The CPC Institute

California All-State Agency Conference 2011

Risk Factors,
Guiding Clinical Theory,
and
CPC's RULE Program

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How do we understand sexual deviance?

Taking sexual pleasure from someone against their will.

WHAT: the Disorder.

- **Behavior Disorder** and a **Character Disorder**
- **Psychological- an extortion of intimacy**
- **Neurological- Limbic dysregulation and low-mode processing (brain-based intervention)**

HOW: the Mechanism of behavior.

- **Stimulus/response:**
  (Triggers, cycles, low response flexibility)

WHY: the Motivation of the behavior.

- **Approach/Avoidance (wants/needs)**
- **The Four "F"s: Fight/Flight/Feed/Fornication**

Types Risk Factors

Static factors (historical variables, e.g., criminal history)

- Assessment of long-term recidivism potential
- Civil commitment hearings.

Dynamic factors (changeable) are used in treatment

- ***Stable dynamic factors*** = endure for months or years and reflect character style (e.g., alcoholism, antisocial attitudes, deviant sexual interest, etc.).
  - ***Treatment addresses stable dynamic factors.***
  - ***Change in these factors is associated with an enduring reduction in recidivism risk.***

- ***Acute dynamic factors*** = may present for weeks, days, or minutes (e.g., intoxication, victim access).
  - ***Acute dynamic factors signal when offenders are most at risk***
  - ***Important for community supervision.***

Static-99 Risk Factors

- Prior Sex Offences
- Prior sentencing dates (excluding index)
- Index non-sexual violence
- Prior non-sexual violence
- Any Unrelated Victims
- Any Stranger Victims
- Any Male Victims
- Young
- Single

Acute - 2007

- Sexual and violent recidivism
  - Victim access
  - Hostility
  - Sexual pre-occupation
  - Rejection of supervision
- Criminal recidivism
  - Emotional collapse
  - Collapse of social supports
  - Substance abuse

Stable variables:

1. Significant Social Influences
2. Intimacy Deficits:
    1: Intimate Partners
    2: Emotional Identification with Children
    3: Hostility toward women
    4: General Social Rejection/Loneliness
    5: Lack of concern for others
3. Sexual Self-Regulation
    1: Sexual Pre-occupation/sex drive
    2: Sex as Coping
    3: Deviant Sexual Interests
4. Attitudes Supportive of Sexual Assault
    1: Entitlement
    2: Rape Attitudes
    3: Child Molester Attitudes
5. Cooperation with Supervision
6. General Self-Regulation
    1: Impulsive Acts
    2: Poor Cognitive Problem Solving
    3: Negative Emotionality/Hostility

Adult Sex Offender Assessment Protocol-II

I Sexual Drive/Preoccupation Scale

1. Prior Legally Charged Sex Offenses
2. Number of Sexual Abuse Victims
3. Male Child Victim
4. Duration of Sex Offense History
5. Degree of Planning in Sexual Offense/s
6. Expressive Aggression in the Sexual Offense
7. Sexual Drive and Preoccupation
8. Sexual Victimization History

Sexual Drive Preoccupation Scale Total

II Impulsive, Antisocial Behavior Scale

9. Juvenile Antisocial Behavior
10. Ever Charged/Arrested Before Age 16
11. Adult Antisocial Behavior
12. Pervasive Anger
13. Multiple Types of Offenses
14. Impulsive Lifestyle
15. Physical Assault History and/or Exposure to Family Violence

Antisocial Behavior Scale Total

III Intervention Scale

16. Accepting Responsibility for Offense/s
17. Internal Motivation for Change
18. Understands Risk Factors/Applies Strategies
19. Empathy
20. Remorse and Guilt
21. Cognitive Distortions
22. Quality of Relationships

Intervention Scale Total

IV Community Stability/Adjustment Scale

23. Intimacy Needs
24. Management of Anger
25. Work Stability
26. Support Systems

Community Stability Scale Total

Dynamic Risk Factors in Sex Offenders

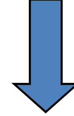
- **Intimacy deficits**
- **Emotional disconnection/loneliness**
- **Lack of empathy/Narcissism**
- **Vulnerability to humiliation/fragile self-esteem**
- **Inability to regulate strong negative emotions and behaviors**

❑Marshall proposed a general theory of sexual

Offending: ***"…the failure to achieve intimacy in relations with adults produces emotional loneliness, which leads to an aggressive disposition, and a tendency to pursue sex with diverse partners in the hope of finding intimacy through sexuality or through less threatening partners."*** Marshall W. (1989) Intimacy, Loneliness and sexual offenders. Behaviour Research and Therapy, v27 n5, p491

Attachment/Intimacy deficits

(Core dynamic risk factor)



Narcissism

(Exploitative relational style used to self-regulate)

Self-esteem dysregulation

(Emotional instability/vulnerability to *shame*)

Sexual and aggressive behavior

(Break down product of attachment deficit)

Models

Sexual violence and sexual exploitation can be seen as a symptom of :

A Trauma Disorder creating an Attachment Disorder manifesting symptoms of a:

- ***Behavior Disorder***
- ***Cognitive Disorder***
- ***Emotional Disorder***
- ***Character Disorder***
- ***Neurological Disorder***

The problem of sexual acting out is multidimensional and treatment requires the utilization of various methodologies.

- **Complexity Theory:** **Human behavior is a nonlinear system and outcome is not based on an additive equation - output is not proportional to input. "Sensitive dependence on initial conditions". (Edward Lorenz)**

  Changing human behavior requires several different interactive human systems to alter.

  Thoughts affect behavior and feelings,
  Behavior affects feelings and thoughts
  Feelings affect thoughts and behavior.

The reaction to the lack of scientific method in Psychoanalysis grew attempts to quantify psychology.

- **Behavioral Science focuses on reconditioning the response behaviors to different stimulus.**
  - **Aversive conditioning**
  - **Positive reinforcement**
- **Cognitive Science focuses on the thinking that causes us to feel and act the way we do.**
  - **Psychoeducation**
  - **Cognitive restructuring**
  - **Relapse Prevention**

- **Interpersonal Neurobiology (Dan Siegel):** Brain integration and psychological well-being is promoted by secure attachments.
- **Object Relations Therapy:** focuses on the nature of the attachments that people form and how needs are expressed and met in relationships
- **Trauma Theory:** trauma occurs when both internal and external resources are inadequate to cope with an external threat compromising neurological processing and ability thrive in secure attachments.
- **Psychopharmacology:** medicating depression (emotional disconnection), ADHD (impulsivity), compulsivity, and the libido (testosterone-in more severe cases) can mitigate sexually aggressive behavior.

•**Neurobiology/psychology** **now shows through MRI studies that *emotion is intrinsic to thinking*.**

- **People who were cognitively normal but neurologically couldn't access emotion, had extreme difficulty in making rational decisions.** **(Antonio Damasio, Iowa U, Behavioral Brain Research 1990).**

- **Low mode processing (emotion centers) is twice as fast as high mode (cognitive centers). We experience strong emotions faster than we know what we are reacting to.** **(Joseph LeDoux, NYU, Journal of Neuroscience 1990).**

- **Moral decisions trigger areas of the brain that generate emotion and work to pair thoughts of violence with aversive negative emotions.** **(Joshua Greene, Harvard U., 2004, and Science, 2001.)**

A Low Risk Offender

- Supportive social network
- Secure pair bonds
- Avoid high risk situations
- Manage stress by means other than sexual fantasies [4/99[Sex Abuse.., *Knowing What Works*, Hanson.]

Interpersonal Neurobiology:

Trauma
Dysregulation
Mindfulness
Attunement
Attachment

The Prefrontal Cortex and Self-Regulation

Nine Functions of the Pre-Frontal Cortex

- Regulation of the body
- Regulation of emotion
- Emotionally attuned interpersonal communication
- Response flexibility
- Self-awareness
- Autobiographical memory
- Self-soothing abilities
- Intuition
- Morality

Interpersonal Neurobiology

Daniel J. Siegel, MD, "Toward an Interpersonal Neurobiology of the Developing Mind: Attachment Relationships, Mindsight, and Neural Integration" in Infant Mental Health Journal, 2000.

- 5 Basic elements of Secure attachments:

1. **Collaboration**- attuned communication builds a coherent core and autobiographical sense of self.
2. **Reflective dialogue**- share internal experiences
3. **Repair**- when attuned communication is disrupted, as is inevitable, repair of the rupture is important in reestablishing the connection. Prolonged disconnection has a negative effect on a child's sense of self.
4. **Coherent Narrative**- allows integration of experiences
5. **Emotional communications**- allows to reduce, regulate and sooth negative emotional states.

Object Relations Theories

- The **Relational Models** examine the **interpersonal realm** of experience throughout development and the role attachment plays (rather than intrapsychic conflicts) in the development of a ***sense of self/and stable self-esteem***.

- **To victimize another is a narcissistic act – a devaluing of another**. The formation of a narcissistic relational style can be seen as a defense against a fragile self-esteem and a vulnerability to shame.

- **The study of Narcissism**, pioneered by Kohut, organizes much of the understanding about sexually deviant behavior by suggesting that:

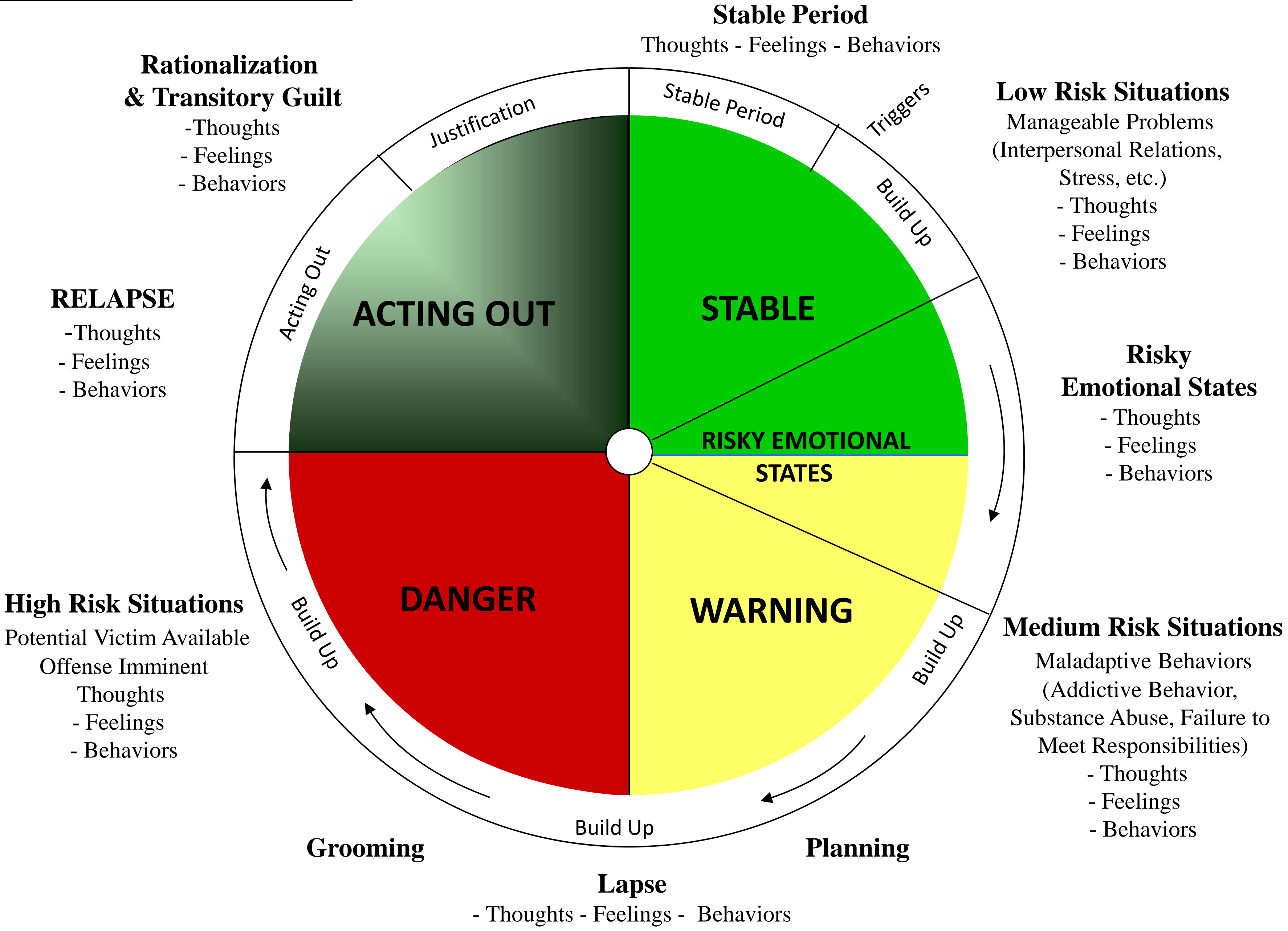
    - ***Traumatic disruptions in early attachments derails the development and regulation of self-esteem and the formation of intimacy.***

Restoration of Self-esteem

- Bring **needs of the self into the context of an intimate** relationship.

- **Attunement /empathy addresses the <u>need</u> for sexually exploitative behavior.**

- **Listening , understanding , and “self affirming” responses builds the *relational field*.**


RELAPSE CYCLE
The Counseling and Psychotherapy Center Inc.
Stable Period
Thoughts - Feelings - Behaviors
Low Risk Situations
Manageable Problems
(Interpersonal Relations,
Stress, etc.)
- Thoughts
- Feelings
- Behaviors
Risky
Emotional States
- Thoughts
- Feelings
- Behaviors
Medium Risk Situations
Maladaptive Behaviors
(Addictive Behavior,
Substance Abuse, Failure to
Meet Responsibilities)
- Thoughts
- Feelings
- Behaviors
Planning
Lapse
- Thoughts - Feelings - Behaviors
Grooming
High Risk Situations
Potential Victim Available
Offense Imminent
Thoughts
- Feelings
- Behaviors
RELAPSE
-Thoughts
- Feelings
- Behaviors
Rationalization
& Transitory Guilt
-Thoughts
- Feelings
- Behaviors
Justification
Stable Period
Triggers
Build Up
Acting Out
ACTING OUT
STABLE
RISKY EMOTIONAL
STATES
DANGER
WARNING
Build Up
Build Up
Build Up

RELAPSE CYCLE

Risk Situations

LOW RISK SAFE	MEDIUM RISK WARNING	HIGH RISK DANGER
-Argument w spouse/family -Conflict at work -Financial Problems -Fender Bender -Lateness to work (unusual) -Developing habits: smoking, swearing, overworking, excessive sleeping, eating problems -Reduction in familial and/or peer contacts -Survivor issues (Manageable)	-Alcohol use, Substance use -Entitlement -Deviant Sexual Outlet: Deviant Fantasizing, Pornography, X-rated Movies, Compulsive Masturbation -Physical confrontations -Frequent lateness to work, missing therapy and/or P.O. appointments -Failing to meet financial obligations -Change in general daily functioning; eating, hygiene, isolating, increased irritation -Noticeable shift in style of relating to monitors such as P.O. or Therapist (HR emotional states) -Intrusive Survivor issues (overwhelming) -Victim Stancing, poor me attitude	-Cruising -- looking for victim -Hanging around playgrounds -Frequenting malls during peak children hours -Arcades, Miniature Golf -Babysitting -Offense Plan -Grooming Environment, Self, Others, Victim -Employment which involves children -Soliciting Sex -Driving around without a pre-determined destination (P.O.'s can do mileage and journal checks)

tlscycle98

Dialectical Behavioral Therapy

There are four main types of skills in DBT skills training.

1. **Mindfulness Meditation Skills**. These skills center on *learning to observe, describe and participate in all experiences* (including thoughts, sensations, emotions and things happening externally in the environment) without judging these experiences as "good" or "bad."

2. **Interpersonal Effectiveness Skills**. The focus of this skill module is on learning to successfully *assert your needs and to manage conflict in relationships.*

3. **Distress Tolerance Skills**. *Accept and tolerate distress* without doing anything that will make the distress worse in the long run (e.g., engaging in self-harm).

4. **Emotion Regulation Skills**. Identify and manage emotional reactions.

Goals of Attachment-based treatment

- Self-regulation, self efficacy, security
  - This is achieved in treatment through:
    - Empathic attunement
    - Affirmation of the clients strengths
    - Provide role models
    - View irrational behaviors as insecure attachment strategies

Risk Management versus Good Live

Risk Management strategy

Avoid contact with children

Leaves a void in the offenders life

Good Lives strategy

Look at ways to develop appropriate attachments and intimacy e.g. sexual knowledge training, relationship skills

Engagement in appropriate activities that promote self-worth, e.g. work, school, skills and talents

Must be realistic (e.g. trying to develop intimacy may not be the first step, but developing friendships would

In Daniel Siegel's (2007) work on Mindfulness and emotional regulation.

1. "We create nonreactivity by developing the circuits in our brain than enable the lower affect-generating circuits to be regulated by the higher modulating ones…..this is called "response flexibility"

   The way that we pause before action and consider the various options that are most appropriate before we respond.

2. States of "mindfulness", can be achieved when we coordinate our autonomic systems with our intentional systems.

   For example breath awareness can create a state of mindfulness that leads to emotional regulation, emotional integration and ultimately resiliency.

3. While an intimate interconnection to others helps with emotional regulation, an intimate intra-connection between our brains and minds can directly impact emotional regulation also.

4 Components of Change

R.U.L.E

Responsibility:	The impact the offender's behavior has had on his victims, himself, and others
Understanding:	The experiences and decisions that have led him to this point
Learning:	New patterns of appropriate behavior
Experience:	The benefit of using new skills in relating to others and in managing strong negative emotional states

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PROGRESS REPORT/TREATMENT PLAN UPDATE

Month: ______________________________ **Year:** ____________________
Client's Name: ____ **DOB:** _______________
Case Worker: ____ **FAX #:** _____________

RESPONSIBILITY: ***Denies*** ***Minimizes*** ***Accepts*** ***Victim Empathy*** Total

0 --------1----------5----------------8-----------------------20 ___

***Goals**: Admits Offense/Offense Walk Through ( );Clarification Letter to victims ( );Others ( ); Self ( ); Displays compassion and empathy for victim and displays remorse ( );Polygraph( )*

UNDERSTANDING**:**Beginner ***Intermediate*** ***Advanced*** Total

Risk Factors/Self Esteem	0 ------1---------2-----------3----------4-----------5	___
High Risk Situations	0 ------1---------2-----------3----------4-----------5	___
Fantasy/Deviant Arousal	0 ------1---------2-----------3----------4-----------5	___
Distortion/Entitlement	0 ------1---------2-----------3----------4-----------5	___

***Goals**: Write & present autobiography ( ); Discuss deviant fantasies ( ); Identify Low, Medium, &High Risk situations( );Identify Sexual Assault cognitive distortions( );Complete Acting Out Cycle( )*

LEARNING**:* ***Beginner ***Intermediate*** ***Advanced*** Total

Interpersonal Skills	0 ------1---------2-----------3----------4-----------5	___
Stress Management	0 ------1---------2-----------3----------4-----------5	___
Ways to Interrupt Cycle	0 ------1---------2-----------3----------4-----------5	___
Sexuality	0 ------1---------2-----------3----------4-----------5	___

***Goals**: Assertiveness Training/ Conflict Resolution ( ); Relaxation Training ( );Anger Management( ); Relapse Prevention Plan with Interventions ( ); Open about Sexuality ( ); Add Here and Now cycles to Acting out cycle ( ); Identify Risky Emotional States that drive behavior( )*

EXPERIENCE (Practices):	***Never***	***Sometimes***	***Always***	Total
Informed Support Network	0 -----------------------	5--------------------------	10	___
Practices Stress Management	0 -----------------------	5--------------------------	10	___
Develops Intimacy	0 ----------------------	5--------------------------	10	___
Builds Mastery	0 -----------------------	5--------------------------	10	___

Goals: *Identify informed support network ( ); Develops intimacy in group ( ); Displays a sense of community on the unit ( ); Positive peer relationships( ); Active in Substance Abuse TX ( ); Support Network meeting(s) with support network ( ); Demonstrates recovery through behavior/intervention ( );*

Score indicates demonstrated knowledge and skill level in each component.

Max. score = 100 Total _____

Group Attendance: ____ of ____

Group Participation (Check those that apply)**:**
pays no attention ( ); disruptive ( ); few/no comments ( ); sits/neutral ( ); listens/attentive ( ) contributes moderately ( ); active ( )

Quality of Group Participation (Check those that apply)**:**
not motivated ( ); discusses other's problems ( ); gives feedback to others ( );discusses own problems ( ); accepting of feedback ( );uses feedback ( ); actively working on treatment plan ( )

<u>Scoring Interpretation for R.U.L.E.</u>

Score:		
	0 – 20	Introduction to Treatment.
	21 – 40	**I-** Learning about self and some treatment work being done. May also be a peripheral client who is resisting treatment.
	41 – 60	**II**-Moderate level involvement. Client is making progress.
	61 – 80	**III**-Actively involved in many aspects of treatment. Client has completed some of the objectives outlined in the Treatment Plan.
	81 – 100	**IV**-Client is advanced in treatment. Client has completed many of the treatment objectives outlined in the Treatment Plan such as a written autobiography, letters of clarification, Relapse Prevention Plan, and is viewed as having a successful treatment experience.

<u>Progress comments:</u>

Group Attendance: 0 of 0 **Balance:** 0

RISK LEVEL **Concern** **Serious Concern** **Severe Danger**

*2-3 warning signs- **Concern** around engaging in some problematic behavior is heightened.*

*4-6 warning signs-**Serious Concern** about the client's functioning and immediate intervention required.*

*6 or more warning signs- **SEVERE DANGER** that client **may** be at significant risk to act out. **Supervising agents must be immediately contacted.*** (*)***These items alone may indicate Severe Danger.***

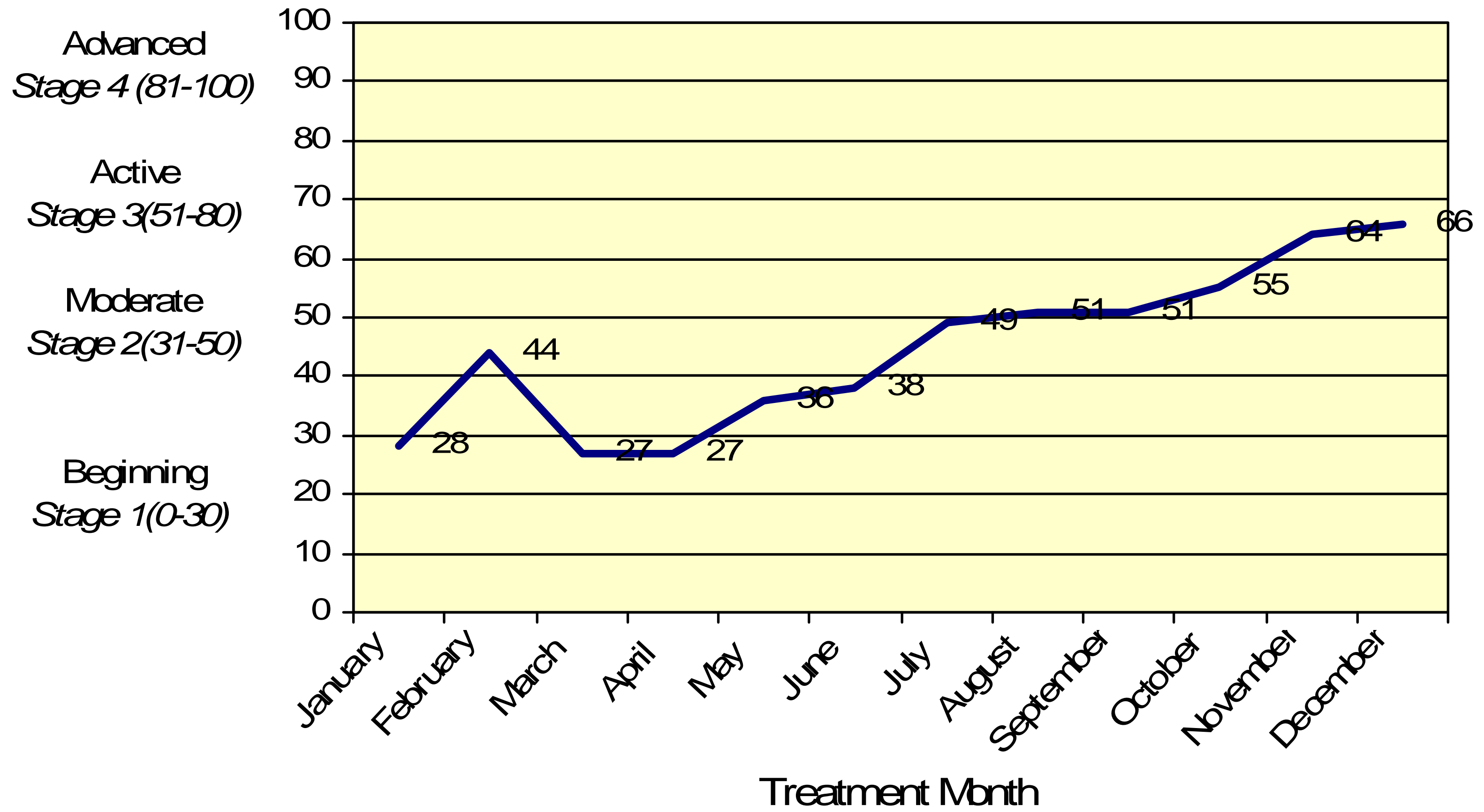
WARNING SIGNS ***(during this period)***

Late to group(s) / Absent from group(s)
Decreased group involvement
No treatment related assignments
Resistant to group feedback/argumentative
Change in employment/loss of job
Change in residence
Relationship ending/change
Pornography usage
Domestic disturbance

***Contact with potential victims**
Failure to attend Probation/Parole meetings
Substance use _______________
***Increased report of deviant arousal**
Change in mood (positive or negative)
Observable anger and agitation
Major life change ____________
Internet use (unauthorized)
Other _____________________________

Progress comments

Clinician's Signature: ____


Progress Points
Advanced
Stage 4 (81-100)
Active
Stage 3(51-80)
Moderate
Stage 2(31-50)
Beginning
Stage 1(0-30)
MONTHLY SCORE CHART
100
90
80
70
60
50
40
30
20
10
0
28
44
27
27
36
38
49
51
51
55
64
66
January
February
March
April
May
June
July
August
September
October
November
December
Treatment Month

THE *R.U.L.E.* STAGE SYSTEM

- **To guide a client through the CPC treatment program we have a series of four clinical "Stages".**
  - ✓**Stage I: Pre-treatment Orientation**
  - ✓**Stage II: Beginning Treatment**
  - ✓**Stage III: Intermediate**
  - ✓**Stage IV: Advanced**

- **Stages indicate treatment progress as they complete treatment interventions and tasks.**

- **Success in treatment, and recommendations for reduction in supervision, depends on the client progressing through these stages.**

THE MAJOR ASSIGMENTS: There are four major assignments that are part of the CPC treatment program. Clients must complete these satisfactorily or give evidence that they have been completed successfully in another CPC treatment program. They are:

- **AUTOBIOGRAPHY – An account of the client's life that is completed using the questions in the guide that is given in the orientation folder.**

- **CYCLE – Clients must complete diagrams of their cycle both in past and present.**

- **CLARIFICATION LETTERS – Letters must be completed (but not sent) to Self, victim(s) and others.**

- **RELAPSE PREVENTION PLAN – A usable and comprehensive Relapse Prevention Plan is completed prior to completing the program or moving to a lower level of supervision.**

THE WEEKLY ASSIGNMENTS:

Group leaders will give assignments each week to be completed for the next week.

These assignments form the backbone of the educational portions in group.

They also give a place for clients to demonstrate competencies, and they are geared to develop skills that are necessary for proper Relapse Prevention Planning and healthy living in an offense-free life.

The weekly assignments will cycle repeatedly through the following general topic areas:

THE WEEKLY ASSIGNMENTS (cont.):

1. **The deviant cycle and its application in understanding client behaviors (past and present)**
2. **Family dynamics and issues**
3. **Sexuality and appropriate sexual relationships**
4. **Victim empathy**
5. **Specifics of own offenses, cycle and patterns; pre-offense patterns; current negative patterns**
6. **Exploration of personal trauma aiming towards healthy resolution**
7. **Developing healthy and non-abusive patterns and means of relating with others**
8. **Properly expressing emotions and planning for future use of supports**
9. **Recognizing and modifying deviant thought patterns**
10. **Relapse Prevention Planning Preparation**

STAGE I: Pre-Treatment/Orientation

In this stage, the offender will address denial and resistance.

GENERAL TREATMENT GOALS:

- ***Accept responsibility***
- ***Be oriented to the treatment program***
- ***Cooperate in treatment planning process***
- ***Develop an attitude of cooperation with treatment process.***

TASKS:

- ***Meet with their individual therapist and review disclosure and treatment goals***
- ***Attend Self Management Group***
- ***Develop initial treatment plan***
- ***Complete Orientation Packet***

FOCUS OF ATTENTION: Take responsibility for offenses and engage in treatment

STAGE II: Beginning Treatment

In this stage, residents will be expected to learn the basic tools needed to be successful in treatment.

GENERAL TREATMENT GOALS:

R: To disclose offenses in detail

U: High, medium, and low risk situations; to identify and label emotional states; the role of fantasy in offending behavior; the connection between thinking errors and problem behaviors; deficits in interpersonal skills.

L: Triggers; the cycle; healthy sexuality, male/female roles; life history; past victimization and trauma.

E: Begin to engage in Family Work/Therapy; disclose offense to family; use skills learned in group; demonstrate responsiveness to feedback; participate consistently in group; show group intimacy; increase the quality of social skills and interactions in the community.

TASKS: Admit role in offenses during disclosure; write and present autobiography; complete general description of the cycle; complete all group assignments

FOCUS OF ATTENTION: Self, the Program, Community behavior

STAGE III: Intermediate Treatment

In this stage, resident will be expected to use the knowledge of themselves gained in Stage II to deepen their work and apply many of the concepts to themselves. This self-application will enable them to develop interventions to prevent relapse.

GENERAL TREATMENT GOALS:

R: Take greater responsibility for the impact their offending behavior had on victims, family, and others; and consider ways to make amends.

U: Risk to offend; the effects of trauma; specific fantasies that are related to their offending; healthy relationships in the future; own thinking errors and define corrections to thinking errors.

L: Interpersonal relationship and social skills; seek out feedback and training; stress management techniques; exits to progression in cycle; identifying own sexual orientation and how sexual needs can be met appropriately.

E: Identify support network to inform; use of exits for low, medium, and high risks; take healthy risks in bringing personal information to group; incorporate goal into every day life.

Stage III TASKS:

Know risk situations; risky emotional states; own sexual assault cycle; cognitive distortions; discuss fantasies in therapy; open in discussions of own sexuality; complete own acting out cycle in written form; support the development of a positive culture in the group; complete clarification letters (victim, self, others); complete Anger Management training; demonstrate improved relationship skills on the milieu; act as a positive role model to others.

FOCUS OF ATTENTION: Milieu, Family, and Skill Building

STAGE IV: Advanced Treatment / Relapse Prevention Planning

In this stage, offenders will be expected to use the insights concerning their own patterns and the skills gained in Stage III to complete their Relapse Prevention Plan in preparation for aftercare.

GENERAL TEATMENT GOALS:

R: Victim Empathy

U: All risk situations; how self esteem has been effected by events in life; openly able to discuss ways to manage risky emotional states; knows deviant fantasy; recognizes entitlement and narcissism.

L: Assertive ways in to deal with anger; improved skills of expressing feelings to others; see how cycle and personal dynamics operate in the here and now; develop positive and healthy sexual relationships.

E: Uses informed support group; actively informs appropriate others of safety measures; Uses exits for risk situations; shows genuine caring; is a self-starter in clinical work.

TASKS:

Family Work/Therapy to prepare for return to the family; Use skills and modify own behavior; Complete Relapse Prevention Plan; Complete assertiveness training; Complete relaxation training; Complete five current cycles in written form - Develop positive peer relationships; Eliminate negative interactions in relationships; Complete support network meeting.

FOCUS OF ATTENTION: Milieu, Family, and Community

Treatment Modalities

Group - individual - family