Treating to Reduce Risk in Sex Offenders

Jay Englehart, MD
Director of Treatment Services
Sex Offender Rehabilitation and Treatment Service of Southeast Missouri Mental Health Center
Amy Griffith, Ph. D.
Clinical Director and SVP Psychologist
Missouri Sex Offender Program,
Missouri Department of Corrections, Corizon Health

Initial Evaluation

- Follow the principle of Risk-Need-Responsivity
  - Determine the level of **risk** for the individual. The higher the risk for re-offense, the higher the priority for treatment
  - Determine the specific areas of **need** for the individual patient in order to reduce that risk
  - Determine the patient's strengths and deficits in order to maximize their **response** to treatment by choosing the best modality for that individual

Determining Risk

- Primarily based on Actuarial assessments, but
  - informed by individual traits (including strengths),
  - studies of individual risk categories,
  - level of supervision/containment
  - Studies of who has been caught (Dr. Dvoskin)

Static Risk

- Factors which influence long-term risk which are not influenced by treatment
  - Age
  - Victim type or types
  - General Criminality Factors
  - Relationship History
- Measured by Actuarial Instruments such as the Static-99-R among others.

Dynamic Risk

- Factors which influence risk either short- or long-term which may be modified through treatment
- These factors become TREATMENT TARGETS
- Actuarial Instruments measuring these to varying degrees include
  - STABLE-2007
  - SOTIPS
  - ACUTE-2007

Dynamic Risk Factors Gold Standard

- **Assessing Risk for Sexual Recidivism: Some Proposals on the Nature of Psychologically Meaningful Risk Factors**
- Ruth E. Mann, R. Karl Hanson and David Thornton, *Sex Abuse 2010 22: 191*
- Reviewed risk factor studies to find those with the most evidence

Empirically Supported Factors

- *Sexual preoccupation*
  - An abnormally intense interest in sex that dominates psychological functioning
  - Feels sexually dissatisfied despite engaging in high levels of (mainly impersonal) sexual behavior
  - Would substantially overlap with having sexual compulsions, sexual addiction and hypersexuality

Empirically Supported Factors

- *Deviant Sexual Interest(s)*
  - Sexual preference of children (PPG or Behaviorally), Such as immaturity in skin texture, degree of body and pubic hair, smell, body shape, musculature and breast and genital development
  - Sexualized violence or sexual interest in violence
  - An interest in sadism or a preference for coercive sex over consenting sex
  - Multiple paraphilias

Empirically Supported Factors

- *Offense supported attitudes*
  - Beliefs that justify or excuse sex offending **in general**
  - Attitudes that condone sexual offenses in others or in general rather than the accounts offenders provide to excuse or justify their own specific behaviors (i.e. children enjoy sex, sex with a child is harmless, children are sexually provocative)

Empirically Supported Factors

- *Emotional congruence with children*
  - Feeling that relationships with children are more emotionally satisfying than relationships with adults
  - May find children easier to relate to than adults or feel like a child himself
  - May believe that children understand him better than adults
  - Feels “in love” with his child victims

Empirically Supported Factors

- *Lack of emotionally intimate relationships with adults*
  - Have no intimate relationships or intimate relationships that involve repeated conflict and/or infidelity
  - Includes those who desire intimacy but have been unable to achieve it and those who do not desire intimacy.
  - Both groups are at increased risk

Empirically Supported Factors

- *Life Impulsiveness*
  - General self-regulation problems with impulsivity/recklessness/low self-esteem
  - Chronic instability in employment and housing
  - Lack of meaningful daily routines
  - Irresponsible decisions
  - Limited or unrealistic long-term goals

Empirically Supported Factors

- *Poor problem solving*
  - Cognitive difficulties in generating and identifying effective solutions to the problems of daily living
  - Deficits include problem recognition or conceptualization; lack of consequential thinking; difficulties generating suitable options
  - Behaviorally, may avoid addressing obvious problems and deploy ineffective problem solving i.e., using avoidance, distraction, rumination vs. active problem-solving.

Empirically Supported Factors

- *Resistance to rules and supervision*
  - Rule breaking and opposition to external control
  - Noncompliance with supervision
  - Violation of conditional release
  - A defiant attitude to authority and a history of oppositional behavior (failing to follow direction, missing or arriving late to appointments, deceiving the supervisor). The underlying propensity here is the defiant attitude to authority with oppositional behavior manifesting this underlying propensity

Empirically Supported Factors

- *Grievance/hostility*
  - Perception of having been done wrong by the world, feeling that others are responsible for his problems, and wanting to punish others as a consequence
  - Preoccupied with obtaining the respect he desires from others
  - Frequently ruminates on vengeance themes
  - Have difficulty seeing other people's point of view and anticipate further wrongs will be perpetrated against him

Empirically Supported Factors

- *Negative Social Influences*
  - A social network dominated by individuals who are involved in crime, promote criminal behavior or weaken the behavioral controls of the offender
  - Can also include those who are supportive of the individuals' negative behaviors while trying to be "supportive" of the patient overall.

Promising Factors

- These risk factors have the support of 1 or 2 prediction studies plus some supporting evidence of other kinds
- *Machiavellianism*
  - Views others as weak, cowardly, selfish and easily manipulated
  - An interpersonal strategy in which it is viewed as sensible and appropriate to take advantage of others

Promising Factors

- *Hostile beliefs toward women*
  - Seeing women as malicious and deceptive in their interactions with men
  - Believing that women like making fools of men, women seldom express their true feelings directly and that if a woman appears sexually interested in a man, the expression is probably deceitful and manipulative
  - Women subsequently are placed into a separate category not worthy of trust and respect

Promising Factors

- *Lack of concern for others*
  - Callous, egocentric, tendency to engage in instrumental rather than affectively warm relationships
  - Poor empathy in general (not just for their victim(s)), lack of sympathy for others
  - Related to Facet 2 of the PCL-R, seen as selfish, cynical, willing to be cruel to meet his own needs
  - Appear indifferent to other people's rights or welfare except as it influences his own interests

Promising Factors

- *Dysfunctional coping*
  - The ways in which sexual offenders manage negative emotions such as anger, anxiety, rejection and humiliation
  - Two forms most relevant to risk assessment involving responding to stress
    - Through sexual responses
    - Through externalizing behaviors more generally

Generally Not Risk Factors

- *Denial of Crimes*
  - May be ego protective for some offenders
- *Low Self Esteem/loneliness* – poor evidence for increasing
- *Major Mental Illness*
- *Depression*
  - is intrinsically worthy of intervention, but it is not related to sexual recidivism.
  - The direction of the relationship is, if anything, negative, such that the most depressed offenders are the least likely to reoffend.

Generally Not Risk Factors

- *Social skills deficits*
  - None of the follow-up studies have found that social skills deficits predicted sexual or violent recidivism.
  - These deficits appear to be more specifically related to intimacy deficits and hostile attitudes toward women, rather than to poor dating skills or problems negotiating routine social situations.
- *Poor victim empathy*
  - is of interest because victim empathy has been a standard component of most sexual offender treatment programs (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010).

TREATMENT

- How do we treat these risk factors so as to minimize them?

Missouri Sex Offender Program (MoSOP)

- Missouri Department of Corrections
  - Services provided by contractor: Corizon Health
- SO Treatment focused in 3 primary institutions
  - Farmington Correctional Center
  - Eastern Reception, Diagnostic, and Correctional Center (ERDCC - Bonne Terre)
  - Womens' Eastern Reception, Diagnostic, and Correctional Center (WERDCC - Vandalia)
- Other institutions
  - Moberly Correctional Center
  - Crossroads Correctional Center (TBA)

How MoSOP Looks Now

- 270-365 day program (9-12 months, per DOC policy)
- Current census ~300 offenders
- 2 Phases
- One-size-fits-all
  - RNR framework within existing structure
    - Treatment needs are targeted on individual basis, but all risk levels together in groups
    - Special Needs Unit (FCC & ERDCC)
    - Social Rehabilitation Unit (SRU)
    - Protective Custody
    - Womens' SO Treatment

Phase I of MoSOP

- Orientation to the program
- Offenders from GP, 14-16 months from their earliest release date
- 4 weeks, 3-4 hours per week
- Utilize advanced Phase II volunteers to assist/engage
- Introduce treatment concepts, engage in treatment and group discussion atmosphere, address stages of change
- Assessment –informed Treatment
  - Static-99R, Stable-2007, SSPI, attitudinal scales to assess offense-supportive beliefs, and clinical interview
  - Assessments identify treatment targets

Phase I of MoSOP cont…

- Currently, DOC Policy requirement that offenders accept responsibility for their offense(s) to participate in treatment
- 2 opportunities to participate in treatment (2nd as time and resources allow)
- MO Statutory requirement that offenders must complete SO treatment in order to be eligible for early release
- If terminated from treatment or refuse, offenders with sex offenses will be released on their Maximum Release Date

Phase II of MoSOP

- Core of treatment program (270-365 days)
- CBT approach, with Good Lives Model (GLM)
- Therapeutic Community (FCC)
- Process Groups
- Psychoeducational programming
- Therapeutic Community Meetings
- Therapeutic Study Hour
- No individual treatment by MoSOP, may go to MH
- Currently, no co-therapy

Phase II of MoSOP cont…

- Process Groups
  - Offense Layout
  - Autobiography with Sexual Victim(s) Disclosure
  - Offense Chain
  - Victim Empathy Exercise
  - Future Me Success Plan
  - Here-and-Now issues
  - Adjunct tasks, as assigned/needed, based on treatment targets
    - Sexual Thoughts/Fantasies Logs
    - Emotion Logs
    - Good Lives Model Primary/Secondary Goals
    - Decision Chains

Phase II of MoSOP cont…

- Psychoeducational Programming
  - Healthy Relationships and Sexuality
  - Healthy Communication and Problem Solving
  - Emotion Management
  - Criminal Thinking
  - Good Lives Model
- Therapeutic Community Meetings
  - "Business"/Problem solving among unit, therapist oversight, but offender-led
- Therapeutic Study Hour
  - Therapist-monitored study session, with opportunity to ask questions about group tasks, go over Individualized Treatment Plans, etc.

MoSOP Now cont…

- Completion of treatment
  - Offender completes required treatment tasks, and demonstrates reduction of risk on post-treatment risk assessments

- SVP End of Confinement Evaluation prior to release:
  - MoSOP performs screening evaluations for all sex offenders in DOC pending release
  - If referred, EOC report initiates civil commitment process, but does not decide

Not-too-distant Future MoSOP

- Updated to reflect empirically-supported best practices
- Goal of targeting/reducing risk, increasing participation, and decreasing attrition
- RNR framework, CBT approach
- 3 Treatment Tracks, based on risk level
  - Standard
  - Enhanced
  - Intensive

Future MoSOP cont…

- Standard Treatment Track
  - Offenders assessed at LOW risk/need
  - 6-9 months
  - Minimum of 100 hours total treatment dosage
  - Treatment will consist primarily of psychoed programming
  - Tentatively will be housed in HU#1 at FCC, adding ~150 beds to our existing census

Future MoSOP cont…

- Enhanced Treatment Track
  - Offenders assessed at MODERATE risk/need
  - 9-12 months
  - Minimum of 200 hours total treatment dosage
  - Treatment will consist of process groups and psychoed programming, with supplementary hours as needed
  - Offenders will be housed in HU#25 at FCC

Future MoSOP cont…

- Intensive Treatment Track
  - Offenders assessed at HIGH risk/need
  - 12-18 months
  - Minimum of 300 hours total treatment dosage
  - Treatment will consist of process groups and psychoed programming, with supplementary hours as needed
  - Offenders will be housed in HU#25 at FCC

Future MoSOP cont…

- Assessment will maintain
  - Static-99R
  - Stable-2007
  - SSPI
  - Attitudinal scales – offense-supportive beliefs
  - PCL-R as needed to clarify responsivity needs
  - WASI/WRAT when needed to clarify responsivity needs

- Progress in Treatment will be assessed using the Goal Attainment Scale (adapted from Hogue, 1994; see Barrett et al., 2007, Hanson et al., 2007, and Stirpe et al., 2002)
- Considering a group for offenders who deny their offenses, or are in earlier stage of change

SORTS TREATMENT

- PHASE I – Entering treatment
  1. Use Motivational Interviewing Techniques and Privilege Expansion through treatment to engage individuals
  2. Teach the basics of therapeutic interventions

SORTS TREATMENT

- PHASE I – Entering treatment
  3. Begin evaluating treatment needs through interviewing, observation and testing
  4. Focus treatment on coming to terms with commitment and beginning to look at risk factors

SORTS TREATMENT

- PHASE II – Cognitive and Emotional Recognition
  1. Fully integrate into group
  2. Challenging the thoughts which can lead to sexual offending

SORTS TREATMENT

- PHASE II – Cognitive and Emotional Recognition
  3. Recognizing and naming the emotions which result from those thoughts
  4. Begin work on developing problem solving and coping skills

SORTS TREATMENT

- PHASE III – Cognitive and Emotional Regulation
  1. Continue to build and integrate into daily living use of learned skills.
  2. Have a thorough understanding of the emotional, cognitive, circumstantial and deviant aspects which ended in offending

SORTS TREATMENT

- PHASE III – Cognitive and Emotional Regulation
  3. Identify idiosyncratic risks
  4. Show ability to use understanding and skills in a wide variety of contexts.

SORTS TREATMENT

- PHASE IV – Community Reintegration
  1. Continuation of work from Phase III.
  2. Develop skills and supports needed for success outside the controlled environment

Protective Factors

- *Proposed in a recent paper, only minimal evidence at this time.*
- **An Exploration of Protective Factors Supporting Desistance From Sexual Offending, Michiel de Vries Robbé, Ruth E. Mann, Shadd Maruna, and David Thornton.** Sexual Abuse: A Journal of Research and Treatment 2015, Vol. 27(1) 16–33

Using Protective Factors in Treatment Planning

- Conveys positive goals
- Must be careful to not expect optimal achievement of each protective factor – may be seen as hopeless
- Follows the Good Lives Model – if you have achieved all these protective factors, your chance for a "Good Life" is enhanced.
- Each can be evaluated on a continuum

Protective Factors

Risk Factor

- Sexual preoccupation

Corresponding Protective Factor

- Moderate intensity sexual drive
- A preference for having sex with someone you are emotionally attached to and who is attached to you. Romantic or emotionally intimate connection is seen as being as desirable as sexual gratification.

Protective Factors

Risk Factor

- Deviant sexual interest

Corresponding Protective Factor

- Sexual preference for consenting adults
- A preference for sex with consenting sexual partners of adult age. Desire for potentially reciprocal sexual activities in which the adult partner is more likely than not to also be interested in the activity.

Protective Factors

Risk Factor	Corresponding Protective Factor
• Offence-supportive attitudes	• Supportive of respectful age-appropriate sexual relationships • Weighs the rights of others equally with own wants and desires. • Recognizes the right to refuse sexual activity . • Recognizes the nature of childhood and the implications of emotional & physical immaturity for likely harm that would be caused by early sexual activity.

Protective Factors

Risk Factor

- Emotional congruence with children

Corresponding Protective Factor

- Preference for emotional intimacy with adults
- Recognizes the nature of childhood developmental stages and the more limited capacity of children in relation to adult-oriented constructs such as reciprocal emotional intimacy.

Protective Factors

Risk Factor	Corresponding Protective Factor
• Lack of emotionally intimate relations with adults	• Capacity for lasting emotionally intimate relationships with adults • Has one or more emotional confidantes; has lasting intimate relationships including sexual relationships; can maintain a stable relationship for longer period of time; relationships are characterized by mutual disclosure of vulnerability and acceptance of each other's faults

Protective Factors

Risk Factor	Corresponding Protective Factor
• Lack of emotionally intimate relationships with adults	• Sustained emotionally intimate marital type relationships; emotionally intimate friendships; cooperative and discriminating approach to casual social/work contacts.

Protective Factors

Risk Factor	Corresponding Protective Factor
• Lifestyle impulsiveness (poor self-regulation, impulsive and reckless, unstable work patterns)	• Self-control • Able to set and achieve medium and long-term goals through effortful goal-directed actions. • Considers consequences before taking decisions, and weighs consequences to others at least as highly as consequences to self.

Protective Factors

Risk Factor

- Lifestyle impulsiveness (poor self-regulation, impulsive and reckless, unstable work patterns)

Corresponding Protective Factor

- Values prosocial solutions and seeks to achieve peaceful resolutions of difference rather than aggressive resolutions.
- Regulating immediate impulses, stress reactions, and general lifestyle.

Protective Factors

Risk Factor

- Poor cognitive problem solving

Corresponding Protective Factor

- Effective problem-solving skills
- Able to articulate different solutions to a problem, including pro-social solutions, and choose between solutions by considering the consequences, to self and others, of each option.
- Weights long-term gain over short-term gain.

Protective Factors

Risk Factor	Corresponding Protective Factor
• Resistance to rules and supervision	• Acceptance of rules and supervision • Capacity to connect with people in authority. Meaningful relationships with supervising or treating professionals. • Able to accept rules and regulations and keep to agreements with treatment staff, employers, probation officers and other professionals.

Protective Factors

Risk Factor	Corresponding Protective Factor
• Resistance to rules and supervision	• Manages to obey imposed legal conditions.

Protective Factors

Risk Factor	Corresponding Protective Factor
• Grievance/hostility	• Trustful and forgiving orientation • An orientation to others that is typically trustful and peaceful, seeing the others' point of view/perspective, preferring peaceful solutions to interpersonal conflict and generally able to offer forgiveness after being wronged.

Protective Factors

Risk Factor	Corresponding Protective Factor
• Negative social influences	• Law-abiding social network • Social network primarily or entirely composed of stable, law-abiding individuals who promote pro-social activity and who offer support and strengthen self-control.

Protective Factors

Risk Factor	Corresponding Protective Factor
• Hostility toward women	• Positive Attitudes Toward Women • Generally pro-social, trusting and respectful attitudes toward women. Views women as equal to men. Believes women have good intentions

Protective Factors

Risk Factor	Corresponding Protective Factor
• Machiavellianism	• Honest and respectful attitudes • Views others as equal. Recognizes others abilities and strengths. Values honesty and does not take advantage of others.

Protective Factors

Risk Factor

- Lack of concern for others/callousness

Corresponding Protective Factor

- Care and Concern for others
- Shows interest in others . Cares about other people's feelings and well-being.
- Attempts to help others when in need and does not act on own needs before considering those of others.

Protective Factors

Risk Factor	Corresponding Protective Factor
• Dysfunctional Coping	• Dealing with negative emotions (like anger, anxiety or rejection) through appropriate, socially acceptable strategies. Managing stress in a calm, non-sexual, and effective manner.

Evaluation and Treatment

- Actuarials, SOTIPS, PCL-R, Cognitive, Personality, Diagnostic, Substance Abuse, Trauma History, Polygraphy, Penile Plethysmograph, Observation of Behaviors and Thought Processes
- Annual Court reports

Evaluation and Treatment

- Motivational Interviewing
- Psychoeducational Groups, (i.e. Understanding Cycles/Pathways to offending, Anger Management, Mindfulness, Social Skills, Medication, Human Sexuality, Coping Skills, Recreational Skills, Arousal Management, Thinking Errors, Empathy, Trauma, etc)

Evaluation and Treatment

- Treatment groups – process groups (including logs, journals, autobiography), DBT type groups, self-regulation, community meetings, substance abuse
- Specialized tracks – SOS for poorly engaged, dysregulated or unable to complete CBT, special needs
- Individual therapy for trauma symptoms/signs, grief, anxiety
- Levels and Problem Behavior Worksheets
- Medications including SSRI's, antiandrogens, naltrexone for sexual preoccupation/deviant sexuality

Release – Wisconsin Model

- Meaningful participation in treatment
- At a level sufficient to allow evaluation of treatment needs
- Shows a willingness to work on treatment needs
- Demonstrates understanding of thoughts, attitudes, emotions, behaviors and arousal linked to his or her offending.

Release – Wisconsin Model

- Demonstrates ability to identify when these linked thoughts, attitudes, emotions, behaviors and periods of sexual arousal occur.
- Demonstrates sustained change in these linked states such that it is reasonable to assume that the change can be maintained

Release – Wisconsin Model

- Reasonable levels of resources are available to insure a level of treatment, supervision, housing and management (along with treatment progress) so that it is substantially probable the person will not engage in acts of sexual violence if released into the community.