Development of an ID Sexual Offender Treatment Program that incorporates DBT reconceptualization, DBT coping skills, and GLM elements specifically for moderate to high risk sexual offenders in a secure setting

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There was an increasing demand to provide treatment to ID sex offenders as more and more of our care recipients have sexual offending issues and/or have sexual offences.

A recent survey at the Mason Clinic showed there is a significant number (17.5%; n = 21) of sex offenders or those who have sex offending issues admitted in the service (Easden & Sakdalan, 2015). Majority of the ID offenders (9 out of 10) are sex offenders (e.g. child and adult sex offenders)
The Adapted Mason – Sexual Offender Rehabilitation and Treatment—Intellectual Disability (AM-SORT-ID) was developed in 2010 as a service initiative within a forensic disability secure setting in Auckland, New Zealand.

This programme aimed to address the treatment needs of high risk sexual offenders with intellectual disability within a secure setting.

At the time of its inception, there was no existing evidence-based treatment program for high risk ID sexual offenders in forensic secure settings in NZ.

Furthermore, there was paucity of research on evidence-based ID sexual offender treatment programs developed specifically for high risk sexual offenders.
At the time, the Sex Offender Treatment Services Collaborative – Intellectual Disabilities (SOTSEC-ID) developed by Professor Glynis Murphy and her colleagues in the UK (SOTSEC-ID, 2010) appeared promising.

- The SOTSEC-ID is a CBT-based program that was developed for community-based ID sexual offenders.

- The SOTSEC-ID was found to be effective in reducing sexually abusive behaviours in ID clients and that treatment gains were generally maintained on six month follow up.
Limitations of the CBT-based programmes

• CBT-based programs in general have limitations in addressing the following issues:
  
  (1) addressing client’s experience of negative affect (e.g. shame and guilt) and their ability to manage emotional and sexual dysregulation;
  
  (2) does not address client’s distal risk factors or vulnerabilities;
  
  (3) tendency for clients to engage in counter-therapeutic strategies when being challenged about their offending
  
  (4) Lack of focus on client’s future goals to leave a meaningful and offence free life in the community
The pilot group (AM-SORT-ID previously called SAFE-ID program) carried out in 2010 was a 7 month programme.

This study showed that participants markedly improved across all outcome measures after completion of the group.

- increased sexual knowledge
- reduction in risk of recidivism
- reduction in cognitive distortion
- reduction in attitude supportive of sexual offending
- increase in victim empathy

Participants generally maintained their gains after one-year follow-up.

Marked reduction in incidents with all participants not only for sexually abusive and/or inappropriate sexual behaviours but for other problematic behaviours such as physical and verbal aggression.
AM-SORT-ID

Background

• The AM-SORT-ID is largely a CBT-based and additional components to address the treatment gaps:
  • DBT reconceptualisation using the Risky Mind-Wise Mind
  • Inclusion of distal risk factors/vulnerabilities in the overall formulation
  • Use of validation strategies
  • Incorporation of DBT coping skills
  • Incorporation of Good Lives Model elements via Wise Life/Wise Journey
AM-SORT-ID

• The AM-SORT-ID is a one-year programme with group sessions delivered once weekly for two hours.

• The incorporation of the additional components particularly DBT concepts and skills would be particularly useful for clients with complex presentations (e.g. personality disorder traits).

• Group sessions are complemented by weekly 30-minute individual sessions (totalling 24 hours); these are provided by the group facilitator(s).

• Groups will be co-facilitated with regular and consistent set of appropriately qualified and skilled staff to manage against disruption and support therapeutic alliance.
The AM-SORT-ID programme is a 12-month programme (2-hour weekly sessions). In addition, each participant receives individual input (either regular debriefing or individual psychotherapy).

- Presence of male and female therapists in every session.
- We require their keyworkers to support them in the group particularly with the first two modules.
- Pre-assessments and suitability assessments are carried out prior to the start of the programme.
• Post-assessments are carried out a week or two after completing the programme. Clients are re-assessed in six months’ time.

• It is preferred that it is a closed group. However, there is also an option of a modular entry to allow some clients to enter the group before the start of the next module. This is assessed on a case by case basis.
AM-SORT-ID

• Inclusion criteria:
  • Clients with intellectual disability or significant cognitive impairment
  • Have been charged and/or convicted of sexual offences (does not matter what type of offence)
  • Some willingness to engage in group treatment

• Exclusion criteria:
  • Clients with mild to moderate ID (IQ in the low 50s)
  • Concurrent mental health issues that is not optimally treated and/or impairs their ability to engage meaningfully in the group process
  • Assessed to have extremely high scores on the Psychopathy Checklist-Revision (PCL-R)
Outcome Measures

- Assessment of Sexual Knowledge (ASK) or Sexual Attitudes and Knowledge Assessment (SAKS)
- Questionnaire on Attitudes Consistent with Sex Offending (QACSO)
- Modified Victim Empathy Scale (VES)
- Sex Offenders Self-Appraisal Scale (SOSAS) – assess cognitive distortions
- Sexual Violence Risk – 20 (SVR-20)/ARMIDILLO-S – assess static and dynamic risk factors
- Modified Abel-Becker Cognition Scale – assess cognitive distortions in child sexual offenders
- Treatment Intervention and Progress Scale for Sexual Abusers with Intellectual Disabilities – assess client’s progress
AM-SORT-ID Programme Structure

• Introduction and Group Rules
• Sexual Education and Healthy Relationships (8 sessions)
• Cognitive Model (Understanding our Mind) (8 sessions)
• DBT Coping Skills Training (6 sessions)
• Sexual Offending Model (Steps to Offending) (10 sessions)
• Victim Empathy and Perspective Taking (4 sessions)
• Relapse Prevention and development of their own safety plan (Wise Journey and Wise Life Plan) (14 sessions)
Dialectical Behaviour Therapy

• Dialectical Behaviour Therapy (DBT) is based on a biosocial theory of personality functioning.

• The DBT approach balances therapeutic validation and acceptance of a person along with cognitive and behavioural change strategies.

• The use of DBT has recently been expanded to populations with additional diagnoses and has been used in additional settings (i.e., correctional facilities, mental health inpatient and outpatients).

• Recent studies have shown that DBT is highly compatible with best-practice principles for effective treatment in forensic settings.
The biosocial theory, which is used in DBT to explain the aetiology of BPD, has proved to be relevant in the genesis of other personality disorders.

Despite the evidence that DBT can be effective with offenders with severe personality disorders and its use in the forensic settings, it appears yet to be embraced in sexual offending treatments.

Currently, there is paucity of research on the use of DBT with sex offenders.
DBT is based on a biosocial theory of personality functioning in which Borderline Personality Disorder (BPD) as with other personality disorders is seen as a **biological disorder of emotional regulation**.

BPD is a **disorder of self-regulation** and particularly of emotional regulation, which results from biological irregularities combined with certain dysfunctional environments, as well as from their interaction and transaction over time.
Biosocial Theory of BPD

• Comes from both a biological propensity to their emotional state, and an invalidating environment, that, by its negative reactions, reinforces their dysfunctional behaviour.

• The disorder is characterized by heightened sensitivity to emotion, increased emotional intensity and a slow return to emotional baseline.
Biosocial Theory of BPD

Biological Dysfunction in the Emotion Regulation System

Invalidating Environment

Pervasive Emotion Dysregulation

(Linehan, 2005)
Clinical Similarities between BPD and Sex Offenders

- Shingler (2004)
  - High levels of potential for self harm
  - Dysfunctional thinking patterns
  - Relatively poor response to treatment
  - Tendency to engender anger, helplessness, hopelessness
  - Issues around impulse control

- Adams (2010) recommended for training in DBT might be a useful way to begin treatment for sex offender as this would provide them with the skills to manage themselves more effectively in treatment
Wise Mind – Risky Mind: A New Dialectic???

• The Emotional Mind does not fully capture the sexual offending client’s experiences as well as the risk issues that we encounter with our clients who sexually offend sexual offending clients could not relate with the use of term Emotional Mind to express their risky thoughts, feelings and behaviours.

• Emotional Mind is more useful for BPD clients than forensic clients with histories of sexual offending and antisocial behaviours.
“Risky Mind” as a dialectic of the “Wise Mind” is a state of mind that incorporates the risk elements particularly around sexual or violent offending.

“Risky Mind” is a state of mind where the offender is having risky thoughts, feelings, and/or is engaging in risky behaviours that can lead to formal offending.

It is a state of mind where the offender’s risky thoughts and feelings take control of him to the extent that he engages in behaviours that can lead to formal offending.
This Dialectic Allows...

• Validation of potential/ongoing experience of psychological tension between the ideal goal/s of offence free cognitions, affects and behaviours, and the pull of risky affects, cognitions, and emerging behaviours that can increasingly locate the person within risky situations.

• It simplifies therapeutic concepts in such a way that clients can begin to self-identify their state of mind. The acknowledgement of the existing tension that they experience to stay in their ‘Wise Mind’ can help validate the client’s experience.

• It works with the need to create a good therapeutic alliance by validating the offender’s experience but at the same time, inviting movement towards change.
• Risky Mind is a state of mind where the offender is having risky thoughts and/or is engaging in risky behaviours that can lead to formal offending.
Wise Mind
- Been busy with unit/ward activities
- My parents visited last week and we had a good time

Risky Mind
- Staring at female staff
- Not following staff directions
- Had an argument with staff or clients
- Fantasising about having sex with children

Note: Clients are encouraged to look at skills they can use to get back to their wise mind. It focuses on overall functioning of the client not just sex offending issues.
Issues with Traditional CBT and Relapse Prevention approach

• Can become more confrontational which can evoke emotional distress
• Harsh challenges may result in negative transference (i.e. increased resistance, denial, non-compliance, reduced self-esteem)
• May make the clients emotionally vulnerable which may further increase their risk as sex has been used as coping mechanism to manage negative emotional states
• Pressuring clients to acknowledge full responsibility at early stages can be counterproductive
• **Validation** is one of the central tenets of DBT
• Validating the client’s sexually abusive behaviours as understandable within the context of their life histories whilst not condoning sexual offending as a long-term effective problem solving strategy
• Use of validation can be used as a therapeutic stance to reach the client
• Deeper levels of validation such as radical genuineness alongside irreverent communication may also become useful tools in engaging with clients
### DBT Coping Skills

**WISE MIND**
- Time out
- Leave the situation
- Talk to staff
- Exercise
- Listen to music
- Do something else
- Ask for PRN
- Breathing/relaxation exercises

**RISKY MIND**
- Becoming to horny and touching others
- Masturbating to risky thoughts
- Telling lies to others (staff)
### Cognitive Model (Understanding Our Mind)

<table>
<thead>
<tr>
<th>Thoughts</th>
<th>Wise Mind</th>
<th>Risky Mind</th>
</tr>
</thead>
<tbody>
<tr>
<td>“It’s unfair how come I was not allowed a phone call today, I am upset but I can manage my feelings”</td>
<td>“This is unfair I won’t let the staff get away with this!”</td>
<td></td>
</tr>
<tr>
<td>Feelings</td>
<td>Angry, frustrated, relieved</td>
<td>Angry, frustrated</td>
</tr>
<tr>
<td>Actions</td>
<td>Taking a time out then later talk to staff</td>
<td>Having an argument and hitting staff</td>
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</table>
Issues around Denial and Offence Planning

• The assumption that all sexual offenders (especially individuals with ID) engage in offence planning has been met with criticisms particularly from clinicians who believe that not all offences are pre-planned.

• Attempts to pressure all sexual offenders to admit pre-planning their offences appears to be seriously misplaced and may prove to be counter-therapeutic (Marshall, Marshall, & Ware, 2009).

• We have approached the sexual offence cycle in more non-judgemental and validating manner without minimising the seriousness of the client’s risky behaviours.
<table>
<thead>
<tr>
<th>1. Risky Buzz (thoughts and feelings)</th>
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<tbody>
<tr>
<td>2. Risky Mind Excuses</td>
</tr>
<tr>
<td>3. Risky Mind Choices/Situation (Planning)</td>
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<tr>
<td>4. Risky Actions (Offending)</td>
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Vulnerabilities and Weaknesses

- Refers to clients emotional and psychological state that in some ways help predispose them to engaging in offending behaviours

- Background (Distal factors) relevant include:
  - Traumatic Childhood experiences (e.g. physical/sexual abuse; history of being bullied; neglect; stigmatisation, etc.)
  - History of Emotional, Psychological and Health Difficulties (e.g. history of mental illness; other serious medical illnesses; attachment problems; traumatic relationships; history of behavioural and emotional problems, etc.)
  - Psychosocial-cultural factors (e.g. limited social support; lack of social network; isolated; poverty; drug and alcohol problems, cultural alienation/disconnectedness, etc.)
Life See Saw Exercise

• Think about a particular client you work with and have a look at his background history.

• Have a look at your client’s “OK” and “not OK experiences” and using the Life See Saw, outline your client’s vulnerability/weaknesses and strengths.
LIFE SEE-SAW

NOT-SO-OK EXPERIENCES

Risky Mind

Wise Mind

OK EXPERIENCES
Example of Mr B’s LIFE SEE-SAW

**NOT-SO-OK EXPERIENCES**
- Bullied and teased
- Sexually abused by my uncle
- Rejected by women
- Feeling isolated
- No history of healthy sexual intimacy
- Early attachment issues

**OK EXPERIENCES**
- Close to siblings
- Some good memories of childhood (i.e. time with dad)
- Have some close friends
- Have a good job

**Wise Mind**

**Risky Mind**
How does this programme address issues around sexual deviance?

Issues around ‘counterfeit deviance’

- Sex education and healthy relationships module (e.g. circle concept, consent, personal boundaries, appropriate and inappropriate behaviours)
- Improving social and interpersonal skills
- Improving self-esteem

Cognitive distortions, offence supportive cognition

- Challenging cognitive distortions (making excuses)
- Improving victim empathy
- Emphasising consequences of offending via ripple effect
How does this programme address issues around sexual deviance?

Self-regulation and self control; impulsivity

- DBT coping skills
  - Mindfulness skills
  - Emotion regulation
  - Frustration tolerance
  - Interpersonal skills
- Specific skills such as Stop and Think, Use of Risky Mind-Wise Mind

Addressing risks related to sexual offending behaviours

- Relapse Prevention and Safety Plans
How does this programme address issues around sexual deviance?

- Improving their ability to develop healthy relationships can lead to much healthier sexual relationships
- Use of DBT strategies: Need to validate their difficulties but moving toward change
- Behavioural intervention (usually part of individual therapy)
- Use of DBT skills
  - Distraction techniques
  - Frustration tolerance skills
  - ‘Radical acceptance’ – accepting but moving towards change
How does this programme address issues around sexual deviance?

Issues around poor self-concept, low self-esteem and sense of hopelessness/helplessness

- Use of Life Story
- Validation of vulnerabilities/life challenges
- Use of GLM within Wise Life/Wise Journey -> rebuilding their lives to realise that there is more to life than sexual offending
- DBT skills → interpersonal skills
Once you have identified your client’s risky mind slope, this will assist you and your client to start working on consolidating their wise mind exits.

Wise mind exits are based on their learning and skills and how they move towards their wise mind state (thoughts, feelings, actions).

These would include identifying how can they move from their risky mind to their wise mind and identifying thoughts, feelings and actions associated to their wise mind state.
Risky Mind Slope (Adapted from Marlatt, 1982)

- Life Challenges
- Weaknesses and Stresses
- Risky Mind Buzz (Thoughts and Feelings)
- Risky Mind Excuses
- Risky Mind Choices/Risky Situation
- Risky Actions/Offending
• Teased and bullied at school
• Older boys sexually touched me when I was boy

Being teased
Feeling rejected/angry

“It’s ok to touch young children because I got touched.”
“I can get away with it.”

• Watching too many TV shows with young children in them or those with sexual acts
• Masturbating to thoughts of children

Going to the park by myself looking for young girls

Touching young girls

Mr B’s RISKY MIND SLOPE
Risky Mind Slope (Adapted from Marlatt, 1982)

Life Challenges

Weaknesses and Stresses

Risky Mind Buzz (Thoughts and Feelings)

Risky Mind Excuses

Risky Mind Choices

Risky Actions/Offending

WISE MIND COPING SKILLS
<table>
<thead>
<tr>
<th>Weaknesses and Stresses</th>
<th>Strengths and Supports</th>
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<tbody>
<tr>
<td><strong>Risky Mind Buzz</strong></td>
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<td><strong>Risky Behaviours/Offending</strong></td>
<td><strong>Wise Path/Wise Journey</strong></td>
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**My Wise Mind Plan**

- STOP
- STOP
- STOP
- STOP
- STOP
### John’s Wise Mind Plan

<table>
<thead>
<tr>
<th>Weaknesses and Stresses</th>
<th>Strengths and Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Feeling Lonely</strong></td>
<td>“I may need to be more proactive in meeting friends.”</td>
</tr>
<tr>
<td>“I have been rejected so many times.”</td>
<td>“I should focus on spending more time with family.”</td>
</tr>
<tr>
<td>“I feel alone and lonely.”</td>
<td>“I can be strong.”</td>
</tr>
<tr>
<td><strong>Risky Mind Buzz</strong></td>
<td><strong>Wise Mind Buzz</strong></td>
</tr>
<tr>
<td>“I am getting to go out and I might see some hot babes. I should take my camera.”</td>
<td>“Great. I can get the chance to do some shopping.” “Life means focusing on other aspects of my life not just sex.”</td>
</tr>
<tr>
<td><strong>Risky Mind Excuses</strong></td>
<td><strong>Wise Mind Truths</strong></td>
</tr>
<tr>
<td>“I am only taking pictures because she is nice.”</td>
<td>“Deep inside I know I am taking this picture because I want to sexually fantasise about her. This is wrong sexual behaviour.”</td>
</tr>
<tr>
<td><strong>Risky Mind Choices</strong></td>
<td><strong>Wise Mind Choices</strong></td>
</tr>
<tr>
<td>“I’ll hide my camera and take pictures when the staff are not looking”</td>
<td>“Stop. I will leave the camera at home. I will stay with male staff members and not stare at young girls.”</td>
</tr>
<tr>
<td><strong>Risky Behaviours/Offending</strong></td>
<td><strong>Wise Path</strong></td>
</tr>
<tr>
<td>Taking pictures of girls and using it to masturbate</td>
<td>Sticking the purpose of the outing and having good fun and staying out of trouble.</td>
</tr>
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</table>
The Good Lives Model (GLM) is a strengths-based rehabilitation theory that can enhance the RNR approach because it focuses on assisting offenders to develop and implement meaningful life plans that are compatible with an offence-free life (Ward, 2002).

There is a growing trend in the utilisation and incorporation of the Good Lives Model in offender treatment and rehabilitation. It is asserted that it has the potential to address the principle of normalisation and reintegration and at the same time, address issues around public protection (Aust, 2010).

Incorporation of GLM or some elements of this rehabilitation model to ID offender programs makes clinical sense given its positive, strengths-based approach and that it offers an alternative and enhancement the RNR approach to offender treatment and rehabilitation (Andrews, Bonta & Wormith, 2011).
The incorporation of GLM elements within FV programs can enhance focus on primary goods that are most important to the individual. Identifying primary goals early in treatment as this can assist with identifying secondary goods which can be incorporated in the post-sentence plan particularly when they eventually get released from prison. Furthermore, this will help with providing the offence with a sense of hope for an offence-free life.

Given that the use of GLM in offenders with intellectual disability is still in its infancy stage, this program would focus on the incorporation of GLM elements in conjunction with other therapeutic models used in this program.
Wise Journey

- This module will focus on their future plans/goals (which include not only an offence free life but a life with possibilities) and foster their sense of hope for their future.

- It is important that relapse prevention should be developed in conjunction with ways of enhancing the participant’s protective factors and a sense that there is more to life than just managing risks.

- This module will link their Wise Life which leads to their Wise Journey. It will assist participants foster commitment to change and live an offence free life.