Ethics in management and treatment of individuals sentenced for a sexual offense

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Criminal Justice Summer Course: Responses to Sexual Violence
Barcelona 5-8 July 2022
Presentation

Speakers and participants
WS 1
Introduction to ethical issues in the management and treatment of individuals sentenced for a sexual offense
Introduction to program

1. Ethical issues and dilemmas in interventions and treatment
2. Importance of context
3. New approaches in assessment and intervention
4. Understanding denial
5. Sexual interest in children and sexual abuse
6. Case studies and working with denial
7. Case studies and working with sexual interest
8. Rethinking ethical dilemmas and moving forward
Expectations

My expectations for this workshop is.........
Workshop-structure

• Check-in: Ready for today’s workshop?

• Review: What was interesting yesterday?

• Topic and group-discussion: Workshop 1-8

• Round up: What do I take home?
  How was our co-operation?
  Short info. next workshop
Prison services and probation should manage and seek to reintegrate persons accused or sentenced for a sexual offense in line with the risk they pose and in accordance with same standards and principles applied to other persons under their responsibility.

Council of Europe Human Rights
Prevention of torture, inhuman or degrading treatment or punishment
Prison Rules
Probation Rules
Interventions and treatment should be evidence-based, proportionate and part of a comprehensive approach which helps individuals to address their offending behaviors.
Rehabilitation ideal

• Enable the person to avoid further crime by increasing personal effectiveness
• Individual wellbeing is as much a consideration as social utility
• The helper is both an agent of the offender and of the society

The benefits to the individual provide ethical justification for intervention
Who determines the need for change?

The person self? Complaint over suffering

Others? Complaint over the persons behavior
Challenges

• Prescribing or advising behavior change usually does not work
• Guidence in how to change is seldom sufficient
• Often attributed to inside the individual:
  ”he is not motivated”
  ”he denies”
  ”his nature is hardened”
Ethics in treatment

Awareness and protection of an individual’s

**Autonomy** – self-determination, freedom
**Integrity** – respect for self-perception
**Vulnerability** – all lives are fragil and valuable
**Dignity** – irreplaceable and equal

*Basic Ethical Principles in European Bioethics and biolaw (Rendtorff, J.D. & Kemp, P. 2000)*

Facilitating the co-operation of the person is central in all aspects of effective reintegration, including risk-assessment, risk-management, treatment and interventions.
Is co-operation possible?

• If the interests of a person and society is not be compatible
  
  \textit{(sexual interest in children vs. society’s norms and laws)}

• If the only negative consequence for the person may be being caught and convicted
  
  \textit{(I have my needs and don’t think I harm anyone)}

• If options are limited; commitment to change may entail acceptance of society’s values
  
  \textit{(reluctant to change or ambivalent)}
How do I co-operate with the person?

How can I enhance the person’s motivation for change?

Is he *ready* to make a change? Is change a priority for him?
Is he *willing* to make a change? Is it important enough to take action?
Is he *able* to make a change? ”I would if I could”
Professional code of conduct

• Individual voluntary consents to treatment
• Coercion interferes with free choice
• Manipulation through positive inducements undermines self-determination – (approach is common)
• Decision to seek help is never wholly free nor free from coercion
• Compulsory treatment (ordered by court) – fx mental illness
Informed consent

Give information about:

• Treatment procedure and purpose (risk assessment and content)
• Role and qualifications of the person providing treatment
• Benefits that reasonably can be expected
• Alternatives to treatment that can help as well
• Withdraw consent any time and discontinue treatment
Discussion:
Ethical justification for intervention/treatment in prison and probation

- Is it possible to establish a helping alliance within a context of restraint and coercion?

- Should we engage those whose motivation to change is in doubt?

- Are there effective programs likely to promote change?
Round up

What do I take home?
How was our co-operation?
Short info. next workshop
Workshop 2: *Importance of context in rehabilitation of men with sexual convictions*
Workshop 2

• Check-in: Ready for today's workshop?

• Review: What was interesting yesterday?

• Topic and group-discussion: Workshop 1-8

• Round up: What do I take home?
  How was our co-operation?
  Short info. next workshop
Positive steps should be taken to meet the distinctive needs of persons accused or sentenced of a sexual offense, including their separate accommodation while in person, where deemed necessary, and special management while in prison and under probation.
• The use of rehabilitative interventions for criminal offenders has expanded over the decades and with it so has evidence of their effectiveness in reducing recidivism (Lipton et al, 2002; Schmucker & Losel, 2015).

• While there is significant body of evidence for the effectiveness of behavioural programmes in reducing recidivism, the broader environment where the treatment takes place has received much less attention (Ware, Frost and Hoy, 2010).

• “the context in which treatment is provided may actually prove to be quite important to the overall effectiveness of treatment” (Ware, 2011: 30).
Context matters because...

High quality meta-analytical studies rarely find an effect in prison (whereas they do in outpatient and community settings).

Both Schmucker and Lösel (2015) and Mann (2009) suggested that whilst poor program design, poor program implementation, or inability to transfer learning to the real world may contribute to ineffective prison-based treatment, it is likely inadequacies in the supporting context for the program are the primary cause (Ware & Galouzis, 2019).

Readiness for treatment is related to prison climate (Blagden et al., 2016, 2017; Williams et al., 2019).
The effects of sexual offender treatment on recidivism: an international meta-analysis of sound quality evaluations

Martin Schmucker & Friedrich Lösel

*Journal of Experimental Criminology, 11*, 597–630 (2015) | Cite this article

4949 Accesses | 109 Citations | 70 Altmetric | Metrics
Treatment Setting

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Hierarchical components of a rehabilitative prison

1. Safety, Decency, Procedural Justice
2. Rehabilitative culture
3. Address drug & alcohol problems
4. Address attitudes & thinking
5. Resettle
Rehabilitative Climate

• The rehabilitative climate is the ways in which the correctional climate fosters and promotes positive personal change and ultimately how conducive it is to reducing reoffending.

• While it focuses on key components of social climate (e.g. growth, support, atmosphere) and moral climate (human decency, fairness and staff-prisoner interactions).

• It also has an emphasis on attitudes towards offending, beliefs about change, readiness to change, promotion of change and relationships that foster change.

• Rehabilitative climate as a responsivity factor (see Birgden, 2004)
Paradigm Shift?

• Moving away from programmes “fixing” individuals

• Owning your own rehabilitation (Perrin & Blagden, 2017; Blagden & Wilson, 2019)

• A move from programmes to lives – Copernican Revolution (McNeill, 2013).

• ‘The desistance paradigm suggests that we might be better off if we allowed offenders to guide us, listen to what they think might best fit their individual struggles out of crime, rather than continue to insist that our solutions are their salvation.’ (Porporino, 2010 pg. 80)
Empirical evidence for accounting for prison climate in programme design
• Stasch et al (2018) found more positive perceptions of prison climate were related to reductions in dynamic risk – particularly important was prisoner-staff relationships.

• Variables that appear to effect correctional environments include, quality of staff-prisoner relationships, organisational culture, degree to which therapeutic integrity is maintained (Day et al, 2011; Goggin and Gendreau, 2006; Stohr et al, 2012).

• It has been argued that the therapeutic and rehabilitative climate of a correctional institution could be vital for offender reform (see e.g Day et al, 2011; Schalast et al, 2008).
Prison climate, risk and recidivism

• Antitherapeutic prison environments have been found to have a negative effect on treatment readiness and programme outcome (Schalast, Redies, Collins, Stacey & Howells, 2008).

• Woessner and Schwedler (2014) positive changes in different aspects of prison climate were related to significant prosocial changes in dynamic risk factors.

• Prisoner and staff relationships (validating, meaningful etc) have been found to be important in the desistance process in that establishing positive and meaningful CJS relationships is important in terms of triggering, enabling, and sustaining change (Weaver 2013, 2015).
• Studies have found higher scores in prison climate to be related to readiness to treatment and change (William et al, 2019), with prison climate predicting readiness for treatment (Blagden et al, 2016).

• There is a considerable amount of recent meta-analytic evidence that a lack of treatment motivation is one of the strongest predictors of treatment attrition, which in turn is a strong predictor of recidivism (Olver et al., 2011).

• Prison climate mediates between rehabilitation and desistance *before, during, and after* the actual programme delivery (Ware & Galouzis, 2019).
Prison climate and personal change

- Studies conducted in correctional facilities provide further evidence for positive effects of prison climate on...

- Attitudes towards offending (Woessner & Schwedler, 2014; Gaab et al, 2020),
- Dropping out of treatment programs (Moos, Shelton, & Petty, 1973),
- Mental health issues during treatment (Gonçalves, Endrass, Rossegger, & Dirkzwager, 2016), increased empathy (Heynen, Van der Helm, Cima, Stams, & Korebrits, 2017),
- Treatment motivation (Blagden et al, 2016; Long et al., 2011, Williams et al, 2019).
- Higher ratings of group cohesion and safety were associated with less institutional aggression (Tonkin et al., 2012)
Group Discussion

• How important are prisoner – staff relationships in the rehabilitative process.

• How can we foster/promote positive prison-staff relationships?

• What do constructive prisoner staff relationships look like?
Exploring Prison Climate
Researching the rehabilitative climate of prisons for those with sexual convictions

<table>
<thead>
<tr>
<th>Prisons</th>
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<tbody>
<tr>
<td>• Rehab Prison – Cat C trainer – specialist sex offender site treatment focused</td>
</tr>
<tr>
<td>• Re-rolled Prison – Cat B trainer – now specialist sex offender site</td>
</tr>
<tr>
<td>• Prison with AC focus – Cat C – specialist prison not treatment focused</td>
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<tr>
<th>Quantitative Phase</th>
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| • **Rehab Prison** Prisoners \( n = 112 \) Prison Staff \( n= 48 \)  
  The mean age for prisoners was 48.87 \( (SD = 14.15, \text{range} = 23-80) \) and the mean age for prison staff was 39.77 \( (SD = 12.02, \text{range} = 24-58) \).  
• **Re-Roll Prison** Prisoners \( n= 111 \) Prison Staff \( n=31 \)  
  The mean age for prisoners was 43.40 \( (SD = 15.16, \text{range} = 22-79) \) and the mean age for prison staff was 34.81 \( (SD = 11.11, \text{range} = 22-60) \).  
• **Prison with AC focus** Prisoners \( n=99 \) The mean age for prisoners was 47.77 \( (SD = 15.16) \) |

<table>
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<tr>
<th>Qualitative Phase</th>
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| • Total of \( n=15 \) prisoner interviews and \( n=16 \) staff interviews at **rehab prison**  
• Total of \( n=30 \) (t1 15/ t2 15) prisoner interviews and \( n=16 \) staff interviews at **re-roll prison**  
• Total of \( n=15 \) prisoner interviews and \( n=16 \) staff interviews at **Prison with AC focus** |
Measures

• EssenCES – Therapeutic Hold, Prisoner Cohesion, Experienced Safety (Schalast, 2008)

• Rehabilitative Climate Questionnaire (RCQ) (NOMS, 2014)

• Attitude Towards Sex Offenders Scale (ATS) (Hogue, 1993)

• Implicit Theories of Offending Behaviour (self and other) (modified from Dweck, 2000; Gerber and O’Connell, 2010)

• Corrections Victoria Treatment Readiness Scale (Casey et al, 2007)

• Warwick-Edinburgh Mental Well-being Scale (WEMWBS)
## Differences in Prison Climate for men with sexual convictions

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<tr>
<th>Group</th>
<th>n</th>
<th>Scale/Subscale</th>
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<th>SD</th>
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# Differences in Prison Climate

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## Rehabilitative Climate

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## Readiness for treatment and change

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Meaningful Relationships/Facilitating Change

Prison with AC focus

It was a prison officer on my wing and to have that, that was like wow. It was amazing because after she said ‘you know what, I respect you more’ and having that feedback like I say, I can put a price on it.

Rehab Prison – Prisoner Participant

IV: What makes them positive relationships?
RSP: The honesty, the honesty, that all comes from you and the courses we’re doing, it spreads and the fact that we are able to talk freely about how we’re feeling, you know, and feeling that someone will care and not like it’s oh it’s a waste of time.
Meaningful Relationships/Facilitating Change

• Being “blown away” emphasising how qualitatively different this experience was to previous establishments. Recognising change and supporting it important – but also is about human interaction.

• The previous extract highlights the transformative potential interactions can have on prisoners. Highlights the importance of reciprocity, being valued and trust in cementing change (Mead, Hilton, & Curtis 2001).

• The process of positive feedback and validation is an important aspect of the desistance literature in that high expectations of an individual produce higher outcomes, known as the **Pygmalion effect** (Maruna et al., 2009; Lebel et al., 2008).
Importance of meaningful, supportive and genuine relationships

Prisoner-staff relationships (and perceived staff support) important for prisoner wellbeing, adjustment and order in prison (Dirkzwager and Krutschnitt, 2012).

Such relationships are important in the desistance process where establishing social relationships is seen as vital to the triggering, enabling, and sustaining of change (Weaver 2013, 2015).

Therapeutic alliance pivotal for effective treatment (see e.g. Serran et al, 2003; Ackerman and Hilsenroth, 2003) particularly as “change is hard” – PCP and relapse.

Relationships and interactions with staff maybe testing grounds for future meaningful relationships (Blagden et al, 2016, 2017).
Experiencing a different world - Acceptance

**Prison with AC focus – Prisoner Participant**

“Yes from the moment you walk in you’re treated as a person not as a prisoner and that I would say is to do with the active citizenship”

**Rehab Prison – Prisoner Participant**

• “It doesn’t matter what you’ve done you’re accepted here and you accept people here...This place gives you the headspace you need to think about things to work things through, and if you need that time to be alone you’re given it”

**Re-Roll Prison - Prisoner Participant**

“Have I really come from that world to this? It really is a different world to what I’ve experienced before”
Experiencing a different world - Acceptance

- Feeling safe and having anxieties reduced gave participants additional ‘headspace’ to think and reflect upon the self in transition (self in relation to past and future selves) and the changes they want to make.

- Headspace in prison can allow offenders to reflect and discover that change is possible and desirable (Blagden et al, 2016, Crewe, 2011). Most participants discussed feeling ‘at ease’ in the prison and that the environment allowed for personal change.

- This links with findings from previous research that highlights the importance of the prison environment for sexual offenders (Ware et al. 2010; Schwaebe 2005).

- The environments in each prison appeared to be somewhat conducive to facilitating personal change.
Impediments to Rehab Climate-Procedural Justice

• Procedural justice theory argues that experiencing fair and just procedures leads people to view the law and authority figures as more legitimate.

• Procedurally just treatment is associated with higher outcome satisfaction ratings and decision acceptance, greater cooperation with, and confidence in, the Criminal Justice System, and more law-abiding behaviours (see Casper, Tyler, & Fisher, 1988; Mazerolle, Bennett, Davis, Sargeant, & Manning, 2013).

• A recent longitudinal study found prisoners who perceived their treatment to be procedurally just reported less rule breaking/misconduct three months later (Beijersbergen et al, 2015).

• Inherently a relational process!
Relationships matter...

The good lives model of offender rehabilitation: Clinical implications

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c University of Kent, United Kingdom

Received 20 October 2005; received in revised form 15 February 2006; accepted 7 March 2006
Available online 7 July 2006

EMPIRICAL PAPERS

Unpacking the therapist effect: Impact of treatment length differs for high- and low-performing therapists

Simon B. Goldberg a, William T. Hoyt, Helene A. Nissen-Lie, Stevan Lars Nielsen & Bruce E. Wampold
Pages 532-544 | Received 09 Apr 2016, Accepted 14 Jul 2016, Published online: 12 Sep 2016
Accumulating meaning, purpose and opportunities to change ‘drip by drip’: the impact of being a listener in prison

Christian Perrin* and Nicholas Blagden

Sexual Offences Crime and Misconduct Research Unit, Division of Psychology, Nottingham Trent University, Nottingham, UK

(Received 8 February 2013; accepted 20 December 2013)

Established in 1991, the Listener scheme, regulated by the Samaritans, is currently the best-established peer support scheme in place to help reduce suicide in prisons. Each prison Listener team is comprised of a group of inmate volunteers who provide face-to-face emotional support to their peers. Although the scheme has been in operation for over 20 years, empirical research on the scheme is limited. A deeper understanding of how being a Listener affects prisoners’ attitudes, beliefs, emotions and experiences of imprisonment is needed. The present study is a qualitative analysis on the experience of being a Listener and the impact it has on individuals and their prison experience. Interviews were analysed using interpretative phenomenological analysis. The analysis revealed two main superordinate themes: ‘Listening and Personal Transformation’ and ‘Countering Negative Prison Emotions’. These themes are unpacked and the analysis focuses on their implications for desistance and offender reform. Results suggest that prisoners who adopt Listener roles experience profound internal changes, shifts in self-identity and gain meaning and purpose from prison. Implications for how such schemes may be utilised in the future and suggestions for further research are offered.

Keywords: desistance; rehabilitation; prison inmates; offending behaviour; peer support
Reciprocity, purpose and personal change

• Mutual reciprocity (LeBel, 2014) enabling prisoners to benefit from opportunities for self-change; links to wounded healer narrative

• The ability to help others may contribute to a sense of purpose and improved self-esteem, both are aspects of positive identity change which are critical for rehabilitation (McCloskey & Newton, 2002).

• Possible selves – narrative selves (McAdams, 1985) – people tend to live by the stories they tell about themselves.

• LeBel et al. (2015) conclude, helping others appears to have adaptive consequences for prisoners and ex-prisoners, and on these grounds, an argument can be made for increasing opportunities to engage in roles characterised by reciprocal helping.
What does this mean for practice?
Increase psychological presence in prison

• Psychological input in staff training
• For example, Five Minute Intervention, allowed for constructive prisoner–staff relationships (Tate, Blagden, Mann, 2017).
• Increased psychological presence in senior prison management

Better working relationships between psychological staff and prison staff – better programme awareness and support.

If we could know who works in programmes, have a closer relationship, if they came onto the wing more. If I said to you “can you see so and so tomorrow”, come and see rather than put in a general app... there’s no trust... We don’t get told anything from programmes, they don’t tell us anything he’s progressing well or he’s had a bad session...I’ve no idea about sex offender programmes, all I know is that they sit around in groups and talk about their offences and how err it effects people.
Owning your own rehabilitation

- Facilitating control for men in prison
  - Increased use of peer support
  - Control over environment
  - Active Citizenship

Dispelling myths

Closer more joined up working.
- Better information sharing
- Dispelling the notion of ‘forensic psychologists’ as the quiet ones with power
Importance of Language Use

• Terms such as ‘con’, ‘inmates’, ‘prisoners’ etc reinforce criminogenic identities and become self-referent labels (Harris, 2014, Willis, 2017).

Why call someone by what we don't want them to be? The ethics of labeling in forensic/correctional psychology

Gwenda M. Willis

Pages 727-743 | Received 22 Feb 2017, Accepted 20 Dec 2017, Accepted author version posted online: 27 Dec 2017, Published online: 08 Jan 2018

• Linked to stigma, shame and reinforcement of negative identities.

• Prisons of purpose “no more victims”, “Returning citizens not offenders to communities”
How could practice be improved?

• **Before Treatment**

  - Volunteering for treatment – climate supportive of therapy. Use of prison staff to help recruit onto programmes. Increased training, support and input from psychological staff.

  - To ensure a positive prison climate supportive of rehabilitation *before* treatment it is important to focus on the engagement and education of non-treatment staff (also attitudes) (Ware & Galouzis, 2019). Training of staff, increased presence in senior management.

  - Wider prison staff attitudes matter. Attitudes have been found to predict punitiveness of response to prisoners. Furthermore, ATS has been linked to therapeutic effectiveness and therapeutic alliance (Hogue, 2009).
How could practice be improved?

• **During Treatment and After**

  - Frost, Ware, and Boer (2017) have also suggested that there are two necessary conditions in providing a positive prison climate during treatment to allow for content rehearsal and practice

  1) There must be a “safe” and containing environment that is conducive to openness, directness and honesty

  2) It must create structured opportunities to develop attitudes and learn skills as an expedient forum for addressing interpersonal relationships

  3) Support the development of positive practical identities and help enact them.
Influencing change

- Personal change – relational desistance (e.g. Weaver, 2015)

- Climate change – contributions to rehabilitative culture (Facilitating change, therapeutic alliance, wider staff training e.g. FMI)

- Influencing policy – Challenging entrenched beliefs i.e. “men with sexual convictions are inherently risky.” **Licence conditions**
• Rehabilitative climate is a responsivity issue that we need to be more responsive to...

• Giving people the latitude to develop viable identities is important for the self-change process. Peer support roles, active citizenship and constructive relationships can assist with encouraging this. It is important to note positive behaviour change outside of programmes.

• Cultivating, investing in and promoting positive and meaningful relationships is important for desistance no matter what the offender.

• Taking ‘rehabilitative climate’ seriously will help to maintain and sustain treatment gains

Drawing it all together...
Round up

What do I take home?
How was our co-operation?
Short info. next workshop
Workshop 3

New approaches in assessment and intervention
Workshop 3

- Check-in: Ready for today's workshop?

- Review: What was interesting yesterday?

- Topic and group-discussion: Workshop 1-8

- Round up: What do I take home?
  How was our co-operation?
  Short info. next workshop
Council of Europe Recommendations, basic principles

Offending behaviour should be considered in a comprehensive manner, which takes account of behavioral, social, psychological and health factors.

Interventions and treatment should be evidence-based, proportionate and part of a comprehensive approach which helps individuals to address their offending behaviours.

Preventing and responding to sexual offending are most effective in a multi-disciplinary setting, involving partner agencies and facilitating sharing of information, expertise and resources in order to build a common vision of risk management and effective social reintegration.

Agencies managing persons accused or convicted of a sexual offense should work with local communities where appropriate, to facilitate risk management approaches and the social reintegration of individuals.
The RNR model - evidence-based principles

- **Risk**: Criminal behavior can be predicted - match levels of treatment services to the persons risk level

- **Need**: All needs are not linked to offensive behavior - adress criminogenic needs (dynamic riskfactors)

- **Responsivity**: Cognitive-behavioral and social learning strategies – deliver treatment in a style and mode that is consistent with ability and learning style of the individual

Andrews, D.A. & Bonta, J. 2010
GPCSL General Personality and Cognitive Social Learning

Key personal and social relationships variables interact with the environment to shape behaviour
LS/RNR: Level of Service Risk-Need-Responsivity

- 8 risk–need factors (*protective factors as well when not present*)
- General factors – specific factors can cause professional override

<table>
<thead>
<tr>
<th>Risk/need</th>
<th>Criminal history</th>
<th>Education/employment</th>
<th>Family/Marital</th>
<th>Leisure/Recreation</th>
<th>Alcohol/drugproblem</th>
<th>Procriminal Attitude/orientation</th>
<th>Antisocial pattern</th>
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</tbody>
</table>
Risk-need factors – juvenile sex offenders

- Emotional and behavioral problems

- Victims of sexual abuse (20-50%)

- Families low levels of positive communication, low rates of parental monitoring, high rates of conflicts and violence and substance abuse

- Socially inept, isolated from same-age peers, often turn to younger peers

- School-difficulties; low grades, behavior problems, suspension, expulsion

Borduin, C.M. et al, Multisystemic Therapy with Juvenile Sexual Offenders, in Boer et al 2011
### Predictors of recidivism (Bonta 2017)

<table>
<thead>
<tr>
<th>Risk-need factors</th>
<th>General convicted</th>
<th>Convicted for sexual offence</th>
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<tr>
<td>Procriminal Associates</td>
<td>.21</td>
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<td>Antisocial Personality</td>
<td>.33</td>
<td>.10</td>
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<tr>
<td>Procriminal Attitudes</td>
<td>.17</td>
<td>.10</td>
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<tr>
<td>Criminal History</td>
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<td>.15</td>
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<tr>
<td>Education/Employment</td>
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<td>.10</td>
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<tr>
<td>Family/Marital</td>
<td>.13</td>
<td>.05</td>
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<tr>
<td>Alcohol/Drug abuse</td>
<td>.20</td>
<td>.06</td>
</tr>
<tr>
<td>Leisure/Recreation</td>
<td>.16</td>
<td>.01</td>
</tr>
</tbody>
</table>
Risk-need factors of persistent sexual offenders

Hanson, R.K., & Morton-Bourgon, K (2005): The characteristics of persistent sexual offenders in: Journal of consulting and Clinical Psychology, 73

<table>
<thead>
<tr>
<th>Risk-need factor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deviant sexual preferences</strong></td>
</tr>
<tr>
<td>Sexual preoccupation</td>
</tr>
<tr>
<td>Approximately 20-50 % of SOC</td>
</tr>
<tr>
<td><strong>Antisocial orientation</strong></td>
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<tr>
<td>lifestyle instability</td>
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</table>
## Effect of treatment for adult persons: low to moderate

*Madvig, F. et al, 2021: Treatment of sexual offenders*

<table>
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<tr>
<th>Significantly lower recidivism</th>
<th>Lower recidivism</th>
<th>No evidence</th>
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</thead>
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<tr>
<td>Hanson et al; RNR-approach (CBT and social learning appr.)</td>
<td>Dennis et al 2012 (diff. appr.)</td>
<td>Furby et al 1989; the higher FU, the higher recidivism, treatment no effect</td>
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<tr>
<td>Harrison et al 2020; CBT</td>
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</tbody>
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**Note:** This table summarizes the findings of various studies on the effect of treatment for sexual offenders, categorizing them based on whether they showed significantly lower recidivism, lower recidivism, or no evidence of treatment effectiveness. The studies cited include different approaches such as cognitive-behavioral therapy (CBT) and social learning, with notable references to specific authors and years.
Interventions and treatment: Strength-based approaches

• James, W (1902): ‘Healthy mindedness’

• Rogers, K. (1961): ‘Fully functioning person’

• Maslow, A. (1968): ‘Self-realizing person’

Positive approach in intervention and treatment

• Resilience (protective factor) is more important than risk-factors in human lives, Bernard (2006)
• Desistance-proces: shift in sense of self from a shamefull past to a productive life, Maruna (2001)
• Self-efficacy and an internal locus of control are essential in motivating to change, Bandura (1984)
Enhancing motivation to change in Danish prison and probation

Cognitive-social learning

Good Lives Model

Motivational interviewing
Group-based interventions DK & Greenland

• Structured and intensive: Treatment manual and participants’ workbook
• Openended groups and individual
• Heterogen group (offenses against children, youth and grownups)
• Interventions focus on cognitive and behavioural aspects:
  • Link between attitudes and behaviour
  • Better selfregulation (feelings, stress)
  • Interpersonal skills (problemsolving, communication)
Motivational Interviewing for reluctant clients

The aim is to increase the individual’s intrinsic motivation to change

“Provide a context within which the individual feels accepted and comfortable enough to face his problem behaviour and ambivalence about change”

(Miller & Rollnick, 2013)
Reflective listening

The individual is an expert on himself:

O = open questions
A = affirmation
R = reflections
S = summary

Reinforce ambivalence and statements of change
Engage the person in own change process - he is an expert on himself!

My values?

My strengths?

My goals?

My risks?
The Aurora Project

PREVENTION OF SEXUAL ABUSE
There is no one to blame for their sexual preference.
Core aim is to improve psychological well being and reduce likelihood of offending behaviour.

By

- Reducing fusion with unhelpful thoughts and identity
- Developing skills for emotional regulation (via compassion and acceptance)
- Developing skills for sexual regulation
- Developing skills for valued living (consistent with ethos of Good Lives Model)
- Psychoeducation work (healthy sex, relationships, the brain)
- Developing skills for healthy sex and relationships
### Quantitative Evaluation

<table>
<thead>
<tr>
<th>Subject</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
<th>RCI</th>
<th>Improved</th>
<th>Unchanged</th>
<th>Deteriorated</th>
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<td><strong>Psychological Distress (on CORE Outcome Measure)</strong></td>
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<td>-2.008*</td>
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</table>

**CORE Outcome Measure**
- **Severe**: 85+
- **Moderate to severe**: 68-84
- **Moderate**: 51-67
- **Mild**: 35-50
- **Low level**: 21-33
- **Healthy**: 1-20

**Internalized Shame Scale**
- **50+**: Problematic shame
- **60+**: Indicates above plus depression
- **70+**: Very likely depression or other emotional/behavioural problems
# Quantitative Evaluation

## Intervention Outcomes

<table>
<thead>
<tr>
<th>Subject</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
<th>RCI</th>
<th>Improved</th>
<th>Unchanged</th>
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</table>

### Adult Hope Scale

- **40-48**: Hopeful
- **48-56**: Moderately Hopeful
- **56+**: High Hope

### Anxiety (on DASS-21)

- **Normal**: 0-7
- **Mild**: 8-9
- **Moderate**: 10-14
- **Severe**: 15-19
- **Very Severe**: 20+
Round up

What do I take home?
How was our co-operation?
Short info. next workshop
Workshop 4: Understanding denial in men with sexual convictions
Workshop 4

• Check-in: Ready for today's workshop?

• Review: What was interesting yesterday?

• Topic and group-discussion: Workshop 1-8

• Round up: What do I take home?
  How was our co-operation?
  Short info. next workshop
3 perspectives on denial

• **Risk-need factor**: Procriminal attitude; neutralization, does not take responsibility for own acts

• **Responsivity factor**: Not motivated, nervous, low intelligence, personality disorder, shame

• **Desistance factor**: Actions are not compatible with self-perception – prosocial identity is reinforced
What is denial?

**Psycho-dynamic:** a defense mechanism

**Cognitive-behavioral:** a process that serves to reduce the offenders’ experience of blame and responsibility for their offense

- Categorial denial
- Minimization
- Full admission
Cooperation in rehabilitative work – invitations to responsibility (empowerment)

- Recognize the individual’s understanding of the convicted, and the reasons he gives for his behavior
- Adjust to the individual’s responsivity, he is "an expert on his own life"
- Do not draw conclusions on pattern recognition – listen respectfully
- Access to treatment and interventions should not be dependent on the acknowledgement of guilt
## Alternative interpretations of neutralizations

<table>
<thead>
<tr>
<th>Unmotivated statement or behaviour</th>
<th>Alternative interpretations</th>
</tr>
</thead>
</table>
| “I didn’t do it”                  | ”I am too ashamed to admit it”  
|                                  | ”I can’t face what will happen next if I admit it”  |
| “It wasn’t such a bad thing to do”| ”It’s the only way I know how to get rewards”  
|                                  | ”If I admit it was bad, that makes me a bad person”  |
| “I don’t need help”               | ”I am scared og what you weill ask me to do”  
|                                  | ”I’ll fail and make matters worse”  |
Desistance-theory


Ego-syntonic = the offence represents who I am
Ego-dystonic = the offence does not represent who I am

"Reintegration into pro-social life... need for programmes that support desistance by promoting succes in education, employment, familyrelations, housing and a prosocial network”
Goals and methods

Goal

*Individual engages in own process of change*

Methods

*Cognitive-behavioral method*
*Social learning theory*
*Good Lives Model*
*Motivational Interviewing*
Cognitive-Behavior Therapy

Critical to securing co-operation:

*Promise not to discuss their offense or challenging their denial*

- Rolling group (aided by the older members of the group)
- Focus on group-dynamics
- Acceptance of the client but not of his criminal behavior
- Invitation to take responsibility for his actions
- Encourage openness
- Denial is subsumed under cognitive distortions

*(Marshall, W. 1999)*
Defining denial

• The APA (1999) defines denial as a “defence mechanism in which the person fails to acknowledge some aspects of external reality that would be apparent to others”.

• ATSA (2001: 63) “the failure of sexual abusers to accept responsibility for their offences”

• Offender Assessment System (OASys) “Does the offender accept responsibility for the current offense(s)?”

• Gibbons, de Volder and Casey (2003) found no difference between offence type and denial type - found the spread of denial variable.
Denial as a form of scaffolding

- Janoff-Bulman and Timko (1987) have argued that denial be seen as a transitory phenomenon, a form of scaffolding that is taken down once the need for denial rescinds.

- Denial as a form of transition, it allows the self-concept to be protected and shielded from deleterious information.

- The problem currently is that we don’t do any building work with deniers – scaffolding remains.
Traditional view of denial

- Maladaptive, signifier of poor insight, needs to be challenged, overcome and broken down.

- Denial is pathological and needs to broken down (Northey, 1999). Denial means the offender is resistant.

- Denial “feels risky” (Blagden et al, 2012).

- Deniers have low motivation for treatment and poor therapeutic alliance.
What’s the worst thing someone can say to someone? I’m Hitler...it would have been easier if I had murdered her...less stigma...the whole character I’ve been portraying would be shattered

Martin

It’s like a lifetime tag... ‘sex offender’ gives you the impression that the tag will be with you for life

John

The main reason I denied was mostly thinking that no-one would ever wanna speak to me again

Graham

From Blagden et al, 2011
What do these brief extracts tell us about denial?

Does denial matter for treatment and risk assessment?
Redeemability in men with sexual convictions

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>23%</td>
<td>‘Most people who commit sexual offences against adults can go on to live law abiding lives’</td>
</tr>
<tr>
<td>16%</td>
<td>‘Most people who commit sexual offences against children can go on to live law abiding lives’</td>
</tr>
<tr>
<td>66%</td>
<td>Guessed that recidivism rates for child sex offenders were over 40%</td>
</tr>
</tbody>
</table>

(From Anne-Marie McAlindden, 2006; see also Brown, 1999; Katz, et al, 2008; Craun & Theriot, 2009)
• McGrath et al (2009) found that 91% of treatment programmes in the US included “offender responsibility” as a treatment target. Furthermore 33.4 % of adult programmes in the US required full disclosure.

• Non-criminogenic targets include: Denial and minimisations; excuse making; offence disclosure; offence accounts; victim empathy (Marshall, Marshall and Ware, 2009).

• Marshall, Marshall and Kingston (2011) found denial to be negatively related to items on three risk instruments (STATIC-99, VRS-SO, STABLE 2000) suggesting that denial may actually predict a lower chance of reoffending.

• There is little reason to assume that how an offender explains, interprets and perceives events in prison are consistent with his world view on the outside (Friestad, 2012).

• Treatment rarely finds an effect in prison (e.g. Losel & Schmucker, 2015).
Normalising denial

There is a tendency in forensic setting to construe denial as something that needs to be ‘broken down’ or ‘challenged’. It is often used as a marker of progress (Hayles, 2006). However...

Denial can be psychological soothing (Goleman, 1989).

Excuse making is a highly adaptive mechanism for coping with stress and maintaining SE (Snyder and Higgins, 1988).

Evolved to be good deceivers (Livingstone Smith, 2003).

“never take away anything [from the client] unless you have something better to offer. Beware of stripping a patient who can’t bear the chill of reality” (Yalom, 1991: 154).
Evolution and Denial

• Livingstone-Smith (2003) contends that one of the reasons humans have evolved to be the dominant species is due to our superiority in deception and being deceitful.

• Humans, like other social mammals, are biologically built end-to-end to belong (Walton, 2019).

• In real terms the effects of loneliness are comparable to major risk factors for early mortality like smoking or obesity (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015).
Intuition
The evidence-base and denial

• Intuitively the question ‘should sexual offenders be admitting their offences?’ is a no brainer...

• Intuitive beliefs i.e. those based on anecdotal evidence rather than empirical evidence, have been termed ‘correctional quackery’

• Where do they come from? Prevailing cultural, religious, moral imperatives?

• “Deniers are a higher risk”, “deniers are risky”

• Deniers are poorly motivated...
Confession as an organising principle of treatment: Why do we think it’s important?

Reductions in denial are seen as observable markers for progress.

A belief that “without congruence between the offender’s version of the events and those other recorded versions, treatment will be more difficult and most likely ineffective” (Theriot, 2006: 34).

Again reflections of moral/cultural/religious positions – it’s the right thing to do, it feels better having a sex offender admit.

Offence accounts – offenders disclosure may give a marker for future risk factors. But is this more a reflection of what we want/expect (i.e. confession?)
Is confession/disclosure necessary for treatment?

No clear evidence that confession is needed in order to bring about personal change or successful treatment.

Kelly (2000 a/b) contends that one cannot expect full honesty and openness from clients nor should we demand it.

Lacombe (2008) warns of the dangers in turning sexual offenders into “confession machines” which turns offenders into a species ‘consumed with sex’ (due to a preoccupation with their deviant thoughts/fantasies and their sexual behaviour).

Thus it relies on ‘passive responsibility’ (Ware and Mann, 2012) as offenders are always looking back at past thoughts, actions and behaviours.
• Are deniers different from admitters? How?

• Does this impact on approaches to assessment, formulation and intervention?

• Most therapists express strong views regarding the need to overcome denial irrespective of evidence. What is your view? Should we overcome denial in treatment?
Evidence
Relationships Between Denial, Risk, and Recidivism in Sexual Offenders

Leigh Harkins • Philip Howard • Georgia Barnett • Helen Wakeling • Cerys Miles

Received: 11 July 2012 / Revised: 21 September 2013 / Accepted: 28 February 2014 / Published online: 9 August 2014
© Springer Science+Business Media New York 2014

Abstract The aim of this study was to examine the relationship between denial, static risk, and sexual recidivism for offenders with different types of current sexual offense. Denial was defined as failure to accept responsibility for the current offense and was assessed using the Offender Assessment System. Static risk level (measured using a revised version of the Risk Matrix 2000) was examined as a moderator in the relationship between denial and sexual and violent recidivism. In the full sample (N = 6,891), lower levels of sexual recidivism were found for those who denied responsibility for their offense, independent of static risk in a Cox regression analysis. Higher levels of violent recidivism among those denying responsibility were not significant after controlling for static risk using Cox regression. For specific offender types, denial of responsibility was not significantly associated with sexual or violent recidivism. In conclusion, the presumption that denial represents increased risk, which is common in much of the decision making surrounding sex offenders, should be reconsidered. Instead, important decisions regarding sentencing, treatment, and release decisions should be based on empirically supported factors.

Introduction

A sexual offender who does not accept responsibility for his or her offense(s) will likely experience a number of negative repercussions. In particular, within the criminal justice system, denial is considered in making a variety of important decisions about the offender. Reduced sentences can be offered for those who offer guilty pleas (Committee on the Judiciary House of Representatives, 2010; Sentencing Guidelines Council, 2007), many treatment programs exclude individuals in denial (Blagden, Winder, Thorne, & Gregson, 2011; Levenson, 2011; Yates, 2009), and those in denial are less likely to be offered early release (Hood, Slute, Feilzer, & Wilcox, 2002).

For the most part, these decisions presume that denial increases risk of recidivism. However, the relationship between denial and sexual recidivism is not as straightforward as it has previously been considered. In the past, the prognosis was viewed quite negatively for those in denial, as denial was assumed to equate to a higher risk of reoffending (Barbaree, 1991; Hood et al., 2002; Levenson & MacGowan, 2004; Lund, 2000; Schlank & Shaw, 1996). However, more recent evidence sug-
Denial and recidivism
(1)

• Most research finds no overall effect for denial – denial does not seem to predict recidivism by itself.

• Meta-analysis found that denial not a predictor of sexual recidivism (Hanson and Morton-Bourgon, 2005; Mann et al, 2010 denial unsupported as risk factor).

• Neither denial nor minimisations are criminogenic. There is also no evidence that an increase in ‘accepting responsibility’ leads to a reduction in reoffending (Marshal et al, 2009; Ware and Mann, 2012). However...

• Nunes et al (2007) low risk (incest) deniers more likely to recidivate...denial did not add to the prediction of recidivism when the PCL-R and RRASOR were already considered.
Denial and recidivism (2)

Harkins, Beech and Goodwill (2010) High risk, high denial decreased recidivism, low risk, high denial increased.

Thorton and Harkins (2007) found the same

- Potentially a risk factor for some (incest offenders low risk high denial), seems to be protective for others.

- Greater denial associated with less self-reported identification as a “sexual offender” (Nunes et al, 2018)
What do cog skills programmes tell us and what does this mean for disclosure?

ETS in custody 2000-2005, for adult males. N = 21,373
If Cog skills did reduce sexual reoffending, what can we learn from this?

No need for an offence focus?  Teaching skills is the most important thing?

Better for an intervention to avoid implying a sex offender identity?
Empirically Supported Risk Factors

Central Eight
- Anti-Social Attitudes
- Anti-Social Associates
- Anti-Social Behaviour
- Anti-Social Personality
- Family/Intimate Relationships
- Employment
- Use of Leisure Time
- Substance Misuse

Empirically Supported RF for SO
- Sexual Preoccupation
- A-Typical Sexual Interest
- Offence Supportive Attitudes
- Grievance/Hostility
- Lack of Emotionally Intimate Relationships with Adults
- Lifestyle Impulsiveness
- Poor Problem Solving
- Negative Social Influences
Are deniers different?

• Although the evidence is mixed deniers have been found to minimise psychopathology, deny psychological problems (contested) and be more defensive (see e.g. Baldwin and Roys, 1998; Birgisson, 1996; Nugent and Kroner, 1996).

• Ware, Blagden & Harper (2019) explored the psychological and personality differences between categorical deniers and admitting sex offenders, and to examine whether these factors could discriminate between deniers and those who admit their offences.

• In terms of personality differences deniers scored significantly lower in relation to antisocial and sadistic personality traits.

• We found that being ‘in-denial’ was statistically associated with higher scores on measures of self-esteem, shame-proneness, and impression management.
• Ware, Blagden & Harper (2019) suggest that deniers are more likely to experience shame-proneness than admitters.

• Previous research on men who deny their offence has indicated that they feared the stigma and shame associated with being identified as a “sex offender” among other prisoners.

• However, this potentially points to the benefits of denial, particularly as they were found to be significantly less likely to be anti-social and sadistic.

• For example, resistance to being labelled a “sexual offender” is likely to have positive implications for the offender, in that adopting and internalizing such a label leaves the individual with an impaired ability to achieve self-respect and affiliation with mainstream society (Maruna et al., 2009).

• Links to “golem effect”
Making Sense of Denial in Sexual Offenders: A Qualitative Phenomenological and Repertory Grid Analysis
Narratives of denial - Summary

• The presentation of denial likely to be doing important identity work.

• Denial has clear relational properties and it could be that through rehearsing such roles (moral/decent character) and enacting them in social settings deniers come to ‘live’ up to them and believe them (Blagden et al, 2016). This may then be protective.

• Mann et al (2010) argue that denial may be protective when positive change can be identified elsewhere.
Discussion

• What do you think are the main problems with working with this client group (in terms of treatment and assessment)?

• How can such problems be overcome?

• What other markers could be used in assessing/understanding change or progression?
Implications for Practice
Should deniers be allowed onto regular treatment?

• New programmes less ‘consumed with sex’ (Lacombe, 2008)?

• There are no real coherent arguments for not letting deniers onto regular treatment...This is addressed in the new programmes.

• Indeed the causal direction of taking responsibility as a condition for personal change has been challenged (Maruna and Mann, 2006; McKendy, 2006; Maruna, 2004).

• Engaging in a therapeutic relationships likely to have a positive affect (Spinelli, 2007)
The challenges

• Poor engagement, motivation and resistance for treatment (Levenson and MacGowan, 2004).

• Disruptiveness, negative impact on group cohesion.

• Suspiciousness “being trick into confession”

• Denial of any problems – saint-like

• Denial as a responsivity issue
Therapeutic alliance and shame management

- The experience of shame is detrimental to self-reform and positive identity change, motivates and acts as a block in the self-change process – a focus on shame management is important.

- Blagden et al (2013) argued that a therapist’s reaction to shame may, in part, determine the level of defense mechanisms utilized by the client.

- For instance a therapist who recognizes that offending behavior is the result of the person looking to pursue the human need/desire for specific experiences (albeit in maladaptive ways), rather than being of ‘bad’ character, is likely to decrease shame responses in the form of denial and other defense mechanisms (Ward, Vess, Collie & Gannon, 2006).

- Thus a collaborative therapeutic alliance built on authentic approach goals is likely to breakdown resistance and facilitate a positive and predictive relationship (Ward et al., 2006).
Relationships matter...Again
Working constructively with deniers

• Invest in the therapeutic relationship, build trust, build rapport and genuine relationships.

• Engaging in a therapeutic relationships likely to have a positive affect (Spinelli, 2007)

• Moving beyond the “It wasn’t me...yes it was” transaction – This is likely to be very frustrating – moving beyond countertransference

• Construe denial as a responsivity factor and be mindful of what denial is ‘doing’ for the client.
Working constructively with deniers

• Use techniques e.g. motivational interviewing to understand the ambivalence the individual may be feeling and to understand their fears and consequences of disclosing.

• Move away from offence focused work, to more strengths-based, values driven work.

• Most meaningful risk factors do not require offence admittance.

• Denial does not need to be the endgame of sex offender treatment.
Compassion-Focused?

Although varied in their specific aims and models, common features of third wave compassion-based CBT include:

• Compassion for self and others
• Shame reduction
• Acceptance of thoughts and feelings
• Value based living
• Aim to help clients thrive and flourish

Still uses typical therapy tools: Socratic questions, behavioural experiments, exposure, imagery, reflection, evidence appraisal etc.
Round up

What do I take home?
How was our co-operation?
Short info. next workshop
Workshop 5
Sexual interest in children and sexual abuse
Workshop 5

• Check-in: Ready for today's workshop?

• Review: What was interesting yesterday?

• Topic and group-discussion: Workshop 1-8

• Round up: What do I take home?
  How was our co-operation?
  Short info. next workshop
## Risk-need factors of persistent sexual offenders

Hanson, R.K., & Morton-Bourgon, K (2005): The characteristics of persistent sexual offenders in: Journal of consulting and Clinical Psychology, 73

### Risk-need factor

<table>
<thead>
<tr>
<th>Deviant sexual preferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual preoccupation</td>
</tr>
<tr>
<td>Approximately 20-50 % of SOC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Antisocial orientation</th>
</tr>
</thead>
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<tr>
<td>lifestyle instability</td>
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</table>
Diagnosis of pedophilia

ICD-11:

*Sustained sexual thoughts, fantasies, urges, or behaviors involving pre-pubertal children. Individual has acted on the thoughts or be markedly distressed by them.*

*Diagnosis does not apply to sexual behavior among pre-or post pubertal children with peers close in age.*

DSM-5 and ICD-10:

*At least present for six months, for subjects aged 16+ and at least five years older than the child of interest.*

DSM-5:

*Differentiates "pedophilic interest" and "pedophilic disorder"*
## Effect of treatment for adult persons: low to moderate

*Madvig, F. et al, 2021: Treatment of sexual offenders*

<table>
<thead>
<tr>
<th>Significantly lower recidivism</th>
<th>Lower recidivism</th>
<th>No evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hanson et al; RNR-approach (CBT and social learning appr.)</td>
<td>Dennis et al 2012 (diff. appr.)</td>
<td>Furby et al 1989; the higher FU, the higher recidivism, treatment no effect</td>
</tr>
<tr>
<td>Harrison et al 2020; CBT</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Inussuk - motivational prison programs, Greenland

**Alloriqarneq: Antisocial pattern**

2 x 2 hours per week, 8 weeks  
Openended group  
Participant-instructor evaluation

**Illerngit: Deviant sexual interest**

2 x 2 hours per week, 8 weeks  
Openended group  
Participant-instructor evaluation  
Psychologist refers to further treatment (deviant sexual preferences)
Moduls motivational program Alloriarneq

Initial encounter
Ending encounter

Values and acts
Gruop rules
Attitudes

Stresscoping
Companions

Communikation
Thoughts and acts

Feelings and acts
Changing behaviour

Changing behaviour
Feelings and acts
Communikation
Stresscoping
Values and acts
Gruop rules
Attitudes

Initial encounter
Ending encounter
Ex: Modul Attitudes
Modul: Thoughts and Behavior

Aim: Understanding the link between thoughts and behavior and training prosocial behavior
Modul: Feelings and Behavior

Aim: Examine different feelings and how they influence behavior. Training self-regulation.
Ex: Motivational program Illerngit

Initial individual encounter
Ending encounter:
What do I take home?

Sexual rights
Consent

Gruoprules
Human needs
Needs and borders

Sexual development
Law
Consequences of sexual abuse
Ex: Modul Greenlandic law
Modul: Needs and Boundaries

Aim: How to fulfill needs without doing harm to others, understanding the importance of personal boundaries
Modul: Consequenses of sexual abuse

Aim: Understanding the harmful effects of sexual offenses on children, youth and adults
Modul: Boundaries and Sexual Concent

Aim: Understanding the implications of sexual concentration and respect for others boundaries
Why is this important?

Assessing Risk for Sexual Recidivism: Some Proposals on the Nature of Psychologically Meaningful Risk Factors

Ruth E. Mann¹, R. Karl Hanson², and David Thornton³
Why is this important?

Deviant sexual interest in children strongly predicts sexual offence recidivism (Mann et al, 2010).

Increasingly large body of research consistently finds that deviant sexual interest/preference is a risk factor for sexual recidivism (see e.g., Hanson and Morton-Bourgon, 2005; Mann, Hanson and Thornton, 2010; Schmidt et al, 2013).

Child molesters’ offence supportive beliefs have been found to be predictive of recidivism (Helmus et al, 2013).

Sexual preoccupation/hyper sexuality a risk factor within DSI.
The prevalence of deviant sexual interest in non-criminal (or rather non-convicted) heterosexual men in the community is estimated to be approximately 5% (Seto, 2009; Dombert et al., 2015).

A recent study of sexual interest in children in non-clinical/non-forensic populations using a nationally representative sample found that 4.1% reported sexual fantasies involving prepubescent children with 5.5% reporting paedophilic interest.

Ogas and Goddam (2012) found that the word “preteen” was the third most frequent search term in men’s online sex searches.
Whether or not sexual preference for children is dimensional or taxonomic remains contested (see e.g., Mackaronis, Strassberg and Marcus, 2011).

Horley (2008) argues for a dimensional view of deviant sexuality rather than to construe it as comprising of discrete or ‘hardened’ categories. He argues that this best captures and reflects a more fluid view of sexuality.

Schmidt, Mokros and Banse (2013) found consistent support for a taxonomic interpretation of paedophilic sexual preference.

Beier (2012) also offers supports for this interpretation and suggests that sexual preference is the result of fate, not choice.
Seto (2012) suggests that paedophilia is viewed by many as having a lifelong course.

Although changes in sexual arousal to children can be made using behavioural conditioning techniques, follow up studies have not shown that these changes are maintained over the longer term or outside of the laboratory (Seto, 2012).

Wilson and Cox (1983) found that participants believed their paedophilic sexual interest was deep rooted and not able to change.

Weighing up the evidence, Camilleri and Quinsey (2008) described the outcome of treatment programmes for paedophiles as “dismal” (p. 203).
## Explaining Child Sexual Offending: Three Frameworks

### Neurodevelopmental Explanations
- Early trauma/injury (Seto, 2008)
- Neurostructural differences (Cantor et al, 2006)

### Conditioning Explanations
- Pairing of stimuli with arousal (Laws & Marshall, 1990) – Does not explain sexual offending by individuals who do not have a sexual preference for children.

### Psychological-Developmental Explanations
- Attachment deficits increase risk (Marshall & Marshall 2000)
Intensity of sexuality (degree of sexual interest/drive and the extent to which sexual urges are perceived as over-whelming)

Sexual self-regulation (Ability to manage sexual thoughts, feelings and behavior in a manner which is consistent with self-interest and which protects the rights of others)

Atypical sexual interest (Preference of deviant over non-deviant sexual behavior e.g. Children or violence)

Sexual Offending (Hanson, 2010)
Deviant Sexual Interest (Paedophilia)

Tracking the biological and developmental causes of deviant sexual interest

Are there meaningful differences between paedophiles and non-paedophiles?
Deviant Sexual Interest (Paedophilia)

Tracking the biological and developmental causes of deviant sexual interest

If there is something wrong with the brain, where in the brain is it?

Middle Frontal Gyrus
Controls inhibition and motor planning

Insula and Opercula
Responsible for sensory integration

Superior/Inferior Parietal Lobules
Controls [thinking about] movement

Occipital Cortex
Responsible for visual processing
Deviant Sexual Interest (Paedophilia)

These four brain structures (grey matter) are all connected by just one neural network in white matter.

Superior Occipitofrontal Fasciculus
Need compassion for a very tricky brain

Tricky Brains
Discussion

Can change be promoted without being confronted with the sexual offense?

Does a strength-based assessment- and treatment approach support motivation to change and desistance from further sexual offenses?

If a sexual interest in children can’t be changed – what should we focus on?
Workshop 6
Case studies and working with sexual interest in children
Workshop 7

- Check-in: Ready for today's workshop?
- Review: What was interesting yesterday?
- Topic and group-discussion: Workshop 1-8
- Round up: What do I take home?
  How was our co-operation?
  Short info. next workshop
Child sexual offending not synonymous with pedophilia

*Not all are characterised by pedophilic interest or preference*

*Not all with a pedophilia diagnosis commit offenses*

- Reports from 10-50% of convicted are diagnosed with pedophilia
- Tend to be "specialists"
- Higher rate of history with sexual offences
- Diagnosis of pedophilic disorder is a risk factor
## Heterogeneous group - 3 typologies

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>SO Children</th>
<th>SO Adults</th>
<th>SO Mixed age</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of sexual, non-sexual and violent offences</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Antisocial lifestyle, personality disorder</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Impulsive behavior and aggressiveness</td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Young age of onset</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Stranger victims</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Male victims</td>
<td>x, some with paraphilia</td>
<td></td>
<td>x and female</td>
</tr>
<tr>
<td>Substance abuse</td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Social functioning</td>
<td>Low selfesteem, avoidant, Sexual abuse</td>
<td>Physical abuse</td>
<td>x</td>
</tr>
<tr>
<td>Traumatic childhood exp.</td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
Case example – sexual interest in children

- John, 50 years
- **Criminal history**: Convicted for downloading child sexual abuse imagery. No former convictions.
- **Education/employment**: Carpenter, unemployed last three years after being fired
- **Family/marital**: Single, no former relationship or sexual experience
- **Companions**: Few friends and acquaintances and friends
- **Alcohol/drug abuse**: Periods of drinking
- **Characteristics**: Loneliness and intimacy anxiety, diagnosis of pedophilia
- **Treatment**: Before conviction John had attended outpatient group treatment for 3 years, but dropped out as he still had an urge to use child sexual imagery several times weekly. John expressed a wish to initiate a relationship to a woman, but did not take action.
Discussion

• What are John’s risk-need factors?
• What needs should be addressed to reduce John’s likelihood of further sexual offensive behaviour?
• How do you engage John in his change-process?
Development in role of prison service DK

- Preventing further offending by removal from society - imprisonment
- 1929 surgical castration (more than 1000)
- 1973 antihormone therapy/psychotherapy (with indeterminate sentences)
- 1997 New treatment order:
  - Psychiatric/sexological treatment as alternative to imprisonment (suspended sentence)
  - Psychiatric/sexological treatment treatment as supplement to imprisonment (unsuspended sentence)
- Motivational programs (preparatory to treatment)
- Continuous learning processes from prison to probation
<table>
<thead>
<tr>
<th>Purpose</th>
<th>What needs must be addressed - at what level - by whom?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factors</td>
<td>Static (1) and dynamic (7)</td>
</tr>
<tr>
<td>What stage in legal process</td>
<td>After conviction</td>
</tr>
<tr>
<td>Competencies</td>
<td>Educational background as social worker or psychologist</td>
</tr>
<tr>
<td>On-going training</td>
<td>4 days course, monthly traininggroups</td>
</tr>
</tbody>
</table>
| Comprehensive assessment       | LS/RNR
Psychiatric assessment
STATIC 99
SVR 20                                                      |
Round up

What do I take home?
How was our co-operation?
Short info. next workshop
Round up

What do I take home?
How was our co-operation?
Short info. next workshop
Workshop 7
Case studies and working with denial
Workshop 7

• Check-in: Ready for today’s workshop?

• Review: What was interesting yesterday?

• Topic and group-discussion: Workshop 1-8

• Round up: What do I take home?
  How was our co-operation?
  Short info. next workshop
Risk does not exist “out there”, independent of our minds and culture, waiting to be measured. Human beings have invented the concept of “risk” to help them understand and cope with the dangers and uncertainties of life. Although these dangers are real, there is no such thing as “real risk” or “objective risk”
Cognitive bias based on the frequency and fluency a category can be retrieved from memory.

If it is with ease then the category will be considered large

The heuristic is based on “the ease at which instances come to mind”

Think about this in terms of plane crashes, political sex scandals, child sexual abuse

So why is this important for risk assessment
YES, RISK TAKING IS INHERENTLY FAILURE PRONE. OTHERWISE, IT WOULD BE CALLED SURE THING TAKING.

JIM MCMAHON

PICTUREQUOTES.COM
Estimated Sexual Recidivism (By Risk Group)

Average rate of recidivism

Static-99R Scores
Remember after 9 year follow-up only about 6% reoffend (12% extrafamilial)
Empirically Supported Risk Factors

Central Eight

- Anti-Social Attitudes
- Anti-Social Associates
- Anti-Social Behaviour
- Anti-Social Personality
- Family/Intimate Relationships
- Employment
- Use of Leisure Time
- Substance Misuse

Empirically Supported RF for SO

- Sexual Preoccupation
- A-Typical Sexual Interest
- Offence Supportive Attitudes
- Grievance/Hostility
- Lack of Emotionally Intimate Relationships with Adults
- Lifestyle Impulsiveness
- Poor Problem Solving
- Negative Social Influences
Protective Factors

- Positive Self-Identity and Sense of Personal Agency
- Constructive Social Support Network
- Emotional Support and Capacity for Emotional Intimacy
- Good Problem Solving
- Constructive Leisure Time
- Closeness to Others
- Stable Relationships (Happy Marriage)
- Sobriety
- Being Believed In
- Hope and Optimism
Getting the Treatment Targets right
GLM Human Needs – ‘Goods’

- Healthy Living
- Knowledge
- Excellence in work and play
- Excellence in agency (self-management)
- Inner Peace
- Relatedness (relating to others)
- Spirituality
- Happiness
- Creativity
Function of denial

Maintain a viable identity and coherent sense of self (Blagden et al, 2011).

Maintain family and social networks (Stevenson, Castillo & Sefarbi, 1990; Winn, 1996).


Face saving manoeuvre and allows self to be presented in a positive light.

Low level of awareness i.e. cognitive deconstruction (Ward, Hudson and Marshall, 1995).

Adaptational defence mechanism to perceived adversarial settings (Rogers and Dickey, 1991).

Minimise and protect self from shame (Tangney and Dearing, 2002).

Transitory? Adaptive?
Positive/protective?
I didn’t eat the ice cream daddy
Narratives of deniers (Blagden et al, 2014)

Deniers distanced themselves from sex offenders and the label ‘sex offender’.

Desire to put across good and moral selves – stable and consistent selves.

Identity management and negotiating desirable and moral identities seemed key for deniers - relational properties.

Presser (2004) has argued that stability narratives present the individual as a good person and someone of steady moral character, which can facilitate the enacting of these roles.
Relational approach to denial

‘Denial’ and ‘identity transformation’ are shaped by and through social interactions.

Whether a deniers offence account is true or false is largely irrelevant, we are always dealing with an illusion of introspective awareness from participants/clients in this setting (or any setting).

Resistance to being labelled a ‘sexual offender’ is likely to have positive implications for the offender – golem effect - internalising such a label leaves the individual with an impaired ability to achieve self-respect and achieve affiliation with mainstream society (Maruna et al, 2009).
Narrative Psychology

Three levels or domains of personality:

a) dispositional traits ("having")
b) personal goals/strivings ("doing"), and
c) identity narratives ("making").

McAdams (1985) people tend to live up to the stories they tell about themselves.
Development and validation of the Good Lives Questionnaire

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Case example - Denial

- Chris, 35 years
- Criminal history: Suspended sentence for theft and possession of illegal arms
- Alcohol/drug abuse: last 15 years heavy drinking
- Chris explains his former girlfriend seldom wanted sex. They had been drinking and Chris felt like having sex. As his girlfriend rejected him, he touched her and masturbated. The day after the girlfriend reported to the police, that Chris had raped her. Chris denies and explains his former girlfriend is overly nervous and has mental problems.
- Employment/education: Dropped out of elementary school, short employment at car mechanic
- Companions: Bar-friends and football-friends
- Spare time: football now and then
- Family/Merital: Single, no contact to parents, has good relationship to two elder brothers who are in work and have families
Discussion

• What are Chris’ risk-need factors?
• What needs should be addressed to reduce Chris’ likelihood of further sexual offensive behaviour?
• How do you engage Chris in his change-process?
Round up

What do I take home?
How was our co-operation?
Short info. next workshop
Workshop 8: Rethinking ethical dilemmas and moving forward: Feedback and reflections
Workshop 8

• Check-in: Ready for today's workshop?

• Review: What was interesting yesterday?

• Topic and group-discussion: Workshop 1-8

• Round up: What do I take home?
  How was our co-operation?
  Short info. next workshop
Ethical balance of harms and benefits - discussion

Have we met the rehabilitation ideal?

”Considerations of the individual and society, the helper is both an agent of the offender and of the society”
Reflection

• What do I take home from this workshop?
• Are my expectations met?
• Reflections and questions
References – Marianne

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References/recommended Reading


