

Practical Strategies for Individualizing Therapy: An Integrated Model of Sex Offender Treatment

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Workshop Goals

- Review past and present sex offender treatment models, and the general strengths and limitations of the current field of sex offender assessment and treatment.
- Present a detailed description of the Integrated Model of Sex Offender Treatment (IMSOT), including the use of best practices and EBP's in the field of sex offender assessment and treatment.
- Provide recommendations for implementing an IMSOT, with a focus on individualizing treatment, therapist variables that impact treatment outcome, and the appropriate role of relapse prevention in the treatment of sex offenders.

Take Home Messages

- Assessment is vital and ongoing
- Provide the right dosage of treatment
- Target dynamic risk factors in treatment
- Individualize treatment
- Remember common and specific variables in treatment outcome
- Keep client engaged in treatment (make treatment rewarding)

A Brief History of Sex Offender Treatment

- Behavior therapies used in the 1960's to decrease the "activities" or "images" of homosexuals, transvestites, and fetishists.
- 1970's - Broadening of behavioral interventions to include cognitive processes, and the development of more comprehensive treatment programs.
- 1980's Application of addiction model (relapse prevention) to sexual offending and the influence of social learning theory on the etiology of sexually unhealthy behavior.

A Brief History of Sex Offender Treatment

- 1990's - Broad use of "cognitive-behavioral" model and relapse prevention, focus on "thinking errors", and research and theory questioning the effectiveness of relapse prevention.
- 2000's -New models conceptualizing offense pathways (Self-Regulation Model) and the importance of approach goals in treatment (Good Lives Model), and broader, more holistic treatment that addresses quality of life, relationships, and motivating the offender in Tx.

What are Therapists Currently Doing?

- McGrath, et. al. (2010), surveying US and Canadian treatment programs, found:
 - Top 3 Theories that describe program
 - More than 90% cognitive-behavioral
 - More than 60% relapse prevention
 - About 35% GLM
 - Core Treatment Targets
 - About 90% offender responsibility
 - About 90% social skills training
 - About 90% victim awareness/empathy

Current Strengths of Sex Offender Treatment

- Empirical evidence exists that indicates sex offender treatment is effective.
- There is increasing accuracy and predictive validity in assessing risk to recidivate.
- There is increasing understanding of "best practices."
- Role of the therapist in the treatment process is much better understood/acknowledged.
- The recent application of "positive" and "motivational" psychology models to the treatment of sexual offenders.

Current Limitations of Sex Offender Treatment

- There remains much debate about what accounts for treatment effectiveness.
- Aside from risk assessment, there remains very little in the form of "evidence based practice."
- Relapse prevention models and manualized (one size fits all) programming remain widely used (or misused).
- Over reliance on group therapy format, failure to take full advantage of the group dynamic, and a lack of individualization of treatment.
- Generic use of cognitive and behavioral interventions, and significantly limited use of behavioral interventions within a "cognitive-behavioral" model of treatment.

An Integrated Model of Sex Offender Treatment (IMSOT)

- The goal of an IMSOT is to develop a semi-structured approach to the treatment of sexual offenders that is based on the best available research relating to the development and maintenance of sexually illegal/abusive behavior, its assessment and treatment.
- This model is necessarily dynamic, and must be able to respond to empirical research and implement new findings into practice on an ongoing basis.

An Integrated Model of Sex Offender Treatment (IMSOT)

- This model suggests that the most effective treatment strategies/programs will be those capable of **integrating** a diversity of treatment interventions:
 - Based upon what has been empirically shown to be effective with this population as a group, and
 - Based upon individual offender risk, dynamic treatment needs and response characteristics.

Integration: What is it?

- Relating to mental health treatment, it refers to the combining of two or more treatment models and/or interventions to achieve a greater treatment outcome than if those models/interventions were used in isolation (e.g., increasing predictive validity of risk assessment by combining Static 99 with Stable 2007).
- Integration is not necessarily eclecticism.

Integration: Why use it?

- The goal is to meaningfully combine and use those treatment approaches and interventions which are demonstrating the greatest effectiveness.
- Allows for the use of the best of two or more treatment approaches into one unified approach.
- Integration of treatment approaches has been an ongoing process in this field for years. However, it is often done somewhat haphazardly and without structure (e.g., "cognitive-behavioral" treatment of sexual offenders).

Past and Present Sex Offender Integrated Models

- Schwartz (The Sexual Offender, 1995)
- Rich (2003) – (Sex Offender Treatment with Juveniles)
- Integrated Humanistic (Bauman & Kopp, 2004)
- Experiential (Juveniles) (Longo, 2004)
- Dialectical Behavior Therapy (Shingler 2004)
- Risk, Need, Responsivity (Andrews & Bonta, 2006)
- Bill Marshall et. al. (2006)
- Individual Psychology (Johnson & Lokey, 2007)
- Good Lives/Self Regulation (Yates & Ward, 2008)
- Acceptance and Commitment Therapy

IMSOT

- An Integrated Model of Sex Offender Treatment Should:
 - Be grounded in etiological theory relating to the development and maintenance of sexually illegal/unhealthy behavior.

IMSOT

- An Integrated Model of Sex Offender Treatment Should:
 - Be capable of addressing and accommodating individualized needs, such as persons with widely varied sexual offense histories, cognitive abilities, and motivation for change.

IMSOT

- An Integrated Model of Sex Offender Treatment Should:
 - Address both approach goals and avoidance goals as important targets of behavior change.

IMSOT

- An Integrated Model of Sex Offender Treatment Should:
 - Effectively utilize the “common factors” and therapist variables that are known to positively impact and facilitate personal change and treatment outcomes.

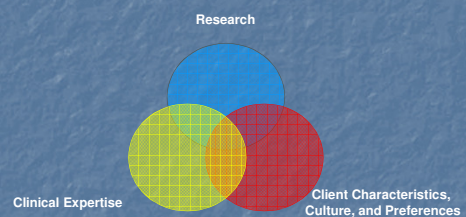
IMSOT

- An Integrated Model of Sex Offender Treatment Should:
 - Encompass the range of treatment needs commonly seen in sexual offenders, including both sex offender specific and sex offender related treatment targets. Treatment interventions, where possible, should be based on empirically validated effectiveness and an “evidence based practices” approach.

Evidence Based Practices

- What are EBP's?
 - The Integration of the best available research with a clinician's clinical expertise, in the context of client characteristics, culture, and preferences.
 - American Psychological Association (2006).
 - Within the EBP trinity, research stands as the primary source of evidence.

The EBP Trinity



EBP's in Sex Offender Treatment?

- The American Psychological Association's Society of Clinical Psychology (Division 12)
 - Website on research-supported psychological treatments (PsychologicalTreatments.org):
 - No research supported treatments relating to sexual offending, sexually illegal, or sexually unhealthy behavior listed on website.

EBP's in Sex Offender Treatment?

- The US Substance Abuse and Mental Health Services Administration (SAMHSA)
 - In 2007 launched the National Registry of Evidence-based Practices and Programs (NREPP): (www.nrepp.samhsa.gov)
 - Multi-systemic Therapy for Youth with Problem Sexual Behaviors
 - Moral Reconation Therapy (EBP for "criminal recidivism")
 - Relapse Prevention (not listed for use with sex offenders)
 - Social Skills Training (listed for persons with schizophrenia)

Etiological Theory Regarding Sexually Unhealthy Behavior

- Marshall & Barbaree (1990)
 - Biological Influences
 - Role of sex steroids in sex and aggression.
 - Childhood Experiences
 - Punitive/violent parenting style, development of self-esteem, interpersonal skills
 - Socio-cultural Context
 - Attitudes toward women, pornography
 - Transitory Situational Factors
 - Emotion, substance use

Etiological Theory Regarding Sexually Unhealthy Behavior

- Ward and Beech (2006)
 - Three sets of factors that interact to produce sexually unhealthy behavior:
 - Biological Factors – Abnormalities of brain development
 - Ecological Niche Factors – Adverse social and cultural circumstances, personal circumstances, and physical environment
 - Neuropsychological Factors – Abnormalities in:
 - Motivational/emotion system
 - Action selection and control system, and/or
 - Perception and memory system

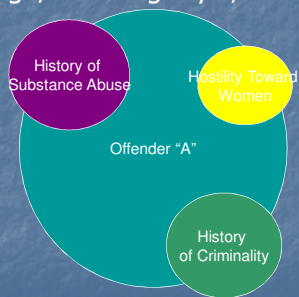
Etiological and Theoretical Assumptions of the IMSOT

- Recognizes the heterogeneity of the client population with respect to etiology, treatment needs (empirically based risk factors), and motivation for change.
- Bio-psycho-social model best explains the development and maintenance of sexually illegal (unhealthy) behavior.

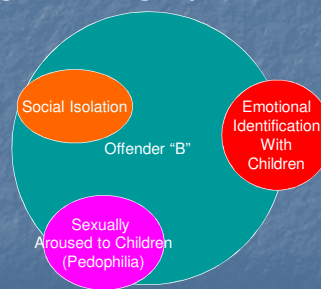
Workshop Exercise: Think of Someone You Know

- Think of someone you know - A friend, family member, colleague:
 - An Adolescent
 - A Grandfather
 - A Teacher
 - A Religious Leader

Offender "A" Ethnicity, Age, Learning Style, Motivation



Offender "B" Ethnicity, Age, Learning Style, Motivation



Sex Offender Heterogeneity

- Diversity of Client Population
 - Demographic characteristics
 - Range of abusive behaviors (frequency, use of force/manipulation, planning)
 - Targets of abuse/violence
 - Motivation and causative factors
 - Risk for recidivism/re-offending

Core Components of the IMSOT

- Actuarial and dynamic risk assessment.
- Treatment preparation and readiness.
- Risk based and individualized treatment.
- Interventions that focus on dynamic risk factors and sex offender specific treatment targets.
- Relapse prevention approaches:
 - are **secondary** to core treatment interventions.
 - are discussed **after** fundamental personal/behavioral **change has been established**.
 - are used to **maintain treatment gains**.

The Role of Assessment in the IMSOT

- Assessment is ongoing:
 - Should inform treatment decisions
 - Should lead to more efficient use of resources
 - Should lead to better treatment outcomes
 - Should involve the client as an informed participant in the treatment process

Assessment

- Actuarial assessment of risk – Overall risk to recidivate:
 - Static 99 (Hanson & Thornton, 2000) or Static 2002 (Hanson & Thornton, 2003)
 - MnSOST-R (Epperson et. al. 1999)
- Actuarial assessment can assist in determining the intensity and duration of treatment.

Assessment

- Individual dynamic risk factors -
 - Dynamic factors associated with recidivism (Hanson et. al., 2007):
 - Stable risk factors (treatment should focus on changing)
 - Acute risk factors (treatment should focus on managing)

Assessment

- Stable Factors (Hanson et. al., 2007)
 - Significant Social Influences
 - Intimacy Deficits
 - Capacity for Relationship Stability
 - Emotional Identification with Children
 - Hostility toward women
 - General Social Rejection/loneliness
 - Lack of concern for others
 - General Self-Regulation
 - Impulsive acts
 - Poor cognitive problem solving
 - Negative Emotionality/Hostility
 - Sexual Self-Regulation
 - Sexual Pre-occupations
 - Sex as coping
 - Deviant sexual interests
 - Co-operation with Supervision

Assessment

- Acute Factors (Hanson et. al., 2007)
 - Victim access
 - Sexual preoccupations
 - Rejection of supervision
 - Hostility

Assessment

- Other individual treatment needs, skill deficits, and offender dynamics:
 - Penile Plethysmograph (Monarch System)
 - PCL-R (Hare, 2003)
 - PICTS (Walters et. al., 2009)
 - MMPI/MCMI

Assessment

- Response to treatment
 - Treatment progress and response:
 - Sex Offender Needs and Progress Scale (McGrath and Cumming, 2003)
 - Goal Attainment Scale (Stirpe et. al., 2001)
 - Treatment planning – Goals and interventions should be clearly communicated and agreed upon between clinician and client.
 - Good old fashioned discussions about client's perceptions of treatment and perceived treatment needs.

Common and Specific Treatment Factors

- As per Garfield (1980)
 - Common Factors: Psychotherapy...
 - Provides meaning to previously ambiguous emotion/thought/behavior.
 - Instills hope (that change is possible, that the client will feel better, fewer symptoms, etc.).
 - Encourages client to think differently, practice new (cognitive, emotive, or behavioral) skills.
 - Allows therapist to show confidence in client's ability to change.
 - Creates a venue in which the therapist, as an expert, can provide information and interventions to facilitate change.

Common and Specific Treatment Factors

- Specific Factors in Therapy
 - Effective therapies utilize the basic common factors, plus some specific procedures selected for the particular case at hand (Garfield, 1980).

Treatment Preparation and Readiness

- Marshall et. al. (2008) have found that a motivational based treatment preparation program can:
 - Instill feelings of optimism and confidence in sex offenders.
 - Can increase their belief that they can be the agency of change that will reduce their risk for recidivism.
 - Offenders receiving preparation programs show a greater belief in the need for change and show higher levels of treatment readiness.

More About Risk Factors and Treatment Targets

- Mann et. al. (2010) looked at the strength of evidence regarding suspected risk factors.
- Meaningful risk factors are those where:
 - A plausible rationale exists that the factor is a cause for sexual offending.
 - There is strong evidence that the factor predicts sexual recidivism.

Risk Factors and Treatment Targets

- Mann et. al. (2010) Continued:
 - Concept of *propensities* vs. static/dynamic risk.
 - Five categories based on empirical findings –
 - Empirically supported risk factors
 - Promising risk factors
 - Unsupported but interesting exceptions
 - Worth exploring
 - Little or no relationship to sexual recidivism

Risk Factors and Treatment Targets

- Mann et. al. (2010) Continued:
- **Empirically Supported Risk Factors** -
 - Sexual preoccupation
 - Any deviant sexual interest (PPG, sexual viol., mult. paraphilias)
 - Offense supportive attitudes
 - Emotional congruence with children
 - Lack of emotionally intimate relationships with adults
 - Lifestyle impulsivity
 - General self-regulation problems (employment instb.)
 - Resistance to rules and supervision (viol. cond. rlse)
 - Grievance/hostility
 - Negative social influences

Risk Factors and Treatment Targets

- Mann et. al. (2010) Continued:
- **Promising Risk Factors** –
 - Hostility toward women
 - Machiavellianism
 - Callousness/lack of concern for others
 - Dysfunctional coping (sexualized coping)

Risk Factors and Treatment Targets

- Mann et. al. (2010) Continued:
- **Unsupported but with Interesting Exceptions** –
 - Denial
 - View of Self as Inadequate
 - Major Mental Illness
 - Loneliness

Risk Factors and Treatment Targets

- Mann et. al. (2010) Continued:
- **Worth Exploring** –
 - Adversarial Sexual Orientation
 - Fragile Narcissism
 - Sexual Entitlement
- **Unrelated to Sexual Recidivism** –
 - Depression
 - Poor Social Skills
 - Poor Victim Empathy
 - Lack of Motivation for Treatment at Intake

Individualizing Treatment within a Group Modality

- Within the IMSOT, individualized treatment needs are targeted within the group therapy process (and/or in individual therapy).
- The sex offender therapist must remain cognizant of two ongoing layers of the treatment process:
 - Individual client needs and progress
 - Dynamics within the group therapy process that influence and facilitate the therapeutic impact upon each individual

Approach and Avoidance Goals

- **Approach Goals:**
 - Should be emphasized over avoidance goals -
 - Healthy, emotionally rewarding relationships
 - Healthy style of satisfying intimacy/sexual needs
 - Healthy leisure, occupational, and personal interests
- **Avoidance Goals:**
 - Should not be ignored or de-valued -
 - Therapeutic targets should be realistic and based on offender risk factors
 - Avoid contact with children
 - Do not purchase or consume pornography
 - Avoid socializing with unhealthy peers
 - Do not purchase or consume alcohol or illicit drugs

Therapist Variables that Impact Treatment Outcome

- The impact of the psychotherapist, as well as other “common factors”, on treatment outcome has long been recognized (e.g. Yalom, 1985; Garfield and Bergin, 1986).
- The impact of the psychotherapist on the treatment of sexual offenders has recently received greater attention and validation.

Therapist Variables that Impact Treatment Outcome

- Marshall and Serran (2004) and Marshall (2005) have shown that therapist’s displays of empathy, warmth, rewardingness and directiveness significantly influenced positive behavior change among sexual offenders.

Therapist Variables that Impact Treatment Outcome

- Williams (2004), in questioning sexual offenders about their treatment experience, found that human relationship dynamics (trustworthiness, a motivational climate, and openness) between offenders and professional staff were foundational to a positive treatment experience.

Therapeutic Interventions within the IMSOT

- Common Factors
 - Program philosophy, treatment preparation
 - Therapist factors
 - Group dynamics that facilitate change
- Specific Factors
 - The treatment core is not RP. Rather, treatment interventions address both sexual and global problems relating to skill deficits, cognitive dysfunction, and behavioral regulation.
 - RP techniques are introduced at the back end of treatment as a way of maintaining treatment gains.

Therapeutic Interventions within the IMSOT

- Skill Development
- Cognitive Dysfunction
- Behavioral Excesses/Deficits
- Maintenance of Treatment Gains
- Enhancing Ego Strength/Healthy Behavior

Therapeutic Interventions within the IMSOT

- Skill Development
 - Interventions: Psycho-educational
 - Social isolation and social relationships
 - Lack of emotionally intimate relationships with adults and general intimacy deficits
 - Dysfunctional coping and stress management
 - Axis I disorders

Therapeutic Interventions within the IMSOT

- Cognitive Dysfunction
 - Interventions: Cognitive Restructuring
 - Offense supportive and criminogenic attitudes/beliefs
 - Hostility toward women
 - Emotional identification and congruence with children
 - Lack of concern for others and empathy development
 - Emotional management/anger management
 - Self-esteem and self concept
 - Axis II disorders

Therapeutic Interventions within the IMSOT

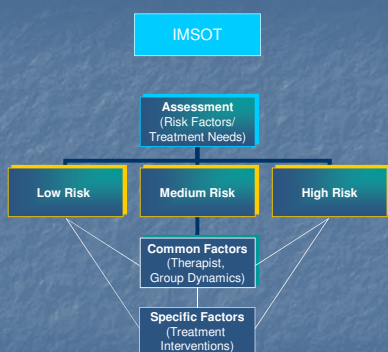
- Behavioral Regulation
 - Interventions: Behavioral Therapies
 - Sexual regulation/arousal management
 - Deviant sexual interests
 - Sexual preoccupation
 - Impulse control and lifestyle impulsivity
 - Resistance to rules and supervision
 - Substance abuse/dependence

Therapeutic Interventions within the IMSOT

- Maintenance of Treatment Gains
 - Intervention: Relapse Prevention
 - Cognitive-Behavioral Relapse Prevention Plans
 - Managing acute risk factors (used primarily with medium and high risk offenders)
 - Access to victims
 - Negative social influences

Therapeutic Interventions within the IMSOT

- Enhancing Ego Strength/Healthy Behavior
 - Intervention: Supportive Therapy
 - Developing and maintaining meaningful, enjoyable, and healthy leisure activities
 - Developing relationships and identity through work and occupational fulfillment
 - Enhancing self esteem
 - Managing re-entry, social stigma, and identity issues (being ostracized by culture/friends)



IMSOT Program Characteristics

- Should strike a balance between structure and flexibility.

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Program Integrity

Program Drift

IMSOT Program Characteristics

- Program is structured in a manner that clients are encouraged and rewarded for taking responsibility for and being actively engaged in their treatment.
- Program is structured in a manner that clients are encouraged and rewarded for being informed consumers of research and information related to the perpetration of sexual violence and abuse, and its assessment and treatment.

IMSOT Program Characteristics

- Value and importance of pre-treatment orientation and preparation (e.g., see Marshall et. al., 2008).
- Consistent and clear communication of program philosophy.
- Importance of communicating belief in the capacity for positive change and the value of every client as a person.

Best Practices Top 10 Checklist

1. Treatment dosage is based on assessment of risks and needs.
2. Treatment targets are supported by existing research.
3. Treatment approach and objectives are clearly communicated to client.
4. Treatment is individualized.
5. The group dynamic works to the benefit of the client.

Best Practices Top 10 Checklist

6. Therapist variables that impact treatment outcome are managed to the client's benefit.
7. A motivational and positive therapeutic environment exists.
8. Progress is measured and discussed with client.
9. Responsivity factors are assessed (especially for special populations) and managed to the client's benefit.
10. All therapeutic interventions are based firmly within a therapeutic model (e.g., cognitive-behavioral, supportive, psycho-educational).

Discussion/Q and A

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