Treatment of Sexual Offending

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Background

- National treatment in English & Welsh prisons since 1992
- Followed by national treatment in probation settings
- Creation & re-organisation of National Offender Management Service
- National joint treatment planned for 2011
Major Rehabilitation Models

- Relapse Prevention
  - Marlatt, Laws

- Risk Need Responsivity Model
  - Andrews & Bonta

- Good Lives Model
  - Ward
Relapse Prevention Model

- Developed from clinical observation
- Offenders want to give up offending but lack the skills to do so
- Recognition and Management of Risk
- Acknowledgement of motivation
- In practice, very avoidance focused
Risk Need Responsivity Model

- Empirically based model
- Risk principle
- Need principle
- Responsivity principle
Good Lives Model

- Theoretically developed
- Offending as an attempt to secure life’s goods
- E.g. intimacy, inner peace, sexual satisfaction, autonomy, mastery
- Strong appeal to clinicians
Which model?

- RP was not designed to be avoidance focused
- RNR appreciates the importance of working positively with offenders
- GLM is experienced more positively but RNR leads to better recognition of risk factors
- RNR has strongest empirical base
Other characteristics of evidence based programmes

- Have a printed manual
- Select and train staff carefully
- Staff understand and can articulate the theoretical model of the program (the “Model of Change”).
Criminogenic needs

- Sexual preoccupation
- Any deviant sexual interest
- Offence supportive attitudes
- Emotional congruence with children
- Lack of intimacy
- Lifestyle impulsivity
- Poor cognitive problem solving
- Resistance to rules
- Grievance & hostility
- Negative social influences

(Mann, Hanson & Thornton, 2010)
Protective factors

- Healthy sexuality
- Constructive occupation (including employment)
- Motivation to desist
- Hope
- Agency
- Positive identity
- An intimate relationship
- Healthy social support (a place within a group)
- Sobriety
- Being believed in

(Maruna, 2010)
Readiness targets?

- Denial?
- Resistance or low motivation
- Ability to handle groupwork

(Mann, Ware & Barnett, 2010)
Current practice (US) >80% programmes *(McGrath et al, 2010)*

- Offense responsibility: Not criminogenic
- Victim empathy: Not criminogenic
- Intimacy skills: Criminogenic
- Social skills: Not criminogenic
Current practice (Canada) 
>80% of programs

- Intimacy skills
- Victim empathy
- Emotional regulation
- Criminogenic
- Not criminogenic
- Criminogenic
Current practice (England/Wales prison)

- Attitude reconstruction
- Victim empathy
- Self regulation (emotional regulation, intimacy, problem-solving)
- Weakly criminogenic
- Not criminogenic
- Criminogenic
Not doing enough of...?

- Sexual self regulation
- Sexual interests
- Offence supportive attitudes
- Impulsivity
- Problem solving & coping
- Grievance, hostility and callousness
- Social support
- Intimacy support
- Employment or constructive use of time
Doing too much of...?

- Offense responsibility
- Victim empathy
- Social skills
Accepting Responsibility

- Often assumed to be equivalent to making a full confession
- Need for a confession may be intuitive or emotional rather than rational
- Failure to confess = refusal to accept sexual offender identity? May be associated with desistance
An alternative to confession-oriented treatment

- Focus on taking responsibility for the future
- More prevalent in desisting offenders (Maruna, 2001)

(Ware & Mann, in preparation)
Victim empathy

- Rehabilitation, punishment or correctional quackery?
  - Rehabilitation – offenders report VE to be important
  - Punishment – offenders report VE to be distressing
  - Correctional Quackery – lack of coherent rationale for VE; lack of VE not an established risk factor
An alternative to Victim Empathy

- Enable offenders to overcome obstacles to empathy
  - Ability to experience emotion
  - Perspective taking (theory of mind)
  - Menschenliebe
  - Situational factors
  - Management of personal distress, shame, stress

(Mann & Barnett; Barnett & Mann; 2010)
Treatment Methods

For a bio-psycho-social programme
“Biological” methods

- Medication (anti-androgen, SSRI) (Grubin, 2009)

- Treatment that is sympathetic to neuropsychology of offenders (Creeden, 2009)
  - Eyebrows-down approach (Visual, audio, kinesthetic)
  - Repetitive skills practice
  - Real life integration
# Case examples

- **Mr A**
  - Experienced persistent neglect as a child
  - Is impulsive, often emotionally driven and struggled at school
  - Finds it hard to articulate his inner world
  - Suspicious of others

- **Mr B**
  - Well educated
  - Had a loving childhood
  - Likes to discuss, analyse, read and write.
  - Enjoys psychometric testing sessions
  - Easily trusts others
Cognitive-Behavioural Methods

- Standard CBT – adjusting thoughts as a way of managing behaviour
- Attitude change – related to attitudinal risk factors (offence supportive attitudes, hostile attitudes, beliefs that hamper intimacy and trust).
- Skills practice, behavioural experiments, etc.
Social methods

- Working positively with those engaged in risk management
- Encouraging social protective factors
  - Employment, accommodation, hobbies, constructive daily & weekly routine
- Enhancing social support
  - Improving relationship skills
  - Filling gaps for those who lack support (COSA)
  - Maintaining family ties
Case examples

- **Mr C**
  - Employed
  - Evenings spent with brother, girlfriend or mother
  - One evening alone per week “me time”
  - Weekly schedule indicated busy life, constructive activity and regular routine

- **Mr D**
  - Unemployed
  - Lack of social contact
  - Mainly watching TV
  - Remained inside for days at a time
  - Irregular sleeping and waking hours
Basic Therapist Competencies

- Understanding normative behaviours and theoretical models of sexual deviance
- Socratic questioning
- Effective use of behavioural techniques such as reinforcement, extinction and modelling
- Generalisation of alternative thinking and behaviour outside the treatment environment
- Understanding and using group process
- Working with a co-therapist
Advanced Therapist Competencies

- Expert therapeutic skills
- Interpersonal skills
- Understanding and accepting the client
- Using positive language
- Instilling hope for change
- Working collaboratively with the client
- Personal resilience

(Fernandez & Mann, 2009)
Four essential therapist skills

- Reinforcing
- Directive
- Warm
- Genuine

(Marshall, 2005)
Treatment Context
The social environment

- Offenders report that this affects their decision to engage in treatment more than other factors
  - Views of family and friends
  - Views of professionals
  - Extent to which sex offenders are stigmatised

(Mann, 2009)
The group environment

- Mixed group and individual sessions work best (Schmucker & Losel, 2009; Ware et al, 2009).
- Effective group environment features:
  - Cohesive, well organised
  - Encouraged open expression of feelings
  - Produced a sense of group responsibility
  - Instilled hope in members
- Detrimental group environment features:
  - Over controlling leaders

(Beech & Fordham, 1997)
Society

- Extent to which sex offenders are stigmatised
- Extent to which communities take responsibility for managing risk (COSA)
- Extent to which policy makers seek evidence to form or to justify policies
Conclusions
Treatment works?

- Overall, treatment seems to reduce recidivism (Schmucker & Losel, 2010)
- RNR principles are upheld (Hanson et al., 2009)
- Not all programmes work, and there are few studies of high quality design
- Major RCT of sex offender treatment did not show a treatment effect (highly structured RP programme) (Marques et al, 2005)
- Treatment unlikely to work in isolation
The best chance for treatment to work?

☐ When there is a clear model of change

☐ When RNR is part of the model of change

☐ When the aims of treatment are understood and supported by people other than the programme staff

☐ When evidence wins over intuition
Thank you for listening

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