REALIGNING OFFENSE SPECIFIC TREATMENT WITH TREATMENT: TAKING RESPONSIVITY TO THE NEXT LEVEL

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# AGENDA

## Part 1 - Morning
- Risk, Need, Responsivity Principles (RNR)
- Professional Ethics
- Dual-Role Relationships
- Responsivity Factors
- Therapeutic Alliance

## Part 2 - Afternoon
- Responsivity Exercises
- Measures of Responsivity
- Measures of TA
- Offender Dropout Risk Factors
- Recommendations
PART 1
RISK, NEED, RESPONSIVITY PRINCIPLES

• Risk = Who
  • Services provided to offenders should be proportionate to the offenders' relative level of static and dynamic risk (i.e., low, moderate, or high risk) based upon accurate and valid research-supported risk assessment instruments (Bonta and Wormith, 2013).

• Need = What
  • Interventions are most effective if services target criminogenic needs (both social and psychological factors) that have been empirically associated with sexual reoffending.

Responsivity = How

• Effective service delivery of treatment and supervision requires individualization that matches the offender’s culture, learning style, and abilities, among other factors.
THINK ABOUT THIS…?

• How do you know if you’re properly adhering to the responsivity principle?

• What measures are available to providers to help understand offender readiness and engagement?

• What does the research say about the responsivity principle in relation to sex offense specific treatment?
PROFESSIONAL ETHICS

- Client Vulnerability
- Perceived or Real Power and Authority
- Professional and Legal Ethical Codes of Conduct
DUAL-ROLE RELATIONSHIPS

- Mandated versus non-mandated clients
- Proper balance of beneficence, nonmalificence, client autonomy, and community safety

“Treatment of sexual offenders referred by the criminal justice system are generally considered involuntary clients where the treating clinician holds considerable power and authority with an obligation to protect the community that may at times override individual client rights” (Sawyer & Prescott, 2011 – citing Prescott & Levenson, 2010).
DUAL-ROLE RELATIONSHIPS

Service Provider Considerations:

- Multiple clients or customers with sometimes contradictory interests
- Need to fulfill ethical/legal obligations
- Punishment versus encouragement
- Client-readiness and appropriateness for developing a therapeutic alliance
GROUP DISCUSSION

• What are the differences between mandated and non-mandated psychotherapy?

• What are the differences in limits to confidentiality for mandated and non-mandated treatment?

• One of the challenges to the therapeutic alliance in mandated treatment is the possibility of detrimental consequences because of information shared by the therapist. How can a therapist reduce the impact of this challenge to the alliance?

• Do therapists working with clients in non-mandated treatment ever need to set boundaries or expectations that could challenge the therapeutic alliance?
Key Points about Responsivity:

- Least studied principle but equal to the importance of the intervention used
- Individualization challenges given client heterogeneity
- Concept is not solely based on internal factors related to client characteristics
INTERNAL RESPONSIVITY FACTORS
(CLIENT CHARACTERISTICS)

- Treatment Readiness and Motivation
- Denial and Minimization
- Demographic Characteristics
  - Age, gender, employment, and marital status
- Cognitive Factors
  - Intellectual Functioning, Mental Health History
- Interpersonal Factors
  - Personality, Hostility, Substance Abuse, Psychopathy
- Behavior in Therapy, Offender Typology, Traumatic Experiences, and Deviant Sexual Arousal
INTERNAL RESPONSIVIVITY FACTORS (CLIENT CHARACTERISTICS)

Personality Disordered Clients

• Good client-therapist relationships can be achieved with personality-disordered patients, but the process can be more difficult for Cluster A patients in particular.

Psychopathy

• Little evidence to suggest that diagnosed personality disorders challenged the development and maintenance of client-therapist relationships (Strauss et al., 2006), including offenders with high levels of psychopathy.

• Olver & Wong (2010) found that the Emotional facet of Factor 1 of the PCL-R and never being married were found to be the most salient predictors of treatment dropout and correctly identified about 70% of 154 cases.
EXTERNAL RESPONSIVITY FACTORS (THERAPIST CHARACTERISTICS)

• Professional Qualifications
  • Level of Experience
  • Professional Training
  • Competencies and Skills
  • Developmental Progress

• Intrinsic Personality and Qualitative Traits
  • Secure attachment
  • Interpersonal Characteristics
  • Healthy & Appropriate Use of Self-Disclosure
  • Quality of Social Network
Consider the following examples. What are the challenges to the therapeutic alliance based on each example? How would you advise the therapist to monitor and manage their schemas and the impact to the alliance?

• Therapist Bob has an anxious attachment style. He is drawn to relationships and blames himself for any detachment others may show towards him. His has an interpersonal schema in which a rebuff, such as receiving a cold shoulder from a client, is interpreted as rejection.

• Therapist Sally has a “demanding standards” schema. She is perfectionistic and rigidly controls therapy to ensure that it is done “the right way.”

• Therapist Andy has a “special superior person” schema. His grandiose expectations of what he can achieve in therapy may lead him to distance himself from clients who are damaging those expectations.

• Therapist Sue has an “excessive self-sacrifice” schema. She overemphasizes the relationship component of the therapeutic alliance, leading to unhealthy and unsustainable levels of commitment to helping clients at all costs.
THERAPIST CHARACTERISTICS

- Excessive Self-Sacrifice
- Special Superior Person
- Demanding Standards
“Presumably to use their reactions to clients in this way, therapists are expected—as a function of their training—to be able to separate that part of the reaction that is engendered by their own schemas from those that are “intended” by the client (i.e., therapists can identify reactions that others might also have to the client's interaction from behavior that the therapist may be prone to interpret disproportionately due to the activation of their own historically dysfunctional schemas).”

(Ross et al., 2008)
EXTERNAL RESPONSIVITY FACTORS (MILIEU AND THERAPEUTIC ENVIRONMENT)

• System Factors (Indirect Services)
  • Statutory requirements, agency policies, and the SOMB Standards and Guidelines
  • Cross-sector and interagency collaboration
  • Eligibility criteria, sentencing structures, and other institutional policies
  • Capacity, funding, and availability of direct and adjunct services
“Specifically, the therapist’s primary responsibility to the client’s welfare is checked in part by the standard of practice to share information with county/state corrections as required by law or by contractual obligations or as needed to protect the community” (Sawyer & Prescott, 2011).
EXTERNAL RESPONSIVITY FACTORS
(MILIEU AND THERAPEUTIC ENVIRONMENT)

• Therapeutic Context for Direct Services
  • Placement Setting
    • Culture and ambiance
  • Program Factors
    • Philosophical/Ideological Orientation
    • Degree of Structure
    • Degree of Individualization to Internal Factors
  • Group Treatment Setting
    • Processes, iatrogenic effects, and therapeutic climate
“Therapists who promote a supportive and encouraging environment using a warm, direct, and empathic style have been shown to improve treatment outcomes with sexual offenders” (Blasko and Jeglic, 2014; Marshall et al., 2002).
Positive TA between the therapist and client consists of the following core elements:

- an agreement on the treatment goals,
- collaboration on the tasks that will be used to achieve the goals (specific interventions), and
- an overall bond that facilitates an environment of progress and collaboration (see, e.g., Flinton and Scholz, 2006; Levenson, Prescott and D’Amora, 2010; Marshall et al., 2002; Polaschek and Ross, 2010; Ross, Polaschek, and Ward, 2008; Schneider and Wright, 2004).

Developing a TA is often a dynamic and challenging process with forensic populations due to the involuntary nature of mandated treatment (Skeem et al., 2007).
REVISED THEORY OF THE THERAPEUTIC ALLIANCE

System
(policies, legislation, etc.)

Therapist Characteristics
- Personality
- Attachment Style
- Interpersonal Schemas
- Professional Skills
- Interpersonal Skills

Goals and Expectations
(client, alliance, intervention)

Setting & Contextual Factor

Therapy-related Interactions
(client and therapist behavior toward each other)

Cognitive processes, emotional responses

Immediate Therapeutic Environment

Client Characteristics
- Personality
- Attachment Style
- Interpersonal Schemas
- Therapy-related competencies (e.g., readiness)

Goals and expectations (alliance, therapy, change)

Therapeutic Alliance

Bond

Goals

Tasks

Cognitive processes, emotional responses

Ross, Polaschek, & Ward, 2008, p. 474
“Within these limits of confidentiality, however, the therapist’s focus is on the sexual offender client. This situation recognizes that the client is best served – and the public is best served – when the therapist and the client develop a therapist-client relationship that is separate from the sexual offender’s relationship with the probation officer and the court” (Sawyer & Prescott, 2011).
GROUP ACTIVITY

• Why would therapists who were rated as empathic, warm, rewarding, directive, and nonconfrontational show higher effectiveness in affecting change in clients?

• The traditional view of treatment readiness/motivation is that of a dichotomous personality trait, either present or absent. How is this view limiting? Is treatment readiness/motivation a static or dynamic construct?

• An unwillingness to participate in treatment can reflect a range of internal and external factors that are not related to the desire to change one’s behavior. What are reasons that a person may or may not be willing to participate in treatment that is not related to their desire to change their behavior?
Empathy is the therapist’s sensitive ability and willingness to understand clients’ thoughts, feelings, and struggles from their point of view.

Carl Rogers, 1961, On Becoming a Person
PART 2
WELCOME BACK!

• Agenda
  • Review of Part 1
  • Responsivity Exercises
  • Measures of Responsivity
  • Measures of TA
  • Offender Dropout Risk Factors
  • Recommendations
BRIEF REVIEW OF PART 1

• Responsivity is:
  • Complex,
  • Dynamic, and
  • Intertwined with external responsivity factors

• Importance of the TA
GROUP DYNAMICS

• Preference for group sessions with offense specific treatment

• Challenges:
  • Therapists who are too charismatic, too confrontational, or too laidback can increase group tension, lower group members' self-esteem, and lead to group breakdown (Beech & Fordham, 1997; Roback, 2000).
  • By contrast, a helpful and supportive leadership style was found in sex offender treatment to be important in creating an atmosphere in which effective therapy could take place (Beech & Fordham).
GROUP DYNAMICS

- Group cohesion and the therapeutic alliance with individual clients... problematic?
- Therapists may opt to de-emphasize their relationships with individual members and focus primarily on creating a therapeutic group climate instead
- Limited knowledge in how TA mediates therapeutic change
- Can groups can be highly cohesive without being in any way therapeutic?
DUAL-ROLE RELATIONSHIP

“By dual relationship, we are referring to the conflict in roles experienced by psychologists who must engage in the competing roles of (1) conducting client-focused therapeutic psychological work, and (2) detecting risk and upholding security principles as prioritized within highly politicized correctional setting ... Psychologists facing the dual relationship problem within corrections are at heightened risk of ‘ethical blindness’ prioritizing security and risk concerns as though they were therapeutic issues.”

DUAL-ROLE RELATIONSHIPS

- Clarity of roles between therapists and supervision officers (custodial staff roles for residential)

- Understand role of risk assessment and clinical interpretation that is used for legal purposes

- The Balancing act:
  - Implications of the “alliance” versus no active role in offenders’ treatment management
“We think therapists in correctional settings routinely experience many challenges to their goals and expectations that threaten the TA. Clients may present at assessment as motivated, engaging and rewarding. However, once into therapy, clients may become hostile, fail to attend therapy tasks, or show themselves to have intractable difficulties that make the therapist re-appraise their ability to work together. Or clients may be compliant with therapy goals and tasks but the therapist may find out from another source that this behavior is limited to therapy sessions.” (Ross et al., 2008).
OTHER IMPACTS TO TA

• Institutional Systems and Offender Attachment
• Repeated relationship terminations
• “Waste of Time” Sentiment
GROUP ACTIVITY

- How do you measure responsivity?
- How do you measure TA?

Five different typology cases for the group to break into five groups and report out their conclusions.
MEASURES OF THERAPEUTIC ALLIANCE AND CLIENT ENGAGEMENT

- Dual Role Inventor-Revised (DRI-R)
- Working Alliance Inventory (WAI)
- Consumer Satisfaction Survey (CSS)
DUAL ROLE INVENTOR-REVISED (DRI-R)

9. I talk down to _________________.
   
   |   |   |   |   |   |   |
   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
   | Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

10. I encourage ________________ to work together with me.
    
    |   |   |   |   |   |   |
    | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
    | Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

11. I trust ________________ to be honest with me.
    
    |   |   |   |   |   |   |
    | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
    | Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

12. I make allowances for ________________’s situation when deciding what he/she needs to do.
    
    |   |   |   |   |   |   |
    | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
    | Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

13. I am really devoted to helping ________________ overcome his/her problems.
    
    |   |   |   |   |   |   |
    | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
    | Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

14. If ________________ does something wrong, I put him/her down to prevent the problem from happening again.
    
    |   |   |   |   |   |   |
    | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
    | Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

15. I am very warm and friendly with _________________.
    
    |   |   |   |   |   |   |
    | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
    | Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

16. I treat ________________ fairly.
    
    |   |   |   |   |   |   |
    | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
    | Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |
IMPORTANT!!! Please take your time to consider each question carefully.

1. As a result of these sessions I am clearer as to how I might be able to change.
   
   Seldom  Sometimes  Fairly Often  Very Often  Always

2. What I am doing in therapy gives me new ways of looking at my problem.
   
   Always  Very Often  Fairly Often  Sometimes  Seldom

3. I believe ___ likes me.
   
   Seldom  Sometimes  Fairly Often  Very Often  Always

4. ___ and I collaborate on setting goals for my therapy.
   
   Seldom  Sometimes  Fairly Often  Very Often  Always

5. ___ and I respect each other.
   
   Always  Very Often  Fairly Often  Sometimes  Seldom

6. ___ and I are working towards mutually agreed upon goals.
   
   Always  Very Often  Fairly Often  Sometimes  Seldom
Thank you agreeing to take part in this survey about sex offender treatment. Please read each statement below carefully and choose the answer that best describes how you feel about it. If you feel an item does not apply to you, please do your best to answer it anyway.

Please tell us your opinion about the **importance** of the following treatment content areas by putting a check in the appropriate box. Please choose the SIX MOST IMPORTANT content areas and assign them a rank of 3. Please choose the SIX SOMEWHAT IMPORTANT content areas and assign them a rank of 2. Please choose the SIX LEAST IMPORTANT content areas and assign them a rank of 1.

<table>
<thead>
<tr>
<th>Importance</th>
<th>Least Important 1</th>
<th>Somewhat Important 2</th>
<th>Most Important 3</th>
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<tbody>
<tr>
<td>1.</td>
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<tr>
<td>Accepting responsibility for my sexual offense(s) (accountability)</td>
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<td>2.</td>
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<td>Learning about different types of denial. (denial)</td>
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<td>3.</td>
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<tr>
<td>Understanding my own tendency to distort, deny, and make excuses. (thinking errors)</td>
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<td>4.</td>
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<td>Understanding the impact of sexual abuse on victims and others in my life. (victim empathy)</td>
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<td>5.</td>
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<tr>
<td>Understanding my offense chains, cycles, and patterns.</td>
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<td>6.</td>
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<tr>
<td>Understanding my triggers and risk factors.</td>
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<td>7.</td>
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<tr>
<td>Learning about what motivated me to offend.</td>
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<td>8.</td>
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<td>Learning about my grooming patterns or the behaviors I used to gain access to victims or offending.</td>
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<td>9.</td>
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<tr>
<td>Developing a relapse prevention plan. (This would include a “maintenance” plan)</td>
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<td>10.</td>
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<tr>
<td>Learning to change or control my deviant arousal.</td>
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<td>11.</td>
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<tr>
<td>Learning to identify and recognize cognitive distortions (thinking errors).</td>
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<td>12.</td>
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<tr>
<td>Learning to change (restructure) cognitive distortions (thinking errors).</td>
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<td>13.</td>
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<tr>
<td>Understanding the development of my sexual behavior problems.</td>
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RISK FOR OFFENDER DROP-OUT (CLIENT ATTRITION)

• Why is offender drop-out important to consider?

  • General offender criminality

  • Risk for sexual recidivism and risk for program dropout or expulsion

  • Dropout from treatment is a static risk factors for sexual recidivism
SHIFT IN INITIAL TREATMENT FOCUS

Pre-Treatment

• Bolster offender motivation
• Identify offenders at risk for dropout

Reduce General Criminogenic Needs

• Antisocial values and attitudes
• Antisocial behavior
• Antisocial personality structure
• Antisocial peer affiliation

Treatment Engagement and Focus on Sexual Deviance Factors

• Offense responsibility
• Stage of change
• Sexual attitudes
• Criminal attitudes
• Impulsivity
• Cooperation with supervision / treatment
You are beginning a group in sex offense specific treatment with twelve group members. Six of the twelve have high criminality factors (related to both sexual and non-sexual recidivism). The other six members have low criminality factors. Sexual deviance factors vary across all members. One of the six members with low criminogenic factors has non-sexual violence associated with his sexual assault of an eight year old. Your goal is to have no drop-outs by the end of group.

What is your approach?
DROP OUT EXERCISE 1

• What do you know about drop-out associated with criminality and sexual deviance factors?
• Who is this group is at higher risk to drop-out?
• What behaviors might you expect from these members?
• Would you interact differently with those at a higher risk for dropping out? How?
• How would you ensure all members feel equally valued?
You are a clinical administrator of a sex offense specific program and your program has struggled with a high drop-out rate, in particular, with regard to clients with high antisocial factors (related to both sexual and non-sexual recidivism). You are designing the groups and curriculum for your clients. You have a client population entering your program consisting of clients with high antisocial orientation and clients without high antisocial orientation.

What is your approach?
DROP OUT EXERCISE 2

- What do you know about drop-out associated with criminality and sexual deviance factors?
- How might you design your program to reduce the drop out rate?
- How are logistical issues (i.e. time, space, and cost) impacted by your design changes?
- What traits in therapists would you look for to work with the clients with a high criminogenic orientation?
- How would you know whether your changes had the desired outcome?
RECOMMENDATIONS

• Responsivity factors, if not considered can reduce the effectiveness of treatment delivery.
• Responsivity factors related to the target population must be considered and addressed by treatment programs.
• Efforts to maximize the TA should be done in concert with measures to collect feedback from clients.
• Programs should identify clients at intake who are higher risk for dropout and target resources to address criminogenic needs that may interfere or disrupt efforts to engage in offense-specific treatment.
SUCCESS AND MASTERY

Success is a moment. … Mastery is not a commitment to a goal but to a constant pursuit.

Mastery is in the reaching, not the arriving.

It’s in constantly wanting to close that gap between where you are and where you want to be.

We thrive not when we’ve done it all, but when we still have more to do.

- Sarah Lewis, Ted Talk, 2014
QUESTIONS