

# A Positive/Motivational Strength-Based Approach to Sexual Offender Treatment

W. L. Marshall, O.C., F.R.S.C., Ph.D.

Liam Marshall, Ph.D.

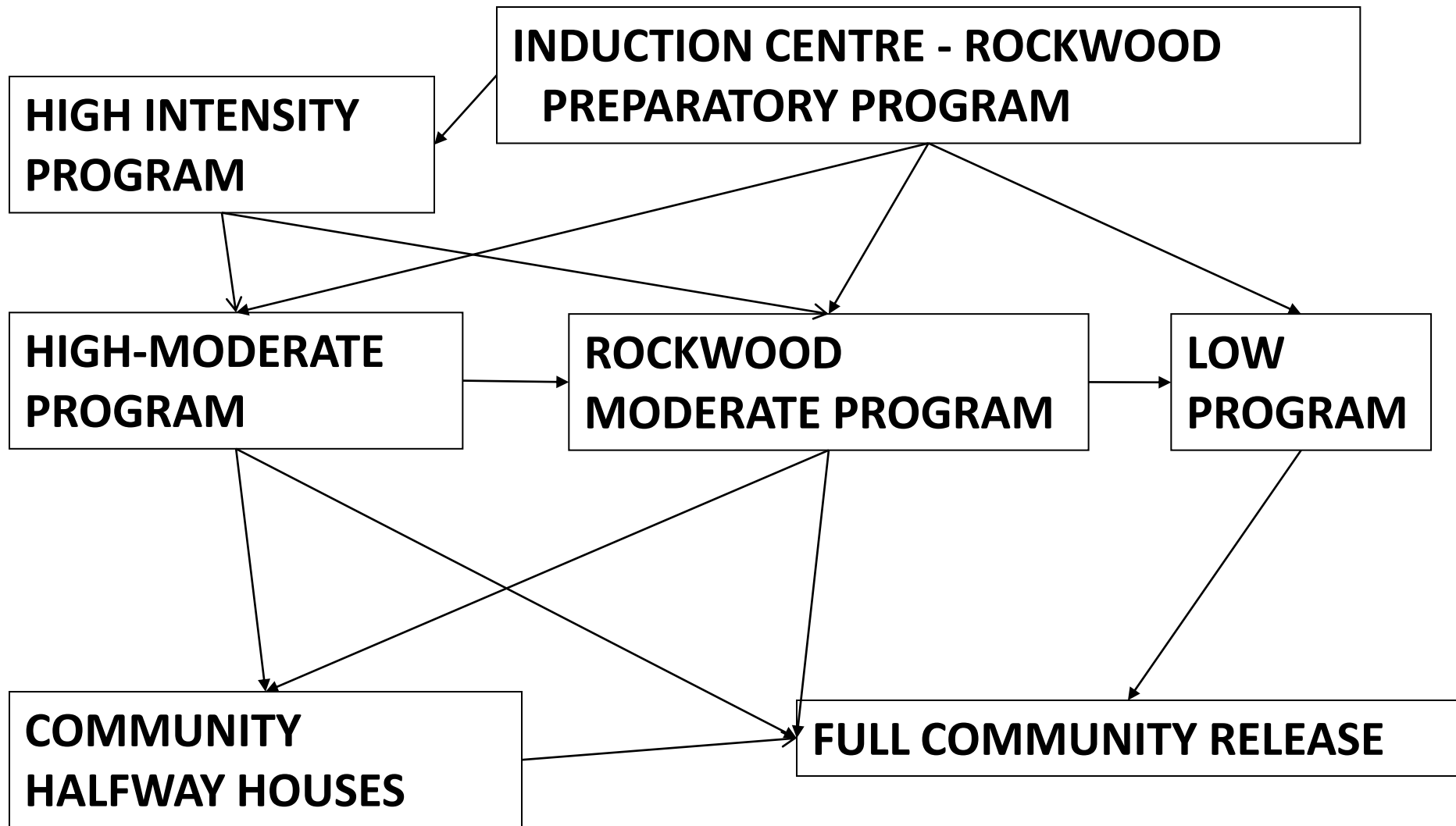
Geris Serran, Ph.D.

Matt O'Brien, M.A., M.Sc.

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# CSC Organizational Layout Example



# Effect Sizes for Sanctions

	N	ES
<u>SANCTIONS</u>		
• Fines	7,162	0.04
• Restitution	8,715	0.02
• Boot camp	6,831	0.00
• Scared straight	1,891	-0.07
• Electronic monitoring	1,414	-0.05
<u>INCARCERATION</u>		
• Longer sentences	68,248	-0.03
• Prison versus Community	267,804	-0.07

(Source – Gendreau, Goggin, Cullen, & Andrews, 2001)

# RISK MANAGEMENT

- Static Risk Factors
  - Static 99 or RRASOR
  - VRAG
  - LSI-R
  - SIR
- Dynamic Risk Factors
  - Stable
  - Acute

# STABLE DYNAMIC FACTORS

1. **SOCIAL INFLUENCES**
2. **INTIMACY DEFICITS**
  - Intimate partners
  - Emotional identification with children
  - Hostility toward women
  - General social rejection / loneliness
  - Lack of concern for others
3. **SEXUAL SELF-REGULATION**
  - Sexual pre-occupation / Sex drive
  - Sex as coping
  - Deviant sexual interests
4. **ATTITUDES SUPPORTIVE OF SEXUAL ASSAULT**
  - Entitlement attitudes
  - Attitudes supporting sexual assault of adults
  - Child molester attitudes
5. **COOPERATION WITH SUPERVISION**
6. **GENERAL SELF-REGULATION**
  - Impulsivity
  - Poor problem-solving
  - Negative emotionality / hostility

# Acute Dynamic Factors

- Symptoms Worsen Immediately Prior to Recidivism
- Increased Social Isolation
- Decrease in Psychological Functioning
- Decreased Cooperation with Supervision
- Increased Sexual Preoccupation
- Increased Anger
- Access to Victims

# CRIMINOGENIC TARGETS

## 1. ATTITUDES/COGNITIONS:

- Adversarial sexual beliefs
  - Men should dominate/control women
  - Women are deceitful
  - Hostile/distorted views of women
  - Some women deserve to be raped
- Child Abuse supportive beliefs
  - Some children want adults to have sex with them
  - So long as the adult does not use force children will not be harmed by sex
- Emotional identification with children
- Antisocial attitudes
- View themselves as low risk to reoffend
- Sense of entitlement

## 2. RELATIONSHIP PROBLEMS

- Intimacy deficits
- Relationship conflicts
- Maladaptive attachment style
- Emotional loneliness

Derived from: Cortoni (2009), Craig, Beech, & Harkins (2009), Craig, Brown, & Beech (2008), Hanson (2006), Hanson & Bussiere (1998), Hanson & Harris (1998), Hanson & Morton-Bourgon (2005).

# CRIMINOGENIC TARGETS

## 3. SELF-REGULATION ISSUES:

- General poor behavioural regulation
- Impulsivity
- Poor problem solving
- Emotional dysregulation

## 4. SEXUAL ISSUES:

- Normative sexual functioning
- Any deviant or paraphilic sexual interest
- Sexual interest in children
- Sexualization of children
- Sexual entitlement
- Sexual preoccupation
- Sexual dysregulation

Derived from: Cortoni (2009), Craig, Beech, & Harkins (2009), Craig, Brown, & Beech (2008), Hanson (2006), Hanson & Bussiere (1998), Hanson & Harris (1998), Hanson & Morton-Bourgon (2005).

# Outcome Determinants

- Refusers
- Dropouts
- Gets it

# Treatment Approaches

## Traditional Approaches

- Psychoanalytic
- Behavioral
- Cognitive
- Relapse Prevention
- Cognitive-Behavioral

## New Directions

- Risk/Needs/Responsivity (Andrews & Bonta)
- Good Lives Model (Ward et al)
- Motivational Interviewing (Miller & Rolnik)
- Positive Psychology (Seligman et al)

# PRINCIPLES OF EFFECTIVE OFFENDER TREATMENT

## Risk:

(Andrews & Bonta, 2006)

- Different intensity/extent of treatment according to risk

## Needs:

- Target criminogenic needs
- Target those non-criminogenic needs related to motivation (e.g., low self-esteem, shame)

## Responsivity:

### 1. General

- Often seen as requiring CBT but not necessarily
- Core Correctional Practices
  - a) Select therapists for therapeutic qualities
    - Empathy, warmth
    - Rewarding, modeling
    - Respectful
  - b) Train therapists to employ these qualities
  - c) Supervise therapists to ensure enactment of these qualities

### 2. Specific

- Adapt approach to each individual's style/culture
- Adapt approach to each individual's day-to-day fluctuations

# Good Lives Model

## Primary goods:

1. Life – healthy/optimal functioning, sex satisfaction
2. Knowledge
3. Excellence in Work and Play – Mastery
4. Excellence in Agency – autonomy and self-directedness
5. Inner Peace – freedom from turmoil and stress
6. Relatedness – intimate, romantic, kinship, community
7. Spirituality – meaning and purpose in life
8. Happiness
9. Creativity

# Hanson et al. (2002)

**K = 16**

**N = 3461**

**Follow Up = 4 years**

	<b>Sexual recidivism</b>	<b>General recidivism</b>
<b>Treated</b>	<b>9.9%</b>	<b>32.3%</b>
<b>Untreated</b>	<b>17.3%</b>	<b>51.3%</b>

# Lösel & Schmucker (2005)

**K = 69**

**N = 22,181**

**Follow Up = 5+ years**

	<b>Sexual recidivism</b>	<b>Violent recidivism</b>	<b>Any reoffence</b>
<b>Treated</b>	<b>11.1%</b>	<b>6.6%</b>	<b>22.4%</b>
<b>Untreated</b>	<b>17.5%</b>	<b>11.8%</b>	<b>32.5%</b>

# Correctional Service of Canada Data

**Nicholaichuk et al. (2000)**

**N = 376; Follow Up = 6+ years**

	<b>Sexual Offences</b>	<b>All nonsex offences</b>
<b>Treated</b>	<b>14.5%</b>	<b>32.1%</b>
<b>Untreated</b>	<b>33.2%</b>	<b>35.0%</b>

**Looman et al. (2000)**

**N = 178; Follow Up = 10 years**

	<b>Sexual Offences</b>	<b>All nonsex offences</b>
<b>Treated</b>	<b>23.6%</b>	<b>61.8%</b>
<b>Untreated</b>	<b>51.7%</b>	<b>74.2%</b>

# **A POSITIVE/MOTIVATIONAL Approach**

- Cognitions, Behaviors, and Emotions are targeted
- Incorporates Approach Goals, Good Lives, & Positive Psychology
- Acknowledges importance of client motivation for change
- Addresses criminogenic needs

# Positive Psychology Features

- Strength focus – not deficits
- Hope theory
- Aim is for a more fulfilling life

## POSITIVE/MOTIVATIONAL PROGRAM (ROCKWOOD PSYCHOLOGICAL SERVICES)

ENGAGEMENT/MOTIVATIONAL PROCEDURES	PRIMARY TREATMENT PROCEDURES	FUTURE LIFE STRATEGIES
<p>INITIAL DISCLOSURE LIFE-LINE/AUTOBIOGRAPHY</p> <p>Goals and Optional Exercises</p> <ul style="list-style-type: none"> <li>• Enhancing self-esteem</li> <li>• Reducing shame</li> <li>• Improving coping and mood management</li> </ul>	<p>EMPATHY/VICTIM HARM OFFENCE ANALYSIS</p> <ul style="list-style-type: none"> <li>• Background Factors</li> <li>• Immediate Factors</li> </ul> <p>Emotional, behavioural, &amp; sexual self-regulation</p> <p>RELATIONSHIP SKILLS</p> <ul style="list-style-type: none"> <li>• Nature and advantages of intimacy</li> <li>• Problems of loneliness</li> <li>• Attachment styles</li> <li>• Communication</li> <li>• Jealousy</li> </ul> <p>SEXUALITY</p> <ul style="list-style-type: none"> <li>• Healthy sexual functioning</li> <li>• Maximizing sexual satisfaction</li> <li>• Reducing deviant interests               <ul style="list-style-type: none"> <li>○ behavioural strategies</li> <li>○ Pharmacological</li> </ul> </li> </ul>	<p>MODIFIED GOOD LIFE PLANS</p> <ul style="list-style-type: none"> <li>• Goal setting</li> </ul> <p>LIMITED AVOIDANCE STRATEGIES</p> <ul style="list-style-type: none"> <li>• Warning signs for self and others</li> </ul> <p>SUPPORT GROUPS</p> <ul style="list-style-type: none"> <li>• Professionals</li> <li>• Family and friends</li> <li>• Colleagues</li> </ul> <p>FUTURE PLANS</p> <ul style="list-style-type: none"> <li>• Accommodation</li> <li>• Employment</li> <li>• Leisure</li> </ul>

# Rockwood Offender Programs

- Preparatory – typically 6 weeks
- Regular – typically 4 months
- Deniers - typically 4 months
- Maintenance - typically 3 months
- Also available – Adapted SOTP, Domestic Violence, Anger Management, Problem Gambling
- Typically run in group format but adaptable to individual treatment
- Open-ended
- 2 x 2 ½ hours/week
- 8-10 offenders
- 1 therapist in each group
- Mix of all types of sex offenders in same group
- Entry to program as close to intake as possible

# Other Rockwood Programs

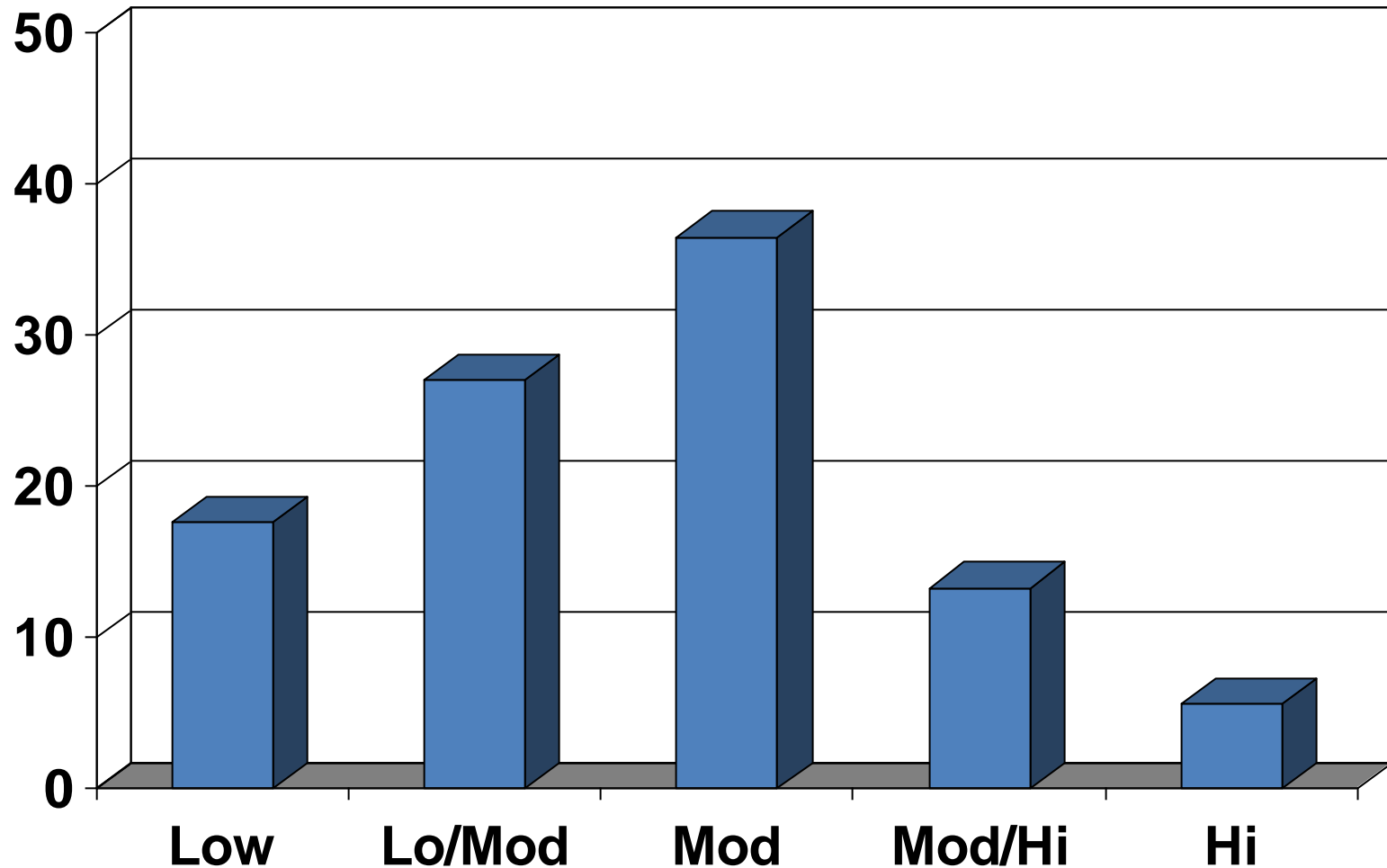
	Recidivism	
Program	Treated	Comparison
Preparatory	1%	5%
Deniers	2.5%	13.5%
Anger Management	Reductions in State & Trait anger, greater motivation for change	
Domestic Violence	Improved dynamic risk factors & improved responsibility taking	

# Rockwood's Program

Refusers	3.8%
Drop-outs	4.2%
Completions	95.8%

# Rockwood Psychological Services Program

Percentage of sexual offenders in each risk category



# Outcome for Rockwood Program - 2005

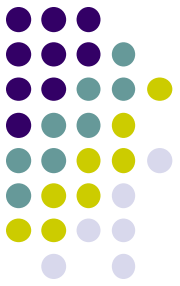


Reoffence	Treated* ( <u>N</u> = 535)	Expected**
Sexual	3.2%	16.8%
General	13.6%	40.0%

\*Mean follow-up = 5.4 years

\*\*Based on Static-99 and S.I.R.

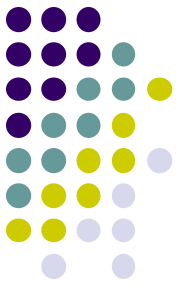
# Outcome for Rockwood Program - 2009



Reoffence	Treated* ( <u>N</u> = 535)	Expected**
Sexual	5.6%	23.8%
Violent	8.4%	34.8%

\*Mean follow-up = 8.4 years

\*\*Based on Static-99 (revised 2003)



# Predictors of Recidivism

Total N = 535; Recidivists N = 30

- Age: AUC = .37
- Sentence length: AUC = .43
- STATIC-99: AUC = .47
- PCL-R: AUC = .62
- Therapist post-treatment rating: AUC = .64\*

# Psychopathy & Outcome

Of 535 offenders in original outcome study 17 reoffended sexually

- PCL-R total score:
  - Sample = 176 Ss (33%) Includes all reoffenders
  - M = 16.39, SD = 7.15, Range 3-38
- Of 10 Ss (5.7%) with PCL-R total score  $\geq 30$ , 1 re-offender (< 1% of total sample, 10% of PCL  $\geq 30$ )
- Of 23 Ss (13.1%) with PCL-R total score  $\geq 25$ , 2 re-offenders (1.13% of total sample, 8.69% of PCL  $\geq 25$ )

# **BASES OF COST ESTIMATES**

1. Police and child protection investigations
2. Prosecuting Attorney's preparation and presentation
3. Medical exam of victim
4. Court costs
5. Prison (food + clothing only for 1 year)

**TOTAL COST PER OFFENDER = \$200,000.00**

## Excluded

1. Legal Aid Defense
2. Treatment for victims

# COST-BENEFIT ANALYSIS OF TREATING SEXUAL OFFENDERS IN OUR PROGRAM

Treated Per year	Actual Failures per year	Expected failures per year	Reduction in number of victims per year
60	2	10	8

Cost per reoffender	\$ 200,000
Cost to treat 60 per year	\$ 205,000

## Savings per year

Savings (8 x \$200,00) \$1,600,000

Less costs \$ 205,000

**TOTAL SAVINGS \$1,395,000**



# Open-Ended Groups

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- Has no predetermined start or completion date
- As group members finish all treatment requirements new members are added
- All offenders complete the same components, but at different times
- The component any one group member is working on depends on how far along that individual is in treatment.



# Features of an Open-Ended Program

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- Flexibility – Can enhance learning with optional assignments
- Therapists have more decision making responsibility.
- High reliance on group process
- High reliance on therapeutic alliance



# Benefits of open-ended groups

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## For Clients:

- Repeated exposure to exercises spaced enough to avoid burnout
- Clients move at their own pace
  - High functioning clients can move quickly
  - Lower functioning clients do not feel pressured or inadequate
- Senior group members get opportunity to nurture new members



# Benefits of open-ended groups

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## For System

- Can increase number of graduates
- Flexibility to deal with special cases
  - Soon to be released
  - Stabilization
- Lower burnout = retention of experienced therapists



# Benefits of open-ended groups

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## For Therapists:

- Less chance of burnout
- Ability to roll in and out of group
- Experienced group members assist in challenging newer clients
- Greater flexibility to deal with issues
  - “outside issues”



# Keys to running an open-ended group

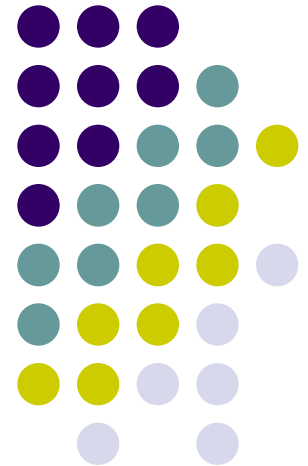
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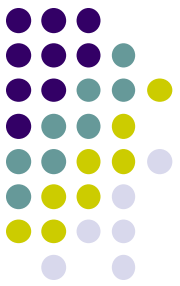
- flexibility
- the ability to think on your feet
- an abundance of good therapist qualities
- understanding that everything that happens in the group provides an opportunity for learning
- willingness to hand some of the control over to the group as a whole

# Therapists in therapy

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What does the research  
show?

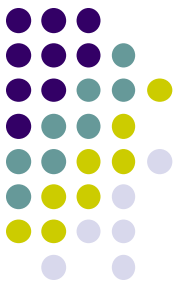




# Positive therapist features

- An ability to create an appropriate alliance with the client
- Ability to generate a belief in the possibility of change
- Providing opportunities for learning
- Instilling the expectation in the client that therapy will be beneficial
- Emotionally engaging clients

# Therapist Interpersonal Characteristics

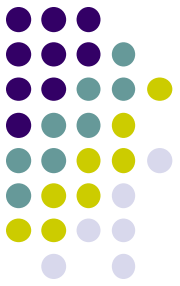


**Empathy** - the ability of the therapist to attempt to understand and relate to, the feelings of the client.

**Genuineness** - described as non-defensive, comfortable with themselves, involved in treatment sessions, honest and interested.

**Warmth** - refers to accepting, caring and supportive behaviour of the therapist.

# Therapist Interpersonal Characteristics



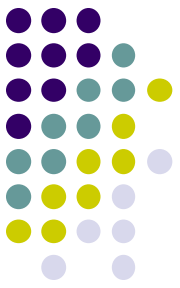
**Support** - reflected by positive valuation, encouragement and comforting statements.

- Clients appear less aggressive and resistant toward therapists who are rated as highly supportive.

**Confidence** - confident presentation by the therapists is crucial to effective treatment.

**Emotional responsiveness** - encouragement of emotional expressiveness by clients and emotional experiences during treatment.

# Therapist Interpersonal Characteristics



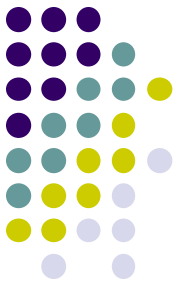
**Open-ended questioning** - helps the client develop insight into his/her difficulties and assists in cognitive restructuring.

- Problematic reactions by clients reduced in frequency when open-ended questions used.

**Directiveness** - encourage clients to exhibit and practice particular behaviours in and out of therapy - optimal level - can increase negativity

- Provides structure for clients and enhances likelihood of cooperation.

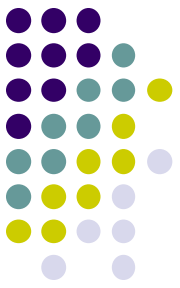
# Therapist Interpersonal Characteristics



**Flexibility** - different clients and the same clients at different times can respond differently to the same counselor skills.

- E.g. directive approach may work with submissive clients but increases aggression in defensive clients.

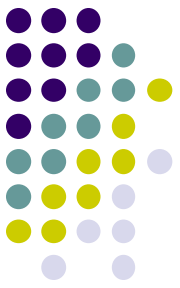
# Therapist Interpersonal Characteristics



**Encouraging active participation** - clients who actively participate are more likely to successfully complete therapy and experience positive outcomes.

- Increases clients' levels of commitment to, and compliance with the therapeutic process, reactance is reduced.
- Clients more likely to participate when new and positive behavior is targeted rather than a negative behaviour is to be reduced.

# Therapist Interpersonal Characteristics



**Rewarding** - reinforcement or encouragement typically given initially for small steps in right direction and then gradually moved to chains of small steps.

**Respect** - behaving toward clients in a respectful manner conveys they are valued and models the type of behaviour therapists expect in return.

- Disrespectful responses to clients' defenses have been related to poor outcome.
- In a series of studies treatment dropouts reported feeling disrespected by the therapist.

(Marshall et al., 2001; Strupp, 1980; Salzman, Luetgert, Roth, Creaser, & Howard, 1976; Rabavilas et al., 1979)

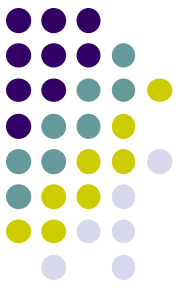
# Therapist Interpersonal Characteristics



## Use of humour

- may increase social interest.
- May reduce feelings of inferiority, help clients recognize the value of humour in their lives.
- Suggested it helps create a therapeutic atmosphere of freedom and openness.
- Releases tension, decreases anxiety, increases therapist-client cohesion.
- But must be in context of empathic relationship.
- Little research to date.

(Rutherford, 1994; Greenwald, 1987; Falk & Hill, 1992; Marshall et al., 2001.)



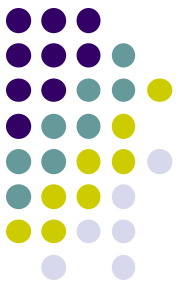
# Features That Impede Change

Poor outcome is also associated with the quality of the therapeutic relationship.

Negative therapist behaviours include:

- Confrontational behaviour
- Rejection of the client
- Low levels of interpersonal skills
- Lack of interest in the client
- Manipulation of client for therapist needs

(Marshall et al., 2001.)

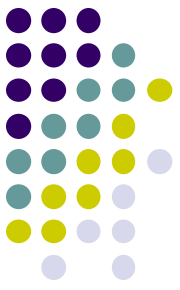


# Features That Impede Change

## Anger and hostility

- Negatively affects therapist-client relationship and treatment outcome.
- Major characteristic of poor outcome cases is therapist hostility in response to client negativism.
- Therapist expressing anger toward client associated with disrupted relationship and diminished progress.

(Marshall et al., 2001; Strupp, 1980; Cullari, 1996; Fremont & Anderson, 1986)



# Confrontation

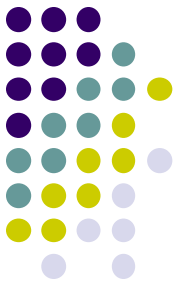
- Particularly damaging to clients with low self-esteem.
- Associated with noncompliance in treatment.

Clients react by:

- discrediting or challenging therapist
- devaluing the issue
- agreeing on surface but dismissing the relevance of the issue

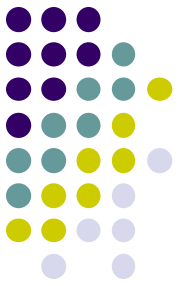
(Annis & Chan, 1983; Patterson & Forgatch, 1985; Cormier & Cormier, 1991)

# Client's perception of the therapist



- Positive correlation between clients' perception of the quality of the therapeutic relationship and perception of positive outcome.  
(Walborn, 1996)
- These perceptions significantly influence client compliance and predict treatment outcome.  
(Saunders, 1999)
- Consequently it is not enough for therapists to believe they are displaying appropriate characteristics  
(Schindler et al., 1983; Ryan & Gizynski, 1971; Ford, 1978; Marshall et al., 2001.)

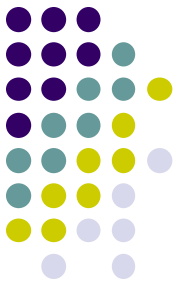
# Client's perceptions of the therapist



Greater treatment benefits generated by therapists who are perceived as:

- Confident
- Involved
- Focused
- Emotionally engaged
- Have positive feelings toward the client
- Directive
- Persuasive
- Sincere

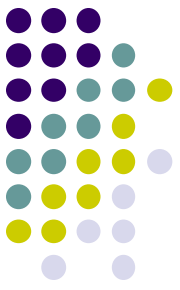
# Client's perceptions of the therapist



- Therapists are relatively poor at evaluating their own therapeutic characteristics and style.
- In 34 of 47 studies (72%) clients' estimates of therapist features correlated with beneficial treatment effects.
- Therapist ratings were related to outcome in only 4 of 15 studies (26%).

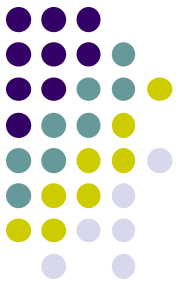
(Free, Green, Grace, Chernus, & Whitman, 1985; Orlinsky et al., 1994)

# Therapeutic Alliance/Atmosphere



- The therapist's interpersonal characteristics and techniques in combination with the client's perceptions of the therapist play important roles in establishing the therapeutic alliance.
- Valued as the context of therapeutic change.
- Key component is collaboration between client and therapist.  
(Luborsky, Barber, & Chris-Christoph, 1990; Marshall et al., 2001; Safran & Murrain, 1996; Matt & Navarro, 1997)
- Strict adherence to treatment manuals without establishing a good therapeutic alliance is not effective. (Fernandez & Serran, in press)

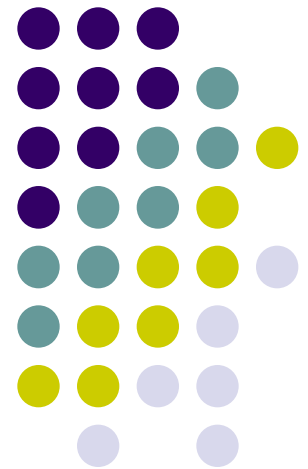
# Therapeutic Alliance



- Poor outcomes show greater evidence of negative interpersonal process in the therapeutic relationship.
  - particularly hostile and complex interactions between therapist and patient.
- Ratings of the therapeutic alliance have been shown to predict dropouts from treatment.

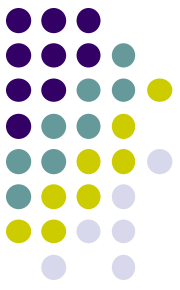
(Marshall et al., 2001.)

# Therapeutic Process in the Treatment of Sexual Offenders

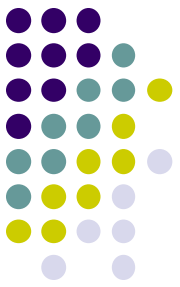


# CLIENTS' PERSPECTIVES

## (Drapeau, 2005)



- 1. See therapist as crucial but also see value of procedures**
- 2. Base judgments of quality of the program on the skills of the therapist**
- 3. Good therapists are seen as: honest, respectful, nonjudgmental, available, caring, confident, competent, and persuasive**
- 4. Good therapists encourage discussion, listen, display leadership and strength, and maintain order**
- 5. Do not respond to therapists who are critical, devaluing, or confrontational**
- 6. Many clients who do well say they are able to re-enact aspects, with the therapist, of their past – reactivation of attachment schemas with the therapist**
- 7. Most prevalent interpersonal interactions involve therapist supportively challenging the clients in a caring manner**
- 8. Clients desire to participate in decision making (work collaboratively) and they wish to attain mastery and feel competent**

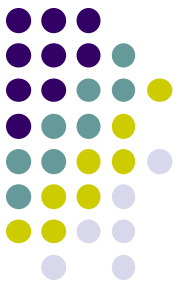


# Group Climate

- Moos' Group Environment Scale (GES)
- 10 Subscales, has norms, well used
  - Expressiveness
  - Cohesion
  - Task Orientation
  - Self-Discovery
  - Leader control
  - Innovation
  - Anger & Aggression
  - Leader Support
  - Independence
  - Order & Organization

# GROUP CLIMATE

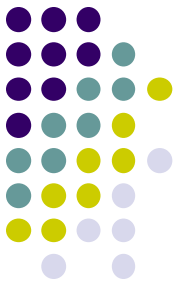
(Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005)



**Used Moos' (1986) Group Environment Scale – 10 subscales**

**Pre to post-treatment changes produced a composite score to identify magnitude of treatment-induced gains**

- **Two of Moos' subscales (Cohesion and Expressiveness) were significantly related to the composite measure of treatment gains**
  - ***Cohesion*** includes involvement, participation, commitment to the group, and concern and friendship for each other
  - ***Expressiveness*** measures the encouragement of freedom of action and the expression of feelings



# Marshall, Serran et al., 2001

- Examined therapist features and their relationship to client changes in sexual offender treatment.
- Videotaped sessions rated and then related to pre-post treatment changes.

# Therapist features that were related to significant treatment - induced changes



- Warmth
- Empathy
- Rewarding
- Directive

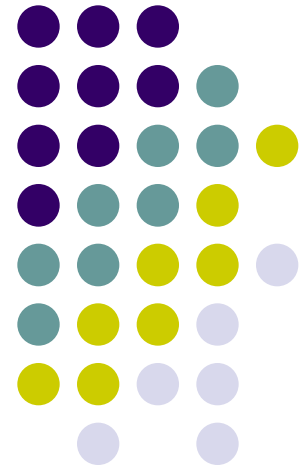
# Results of regression analyses



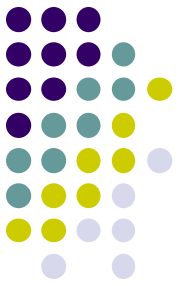
Index of change	Therapist feature	$\underline{R}^2$	$\underline{F}$ ratio	$p <$
Victim blame	E+W+R+D	.41	5.09	.003
	E+W	.34	8.01	.002
	R+D	.39	10.01	.001
Minimizes aspects of offense	E+W+R+D	.61	10.70	.001
	E+W	.55	18.17	.001
	R+D	.33	7.4	.002
Denies responsibility	E+W+R+D	.32	3.51	.02
	E+W	.25	5.20	.02
	R+D	.22	4.41	.02

# Treatment strategies

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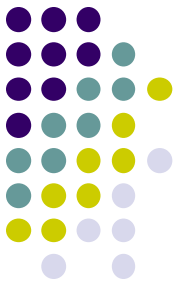


# Treatment Strategies



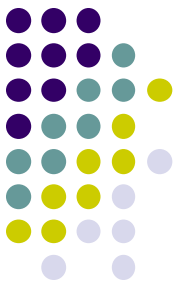
Three approaches have typically been used:

- a) Confrontational approach
- b) Unchallenging approach
- c) Motivational approach



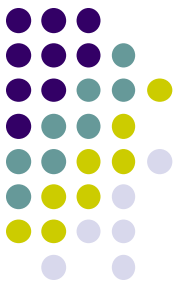
# Confrontational Approach

- Involves challenging the client in an aggressive manner.
- Aim is to achieve an admission of guilt and acceptance of the problem.
- Offender may be required to accept the label of “sex offender” and believe extensive supervision and treatment is necessary.



# Confrontational Approach

- Offenders react to confrontational approach with resistance or passive acceptance.
- Self-confident offenders may become resistant and argumentative.
- Low self-esteem clients may simply passively agree with the therapist to avoid conflict.



# Unchallenging Approach

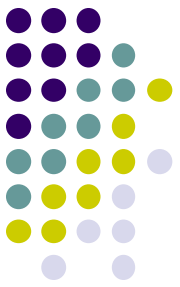
- See sexual offenders as victims.
- Unconditional positive regard for clients.
- Therapists are responsible for changing their clients and solving all their problems.
- Unchallenging therapists demonstrate many positive therapeutic characteristics (E.g., warmth, empathy, rewarding)

# Motivational Approach



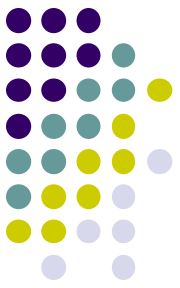
- Motivate change through understanding and acceptance.
- Encourage clients to view themselves as a whole person with strengths who has engaged in an unacceptable behaviour.
- Therapists are encouraging and supportive but set necessary limits, respond firmly, and challenge behaviours.
- A positive approach to treatment motivates clients to make positive changes.
- Therapists place responsibility for change in hands of clients but assist clients in finding ways to make changes.

# Methods for Motivating Clients



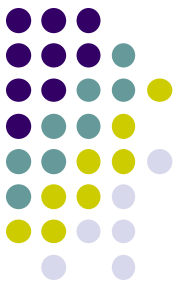
- Express Empathy
  - actively listen without judgement, criticism or blame. Understand client may hold onto cognitive distortions for a reason.
- Avoid Argumentation
  - avoid “labeling” clients; resistance means change strategies; do not force clients to defend their position.
- Roll with Resistance
  - do not fight it (you will lose); try reflecting questions and concerns; have client generate possible answers.

# Methods for Motivating Clients



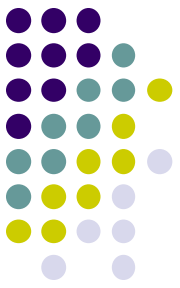
- Deploy Discrepancy (dissonance)
  - Create and amplify discrepancy in the client's mind between their distorted cognitions and the perceptions of others; examine the consequences of their behaviour step by step; have client outline pros and cons of their behaviour; help client create challenges for their own cognitive distortions.
- Support Self-Efficacy
  - Support client's confidence in his ability to change; give examples of distortions he has already moved on and reinforce the change; emphasize the importance and benefits of taking responsibility

# Methods for Motivating Clients



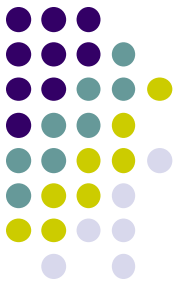
- Ask open-ended questions
  - not easily answered by yes and no; listen for appropriate statements and reinforce them while, initially, actively ignoring cognitive distortions
- Affirmation
  - affirm and support any efforts at change; add compliments and statements of appreciation for pro-treatment changes; the reinforcement will increase the likelihood the client will make more appropriate statements and fewer cognitive distortions

# Methods for Motivating Clients

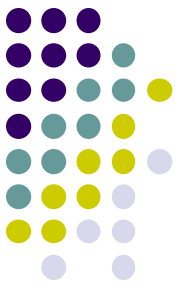


- Summarise
  - good for examining ambivalence around an issue; links material; demonstrates careful listening; prepares client to move on.,
- Reflective listening
  - form a reasonable guess as to the meaning of the client's statement and reflect back; recognize you may not know what he really means; reflect emotions as well as words

# CONFRONTATIONAL VS SUPPORTIVE CHALLENGE

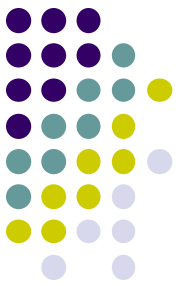


- Confrontational challenge
  - direct, judgmental
  - telling or assumes answer
  - Sarcastic tone
  - Feels hostile to the listener
- Supportive challenge
  - may or may not be less direct
  - spirit of genuine enquiry
  - doesn't assume answer
  - Tone implies interest in client's response rather than searching for the "one correct answer"



# Supportive challenges

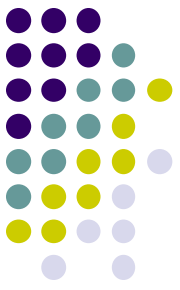
- If a client says something that seems unlikely or does not make sense to you – go with your instincts (they probably already have some idea that what they said is unrealistic).
- Reflect back what the offender said and explain that you are confused or unsure about it. Ask them to expand or explain further so you better understand.
- Point out the inconsistencies in their description and note that it is confusing to you. Add that you really want to have a clear understanding of what they did/thought/felt.



# Supportive challenges

- Ask other group members if they feel the same way (i.e., confused). They will probably do some challenging for you at this point.
- Use empathic facial expressions and body language to soften the blow of a difficult and direct challenge.
- **IMMEDIATELY** reinforce a movement in the right direction after a challenge (even a response that suggests more ambiguity about the issue). Do not move onto another challenge until you have made sure the offender understands exactly what he did/said that revealed a treatment gain.

# Feedback: A how to for group members



## Giving Feedback

- **Think** about what it is you want to say before you say it
- **Direct** your feedback to the person (Maintain eye contact, address the person)
- **Observe** your tone of voice and body language (angry/passive)
- Do **challenge** appropriately by identifying issues rather than attacking and blaming
- **Do Not attack or blame** – Don't be a bully! This may feel satisfying but is not useful
- **Stay on track** – try to only bring up one issue at a time
- **Be specific**: Focus on specific points or behaviours that will help the person change for the better
- **Do** give positive feedback
- **Do challenge** when necessary
- **Use “I” statements rather than “you” statements**
- **Notice** the response/feelings of the other person and learn!

# Feedback: A how to for group members



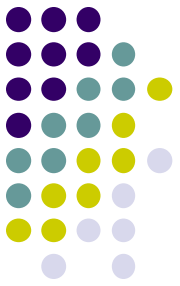
## Receiving Feedback

- **Listen** and **Hear** what is being said – Do not assume you know what the other person is going to say, so wait to respond until you hear what has been said
- **Do not interrupt or talk over**
- Make sure you **understand** what has been said – **clarify** the feedback and if you don't understand, ask!
- If you feel emotional about the feedback, it may be better to reflect on it after the session before saying anything
- If you receive similar feedback from more than one person, it usually means that people are noticing something important about you

## Applying Feedback

- It might be helpful to make **note** of important feedback
- Ask trusted people how you can make the required changes
- Ask people to let you know when you are engaging in the desired/undesired ways of behaving
- Practice changes each day

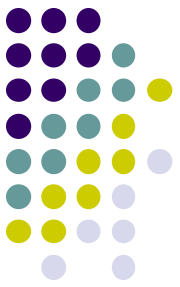
# Feedback: A how to for group members



## When Feeling Frustrated...

At times we feel frustrated when giving feedback to others. It might be necessary to:

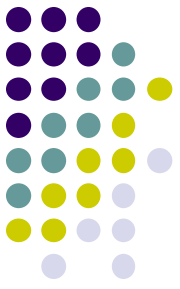
- Repeat ourselves
- Challenge our own expectations
- Recognize that somebody may not want to change
- Change the way we are coming across – everyone responds differently
- Remind yourself that your responsibility is to give feedback, not make somebody accept it!



# Resistance to change

- Not inherent part of our clients
- Observable behaviours
- Fluctuates
- Influenced by therapist's behaviour (therapist confronts: resistance goes up!)
- Resistance is a signal to change strategy

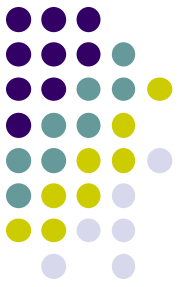
# Resistance in Sexual Offenders



- Lack of trust in professionals
- Bad experiences
- System undermining treatment
- Reactance to pressure to enter treatment
- Lack of insight into own problems
- Lack of future focus in coping
- Cultural issues
- Family factors
- Treatment knowledge & experience
  - Efficacy of treatment
  - Side effects
  - Bad experiences
  - Stigmatization
- More than half of refusers expressed a desire to enter treatment that has a broader aim than addressing offending only

(Mann & Webster, 2002)

# Some common traps that can cause resistance

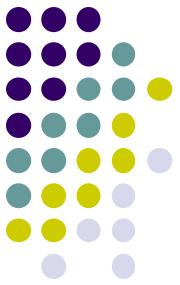


- Confrontation-Denial
- Blaming
- Premature focus
- Labelling
- Question-Answer
- Expert

# Responding to resistance



- Back off
- Warmth, empathy, optimism & genuineness
- Listen, respect and reflect what you hear
- Emphasise personal control and choice  
- and mean it!
- Offer options

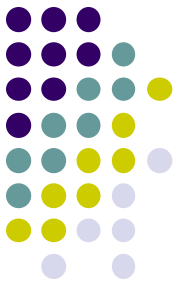


# Behavioural methods

## Positive reinforcement

- Link to specific behaviour
- Give immediately after behaviour

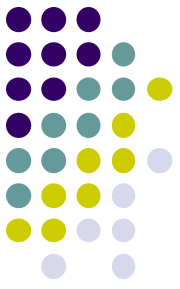
# Factors influencing reinforcement effectiveness



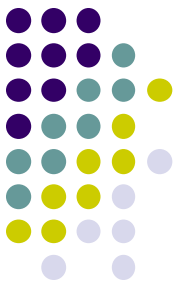
## Clarity of the relationship between a behaviour and the delivery of reinforcement

- Tell clients exactly what they did that was appropriate and why it was appropriate.
- Make sure they understand exactly what behaviour should be repeated and why.
- Reinforcement needs to be proportional to the level of effort that the behaviour took to perform.
- A major gain deserves strong reinforcement. A small gain deserves a little recognition.

# More factors influencing reinforcement effectiveness

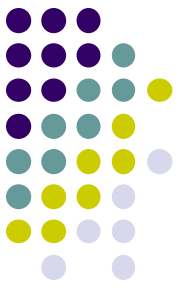


- One person's reinforcer is another person's punisher!
- Remember to reinforce group members as they contribute - not just the group member who's exercise is being discussed!



# What not to reinforce

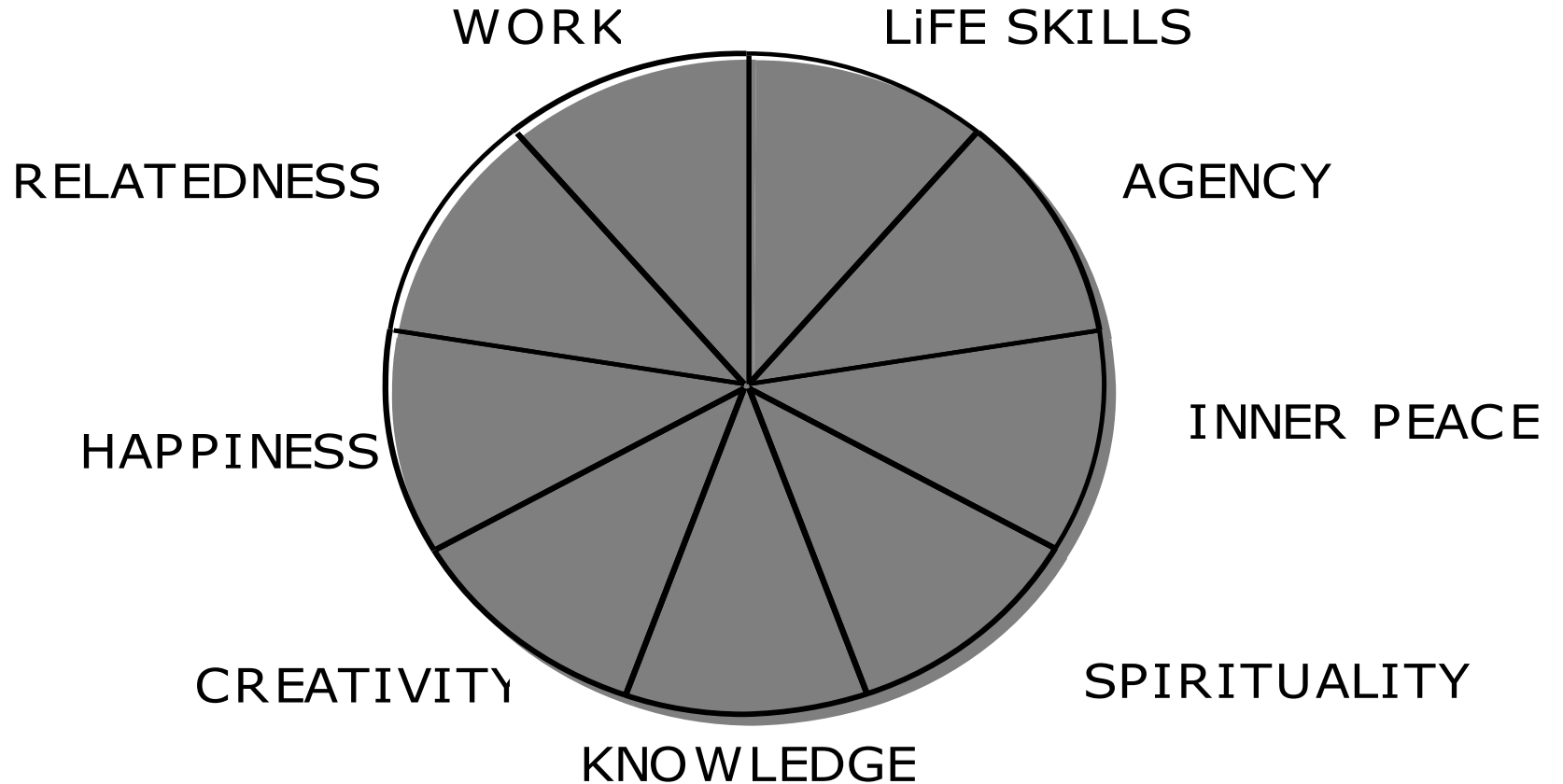
- Negative self statements (“I’m hopeless...”).
- Vague or benign contributions (unless shaping).
- General good behaviour (“You’ve all done very well today”).
- Agreeing with you (“I’m so glad you now see it my way”).
- Attention seeking



# What to reinforce

- Statements of responsibility.
- Statements of motivation/intention to change.
- Self esteem, perspective taking, empathy, concern for others, etc.
- New skills or attitudes.
- Achievement of any other treatment goal

# WHEEL OF LIFE



# A Positive/Motivational Strength- Based Approach to Sexual Offender Treatment

W. L. Marshall, O.C., F.R.S.C., Ph.D.

Liam Marshall, Ph.D.

Geris Serran, Ph.D.

Matt O'Brien, M.A., M.Sc.

[www.rockwoodpsyc.com](http://www.rockwoodpsyc.com)