitive-behavioral and cognitive-social learning models (Andrews & Bonta, 2010).

<https://www.ncjrs.gov/pdffiles1/nij/grants/248590.pdf>

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NIJ, continued

“The following techniques are consistent with these models: “role-playing, modeling, repeated practice of alternative behaviors, cognitive restructuring to modify thoughts/emotions, skills building, or reinforcement”

(Andrews & Bonta, 2010, p. 50).

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Example of resources found online

PowerPoint Slides with Faculty Notes

Slide 59

Unit 4: The Principle of Responsivity & Offender Motivation (Pilot)

Slide 60

Responsivity Principle

- To the intervention, treatment, program, or supervision
- To the personnel delivering the service to the offender

Responsivity: matching the characteristics of the treatment program and treatment provider to characteristics of the individual offender.

Lecture (1-2 minutes)
The responsivity principle is sometimes referred to in the literature as the principle of “specific” responsivity.” When the term “specific responsivity” is used in the literature to describe this principle, it is to contrast this principle with the previous principle we discussed, the “treatment” principle, which is then referred to in the literature not as the “treatment” principle but as the principle of “general” responsivity.” These semantic distinctions have proven frustrating in presenting this curriculum to judges. We include this note to faculty only in case a question on this point arises.

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Continued

Responsivity Factors:
Offender Characteristics

- Age
- Gender
- Culture
- Learning Style
- Intelligence
- Mental Health

Lecture (3-4 minutes)

What are the offender characteristics that need to be "matched" to characteristics of the intervention and/or provider? They are often called "responsivity factors" and these are a few of the most common ones. See research on mental health at slide 30 and see Jennifer Skeem, et al., *Assessing Relationship Quality in Mandated Community Treatment: Blending Care with Control* 19 Psychol. Assessment 397-410 (2007); Jennifer Skeem, et al., *Exploring "What Works" in Probation and Mental Health*, 2008; Skeem, Manchak, and Johnson, *Specialty Mental Health vs. Traditional Probation*, 2008.

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Continued

Promoting Offender Motivation

- Coerced Treatment
- Extrinsic → Intrinsic Motivation
- Engagement
- The Offender is in Charge

Introductory Lecture (5 minutes)

The last responsivity factor we will discuss and perhaps the most important is "offender motivation."

- Coerced treatment is effective; offenders are rarely motivated to change behavior at the outset, and coercion can get the offenders into treatment and keep them there longer. But, external pressure and controls only work as long as the pressure is applied. The goal is to avoid the condition where the offender is only entering or remaining in treatment under coercion and going through the motions of compliance.
- Ultimately, offenders must become self-motivated; they must progress from "extrinsic" to "intrinsic" motivation. The ability to change must ultimately be accompanied by a willingness and a desire to change.
- The way the court and judge interact with the offender can play a

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Continued

Responsivity Principle

- General Responsivity: Asserts the general power of behavioral, social learning and cognitive-behavioral strategies
- Specific Responsivity: Suggests matching the service with personality, motivation, learning styles abilities and with demographics
- It includes matching the personnel delivering the service to the population

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Utah CJ Center

6. **General Responsivity Principle:** responsivity is defined as delivering a program or curriculum in a manner that matches the learning style and ability of the target audience. General responsivity means a program should use methods of delivery that are known to be most effective and include cognitive-behavioral and cognitive social learning approaches. Within cognitive-behavioral and cognitive social learning approaches, effective intervention techniques and strategies include modeling, reinforcement, role playing, skill building, cognitive restructuring, and practicing low-risk behaviors in high-risk situations.

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Responsivity Principle (Jung, 2026)



Using the most effective approaches to facilitate change in attitudes and behaviors of offenders

- Treatment is more effective if the intervention pays attention to personal factors that facilitate learning, change, and growth.
- These interventions should match the general learning styles, motivations, and abilities of the offender, as well as offender's personality, gender, and ethnicity

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General Responsivity

Treatment programs should include:

- Cognitive-behavioral orientation
- Manual based
- Delivered in the intended manner
- Structured, with specific aims and tasks
- Providers dedicated to rehabilitation
- Trained, qualified, well-supervised staff

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Specific Responsivity

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What's missing?

- Motivation
- Scheduling concerns
- Maturity
- Intelligence/Learning difficulties
- Brain injury
- Comorbidity
- Other effects of adversity
- Other "extra-therapeutic" factors
 - e.g., family/community supports

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How did we get here?

- Quick look backwards
- Retrospective bias
- Great respect for all involved
- Intent: Tough on issues, tender on people
 - *People are not now as smart as they think; people used to be smarter than we now think they were* (Quinsey et al., 2006)

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My concern

During the past 30 years, the majority of our progress has been technological

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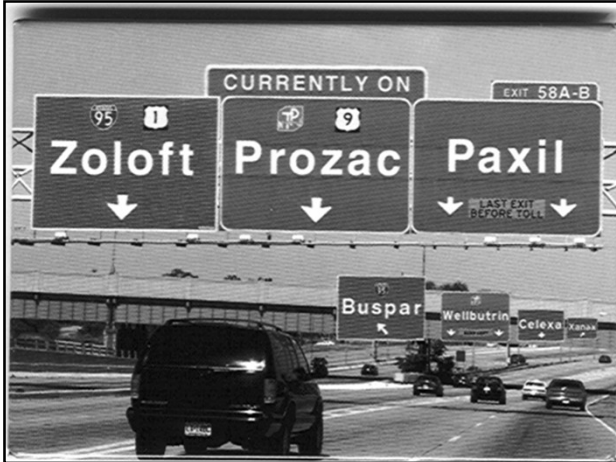
IN THE BEGINNING...



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Martinson, 1974

probable duration of this
not know.

Does nothing work?

Do all of these studies lead us irrevocably to the conclusion that nothing works, that we haven't the faintest clue about what works and reduce recidivism? And "

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Paul Gendreau

- "Something works"
- "What works!"



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1979: Edward S. Bordin

- Therapeutic alliance:
 - Agreement on relationship
 - Agreement on goals
 - Agreement on tasks
 - (Norcross, 2002, would add client preferences)
 - Over 1,100 studies have emphasized the importance of the alliance in psychotherapy since (Prescott et al., 2017)

What are the implications for scripted manuals in treatment?

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Hope Theory (Snyder, 1999)

- C.R. "Rick" Snyder:
- Agency Thinking
 - Awareness that a goal is attainable
- Pathways Thinking
 - Awareness of how to do it
- ***"Therapists who are burned out or otherwise fail to convey hopefulness model low agency and pathways thinking."***
- (in Hubble, Duncan, & Miller, 1999)

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Smith et al. (2002)

- Meta-analysis of 117 studies
- $N = 442,471$ (including juveniles)
- No form of punishment reduced re-offense risk

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Marshall, 2005

- Warm
- Empathic
- Rewarding
- Directive

**Problem:**

Many people think they have these qualities, but don't

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Parhar, Wormith, et al., 2008

- Meta-analysis of 129 studies
- *In general, mandated treatment was found to be ineffective ... particularly when the treatment was located in custodial settings, whereas voluntary treatment produced significant treatment effect sizes regardless of setting.*



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PETRICH ET AL (2021)

- Meta-analysis of 116 studies
- 4.5 Million people convicted of crimes
- Custodial sanctions had no effect on reoffending or slightly increased reoffending compared to noncustodial sanctions

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Treatment effectiveness 2024

**Moderators of Sexual
Recidivism as Indicator of
Treatment Effectiveness in
Persons With Sexual Offense
Histories: An Updated
Meta-analysis**



Lisa Holper¹ , Andreas Mokros² , and Eimar Habermeyer¹

Sexual Abuse
2024, Vol. 36(3) 255–291
© The Author(s) 2023

Article reuse guidelines:
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DOI: 10.1177/1079062323119071
sagepub.com/journals

Sage

Treatment associated with 31.8% reduction in
sexual reoffending
(9.3% treated, 13.6% untreated)

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Moderators of treatment effectiveness

(Gannon et al., 2019; Holper et al., 2024)

- Consistent input from psychologists
- Incorporating active behavioural components to restructure/manage offence-related sexual arousal
- Absence of polygraph testing
- Focusing on clients assessed higher risk versus lower risk
- Specialised versus nonspecialised programs

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What *else* works?

- ‘Common factors’ of effective psychotherapy
(e.g., Marshall, 2005; Marshall et al., 2002)
- Comprehensive re-entry planning
(e.g., Willis & Grace, 2008, 2009)
- ‘Cognitive transformations’; achieving informal social control
(e.g., Sampson & Laub, 1993; Maruna, 2001)

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Client perspectives on treatment

Levenson et al. (2024) asked 291 individuals subject to registration in the US about their experiences of treatment. Positive experiences included:

- Positive therapeutic relationships
- Learning new tools / skills
- Learning the why of offending including acknowledgement of victim status
- Being a part of a group / experiencing group cohesion
- Opportunities to learn about self

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One Administrative Perspective

1. Assess and classify clients according to risk
2. Assess treatment needs
3. Assess protective factors
4. Conduct comprehensive assessment to develop understanding of specific responsivity
5. Develop understanding of the narrative underlying risks, needs, and responsivity factors
6. Formulate initial hypotheses about how risk/need factors have played a role in the client's life and offending.

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Ultimately

By the most rigorous/conservative standards:

1. Punishment doesn't reduce risk
 - Punishment = punishment
2. Treatment can work
3. Treatment can be better with the right community supervision

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What works?

***Who* works?**

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4) How Do We Lose Responsivity?

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We stop adhering to the responsivity principle when:

- We don't properly assess clients
- We drift from program integrity
- We use one-size-fits-all approaches
- We don't attend to the characteristics of effective therapists
- We don't attend to group cohesion
- We compel clients to change on our timetables
- Scripted manuals

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Scripted Manualization

Never the complete treatment program

- The map is not the territory
- The menu is not the meal

Cognitive Behavioral Interventions for Sexual Offending

Prerequisites	Sessions
• Learning Basics: People, Risk • Reducing Resistance • Managing the Process and Goals	• Module 4 (Continued) • Dealing with Negative/Overload Life Events • Dealing with Anger • Dealing with Shame • Dealing with Respect and Failure • Dealing with Anxiety/Fear
Module 1	Module 5
• Identifying the Contribution • Clarifying Values • Setting a Goal • Managing the Costs and Benefits • Social Skills - Reflective Listening • Social Skills - Giving Feedback • Developing Emergency Strategies • Developing Emergency Strategies (Continued)	• Asking for Help • Taking the Perspective of Others • Dealing with Mixed Messages • Dealing with Criticism • Resolving Conflicts • Resolving Conflicts with Others • Asking for Forgiveness • Disclosing Personal Information
Module 2	
• Identifying the Behavior Chain	

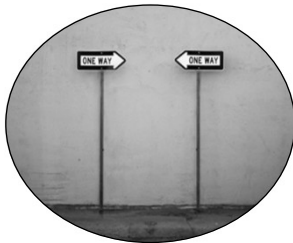
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Change

- Why?
- How?



63

Berlin

64



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66

Robben Island

67

“Tank Man”

68



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Where we are and where we want to be



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Where we are and where we want to be



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Take-Home Skills

- What are the smallest differences between where this client is and where they want to be?
- What is your client's "theory of change"?
- In accordance with what values?

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A big question

What gets in the way of change?

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The Power of People

“The power of people in rehabilitative behaviour change is all too often neglected in favour of a bureaucratically streamlined, “doing more with less”.

Theresa A. Gannon, DPhil, Professor of Forensic Psychology at University of Kent, UK
& Director of the Centre of Research and Education in Forensic Psychology (CORE-FP)

Justice Trends Magazine August 2025
<https://justice-trends.press/rehabilitation-and-reintegration-lessons-from-the-frontlines-of-research-and-practice/>



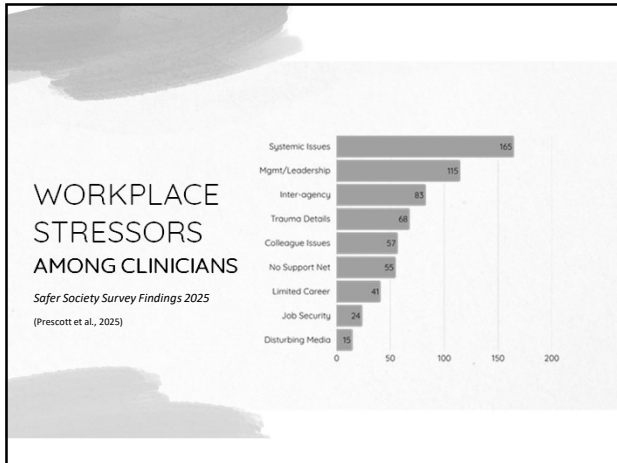
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Institutional Responsivity

Creating the
environment where
responsivity is
possible

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Systems Matter

- How much time do you see your client each week?
- How much time does your client spend outside of treatment?
- How do systems influence your client's life?

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Who is in the system?

- Other treatment providers / supervisors / program directors
- Institutional staff
- Institutional leadership
- Other departments

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How do we influence the system?

- Get buy-in
- Provide education
- Enlist support and let them know how to support

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Getting Buy-In

- Focus on shared goals
 - Prevention of sexual harm
 - Safety / Security
 - Effective use of resources
- Establish credibility
- What you do matters. What they do matters.
- Enlist in collaboration

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Educate with a Focus on Shared Goals

- Why they should care about treatment
 - Prevention
 - Institutional safety
 - Makes the job easier
- Value of external motivators
- People enter treatment with problems
- We are working on generalizing skills

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How Non-Clinicians Can Help

- Encourage treatment engagement
- Let us know about behaviors that occur outside of treatment
- Provide opportunities to use skills
- Role-model appropriate boundaries and skills use
- Provide fair and consistent rules enforcement
- Reinforce progress as you see it

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Things to Know About Treatment

- This is neither a punishment nor a reward
- Our focus is on prevention of future sexual harm
- While giving us information can be helpful, we may not be able to provide you all of the information you want
- Effective treatment is not always intuitive

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Where can we provide influence?

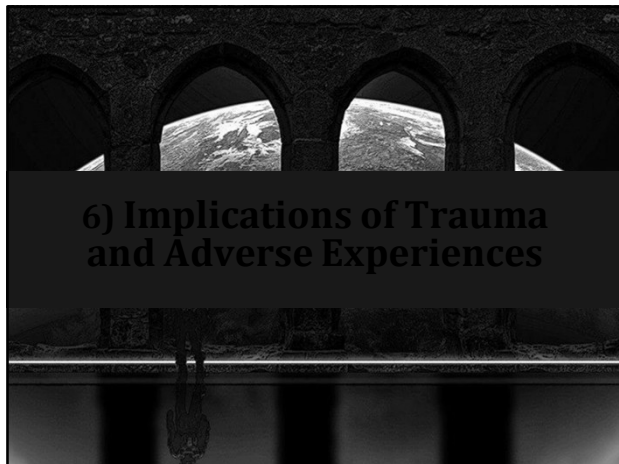
- Policies
- Scheduling
- Environment
- Parole Boards
 - Reinforce treatment participation and progress
 - Create cultures supportive of change
 - Language makes a difference

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Addressing Staff Concerns

- Biases that reduce responsivity
- Punishment over recidivism-reduction
- Oversharing and poor boundaries

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What I *don't* mean

Strategies To Help Heal Trauma

- Use the "Brain-Body" Connection
- Get the Right Help
- Understand Your Triggers
- Practice Self-Care
- Lean on Social Support
- Be Your Own Best Friend
- Express Yourself
- Move Into Joy

Reframe

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We can't ignore what *happened to them*

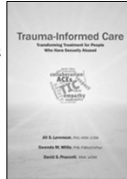
Article

Exploring Risk for Sexual Recidivism and Treatment Responsivity Through the Lens of Early Trauma

Gwenda M. Willis, PhD¹ and Jill S. Levenson, PhD²

(Willis & Levenson, 2022)

Sexual Abuse
2022, Vol. 34(5) 597–619
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sagepub.com/journals-permissions
DOI: 10.1177/10790632211051681
journals.sagepub.com/home/sax
SAGE



Levenson et al., 2017)

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What is trauma?

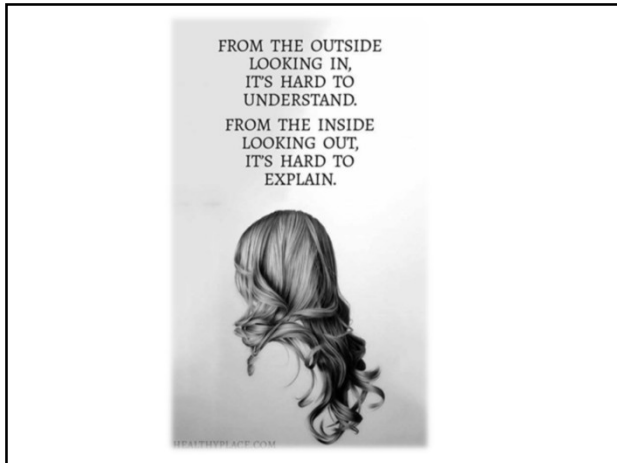
- PTSD
- Complex PTSD
- DESSOS
- Complex trauma
- Developmental Trauma Disorder



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What is Trauma?



Trauma is the desperate hope that the past was somehow different.

– Jan Hindman

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What is trauma?

- APA:
- **Trauma** is an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives. Psychologists can help these individuals find constructive ways of managing their emotions.

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ABSENCE OF CURIOSITY



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KEY THEME

- Just notice
- See what happens next
 - Not just mindful...
 - Investigating each experience
 - Practice Making Choices based on what you notice

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Trauma

- Relational issues
- Somatic challenges

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What is Trauma?

The goal of (trauma) treatment is to help people live in the present, without feeling or behaving according to irrelevant demands belonging to the past.

– Bessel van der Kolk

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SEPTEMBER 11

- Critical Incident Stress Debriefing
- Some treatments cause harm
- Lilienfeld (2007)



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Ultimately

No intervention that takes power away from the survivor can possibly foster her recovery, no matter how much it appears to be in her immediate best interest.

– Judith Herman, M.D.

- Reframe: Interventions that empower survivors foster recovery

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Post-traumatic Stress Disorder



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Post-traumatic Stress Disorder

- Traumatic event including
 - Actual or threat of death or serious injury
 - Threat to physical integrity
 - Response of intense fear, helplessness, horror
- Persistent re-experiencing of events
- Persistent avoidance of associated stimuli & numbing of responsiveness
- Persistent symptoms of increased arousal
- Duration >1 month, significant disturbance in functioning

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Post-traumatic Stress Disorder

- Re-experiencing distress
 - Recollections, images, thoughts, perceptions
 - Dreams
 - Flashbacks, illusions, hallucinations
- Avoidance of related stimuli
 - Thoughts, feelings, conversations
 - Activities, places or people

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Post-traumatic Stress Disorder

- Numbing of general responsiveness
 - Inability to recall important aspects of event
 - Diminished interest/participation in activities
 - Detachment/estrangement from others
 - Restricted range of emotions (e.g., love)
 - Sense of foreshortened future
- Arousal symptoms
 - Insomnia, anger, hypervigilance, difficulty concentrating, exaggerated startle response

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Post-traumatic Stress Disorder

- Events
 - Military combat
 - Violent personal assault (physical, sexual, mugging)
 - Kidnapping, terrorism, torture, incarceration, disasters, auto accidents, terminal diagnosis)
 - Witnessing fatal accident, body parts
- Typically worse when event is of human design
- Typically worse when stressor is repeated, chronic

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IMPORTANT

- Not all trauma results in PTSD
- Trauma can have a devastating effect on life outside of PTSD

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Take-Home Skills

- Distinguish between trauma treatment and trauma-informed care
- Think about trauma physically as well as emotionally, executively, etc.
- Establish a plan of self-care

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2023: Definition

- MI is a particular way of talking with people about change and growth to strengthen their own motivation and commitment.

(Miller & Rollnick, 2023: p. 3; 328)



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“Helping People Change and Grow”

*Whereas early editions focused on **preparing** people for change, we now understand MI as a way of accompanying people throughout the journey of change and growth. (p. ix)*

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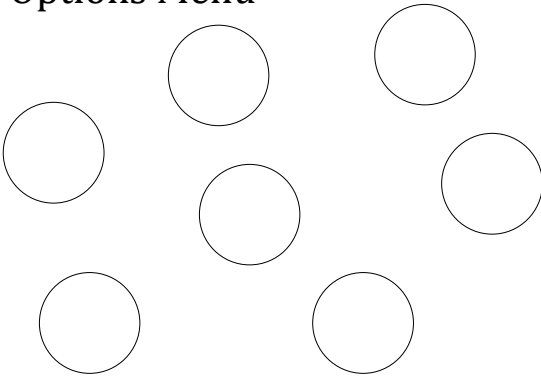
Motivational Interviewing

Hettema, Steele, & Miller (2005)

Observed effect sizes of MI were larger... when the practice of MI was not manual-guided.

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Options Menu



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Good/not-so-good things about change

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Discussion



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How do professionals get more effective?

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Demonstrating Empathy (Adapted from Andrew, 2022)

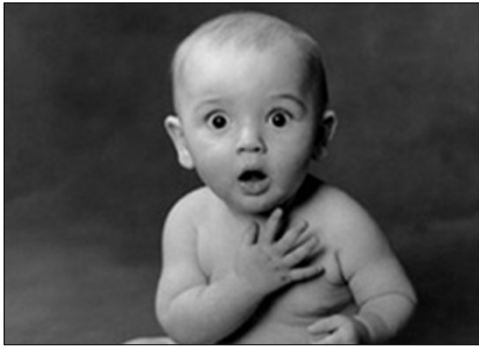
- Listen with a goal of understanding
- Sit with what they say
- Consider what it's like to be them or what they must be thinking
- Seek the meaning beneath the words
- Respond with a gentle guess that starts by naming the meaning
- Watch how that response lands
- Tune in to their reactions and listen with a goal of understanding
- Repeat, going ever closer to accurate empathy

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Openness and surprise



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Miller, Duncan, et al. 2006

- 75 therapists and 6,424 clients over two years
- Formal, ongoing feedback about the alliance and progress in treatment resulted in significant improvements, client retention, and outcome
- Clients of therapists who did not seek feedback regarding the alliance were three times less likely to return for a second session and had significantly poorer outcomes

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ROUTINE OUTCOME MONITORING

- Tracking global outcomes
- Tracking the working alliance
- Session-by-session feedback
- Examples include Youth Outcome Questionnaire, Outcome Rating Scale, Session Rating Scale, etc.

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OUTCOME RATING SCALE

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels.

If you are filling out this form for another person, please fill out according to how you think he or she is doing...

Individually
(Personal well-being)

|-----|

Interpersonally
(Family, close relationships)

|-----|

Socially
(Work, school, friendships)

|-----|

Overall
(General sense of well-being)

|-----|

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Please rate today's session by placing a mark on the line nearest to the description that best fits your experience:

I did not feel heard, understood, and respected

We did not work on or talk about what I wanted to work on or talk about

The therapist's approach is not a good fit for me

There was something missing in the session today

Relationship

Goals and Topics

Approach or Method

Overall

I felt heard, understood, and respected

We worked on and talked about what I wanted to work on and talk about

The therapist's approach is a good fit for me

Overall, today's session was right for me

(Miller, Duncan, & Johnson, 2002)

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WELCOME TO MY WORLD

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Take-Home Skills

- Establish a culture of feedback
- Get actionable feedback:
 - Clients
 - Colleagues

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